OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of** Thomas Dion WAITE Mieng HUYNH James Henry JACOBS James Michael GEAR
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	Various
DELIVERED ON:	17 March 2008
DELIVERED AT:	Brisbane
HEARING DATE(s):	7 September 2006, 16-19 October 2006, 23-26 October 2006, 30-31 October 2006, 6-8 November 2006 & 14-16 May 2007
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, police shooting, mental health assessments, involuntary treatment criteria, post prison release mental health, prescription drug screening, dissemination of information to mental health information to police officers, critical incident command training.

REPRESENTATION:

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WAITE Inquest

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Queensland Health – Logan-Beaudesert Health Service District:	Ms Stephanie Gallagher (instructed by Corrs Chambers WestGarth)
Senior Constable Steven Quill & Constable Jacinta Pannowitz:	Mr Paul Smith (instructed by Gilshenan & Luton Lawyers)
Nurse Kathleen Kerwin & Nurse Chris Leary:	Mr Gavin Rebetzke (Roberts & Kane Solicitors)

HUNYH Inquest

Family of Mr Huynh:	Mr Sam Nguyen, Barrister-at-Law
Constable Jamie Hyland & Constable Ian Goeths:	Mr Adrian Braithwaite (Gilshenan & Luton Lawyers)
Queensland Health – Princess Alexandra Health Service District:	Mr Andrew Ross (Crown Law)

JACOBS Inquest

Family of Mr Jacobs:	Mr Chris Nyst (Nyst Lawyers)
Constable Jeverne Booker & Constable Gregory Nunn:	Mr Adrian Braithwaite (Gilshenan & Luton Lawyers)
Queensland Health – Gold Coast Health Service District:	Ms Lisa Evans (Crown Law)
Department of Corrective Services:	Mr Jarrod Cowley-Grimmond, Barrister-at-Law
GEO Group Aust. Pty. Ltd.	Mr Craig Harding (instructed by Blake Dawson Waldron
Dr Judith Kelly:	Mr Harry McCay (United medical Protection)

GEAR Inquest

Family of Mr Gear:	Mr Stephen Grosser (instructed by M. A. Kent & Associates)
Queensland Health – West Moreton Health Service District:	Mr Kevin Parrott (Crown Law)
Constbale Andrew Dixon, Constable Warren Campbell, Constable David Olsen, Constable Jeffrey Reis, Senior Constable John Russell, Constable Ian Stephens & Constable Lyane O'Toole:	Mr Steve Zillman (instructed by Gilshenan & Luton Lawyers)

All Inquests

Commissioner of Queensland Police Service:	Mr Jeffrey Rolls (instructed by QPS Solicitors)
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Director of Mental Health	

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ABBREVIATIONS

The following is a list of abbreviations used throughout the report:

ACT	Acute Care Team
AGCC	Arthur Gorrie Correctional Centre
AMHP	Authorised Mental Health Practitioner
ATODS	Alcohol, Tobacco and Other Drugs Service
CAAT	Crisis Assessment and Treatment Team
CIB	Criminal Investigations Branch
CMC	Crime and Misconduct Commission
CMHS	Community Mental Health Service
CMHU	Community Mental Health Unit
CPR	Cardio Pulmonary Resuscitation
CYMHS	Child and Youth Mental Health Service
DPP	Director of Public Prosecutions
ESC	Ethical Standards Command
GPAPP	General Practice and Psychiatry Partnership Program
IMS	Information Management System
ITO	Involuntary Treatment Order
JEO	Justice Examination Order
MCMH&W	Multicultural Centre for Mental Health and Well-being
MHIP	Mental Health Intervention Project
MHS	Mental Health Service
MOU	Memorandum of Understanding

OC	Oleoresin Capsicum
OPM	Operations Procedures Manual
QAS	Queensland Ambulance Service
PAH	Princess Alexandra Hospital
QHealth	Queensland Health
QPS	Queensland Police Service
TSS	The Southport School
VB	Victoria Bitter
WMMHS	West Moreton Integrated Mental Health Service

Preface

In 2006 and 2007, an inquest was held into the deaths of Thomas Dion Waite, James Henry Jacobs, Mieng Huynh and James Michael Gear; all of whom were shot and killed by police officers while suffering psychotic episodes. These are the findings of that inquest. They are divided into eight parts. Part 1 contains an introduction and sets out the extent of a coroner's jurisdiction in relation to such matters. It also makes observations and about the investigation of deaths in custody and draws attention to some shortcomings in the investigation of these matters. That part also describes the inquest proceedings. Parts 2, 3, 4 and 5 contain a summary of the evidence in relation to each of the deaths and my findings in relation to the particulars of each death. Those parts also contain a critique of the mental health care provided to each man and the appropriateness of the police response to the emergent situation. Part 6 gathers together the issues relating to mental health care and makes recommendations aimed at addressing the shortcomings identified in these cases. Part 7 does the same in relation to the interaction between police officers and those suffering from mental illness. Part 8 contains a summary of the findings in relation to the actions of the police and the mental health workers.

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Introduction

Between October 2003 and February 2006, officers of the Queensland Police Service (QPS) acting in the course of their duty, shot and killed four young men in separate incidents in South East Queensland. Each of them was a long term sufferer of mental illness and was experiencing serious symptoms of that illness at the time they were killed. Their mental illness caused them to come into contact with the police and directly led to the death of each of these young men.

Police officers have the onerous responsibility of protecting the community. In order to do this it is necessary that they have resort to firearms as it is unavoidable that, at times, they will need to use deadly force to defend themselves or others. As can be readily appreciated, the use of firearms by police officers must be strictly controlled and scrutinised; particularly when it results in a death. Citizens cede autonomy to the State for the mutual benefit of all members of society. The deliberate killing of a citizen in his home or on the street by an officer of the State is the most extreme exercise of executive power. The denouement of the life of the deceased is traumatic for his family and the police officers involved. Family members are entitled to a thorough and impartial examination of the circumstances of the death to determine whether what would normally be a serious crime was justified. The community needs to be satisfied that the use of deadly force was necessary if it is to maintain its trust and confidence the police service. If the death was avoidable, the public is entitled to expect that those responsible will be held accountable and that changes will be made to reduce the likelihood of similar deaths occurring in future.

It is also in the interests of the officers involved that these maters be scrupulously and independently investigated and publicly reported on so that there can be no suggestion of a "cover up."

The *Coroners Act 2003* recognises and responds to this need for public scrutiny and accountability by requiring all deaths in custody[1] to be investigated by the State Coroner or the Deputy State Coroner and by mandating that an inquest be held into all such deaths.[2]

The contribution of mental illness to the four deaths referred to in these findings makes them more distressing for the families of the deceased, the police officers involved and the community. The dead men were not engaged in some intentionally unlawful or culpable activity; they were, because of their illness, incapable of understanding their circumstances and responding in a way that would have enabled the incidents to be resolved without harm to

[1] Section 10 defines "death in custody" to include a death which occurs when the dead person is trying to avoid being taken into custody. The death of Mr Waite was dealt with under the Coroners Act 1958 which requires violent or unnatural deaths to be reported to a coroner and requires a coroner to convene an inquest when the circumstances of the death require it – see s7B

[2] See s11(7) and s27(1)(a) respectively.

anyone. Each had been diagnosed with mental illness for many years and was receiving some treatment in the months before his death. This raises the question of whether the treatment and/or the legislative regime under which they were managed were adequate.

I readily acknowledge the anguish these incidents cause for the police officers involved. In each case the officers were at some stage in great risk of harm or even death. I unreservedly accept the accuracy of the observation tearfully made by Constable Jacinta Pannowitz when giving evidence in relation to the death of Dion Waite. She said, "*Nobody wants to shoot somebody; that decision isn't made until the threat is upon you or one of your colleagues."*

In these findings I am critical of some actions of some of the police officers involved in these incidents. That does not mean that I do not recognise the vital contribution the officers of the Queensland Police Service make to the safety of the community. Rather, it reflects my aspiration to enhance that role by constructively highlighting any shortcomings.

Similarly, I am sure the death of a patient causes distress and anxiety for mental health workers. In none of these cases was there any evidence of deliberate neglect or professional misconduct. Although some of my findings are critical of the case management and decision making of the mental health workers involved in the care of the dead men, I readily acknowledge that many thousands of people receive excellent care that enables them to cope with mental illness that would be impossible without the expert assistance of these dedicated professionals.

All of these incidents should be avoided. All of them are tragic. By their nature inquests focus on those cases in which systems fail the individuals. So, it is important to remember that they represent a minute proportion of the interactions between police and the mentally ill; just as it is necessary to keep in mind that most mental health patients hugely benefit from their contact with Queensland Health.

Jurisdiction

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die. [3]

Each of these shooting deaths was reportable because each was violent and unnatural. Further the deaths of Messrs Jacobs, Huynh and Gear were deaths

[3] s45 *Coroners Act 2003*, s24 *Coroners Act 1958*

in custody within the terms of the *Coroners Act 2003* because the men died while attempting to avoid being taken into custody.[4]

As required by the relevant legislation, I have made findings in relation to the particulars of each death. I can not even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made. I have therefore set out in some detail a social and medical history of each of the men and described the circumstances of their deaths.

Importantly, under the *Coroners Act 2003* a coroner may also comment on anything connected with a death investigated at an inquest that relates to public health or safety, the administration of justice or ways to prevent deaths from happening similar circumstances in the future.[5] This greater emphasis on prevention is the most significant reform introduced by the new Act. It places a positive obligation on coroners to seek to identify systematic, underlying, contributory causes to a death with a view to formulating changes to practice or policy that may limit the risk of future deaths and contribute to a fairer and/or safer society.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [6]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[7] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[8]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because section 37 of the Act provides that the court "*may inform itself in any way it considers appropriate.*" That doesn't mean that any and every piece of

[4] See s10(1)(c)

[5] s46 *Coroners Act 2003, s24 Coroners Act 1958* was more limited in scope simply providing that riders could be made aimed at preventing deaths occurring in similar circumstances. None of those granted leave to appear submitted this should limit the scope of any comments *I made in the Waite case*

[6] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

[7] s46

[8] s45(5) and 46(3)

information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[9]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[10] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the fact finder to be sufficiently satisfied that it has been proven to the civil standard.[11]

It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[12] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[13] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation. This was done by circulating the submissions made by counsel assisting and inviting those granted leave to appear to respond to them.

Investigation of deaths in custody generally

In the final report of the Royal Commission into Aboriginal Deaths in Custody, Commissioner Johnston referred to the understandable anguish, anger and suspicion felt by the relatives of a person who dies in custody. He wrote that these concerns "*demand an assurance that the circumstances of the death will be thoroughly and fairly investigated."*[14]

Commission Johnston went on to observe that it was not only the family of the deceased who are concerned about a death in custody.

> *A death in custody is a public matter. Police and prison officers perform their duties on behalf of the community. They must be accountable for the proper performance of their duties. Justice requires that both the individual interests of the deceased's family and the general interest of the community be served by the conduct of thorough, competent and impartial investigations into all deaths in custody.*[15]

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[9] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[10] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[11] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[12] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[13] (1990) 65 ALJR 167 at 168
[14] Royal Commission into Aboriginal Deaths in Custody, National Report Vol 1, 109
[15] *ibid*

The report recommended that such investigations only be conducted by qualified and experienced detectives selected from an internal investigations section or from a police command area other than the one in which the officers involved in the death are posted. It suggests that police standing orders direct that all death in custody investigations "*should be approached on the basis that the death may be a homicide.*" [16]

The QPS has implemented these recommendations by requiring all such incidents to be investigated by the local regional crime co-ordinator or an independent senior investigator with sufficient criminal investigation experience to carry out the investigation. The Operations Procedures Manual (OPM) instructs that a detective other than from where the incident occurred or where the officers directly involved in the incident are stationed should be appointed to investigate.[17]

The investigation of these deaths in custody

The requirements of the QPS OPM were followed in each of the cases referred to in these findings. In three matters, detectives from the Homicide Investigation Group undertook the investigation. In the fourth, the death of Mr Gear, an experienced detective from the Ethical Standards Command was the lead investigator.

In none of the cases did I detect any bias or lack of diligence on the part of the investigators. There were instances of poor scene control which I shall detail later. I suspect that, with one exception, those mistakes may have been made even if police officers had not been involved in the death. There were also signs, on occasions, that the investigators allowed their natural sympathy for the officers involved to affect them. All of the officers directly involved in the shooting were young and relatively inexperienced. When they were interviewed very soon after the shootings, they were all obviously distressed by what they had just witnessed. The OPM instructs that human services officers be deployed where necessary to assist with the subject officers' psychological welfare. This happened in these cases. It is not part of the investigators' role to attend to these issues. While their sympathy for their junior colleagues is understandable, they must remain conscious of the appearance of partiality that solicitous comments can generate. [18]

In my experience, all police officers recognise that when an officer fatally shoots someone, a through investigation must ensue. In some respects police officers have fewer rights in these situations than do members of the public: they are for example compelled to answer questions and are routinely directed to participate in re-enactments of the events.[19] Conversely, there is

[16] *Ibid*, 179
[17] OPM para 1.17
[18] I readily acknowledge that investigators may make similar comments when investigating civilian shootings but that is not to the point; in those cases there is little likelihood of their impartiality being questioned.
[19] Officers are required by the *Police Service Administration Act 1990* to comply with a direction given by a superior officer to answer questions about any work related incident.

an eagerness to accept that the officer “was only doing his/her job” that can cause investigators to be less rigorous than would be the case if the fatal shot was fired by a civilian.[20] This needs to be guarded against.

Instances of poor scene control

As I mentioned earlier there were instances of poor scene control that had the potential to undermine the effectiveness of the investigation. I don’t believe that occurred in these cases but it is sloppy practice that needs to be avoided. Examples are:-

- During the stand off that preceded the shooting of Mr Waite, a police car was parked near the drive way of a neighbour’s house very near where he was subsequently shot. That car was moved and another was parked in the vicinity by scenes of crime officers who participated in the investigation. That vehicle was then photographed as if it was part of the crime scene.

- The officer who shot Mr Jacobs and his partner were directed to drive themselves from the scene back to the local police station in the vehicle they arrived in. Not only did this create an opportunity for collusion or the accidental distortion of their memories of the incident, it removed a significant item from the crime scene. The position of the car at the scene was not marked. A car that was driven to the scene by one of the crews who responded to the emergency was subsequently included in the crimes scene photographs and the scale plan of the scene as if it were present when the shooting occurred, while the position occurred by a significant witness was not.

- A knife thought to have been brandished by Mr Gear was noticed on the floor of the room in which he was shot by one of the first officers to enter the house after the shooting. That officer picked it up and placed it in the boot of his car. It was not photographed *in situ* nor was its position marked.

Death in custody MOU

In 2006 the Office of the State Coroner, the Crime and Misconduct Commission and the Queensland Police Service entered into a memorandum of understanding to record how each agency would discharge its responsibilities that arise in connection with a death in custody. Following criticism of the QPS investigation of the death in custody of Mulrunji by the Deputy State Coroner in her findings in the inquest into that death, the three agencies are reviewing that MOU.

Their answers can not however be used against them in criminal proceedings should any eventuate.

[20] For example, although the shooters are routinely asked what happened right up until the shooting occurred; they are frequently not asked why they shot or are only required to respond to a leading question along the lines of “*and so you thought you had no other option other than to shoot?”*

The focus of the review is on balancing the need for impartiality with the desirability of ensuring the most expert investigators undertake the inquiry. The CMC would be seen as being more impartial than units within the QPS; however its investigators, generally, do not have current expertise in homicide investigations. This limitation until recently also applied to the Ethical Standards Command (ESC) of the QPS but with recent transfers to that command this limitation has been overcome. Of course deaths in custody can occur anywhere in the state and the ESC is based in Brisbane. It will still therefore be necessary for local officers to undertaken the all important scene preservation and initial exhibit control. The MOU will therefore seek to ensure that these issues are managed at a sufficiently high level within the local command to give confidence that they will be attended to appropriately.

The inquest

A pre-inquest conference was convened on 7 September 2006. Mr Alan MacSporran SC and Ms Jenny Rosengren were appointed counsel assisting. They outlined the issues they submitted should be examined during the inquest and the witnesses that should be called. The similarity of the circumstances under which these four men died made it appropriate that the inquests into their deaths be held concurrently so that the issues that were raised and the proposals to address any deficiencies could be considered in the context of the various, different scenarios that led to the deaths.[21]

Leave to appear was granted to the following people in relation to the death of Mr Waite:-

- Mrs Marino, the mother of deceased (subsequently withdrew)
- Queensland Health – Logan-Beaudesert Health Service District
- Police officers Quill and Pannawitz
- Nurses Kerwin and Leary

Leave to appear was granted to the following people in relation to the death of Mr Huynh:-

- The family of Mr Huynh (subsequently withdrew)
- Police officer's Hyland and Goeths
- Queensland Health – Princess Alexandra Health Service District

Leave to appear was granted to the following people in relation to the death of Mr Jacobs:-

- Mrs Kealton, the mother of the deceased
- Police officers Nunn & Booker

[21] Section 33 *Coroners Act 2003* authorises the holding of an inquest into a number of deaths that happened at different times and places but which appear to have happened in similar circumstances. The death of Mr Waite occurred before the *Coroners Act 2003* came into operation but the repealed Act allowed a coroner to "admit any evidence the coroner thinks fit." See s34 *Coroners Act 1958.* Therefore, for the purpose of making riders in that case, I was authorised to have regard to the evidence tendered in the other three cases.

- Queensland Health – Gold Coast Health Service District
- The Department of Corrective Services
- Dr Judith Kelly
- GEO Group Australia

Leave to appear was granted to the following people in relation to the death of Mr Gear:-

- Mr Gear's family
- Queensland Health – West Moreton Health Service District
- Police officers Dixon, Campbell, Olsen, Reis, Russell, Stephens and O'Toole

Leave to appear in relation to all matters was granted to:-

- The Commissioner of the Queensland Police Service; and
- The Public Advocate
- The Director of Mental Health

The inquest proper commenced on 16 October 2006 and proceeded over the following four weeks when evidence was heard in relation to the mental health treatment of each of the four men and the circumstances of their deaths.

The inquest was then adjourned until 14 May 2007 when evidence was heard from senior police officers and mental health practitioners in relation to training and generic policy and procedural issues. Mr Geoffrey Cheverton, the CEO of Queensland Alliance, the peak body of NGOs involved in mental health issues, also gave evidence and the organisation made a very helpful written submission.

In total 16 days of evidence was heard, 79 witnesses gave evidence and 753 exhibits were tendered.

In order to provide procedural fairness to all parties, at the close of evidence the matter was adjourned to allow for the making of written submissions. The last of these was not received until December 2007, substantially delaying the finalisation of these matters. Nevertheless, I was greatly assisted by those submissions and I thank the lawyers for them. In particular, the submission of the Public Advocate were helpful as the independent expertise of that office enabled me to resolve some of the conflicts in the submissions made by the parties who had more vested interests.

I also wish to acknowledge the great assistance given to me by both of the counsel assisting and the staff of the Office of the State Coroner. In particular, Mr Grice, the case co-ordinator who expertly managed the exhibits and the schedule of witnesses and Ms Jo Dickson who liaised with the families of the deceased and managed the preparation of the briefs of evidence.

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Introduction

On 24 October 2003, Thomas Dion Waite was shot and killed by a police officer outside his home in Regents Park, a suburb of Logan City. At the time of his death he was 30 years old. He had suffered from mental illness for more than 10 years, although for much of that time it was sufficiently well controlled to enable him to lead a relatively normal life. In the months before his death however, Mr Waite was exhibiting severe symptoms that had caused him to come to the attention of police and into contact with local mental health services. Immediately prior to his death, Mr Waite was engaging in violent and bizarre behaviour. He was shot by a police officer when he lunged at the officer with a knife.

These findings detail the circumstances of the death and consider whether any changes to police procedures or the practices of relevant mental health professionals could prevent deaths occurring in similar circumstances in the future. They also determine whether the officer who shot Mr Waite should be committed for trial in connection with the death.

The investigation

Immediately after the shooting, officers at the scene used the police radio system to request ambulance attendance.

Detective Senior Sergeant Watts, the Officer in Charge of the Logan District Criminal Investigation Branch, quickly arrived on the scene and took initial charge of the investigation. He ensured the crime scene was cordoned off and requested the attendance of investigators and specialist support officers. He co-ordinated the crime scene examination and tasked investigators. A log of events was maintained which recorded all officers entering and exiting the scene.

Scenes of crime and scientific officers attended and conducted forensic investigations including photographing and video-taping the scene and the various exhibits. Items of interest were seized and secured for evidentiary purposes. The handgun used in the shooting and a spent cartridge found on the footpath were seized and later forensically examined.

Unfortunately, scene control was not exemplary in that a motor vehicle used by one of the officers responding to the incident before the shooting was moved before the scene was photographed. A scenes of crime officer's car was parked in the vicinity. During the inquest this caused some confusion. Witnesses accurately remembered the position of the original vehicle but were misled by photographs showing the scenes of crime car. I don't believe that

this mistake had any material impact on my findings but it is obviously undesirable for this type of laxity to occur.

Detectives from the Homicide Investigation Unit attended the scene. Detective Senior Sergeant Drinnen of that Unit was appointed as the primary investigator of the incident and took control of the investigation.

Inspectors from the Ethical Standards Command and detectives from the Crime and Misconduct Commission also attended the scene. These officers had been assigned to undertake their respective organisation's overviewing role.

Investigators undertook a "door knock" of the area to locate possible witnesses. Potential witnesses were identified and statements taken.

In order to better manage the investigation of this incident, Detective Senior Sergeant Swan of the Logan District CIB set up a Major Incident Room at the Logan Police Station. This enhanced the co-ordination of the many tasks to be undertaken by the investigators and specialist officers, as well as ensuring the collation of information and the results of inquiries.

Senior Constable Quill, the officer who shot Mr Waite, was interviewed later that afternoon and performed a "walk through" of the events which was video-recorded.

A Beenleigh Accident Investigation Squad member attended and conducted a survey and prepared scale plans of the scene.

I am satisfied that the investigation was thorough, professional and independent. I commend Inspector Drinnen (as he now is) on the quality of his work.

The evidence

Family History

Mr Waite was born in Rotorua, New Zealand on 3 April 1973 making him 30 years of age at the time of his death. His family called him Dion. He was one of four children and had a good relationship with his siblings.

His parents separated early in his childhood. In 1977 Dion's mother Gaye formed a relationship with Warren Marino. They married in 1984.

The family lived in New Zealand until 1997/1998 when they migrated permanently to Australia. Mr and Mrs Marino moved to Brisbane and Dion initially moved to Sydney with his brother, Corbyn. After about two weeks Corbyn phoned his mother to inform her that he was sending Dion to Brisbane because he could no longer live with him. Dion then lived with his mother and step-father in Brisbane until the time of his death.

Dion left school in New Zealand at age 15 after having completed second year of high school. After leaving school he found employment at a paper bag factory and worked there for about seven months. He left this employment following a traumatic incident involving youths coming to his house, taking him away against his will and threatening him with extreme violence. As detailed below it seems this incident may have precipitated his enduring mental illness.

Mr Waite didn't work again until he came to Australia. Initially he was listed with an employment agency which sent him to various locations to perform mainly factory type work. It wasn't until about three years later that Dion was able to secure permanent employment with a firm of garage and shed manufacturers in Logan City. He worked there for a period of 18 months and left in the April or May of 2003. This was his last job before his death.

Dion Waite's mental health history

Mr Waite's mental health history can be traced back to his teenage years. When he was approximately 16 years of age, he was confronted by a group of youths in relation to $300 he allegedly owed them. They threatened to break his legs and neck and suffocate him by placing a bag over his head. Following this incident, his mother and stepfather noticed a marked change in his behaviour. He barricaded himself in his bedroom for long periods over almost two years. When his mother went to work Dion would hide in the roof ceiling cavity. He started to carry kitchen knives around the house and hide them under his pillow and was generally seriously disturbed.

In mid 1993, Mr Waite came to the attention of the Rotorua Mental Health Service in New Zealand when he was found by his mother after he tried to cut his wrists. During a subsequent mental health assessment he reported that there were people in cars driving past his house who were *"out to get him*". He was worried they were trying to kidnap him. He said he was not leaving the house as he was afraid people were hiding in toilets and were waiting to kill him. It was arranged for a social worker and community mental health nurse to visit him at his home, but Mr Waite refused this assistance and indicated that he wished to have no further contact with the service.

However, at the instigation of Dion's mother, there was, in May and July 1994, further contact with the service but treatment of Dion's condition was made difficult by his belief he had no mental illness. On 12 July 1994 his mother made an application for him to undergo a mental health assessment because his behaviour had become more bizarre and erratic and he was verbally abusive towards her. This assessment resulted in Mr Waite being admitted as a regulated patient under the *Mental Health Act* of New Zealand and he remained an inpatient until discharge on 29 July 1994.

Initially on admission he was very isolative and refused to come out of his room. He was paranoid people on the ward were out to get him and he refused to wear his cord around his pyjama pants as he was fearful people would use it to strangle him. He would not eat food in case it was poisoned.

He was commenced on antipsychotic medication and was discharged with a provisional diagnosis of paranoid schizophrenia/delusional disorder.[22]

Regrettably, although not unusually, the antipsychotic medication was having undesirable side effects and after a few months Mr Waite stopped taking it.[23] In March 1995, he made a further attempt at suicide by cutting hoses to gas bottles at his home and in June 1995, his mother reported he had taken an overdose of his medication. The police went to his home only to find him watching television with his grandmother. He denied having taken an overdose. By January 1997, Mr Waite's stepfather was seeking counselling to enable him to cope with Dion's behaviour at home.

When Dion and his family relocated to Australia in mid 1997, his behaviour did not improve and he continued to believe everyone was out to get him and the only person he could trust was his mother.[24] However, until shortly before his death, neither Dion nor his family sought any further medical intervention for his condition. It seems the family had no confidence in the capacity of psychiatry to assist Dion. It also seems that, as is sometimes the case with delusional disorders, at least at a superficial level, Dion was capable of functioning at a relatively normal level despite his condition.

Previous interaction with police

Prior to the fatal shooting, Mr Waite had been involved in three previous incidents with the local police, each of which involved quite bizarre behaviour on his part.

On 25 May 2000, police attended an incident at the Greenbank RSL Club involving Mr Waite. He was observed to be heavily intoxicated. Police advised Mr Waite to make arrangements for somebody to transport him from the premises. About an hour later, police observed Mr Waite driving a motor vehicle out of the RSL car park and intercepted him. Mr Waite got out of the vehicle, immediately took up a fighting stance and challenged the officers resulting in a fracas. During the incident, Mr Waite ended up on the ground and, in order to subdue him, the police used OC spray. He was handcuffed and provided with after care for the OC spray. He was then transported to the Beenleigh Police Watchhouse and charged.

While at the watchhouse, Mr Waite again became aggressive and another scuffle ensued, which necessitated him being restrained and placed in the padded cell.

On 1 August 2003, Mr Waite was observed running naked along Grand Plaza Drive at Browns Plains. He climbed onto the top of a motor vehicle while the female driver was inside and began to smash the perspex roof of the vehicle with his feet. Browns Plains police arrived and observed Mr Waite jumping onto the bonnets of other vehicles and smashing windscreens. He leapt onto

[22] Exhibit 129
[23] T243
[24] T244

the police car and smashed the windscreen with his feet. The police endeavoured to restrain Mr Waite but were unable to do so. Both officers deployed their OC spray and despite emptying two canisters onto Mr Waite's face they still required the assistance of workers from a nearby building site to bring him under control.

Mr Waite was transported to the Logan City Hospital for treatment and, in view of his bizarre behaviour, psychiatric assessment. As detailed below, the psychiatric registrar who examined Mr Waite concluded that he was not suffering from any mental illness and he was therefore released back into the custody of police.

On 23 September 2003, Mr Waite's sister, Jacinda Marino contacted police concerned at finding blood at her brother's residence at 195 Vansittart Road, Regents Park. Police attended the residence and located a large pool of blood at the side of the bed and a large blood stain on the mattress. Blood soaked clothing belonging to Mr Waite and two knives covered in blood were found in a rubbish bin at the house.

Mr Waite's family confirmed he was suffering from mental health issues and was failing to take his prescribed medicine, which resulted in his destructive behaviour.

Mr Waite was later located by police with a large cut under his arm, which he claimed had occurred accidentally. Mr Waite advised he would seek medical attention for his injury and at that time did not appear to be displaying indicators to warrant an involuntary mental health assessment. Police took no further action.

Contact with the Logan and Beaudesert Health District mental health services

As mentioned earlier, following the incident at Browns Plains Plaza on 1 August 2003, the police involved in arresting Mr Waite had concerns about his mental health. Accordingly, they made application under s16(a) of the *Mental Health Act 2000* for him to undergo a mental health assessment at the Logan Hospital.

After having his surprisingly minor injuries attended to, Mr Waite was referred for a psychiatric review by Dr Sunil Weerasekera. At the time of the assessment, Dr Weerasekera was given a brief outline of the incident and was informed that Mr Waite had reported to the police a history of paranoia, recent visual hallucinations, thoughts of self harm; his requirement for medication and inpatient treatment in New Zealand in 1998; and that he had consumed four to five cans of VB and one cone of marijuana earlier that day.

Dr Weerasekera found no evidence of thought or mood disorder; no evidence of psychotic or depressive symptoms; no evidence of self harm or homicide;

and no delusions or hallucinations. He considered Mr Waite had good insight, judgment and impulse control.[25]

It was Dr Weerasekera's opinion that Mr Waite did not have a mental illness. Dr Weerasekera considered the incident with the police earlier that day was likely to have been an incident of drug induced psychosis. He considered it likely Mr Waite had under reported to him the level of his alcohol and cannabis use earlier that day. He believed the absence of any indicia of drug or alcohol intoxication at the time of the assessment could be explained by the passing of some three to four hours between the incident and the assessment.

The Logan Hospital policy required Dr Weerasekera to discuss his assessment with the consultant on call, Dr Tucker. Dr Weerasekera says he could not contact Dr Tucker and therefore simply discharged Dion back into police custody without seeking input from any consultant psychiatrist about the most appropriate treatment plan for Mr Waite. Dr Tucker is unable to say why he was not available for consultation on the issue.

Approximately five weeks later, on 9 September 2003, Mr Waite and his mother presented at the Logan Community Mental Health Service ("the CMHS") as his mother had become increasingly concerned about his deteriorating condition. She says Dion was drinking more and becoming increasingly difficult to live with. He was not communicating with family members and was generally very disconnected.

He was initially assessed by Anne Butler, registered nurse. Dion and his mother reported that Dion was smoking cannabis occasionally; his alcohol intake had increased over the previous 4 weeks; he believed people/things were racing through his veins; he would shoot himself if he had a gun and would cut his wrists. Ms Butler was also told of a family history of mental illness, Dion's previous suicide attempts and his involvement and diagnosis by mental health services in Rotorua, New Zealand.

Ms Butler found Mr Waite to be anxious, agitated and paranoid. His conversation was disjointed and there was evidence of thought disorder. She considered he required referral for a mental health assessment and arrangements were made for Dr Deborah Wiens, psychiatric registrar to perform the assessment later that day.[26]

During the course of the assessment, Dr Wiens was informed that:

- his functioning had generally deteriorated;
- he had suddenly left his job which he claimed to be due to racing thoughts and paranoia;
- he had been involved in an incident where he was running naked down the street in circumstances where he believed the police had a plot to kill him;
- he was showing other signs of increasing paranoia;
- he had become more angry and hostile towards his family;

[25] T273
[26] Ex 130 pp71-74

- he had thoughts of suicide and was fighting off thoughts of someone wanting to kill him;
- he was afraid the police and even Dr Wiens was part of his paranoid delusion;
- it was the first time he had asked for help;
- his mother and step-father were going to New Zealand for a holiday and his mother was concerned there would be no-one to monitor and support him while they were away and
- Mr Waite thought he would be better in hospital.

Dr Wiens thought Mr Waite may have had a personality disorder but her provisional diagnosis was some kind of psychotic episode and anxiety. She prescribed Risperidone, an antipsychotic medication and Valium, a sedative.[27] Her plan was to closely monitor him over the following few days.

Dr Wiens also considered Mr Waite would be best managed by the service's Acute Care Team (ACT). In addition to her half time role with the team, the other members were Mr Gus Sims - team leader who fulfilled an administrative role (he never met Mr Waite); a clinical nurse consultant – Mr Arthur Fernandez; two clinical nurses - Kathleen Kerwin and Chris Leary; and a social worker, Kamalam Sivadorai. Dr John Davies, the district director of mental health, was nominally the consultant psychiatrist for the team. However, the demands of his other duties meant his involvement with the ACT was fairly limited. He did not do home visits and only assessed clients if the registrar considered it necessary. He would attend the weekly case review meetings and while he would oversee treatment, he did not read the client files and was largely reliant on the information provided by the other team members.[28]

The purpose of the ACT was to provide a comprehensive assessment and early intervention to:

- new clients who had been assessed and were awaiting a medical review by the MHS; and
- existing clients who had experienced acute illness episodes.

The ACT was not designed to provide a crisis intervention service. Rather, its focus was on stabilizing a client and developing mainstream support links. It was directed at providing care to clients whose mental health issues did not warrant inpatient treatment but required a higher level of input than could be provided by the ordinary care teams. The ACT had contact with a client at least once per week and reviewed every client's case each week.

On the day following his initial assessment, Dr Wiens and Ms Kerwin, an experienced psychiatric nurse, visited Mr Waite at his home. Dr Wiens observed that he was reactive and more relaxed. He reported he had slept well the previous night and had a good appetite. He described some issues of conduct disordered behaviour and it was evident he still appeared to have

[27] T299
[28] T379

problems of a developmental nature with his family. Dr Wiens thought that while Mr Waite did not seem psychotic, it was clear that something was not right and the likelihood of a mental illness could not be removed from the diagnostic dilemma. She considered his level of alcohol use may have been contributing to his presentation. She increased the dose of Risperidone. Dr Wiens says after this visit she was doubtful whether the diagnosis which had been made in New Zealand in 1994 was correct. This uncertainty was based on Dr Wiens' belief that diagnosis of schizophrenia in teenagers is problematic and made more so in this case by Mr Waite's long periods of relative normalcy.

On 11 September 2003, Ms Kerwin telephoned Mr Waite to see how he was going and whether he had experienced any side effects from the medication. Mr Waite reported he had slept well, was doing some housework and had an appointment to meet with his lawyer that afternoon. Ms Kerwin advised Mr Waite she would telephone him the following day to arrange another home visit.[29]

The following day Dr Wiens and Mr Leary were scheduled to attend Mr Waite's residence for a home visit. While they were in transit, Dr Wiens received a phone call from Mr Simms who said Mr Waite had telephoned and advised he was not at his home and he had fabricated his symptoms because he was facing a court case. He said he did not require assistance from the MHS. Mr Waite then telephoned Dr Wiens, expressed his remorse for misleading her and explained it was due to the stress of the pending court case. Dr Wiens questioned him about the bizarre nature of the altercation with the police on 1 August. Dion responded it had been just a bit of foolishness while he was stressed by his unemployment. At this point, Dr Wiens says she was not so concerned about the diagnostic label to be attributed to Mr Waite but was more focused on the fact he was troubled and required the support of the MHS.

Dr Wiens was actually just outside the Waite/Marino residence when she received the call so she took the opportunity to talk to Mr Waite's step-father, Warren Marino about Dion's condition. He told her of the emotional and physical struggles he had had with his step-son. He told her the family locked their rooms to prevent theft by Mr Waite. Mr Marino also said he and his wife had been unable to take holidays away from the home because the deceased would act out in some way forcing them not to go. He felt Mr Waite required psychiatric care. Dr Wiens thought it was important to hear Mr Marino's concerns *"to know what a struggle it had been"*. This information from Mr Marino did not resolve the diagnostic dilemma.[30] Dr Wiens says while Mr Waite frequently described feeling paranoid, she considered it was difficult to know what he meant by this.

Mr Waite's mother and step-father left Brisbane on 13 September 2003 for their 10 day holiday in New Zealand and arrangements were made for his

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[29] T352
[30] T312

sister to reside with him during their absence. Mr Waite called Dr Wiens after their departure and told her it was harder than he thought and he missed his mother. He said this had made him feel paranoid and he had been unable to leave the house. Dr Wiens suggested his sister collect a small quantity of Risperidone and Valium tablets for him from the MHS which she did.

The following day Mr Leary and Mr Fernandez, neither of whom had previously met Mr Waite, made an unannounced visit to his house to assess him and provide support. Mr Leary gave evidence that at the time he understood Mr Waite had a history of intravenous amphetamine use. It is not known how Mr Leary came to this understanding as Mr Waite had previously categorically denied such use and there was no objective evidence in support of it. This understanding seems to have been based on little more than speculation caused by the fact that Mr Waite's overall clinical presentation could not be conclusively explained by a psychotic disorder.

Despite several attempts Mr Waite refused to engage in any conversation with Mr Leary or Mr Fernandez and indicated that because he was paranoid he would only speak to Dr Wiens.

A weekly team meeting was held on 17 September 2003. Unfortunately, no notes were taken of the significant treatment and management decisions made at this meeting or the reasons for such decisions. This was a regrettable oversight by the MHS. The recollections of all the witnesses who attended this meeting are rather vague. However, there appears little doubt at that meeting a decision was made that Mr Waite needed to be assessed by Dr Davies so he could make a clinical judgment as to whether Dion was suffering from a mental illness and give input to his treatment. Dr Wiens says she considered such an assessment necessary because Mr Waite remained a diagnostic dilemma. The two matters that concerned Dr Davies were the atypical aspects of his reported history of schizophrenia and the aspects of Dion's altercation with the police that indicated his behaviour could have been explicable by a mental illness.

On 19 September 2003, Dr Wiens telephoned Mr Waite to inform him an appointment had been made for him to be assessed by Dr Davies at 3.30pm on 23 September. Mr Waite told Dr Wiens he had attended court earlier in the day and his hearing had been adjourned until 11 December 2003. He reported feeling much better and was no longer obsessing about his mother. After some encouragement Mr Waite agreed to attend the MHS for the appointment and requested he be given a reminder call on 22 September. Ms Kerwin telephoned Mr Waite as arranged and left him a message.

At approximately 11.30am on 23 September 2003, Mr Waite's sister telephoned the MHS and spoke to Mr Leary. She reported that Dion had cut himself and there was a lot of blood in his bedroom and in the laundry and while she was concerned about him, she did not think he was suicidal or homicidal. Mr Leary advised her to contact the police and to have him taken to the Logan Hospital Emergency Department.

Mr Leary immediately reported to Dr Wiens the telephone conversation he had had with Mr Waite's sister. Later that day, at approximately 3.15pm Mr Waite telephoned Dr Wiens to say he would not be attending the scheduled appointment with Dr Davies at 3.30pm as he had not been suffering from paranoia and had not needed to take any medication for seven to eight days. He said he would call the MHS if he required assistance and there was no longer a need for a court report.

It appears that Mr Waite presented at the Logan Hospital Emergency Department at approximately 7.45 pm that night. On examination he was found to have self inflicted superficial wounds to both elbows which were dressed.[31]

Mr Waite's mother and step-father returned from their holiday later that evening and on learning of her son's self harming behaviour, Mrs Marino telephoned the MHS after hours service number and left a message to the effect her son was suicidal and she wanted to speak with his treating doctor. Ms Kerwin transcribed this message into Mr Waite's file shortly after she arrived for work on 24 September 2003. A few hours later, Mrs Marino telephoned the MHS at which time she spoke with Ms Kerwin and requested her son be hospitalized. Ms Kerwin informed Mrs Marino the team were meeting later that day to discuss Mr Waite's case and she would let her know the outcome of the meeting.

The ACT met on 24 September 2003 and once again the recollections of the team members as to the discussions had and the decisions made, are very vague. Again, this was not helped by the lack of any contemporaneous written record of what was discussed or the decisions made. It became apparent during the course of this inquest that Dr Davies had an understanding of what was decided in relation to Mr Waite's treatment and the reasons for those decisions that differed from that of the other members of the team.

All members of the team, apart from Dr Davies, believed a decision was made to discharge Mr Waite from the MHS on the basis his primary problem was substance and alcohol abuse. Importantly, Dr Wiens thought the self harming incident on the previous day was a way for Mr Waite to communicate to his mother how hard it had been for him while she had been away. She considered that he was not mentally ill. Ms Kerwin, Mr Leary and Ms Sivadorai seemed to have been influenced by Dr Wiens' opinion in this regard.

It was Dr Davies' recollection that he was informed Mr Waite had made it clear to the other members of the team he was not prepared to attend the MHS for further treatment or assistance. Therefore the issue for Dr Davies was not whether or not Mr Waite had a mental illness but whether there was any way Mr Waite could be compelled to attend for treatment, in circumstances where he was refusing to co-operate. He considered the purpose of Ms Kerwin's meeting with Mr Waite's mother the following day was to seek out her assistance in gaining Mr Waite's co-operation. It was Dr Davies'

[31] E130 p 58

understanding he had only approved Mr Waite's discharge from the MHS if further attempts to engage him were unsuccessful.

At the meeting on 25 September 2003, neither Ms Kerwin nor Ms Sivadorai discussed with Mr Waite's mother the importance of her son being assessed by Dr Davies. To the contrary, not only was Mrs Marino not informed of the need to encourage her son to maintain contact with the MHS but, regrettably, Ms Kerwin sought to persuade her that her son did not have a mental illness.

Of significant concern is that the MHS withdrew treatment from Mr Waite, in circumstances where Dr Davies did not share Dr Wiens' views regarding the significance of Mr Waite's self harming behaviour and where he had concerns Mr Waite may have been suffering from a mental illness, but felt that reasonable attempts to gain his co-operation had been exhausted. Dr Davies conceded in evidence that the attempts that were in fact made were insufficient and that the MHS fell short in discharging its responsibility to Mr Waite.

Ms Kerwin's erroneous belief that the MHS could not assist Mr Waite was reinforced during the course of the telephone conversation with Mrs Marino on 1 October 2003. Mrs Marino indicated her son was refusing to seek assistance for any alcohol or drug problems he may have had, to which Ms Kerwin responded there was nothing the MHS could do to assist until these other issues had been addressed. By this time, Mrs Marino had given up hope of receiving any support from the MHS.

Mr Waite was simply advised of the desirability of his contacting the Alcohol, Tobacco and Other Drugs Service (ATODS) for assistance with his drug abuse problem. No steps were taken by the staff from the MHS to facilitate Mr Waite's referral to ATODS and indeed there was no good reason why he could not have been treated by the two services simultaneously.

The days leading up to the death

In the days before his death, Mr Waite's behaviour was described by his mother as "*extra strange*". She said she could "*see the tension and stress in his face*". He was not eating and barely communicating with family members. He spent most of his time at home although it was apparent to his mother he must have been going out to get alcohol as he was frequently intoxicated.

On 23 October 2003, Dion was at home when his step-father returned from work at about 4.00pm. He made some delusional comments and then retreated to his room. Throughout the evening he frequently came out of his room into the family area for a short period of time before getting up and returning to his room. It did not appear then that he had been drinking.

Dion's mother and step-father retired to bed between 9 and 10.00pm. At this time Dion was still pacing the house.

Events on the day of the shooting

Mrs Marino arose at 4:30am. Dion was in the living room. It seemed to her that he had been up all night. Dion told her he couldn't sleep. When Mr Marino got out of bed at about 5.00am he saw Dion sweeping the dining room floor. They did not speak and Mr Marino left for work.

Shortly after 11.00am, Constable Giggins, an officer who had previous contact with Mr Waite, was making inquiries at a school a few hundred metres from the Marino/Waite residence when Dion came along the footpath. Constable Giggins spoke to him and said in evidence he seemed quite normal, not at all aggressive or in any other way unusual. It is not known where Dion was going or what he did but the change that apparently came over him in the next hour is startling.

Mrs Marino finished work and returned home at about 12:45pm. She let herself into the house and noticed all the doors and windows were closed and the house was very hot. She saw Dion jump up from the couch in the lounge room when she was walking through it to her bedroom to get changed. At about this time Dion walked out the glass sliding door at the back of the lounge room into the backyard.

When Mrs Marino came out of her bedroom she looked through that door and saw Dion standing near a garden shed in the backyard. He looked strange to her and she asked him what he was doing. He didn't respond. Mrs Marino went into Dion's room and shut his windows. As she was doing so she heard a loud crash and the sound of breaking glass. She came out of Dion's room and looked towards the backyard. She saw Dion standing just outside the house. He had both arms outstretched above his head and he was holding a carving knife in each hand. She saw the glass sliding door leading from the lounge dining area into the backyard was smashed and there was glass all over the floor.

She saw that Dion's face was contorted with what appeared to be rage. She said she had never seen him look like this before and asked him, "*What are you doing?*" She said he screamed at her, *"Get out of my fucking house.*" Mrs Marino tried to remonstrate with her son by saying "*Oh Dion don't be stupid*", but he did not engage with her and just screamed, *"Now!"*

Mrs Marino became very scared. She ran out of the front door and across to the house directly opposite and asked a woman there to ring the police. While she was at this neighbours house she could hear coming from her house what sounded like furniture being thrown around and broken. She called her husband and her daughter Jacinta. She also called the police again as it seemed to her they were taking a long time to arrive. Her daughter Jacinta soon arrived at the house.

Mr Marino arrived and parked his work truck in the driveway. He was making for the house when his wife called out and persuaded him not to go in. He, Mrs Marino and their daughter, Jacinta, then stood on the roadway outside the house.

The police response

The neighbour, to whom Mrs Marino ran for help, called her neighbour and asked her to telephone the police. As a result of that call, an officer from the Beenleigh Communication Centre called the house of the first neighbour and spoke with Mrs Marino. She told him her son Thomas Waite was in their house armed with knives and smashing property. As a result the officer who entered the job onto the computer aided dispatch system checked police records. He then entered onto the system in a field the officers responding would read that the subject person had previously been involved in a violent confrontation with police and he was not affected by O.C. spray.

The call was received by police at about 1.00pm. The first car containing two uniform officers, Constables Gould and Giggins arrived at the house at about 1.05pm. Coincidentally, they were the officers who had spoken to Mr Waite near the school some 90 minutes earlier.

The Marino residence is on the corner of Vansittart Road and Waller Road. It is a low set brick house on an elevated block with a retaining wall running across the Vansittart Road frontage and down the Waller Road side boundary. Along both sides and across the back of the yard is a six foot high paling fence.

As the first response officers approached the house they spoke with Mr and Mrs Marino and were given keys to the front door. They approached the house and opened the front door. They could hear the sounds of things being thrown and broken. They called out to Mr Waite but were not able to engage him in conversation. He did not respond to their requests to come outside.

Over the next few minutes numerous other officers arrived at the scene. They too approached the house and positioned themselves in the front and back yards and along the road way. By 2.00pm, 19 officers had assembled and the command of the scene had changed a number of times as more senior officers arrived and took control. Throughout this period the focus was on containing Mr Waite in the house and attempting to talk him into putting down the knives and coming outside.

At times Mr Waite could be seen in the house. It was noticed he was naked and carrying a knife and on occasions, what appeared to be half a brick. He could be seen and heard throwing furniture and appliances around in the house and on occasions he threw household items out of the windows.

The officers continued to try to talk to him. Mr Waite made repeated threats to kill them. One of the officers, Senior Constable Fitch, gave evidence that as a result of seeing blood on the floor and having been told by one of the other officers that it looked as though Mr Waite had cut himself; she offered to call an ambulance and asked him to come outside so that his wounds could be attended to. He rejected this offer and responded with threats to harm any officer who came inside. Mr Waite also made bizarre comments, such as he was a tiger and the police were tiger killers. He claimed their bullets would not harm him but go right through him. He invited the police to shoot him.

A dog squad officer, Senior Constable Quill and his dog arrived at about 1.45pm and took up a position in the front yard of premises at 161 Waller Road which abutted the rear boundary of the Marino's yard. He was authorised to use his dog to restrain Mr Waite if an appropriate opportunity presented itself. Also in the yard were Constable Buick and Constable Pannowitz, who had relocated there after the officer in charge came to the view their earlier location in the back yard of the Marino premises was too dangerous. Unfortunately those officers did not position themselves in such a way that Mr Waite could see them or so they could see the back of the house. It seems they were standing near the front corner of the adjoining house, talking among themselves.

Soon after the siege started, it was determined police negotiators should be deployed but none were on duty and so two officers on call were contacted. They did not arrive at the scene until about 2.20pm. Immediately after being briefed by the district duty officer they took up with Mrs Marino in order to acquaint themselves with relevant background of Mr Waite's condition and concerns.

However, before they could attempt to engage with Mr Waite, he left the house and climbed over the back fence into the adjoining property where the dog squad officer and two constables were positioned.

This movement was first detected by an officer on Waller Road, Constable Joch, who says he heard the sound of heavy items hitting the side fence adjacent to where he was standing and saw the fence swaying. He then saw movement in the yard and a naked man climbing over the back fence. He saw the man was carrying a knife. Constable Joch called out to the other officers that Mr Waite was on the move and ran along Waller Road in the direction he had seen Mr Waite take.

The yelling by Constable Joch and a radio broadcast to the effect the subject had left the house caused Constable Buick to walk down the driveway of 161 Waller Road. When he got to the property line he turned towards the Marino residence and saw Mr Waite in the yard of 161 Waller Road, coming towards him.

Senior Constable Quill and Constable Pannowitz saw Mr Waite soon after he climbed the fence. They saw he was carrying two knives in one hand and a rock in the other which from time to time he threw up and caught. They drew their service handguns and called on him to stop and put down the knives. They moved towards him pointing their guns. Mr Waite did not say anything but walked at a fairly slow pace across the front yard of 161 Waller Road. The officers suggested he jabbed at them with one of the knives but did not try to attack them. As Mr Waite reached the driveway, Constable Buick backed up it and shepherded Constable Pannowitz out of the way so they did not obstruct Mr Waite as he left the property. Constable Joch had by this stage also run onto the driveway and he too backed away from Mr Waite but in the opposite direction to the others: he went down the driveway and down

Waller Road, also with his gun drawn and also calling on Mr Waite to drop the knives and get onto the ground.

Constables Pannowitz and Buick say that Mr Waite had a smirk on his face and did not say anything or appear to respond in anyway to what they said.

As Mr Waite neared the footpath and appeared to be intent on moving down the street, Senior Constable Quill directed his police dog to apprehend Mr Waite. The dog was trained to take hold of a target with its jaws and keep that hold until directed to release. The dog weighed about 50 kilograms and could be expected to pull a man to the ground. There are some material differences in the accounts of the witnesses as to exactly what happened next. I will need to resolve these inconsistencies when determining whether any person should be committed for trial. For the purposes of this part of the findings, however, it is sufficient that I give a more general outline of what occurred.

It seems the dog leapt at Mr Waite from behind, although some witnesses suggested he saw it coming and turned to meet it. It seems clear the dog latched onto Mr Waite although again there are discrepancies as to what part of his body it grabbed. Some of the witnesses say the dog knocked him to the ground, others say it merely spun him around or that he turned to fend it off.

All witnesses say that soon after being attacked, Mr Waite was on his feet and stabbing at the dog with one of the knives. There are numerous consistent accounts which indicate he succeeded in hurting the dog as it was heard to yelp and seen to release its grip. There are varying accounts as to whether the dog backed away, was pulled away by its handler or continued to attack Mr Waite. There are also inconsistencies in the descriptions of exactly what Mr Waite did. All witnesses, including Senior Constable Quill, agree however, that very soon after the dog lost its grip of Mr Waite, he was shot once in the chest by Senior Constable Quill and fell to the ground.

Post shooting events

First Aid

Immediately after the shooting, a radio request was made by police on scene to the Beenleigh Police Communications Centre for assistance, which resulted in two Queensland Ambulance Service paramedic crews being despatched.

A number of police on scene commenced first aid treatment, including cardiac pulmonary resuscitation (CPR) on Mr Waite in an attempt to save him. Police endeavoured to cover the chest wound which was bleeding. Pressure was kept on this wound, while officers took turns, conducting the CPR.

The CPR procedure continued until the arrival of the Queensland Ambulance Service. The ambulance officers arrived and commenced treatment. These officers were briefed on Mr Waite's condition during the handover. Although Mrs Marino felt the ambulance took too long to arrive and the officers took too long to commence treatment, I understand in such circumstances any delay can seem much longer than it is. The records indicate that the ambulance was

dispatched at 2.28pm and arrived at the scene at 2.38pm. The QAS officers took their first readings of Mr Waite's vital signs at 2.39 and found he had no pulse or respiration. I have no reason to reject these records.

After treating and examining Mr Waite, Advanced Care Paramedic Allan and Intensive Care Paramedic McIlroy determined at 2.46pm, that he had no signs or symptoms compatible with life. As a result, all equipment was removed from Mr Waite and a sheet was placed over him.

I am satisfied that after the shooting, the police and the paramedics did all they could, under the circumstances, to try to save Mr Waite. I commend all involved for their efforts. However, due to the critical injuries inflicted by the shooting, Mr Waite was destined to die quickly and nothing could have been done at the scene which would have saved him.

Gun and scene secured

Immediately after the shooting occurred, the Logan District Duty Officer, Senior Sergeant Russell approached Senior Constable Quill, and directed him away from the immediate scene. Senior Constable Quill's service issue 40 calibre Glock pistol, serial number QP11443 and a 15 round magazine were seized and secured and later handed to Logan Police Scientific Officer, Sergeant Rasmussen on 24 October 2003 for the purposes of forensic examination.

The scene was secured and the investigation described earlier commenced.

The identification

The Government contracted undertaker transported Mr Waite's body to the John Tonge Centre Mortuary for autopsy. On the afternoon of 25 October 2003, Gaye Lynette Marino formally identified her son, Thomas Dion Waite to Detective Sergeant Neville Huth of the Logan District CIB.

The autopsy

On Saturday 25 October 2003, an experienced forensic pathologist, Doctor Guy Lampe performed an autopsy on Mr Waite's body. He found a wound caused by a projectile entering the right side of the chest. The wound was above and medial to the nipple. The gunshot wound was directed from left to right in a slightly downwards and backwards direction. It punctured the right lung, lacerated vital arteries and perforated the body of the fifth lumbar vertebra. The projectile lodged in the lumbosacral joint.

The absence of powder staining around the wound suggested the firearm had been discharged from a distance at least greater than one metre from Mr Waite.

Also found on his chest was a series of linear parallel wounds and a stab wound that appeared to have been inflicted by a sharp edged instrument. A third series of injuries consisted of linear abrasions consistent with dog claw marks. These were found around the chest, hips and thighs of Mr Waite.

Analysis of blood taken from Mr Waite found no drugs that would explain his bizarre behaviour.

In Dr. Lampe's opinion, the mechanism of death was internal haemorrhaging caused by a gunshot wound to the chest.

Ballistics evidence

An examination of the Glock handgun, magazine and ammunition issued to Senior Constable Quill showed the magazine contained 13 bullets. One live round had been taken from the chamber of the semi-automatic gun after its initial discharge. The maximum number of projectiles able to be stored in the magazine is 15.

An examination of the projectile removed from Mr Waite's body at autopsy showed it was consistent with the type issued to police officers and markings on it were consistent with it having been fired by a Glock pistol. The markings were such that it was not possible to positively connect the projectile to Senior Constable Quill's gun. However, such a connection was able to be made with a spent cartridge case found on the footpath near to the shooting.

Findings

Findings required by s43(2)

I am required to find, so far as has been proved, who the deceased was and when, where and how he came by his death.

As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, I am able to make the following findings.

Identity of the deceased – The deceased was Thomas Dion Waite

Place of death – He died at 161 Waller Road, Regents Park, in Queensland.

Date of death – He died on 24 October 2003

Cause of death – The cause of death was a single gunshot wound to the chest.

The committal question

In so far as it is relevant to this case, the *Coroners Act 1958* provides in s.41(1) that if a coroner holding an inquest into a death, considers the evidence is sufficient to put a person on trial for murder or manslaughter, the coroner may order the person be committed for trial.

It is not my role as coroner to decide whether any person is guilty of an offence in connection with the death or indeed, even whether the prosecutorial discretion should be exercised in favour of presenting an

indictment and bringing the matter before a jury. Rather, I only have jurisdiction to determine whether anyone should be committed for trial. That requires I consider whether a properly instructed jury *could,* on all of the evidence presented at the inquest reasonably convict any person of any of the offences raised by the evidence.[32]

Section 291 of the Criminal Code provides that it is unlawful to kill another person unless that killing is authorised, justified or excused by law.

Section 300 of the Criminal Code states that "*any person who unlawfully kills another person is guilty of a crime, which is called murder, or manslaughter, according to the circumstances of the case".*

There are various definitions of murder provided by s.302 of the Code. Most relevant to this case, s.302(1) provides that a person who unlawfully kills another person with the intention of causing the death or doing grievous bodily harm is guilty of the crime of murder.

In this case there is an abundance of evidence indicating that Thomas Dion Waite died as a result of being shot by Steven Frederick Quill. For example, Senior Constable Pannowitz gave evidence she was standing only two or three metres away from Mr Waite when he was shot. She was pointing her firearm at him as was Constable Buick and Senior Constable Quill when she heard a shot and saw Mr Waite fall to the ground. She saw blood issuing from a wound to his chest. Senior Constable Pannowitz at first wondered whether she had fired but then quickly realised the shot had been fired by Senior Constable Quill. Constable Joch was also close at hand and he too gave evidence he saw Senior Constable Quill shoot Mr Waite once.

When coupled with what was found at autopsy, I am satisfied this evidence sufficiently proves that Senior Constable Quill caused Mr Waite's death.

The remaining element to be considered is that of intention. When interviewed by investigators immediately after the shooting, Senior Constable Quill informed them he had shot Mr Waite intending to incapacitate him. However, this admission was made after he was given a direction pursuant to the *Police Service Administration Act 1990 t*o answer questions. The answers were not therefore voluntary and can not be used against the former officer in criminal proceedings. However, the intention of an actor can be inferred from the circumstances of the act: the natural and usual consequences of an act will be presumed to have been intended.

In this case, I consider a jury could infer from the deliberate close range shooting of Mr Waite with a large calibre handgun that Senior Constable Quill had the intention to kill or do grievous bodily harm. I therefore consider all the elements of the offence of murder can be made out against Senior Constable Quill.

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[32] see *Short v Davey* [1980]Qd R 412

Accordingly, the only issue to be further considered is whether the killing was authorised, justified or excused by law. If it was, that is the end of the matter. If not, I must commit Senior Constable Quill for trial and allow the Director of Public Prosecutions to consider whether an indictment should be presented.

This requires consideration of any defences open to Senior Constable Quill, because, before a jury could convict him, the prosecution would have to exclude the operation of any defences. The two statutory provisions relevant to that issue in this case are s.271 and s.283 of the Criminal Code.

Section 271, short-titled "*Self-defence against unprovoked assault,*" provides that if a person is assaulted in such a way as to cause reasonable apprehension of death or grievous bodily harm, and the person reasonably believes that he can not otherwise protect himself from that, it is lawful for the person to use such force as is necessary for his defence even though that force may cause death or grievous boldly harm. So far as is relevant to this case, "assault" is defined in s.245 to include not only the application of force but also the threatened application of force in circumstances where the person making the threat has an actual or apparent ability to carry out the threat.

It is also important to note that s.283, short-titled "*Excessive force*", provides that *"(i)n any case in which the use of force by one person to another is lawful the use of more force than is justified by law under the circumstances is unlawful".*

I will now apply that law to the facts of this case.

A number of the witnesses say that immediately before Mr Waite was shot he lunged at or moved towards Senior Constable Quill.

For example, Constable Libor Joch gave evidence that he ran towards the driveway where Mr Waite was shot when he saw him jump over the fence into the yard of the residence at 161 Waller Road. He heard numerous officers calling out to the deceased to put the knife down. He saw the deceased naked and armed with at least one knife approaching the police officers. He then saw the police dog go to the deceased and appear to knock him off balance. The deceased attempted to stab the dog a number of times. At this stage Senior Constable Quill was about three metres away. After he had stabbed the dog, the deceased got up and moved forward towards Senior Constable Quill. Senior Constable Quill was about 1 to 2 metres away from the deceased when the shot was fired. The deceased was within striking distance of Senior Constable Quill with the knife when he was shot. Constable Joch considered he and other officers in the immediate vicinity were in great danger immediately prior to the deceased being shot.

Constable Darren Smith gave evidence he was near Constable Joch as they ran towards the driveway of 161 Waller Road. He saw the deceased approaching police officers in the front yard of that residence. Mr Waite did not comply with the shouted demands to drop his weapon. As the deceased walked onto the footpath outside No. 161, a police dog ran and leapt at him.

Constable Smith says the deceased stumbled and then recovered his balance. He stabbed at the dog twice which caused it to release its grip on. Him. Mr Waite then lunged towards the police officers in an aggressive fashion with a knife in his outstretched arm. At this stage, one shot was fired.

Constable Danilo Vojvodic gave evidence that shortly after 2.00 p.m. he ran down Waller Road, towards the rear of the dwelling in which Mr Waite had been contained after hearing shouting coming from there. He saw the deceased moving down a driveway at No. 161 Waller Road. He then saw the police dog had latched onto his arm. The deceased moved behind a police vehicle and went to the ground.

Seconds later he saw Mr Waite get back to his feet and move towards the Dog Squad officer, Senior Constable Quill, who was only one to two meters away when this happened. In his interview, Constable Vojvodic described Mr Waite making a lunging motion towards Senior Constable Quill with a knife in his outstretched hand. It was at that stage the one shot was fired by Senior Constable Quill. Constable Vojvodic said on numerous occasions the deceased had been told to drop the knife and get down but he did not comply with these demands.

Constable Jacinta Pannowitz was one of the two officers in the front yard of 161 Waller Road with Senior Constable Quill. Her evidence was that from the time Mr Waite jumped over the fence into that yard, she and other officers were calling on him to drop the knives he was carrying and to get down onto the ground. Even though Mr Waite lunged at them with a knife as he was making his way out of the yard, she did not shoot but instead backed away from him up the driveway as other officers who had come into the yard backed down it. Constable Pannowitz then recalls the police dog being released and knocking Mr Waite over. He quickly recovered his feet and struck at the dog with the knives. Senior Constable Quill followed the dog closer to Mr Waite (indeed it seems he may have been connected to the dog by a long lead) at which point Mr Waite seemed to stop focusing on the dog and fix his stare on Senior Constable Quill who was two to three meters away. He had the knife raised and he brought it down towards Senior Constable Quill. Constable Pannowitz says she was in fear for Senior Constable Quill's life and her own. She says one shot was fired in response to the stabbing motion. She says she believes there was no other option available to secure their safety. She says she was about to shoot as well.

Numerous other officers give similar, but not identical, accounts. All of those officers who gave evidence say they believed Senior Constable Quill to be at risk of serious injury or death when Mr Waite lunged at or moved towards him.

Other witnesses, however, give different accounts of the actions of Mr Waite immediately before he was shot that do not include him lunging or moving towards Senior Constable Quill. I have been troubled by these accounts and have given them careful consideration particularly that of Constable Buick who was in the driveway very close to both Senior Constable Quill and Mr Waite when the latter was shot. Constable Buick says the dog was still attached to

Mr Waite when he was shot and he did not consider that either Senior Constable Quill or anybody else was at risk at the time of the shooting. He did concede however that Mr Waite may have lunged towards Senior Constable Quill and he just didn't see it because it happened so quickly. It also seems his evidence at the inquest may not be entirely consistent with what he said when interviewed immediately after the shooting.

Other witnesses who did not see any movement by Mr Waite towards Senior Constable Quill at the material time include the civilians Benjamin Charles, Christopher Collins, and Marina Gettajanc. They all say the dog was attacking Mr Waite and he was fighting it when he was shot. These accounts obviously raise a concern that the police witnesses are not being truthful and are trying to protect a former colleague. There are certainly inconsistencies in some of the officers versions that could support a conclusion the dog handler was acting to protect his dog that he thought (wrongly as it turned out) had been stabbed by Mr Waite. However, it also needs to be acknowledged the civilian witnesses were much further away from the shooter and the shot man than the officers who exculpate Senior Constable Quill. Further, their accounts are inconsistent with each other in some material respects.

I have come to the conclusion that the preponderance of evidence strongly favours a series of events that would prevent the prosecution from negativing self defence. Notwithstanding the decision of *Doney v The Queen*, I do not consider I am obliged to commit Senior Constable Quill merely because some of the evidence would enable a jury to convict him. I believe I am required to consider the evidence in its entirety. I have to consider whether a reasonable jury could disregard the evidence of the officers who were standing with Senior Constable Quill when he shot Mr Waite. When I undertake that exercise, I am firmly of the view a reasonable jury could not convict Senior Constable Quill because they could not be satisfied he was not acting in self defence when he shot Mr Waite. Accordingly, I find that no person should be committed for trial.

All of the police officers involved in these events were placed in a very difficult and at times terrifying situation. None of them is above the law: they are charged with upholding it and protecting the life of even those who are endangering others. However, police are also entitled to the protection of the law. They are entitled to defend themselves and even use deadly force if they can not in any other way secure their own safety. In this case, Senior Constable Quill did not have to wait until he was stabbed before he could use his gun to neutralise the risk of that happening. Nor, when considering whether he should face criminal sanction, is it appropriate to weigh in the balance every possible piece of evidence or opinion against him to determine whether any other outcome was possible. Faced with a clearly deranged and violent man armed with knives and acting in a threatening manner, society can expect no more than its police officers act reasonably. I accept that Senior Constable Quill did that in this case while ardently trying to protect the community by apprehending someone who had shown a potential to be very dangerous.

Comments and preventative recommendations

The Act, in s.43(5), authorises a coroner conducting an inquest to make riders designed to prevent deaths occurring in similar circumstances. In this case I have found that the officer who shot Mr Waite was acting in self defence and thus should not be prosecuted for his actions. However, it is still appropriate to consider whether the authorities who had contact with Mr Waite could have responded in ways that might have avoided his death.

The issues which need to be considered from that perspective are:-

- The adequacy of the care provided by the Beaudesert and Logan Community Mental Health Service; and

- The police management of the “siege” situation.

Critique of the mental health care

On 1 August 2003, Mr Waite engaged in violent and bizarre behaviour at the Grand Plaza Shopping Centre that has been described earlier. Police had to use considerable force to restrain him but managed to do so without causing him any significant harm. Ten weeks later, Mr Waite engaged in similar behaviour but on that occasion he was armed with a knife and so police were forced to use deadly force to subdue him.

On both occasions, his behaviour was strongly suggestive of severe mental illness and followed a long history of mental illness.

In between those two episodes, Mr Waite had repeated contact with the community mental health services offered by the Logan and Beaudesert Heath District. The failure of that contact to avert the death of Mr Waite does not necessarily mean that gross mistakes were made but it does require me to consider whether that service appropriately responded to Mr Waite’s need for treatment.

Was Mr Waite’s mental state adequately assessed when taken to the Logan Hospital by police?

Mr Waite’s mental health was assessed by Dr Weerasekera, psychiatric registrar after he had been taken to the Logan Hospital by police. It was Dr Weerasekera’s opinion that Mr Waite did not have a mental illness even though he had been informed that Mr Waite had:

- been apprehended by police after running naked, leaping on moving motor vehicles and violently resisting efforts to take him into custody;
- told police he had a history of recent visual hallucinations, paranoia and thoughts of self harm;
- required psychiatric medication and inpatient treatment in New Zealand in 1998; and
- consumed four to five cans of VB and one cone of marijuana earlier that day.

Dr Weerasekera thought that Mr Waite's *"odd"* behaviour earlier that day could be explained by his alcohol and cannabis use earlier that day. Given that Dr Weerasekera detected no signs of excessive alcohol or cannabis consumption at the time he assessed him only a few hours later, this seems questionable. Further, attempts to rationalize Mr Waite's conduct on this basis, in my view, gave insufficient weight to the previous psychiatric history that had been reported to him.

I recognise and acknowledge the difficulty of the situation confronting Dr Weerasekera. He had the police report of extremely bizarre and dangerous behaviour and advice from the patient of a long history of mental illness. However, the patient was not at the time of the assessment displaying any indicia of mental illness. In these circumstances Dr Weerasekera seems to have assumed that Mr Waite was suffering from drug induced psychosis even though he had insufficient evidence to make such a diagnosis. His lawyers submit that he may have been led into this error by a notation in the chart made by the doctor who attended to Mr Waite's physical injuries *"apparently under the influence of ethanol and query, amphetamines."* That may be so but it does not excuse the error. Nor do I accept that just because many drug users under report their level of consumption Dr Weerasekera was justified in presuming that Mr Waite was doing this when he claimed to have drunk only four cans of beer and smoked a small amount of marihuana. I also reject the evidence that such consumption could lead to hallucinations in a person with a long history of alcohol abuse. I acknowledge that Dr Weerasekera's evidence to this effect was not challenged during the hearing but I have heard from numerous experts on that point. The vast majority of alcoholics and drug abusers become more tolerant of the drug of abuse. Dr Weerasekera had no basis on which to presume that Mr Waite might be in that small minority in which the opposite is the case.

I readily accept that the marked increase in such presentations of drug induced psychosis in recent years, particularly in places like Logan may explain how such an error could be made but it also should be recognised as a risk that needs to be guarded against. It may be had the registrar followed the hospital's documented procedures and had his provisional diagnosis been reviewed by a consultant psychiatrist, a more experienced practitioner would have recognised the leaps in logic that were being made and Mr Waite may have been admitted for further investigation. It is impossible to speculate what this may have revealed or whether it would have had any bearing on the final outcome.

It is material, however, to observe that when junior police officers make the appropriate decision based on their knowledge of the situation to take a member of the public to a mental health facility, they are entitled to expect that the information they provided will be given more weight. I frequently hear of the frustration police feel at having to deal with the sufferers of mental illness who should be dealt with by the health system not the criminal justice system. This case would seem to validate those concerns. I shall return to the issue in the recommendations chapter.

Was Mr Waite's mental health care appropriately managed by the Logan Community Mental Health Unit (the CMHU)?

I was greatly assisted by the report and oral evidence of Dr Jill Reddan, a very experienced psychiatrist who was retained by my office as an independent expert. She thought that the most significant concern relating to Mr Waite's mental health care was the circumstances in which he was discharged from the Logan Community MHS about a month before his death. Her concerns were that Mr Waite's difficulties with substance abuse were given disproportionate weight, that *"the right hand did not know what the left hand was doing"*; that *"Dr Davies sort of grafted himself onto the team"* and that *"the matters for discussion were not being recorded".* Dr Reddan considered that more assertive outreach in terms of encouraging Mr Waite to see Dr Davies was required and a consultation with Dr Davies would have facilitated better integration of his forward management. Dr Reddan opined it would have been preferable for Mr Waite's treating team to have arranged for him to receive treatment from ATODS in a coordinated fashion or at the very least, for more concerted efforts to have been made to ensure that he was linked up with ATODS.

I acknowledge that staff of the ACT made ongoing efforts to encourage Mr Waite to constructively engage with his illness but they provided very little actual treatment; failing to even establish a firm diagnosis. Despite having adequate information about his history and current symptoms to alert them to the likelihood he was suffering a re-emergence of some mental disorder, they chose to discharge him without his ever being seen by Dr Davies, the consultant psychiatrist to the team. I can readily understand the concern of Mr Waite's mother who felt that the MHU staff failed to have sufficient regard to the fears she relayed to them about her son's condition and her resentment at their efforts to persuade her Dion was not suffering from mental illness. I also acknowledge, however, there was insufficient basis for the making of an involuntary treatment order in relation to Mr Waite and when attempts to persuade him to see Dr Davies were rebuffed there was little more the ACT could have done.

The "bouncing" of patients back and forth between mental health and ATODS has long been recognised as undesirable and this case is a typical example of that. There was absolutely no reason why Mr Waite's drug and alcohol problems could not have been addressed simultaneously with his mental illness. Undoubtedly the combination of these two problems made treating Mr Waite more difficult but as a result of the course adopted by the MHU, neither was addressed.

A cynic might even consider that it was his failure to accept their offers of assistance that led the ACT to conclude he should be discharged from the MHU program and referred to ATODS.

Obviously the management of the ACT was suboptimal: no minutes were kept and there was an incomplete shared understanding of what was decided during case management meetings. Further the workload of Dr Davies meant that the team did not have adequate input from a psychiatrist. I understand that this has now been addressed and the other deficiencies have been remedied.

The Acting Director of Mental Health Dr Ness McVie gave evidence and accepted there are some basic principles treating teams should apply when determining whether to close a client's file and there would be no practical impediments to implementing a state wide policy that would reflect these principles. She also accepted these were not followed in this case.

The management of the "siege"

The officers who responded initially effectively isolated Mr Waite in the house and secured the scene.

Delay in arrival of negotiators

It is regrettable that over an hour and twenty minutes transpired from the time police were notified of the situation until negotiators arrived. It is impossible to be confident that negotiators would have any more effectively engaged with Mr Waite than did the other officers who repeatedly tried to persuade him to cease his violence. However, in a suburban setting more ready access to such important resources would be desirable.

Manning of the inner cordon

I accept the wisdom of moving the officers manning the inner cordon from the back yard of the incident house in view of its high fences: they may have been endangered if Mr Waite had suddenly run at them. However, the manner of their deployment in the yard of the adjoining property was sub-optimal. They did not position themselves so they could see the house or so its occupant, Mr Waite, could see them. It seems likely it was this lack of a visible presence that caused Mr Waite to exit the property where he did. It is fortuitous he jumped the back fence of his house near the front property line of the adjoining property as the three officers, Buick, Pannowitz and Quill who were standing talking near the front corner of the neighbouring house were not paying sufficient attention to even be aware he had left his house. They heard over the police radio and from the shouting of more observant officers that the subject was jumping the fence. They adjusted quickly and moved with him down the driveway and onto the street. Officers Pannowitz and Buick displayed considerable courage in trying to persuade Mr Waite to drop his weapon and surrender but it seems he was in no state to understand their commands.

Failure to warn of intention to shoot

Indeed, in view of his deranged state I consider it most unlikely that the failure of Senior Constable Quill to warn Mr Waite he would shoot before doing so, as is required by police procedures, made any difference to the outcome in this case. However, that was not an assessment Mr Quill was entitled to make. It is an issue that was raised in a number of cases and will need to be addressed.

Leashing of the police dog

I accept the officers could not reasonably have allowed Mr Waite to leave the area and the decision of Senior Constable Quill to deploy the police dog was reasonable in the circumstances. I am concerned, however, about the way in which the officer sought to maintain control of his police dog by giving him a command to apprehend Mr Waite while the dog was still attached to a lead held by the officer. The lead was only some three metres long and the officer's actions meant he was much closer to Mr Waite than was safe in the circumstances.

Conclusion

Apart from these relatively minor lapses, I consider the situation was well managed. I consider the officers who attended repeatedly tried to de-escalate the situation by talking to Mr Waite and when they could not persuade him to come out they backed off and awaited the arrival of negotiators and the Special Emergency Response Team. The actions of Mr Waite then brought matters to a head and the officers were left with no choice but to shoot.

Part 3 – Findings into the death of Mieng Huynh

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Introduction

Just after dawn on Boxing Day 2003 Mieng Huynh, without warning or provocation, stabbed an elderly neighbour who was sitting on his front veranda in inner city West End.

He also stabbed another neighbour who responded to the calls of the first and a little while later he stabbed a teenage boy in the street in front of the unit block where the first two attacks occurred.

Police were called and saw a man matching Mr Huynh's description on the footpath a few blocks from where the earlier attacks had taken place. As they approached him Mr Huynh attacked a council worker watering treis on the footpath. The police officers pulled Mr Huynh off the council worker and attempted to disarm him with the use of OC spray. He regained the knife and ignored their repeated instructions to drop it. He was shot five times and died at the scene.

At the time of his death Mr Huynh was an involuntary patient under the Mental Health Act but was allowed to reside in the community subject to certain conditions.

These findings explain how the death occurred and consider whether any changes to the procedures, policies or practises of the Queensland Police Service or the Queensland Health mental health services could reduce the likelihood of deaths occurring in similar circumstances in the future.

The investigation

As would be expected, senior police arrived promptly on scene and ensured the two crime scene areas were cordoned off and secured to enable investigations to be undertaken. A log of events at the Vulture Street shooting scene was commenced.

Specialist police, including scenes of crime, scientific and ballistics officers attended and conducted examinations. Photographs and video-recordings were taken of the scene and items of interest and exhibits were seized. Interactive crime scene recording was conducted of the shooting scene in Vulture Street. A plan drawn to scale was prepared.

Senior Detectives from the Homicide Investigation Unit attended and Detective Sergeant Edwards was appointed as the primary investigator.

Senior investigators from the Ethical Standards Command and the Crime and Misconduct Commission also attended the scene and undertook an over-viewing role on behalf of their respective organisations.

The officers involved in the shooting were driven in separate cars to the West End police station and kept apart until after they were interviewed to avoid any perception of collusion or the unintentional corruption of their recollections of the incident.

In order to gain a greater understanding of the circumstances of this complex incident, I attended the scenes later that day and also observed the "walk through" interview with Constable Hyland.

I am satisfied that the investigation was thorough and impartial. Sergeant Edwards is to be commended on his work.

The evidence

Family history

Mr Huynh was born in Saigon, Vietnam on 16 January 1963 making him 40 years of age at the time of his death. He was the youngest of six children and he reported his childhood was reasonably happy. One of his brothers was presumed to have died in the war and both of his parents are deceased.

Mr Huynh was a Buddhist and spoke Mandarin, Cantonese and Vietnamese.

Little else is known about his family circumstances in Vietnam.

Social history

His exact level of education is unclear, however, it would appear that Mr Huynh achieved about 8 years of education in Vietnam. His education might well have been interrupted by the war and subsequent upheaval in Vietnam. He also appears to have received some informal training in mechanics.

Mr Huynh migrated alone to Australia in 1983. After his arrival, he lived in Sydney and obtained Australian Citizenship in March 1987. He worked mainly in factory type employment such as a forklift driver, spray painter and welder.

Sometime in 1992, he appears to have relocated to Queensland. It is at this time he first came to the attention of Queensland Police. His contact with police will be detailed later in these findings. It is also clear he was somewhat transient and returned to Sydney to live from time to time

In 1998 Mr Huynh obtained employment with a Vietnamese couple, Tam Van Troung and Nga Tran who owned a bakery at Mount Warren Park where he was living at the time. Unfortunately, he made several unwelcome advances towards Ms Tran and his employment was terminated. His conduct also led to him being charged with unlawful stalking of Ms Tran.

Following this contact with the criminal justice system Mr Huynh moved away from the area and relocated to West End in order to distance himself from exposure to Ms Tran.

In 1999, he undertook a TAFE bakery course and worked as a baker's assistant for a brief period.

In March 2001, Mr Huynh returned to Vietnam and married a Miss Thanh Binh Le, a resident of Vietnam. It is not known how he came to know Ms Le but his friends believed the relationship blossomed through letters and email.

Mr Huynh returned to Australia in June 2001. In October, he informed his mental health caseworker, Mr Seefeld, he was making arrangements through the Department of Immigration for his wife to join him in Australia. However, Mr Seefeld considered that Mr Huynh was not making a concerted effort for this to occur.

Mr Huynh's accommodation varied from boarding houses and hostels to private rented residences and Housing Commission units.

A Mr Sang Nguyen gave evidence he befriended Mr Huynh after they met in West End after Mr Nguyen heard him speaking Vietnamese as they passed on the street. When Mr Nguyen became aware of Mr Huynh's isolation and mental illness he looked after him. He provided Mr Huynh with accommodation, monitored his medication compliance and took him to the hospital when it became apparent Mr Huynh's condition was becoming acute. He said in evidence that when Mr Huynh would call out for long periods in the night, a result no doubt of auditory hallucinations, it made him difficult to live with especially as Mr Nguyen had to go to work early. However, he knew Mr Huynh had nowhere else to go and so tolerated the aberrant behaviour. Mr Huynh lived with Mr Nguyen and his wife for the last two years of his life. I am sure the support the couple gave Mr Huynh ameliorated some of the effects of his mental illness.

In November 2003, Mr Huynh obtained employment as a delivery driver for an Asian food company at West End. He was subsequently transferred to a role loading the deliveries as his employers considered he was unable to manage the demands of the driving position.

On 5 December 2003, Mr Huynh relocated to a new residence in Browning Street, West End where he would live on his own. This was part of his plan to set himself up in circumstances in which his wife could join him.

Previous interaction with police

Mr Huynh's first dealings with Queensland Police occurred in 1992, when he was charged with break and entering offences for which he was ordered to perform 200 hours community service. Again in 1992, he was charged with possession of stolen property and failed to appear causing a bail warrant to be executed upon him. He was convicted and fined $60 in relation to this matter.

In 1993, he was sentenced in the Brisbane District Court to 12 months imprisonment for breaking and entering a dwelling house and stealing.

In 1995, Mr Huynh was involved with violence towards police for the first time. He was located carrying a suspicious bag which was searched and a knife wrapped in a T-shirt was located. He then refused to supply police with his name and became violent towards the police, including spitting on them. He was charged with serious assault; fail to state name and address and obstructing police. As he had no fixed place of abode, he was remanded in custody for 9 days. He was convicted and not further punished when dealt with by the courts. Again in 1995, he was charged with using threatening words and convicted and fined $100.

His next recorded dealing with police was in 1999, when he was charged with breaching his bail conditions, unlawful stalking and unlawful entry of a dwelling house. These charges were dismissed. The circumstances were that he commenced working at a bakery south of Brisbane which was owned by a Vietnamese couple, Tam Van Troung and Nga Tran. Mr Huynh made unwelcome advances towards Ms Tran and made disparaging remarks concerning her husband. Apparently, Mr Huynh believed that her husband was treating her badly. His employment was terminated. Later, he was found inside the couple's residence, police were called and he was arrested and charged. He was released on bail on the condition he not approach the couple or their residence. The next day Mr Huynh attended at their bakery and refused to leave. Police charged him with unlawful stalking and breach of bail. He was remanded in custody. He was examined by a Government Medical Officer in the watch house who considered he was in need of a mental health assessment and was therefore transferred to the John Oxley Centre. He was found to be of unsound mind and the charges were later dismissed. He was then issued with a Mental Health Act order and transferred to the Princess Alexandra Hospital for treatment prior to being returned to the community under the direction of the Princess Alexandra Hospital District, Division of Mental Health.

Two other incidents also demonstrate Mr Huynh's continuing bizarre behaviour. In 2002, Mr Huynh was located by his care worker standing and staring at a lady at a coffee shop. He told his care worker the lady was talking to god and he was waiting to ask her about dogs. There is no record in his criminal history of a prosecution being commenced in this instance. In 2003, police detained Mr Huynh after he had been following a woman not known to him, around the inner city shopping area. Security confronted him and he became hostile and accused them of being "evil". There is no record of a prosecution being commenced in connection with this incident.

Mental health history and treatment

It appears Mr Huynh first developed a psychotic illness in 1997 while residing in New South Wales. The circumstances surrounding the diagnosis are not known.

The following year he returned to Brisbane and obtained employment at a bakery at Mr Warren Park. As has been mentioned earlier, he made a number of unwelcome advances to his employer's wife, was sacked and charged but returned to the premises despite that being in breach of his bail. When he was remanded in custody, he was referred to the John Oxley Memorial Hospital, where he remained a regulated patient until 20 May 1999.

Initial diagnosis in Queensland

The records show that on admission to the John Oxley Memorial Hospital, Mr Huynh was grossly thought disordered and fatuous, with disorganized persecutory delusions. He claimed to be hearing the voice of his deceased brother. He was found to be psychotic and a diagnosis of schizophrenia of the disorganized sub-type was made. Neuroleptic medication was prescribed to treat this illness and resulted in a reasonable recovery. On 20 May 1999, he was transferred to the Princess Alexandra Hospital ("the PAH") to be re-integrated into the community. He remained an inpatient until 31 May 1999.

The PAH was the inpatient mental health facility for the Princess Alexandra Hospital Health Service District. The West End Adult Mental Health Service ("the MHS") provided community care to persons with mental illnesses in the district. Mr Huynh was a client of the community and hospital mental health services from the time of his first admission in March 1999 until his death in December 2003. Dr Janice De Souza-Gomes was his treating psychiatrist and assessed him at least bi-monthly and more frequently when necessary. A number of mental health workers were involved in monitoring his welfare and working with him in the community in the four and a half years he was cared for by the service.

Over this time Mr Huynh required approximately 10 separate inpatient admissions to the PAH which were mostly related to his non compliance with medication. Dr De Souza-Gomes was responsible for supervising the treatment provided to Mr Huynh during these admissions. Deterioration in his self care and ability to organize himself, in conjunction with bizarre and paranoid beliefs and generally disturbed behaviour, were the typical indicators of a significant relapse requiring hospitalization.

The forensic order

Mr Huynh was referred to the Mental Health Tribunal for assessment in relation to his involvement in the March 1999 incidents. On 15 July 1999, the Tribunal found him to be of unsound mind in relation to the charges he was facing. He was placed on a forensic order, the conditions of which required:-

- he attend the MHS for after care;
- he reside at an address approved by Dr De Souza-Gomes;
- the PAH be advised of any changes to his residential address and any significant breaches of conditions of leave including a refusal to continue treatment;
- he be reviewed by the Patient Review Tribunal at regular intervals; and

- Dr De Souza-Gomes informs the hospital administrator or clinical director if she at any time formed the view his leave needed to be revoked.

Around this time Dr De Souza-Gomes commenced Mr Huynh on Melleril, an anti-psychotic. This medication seemed to control Mr Huynh's symptoms but by February 2000, he was reporting tiredness and sedation which Dr De Souza-Gomes thought may have been a side effect of the Melleril. She therefore changed his medication to olanzapine, an atypical anti-psychotic. Some three months later, Mr Huynh was evicted from the boarding house where he was residing and on 24 May 2000 he was admitted as a regulated patient to the PAH. He was incoherent and was exhibiting clearly psychotic behaviour with thought disorder and spiritual themes of healing powers. It was apparent this relapse had been caused by non compliance with his medication. He absconded from the hospital on 27 May but voluntarily returned on 1 June 2000 and remained an inpatient until 28 June 2000.

In early August 2000, Mr Huynh's case manager, Ms O'Brien reviewed Mr Huynh's medication and found he had not taken it for the previous month. He was erratic and unable to organize himself. He did not attend his scheduled appointment with Dr De Souza-Gomes on 2 August 2000 and she made the decision to commence him on bi-monthly 40mg fluxopenthixol depot injections. This was first administered the following day.

Dr De Souza-Gomes reviewed Mr Huynh a fortnight later. He told her he did not want to be on the depot medication but gave her no sound reason why. She explained to him she did not feel she could put him back on oral medication because in the past he had not taken it. On review six weeks later, Mr Huynh complained to Dr De Souza-Gomes of restlessness and akathisia, which she thought were probably adverse effects of the depot medication. She decided to reduce the frequency of the depot injections from bi-monthly to tri-monthly. A few days later Ms O'Brien found Mr Huynh to be extremely distressed and restless. In an attempt to address the continuing side effects of the medication, Dr De Souza-Gomes reinstituted bi-monthly injections but halved the dose to 20mg. By 23 October 2000, the side effects had not abated and Dr De Souza-Gomes felt she had no choice but to cease administering the medication in depot form. Mr Huynh indicated to Dr De Souza-Gomes he would take oral medication and he was recommenced on olanzapine 10mg to be taken at night.

Over the next few months Mr Huynh was relatively stable and occupied his time by looking for a job as a cleaner and pursuing his interests in science and medicine by attending the museum and library. His case manager saw him weekly and in late November 2000 he was reviewed by Dr De Souza-Gomes and she made it clear to him if he did not keep taking his tablets she would need to recommence the depot medication.

In early 2001, Mr Huynh did not attend the MHS for his scheduled appointments and on 13 February 2001, his flat mate took him to the emergency department at the PAH as he had been talking to himself and

walking around with no pants on. He was admitted but absconded from the hospital the following day. He voluntarily presented at the emergency department again on 23 February 2001, at which time he said he was there *"to visit the house and visit the spirits".* He was readmitted but absconded again on 3 March 2001. He was found three days later by his carer and returned to the hospital where he remained an inpatient until 12 March.

Between April and June 2001, Mr Huynh returned to Vietnam to marry a woman with whom he had been corresponding. On his return he did not attend the MHS as he had been instructed to do.

On 20 September 2001, he was taken to the emergency department by his flat mate, Mr Nguyen because over the previous week he had become increasingly confused and had not eaten unless prompted. He had not been taking his medication. He was made the subject of an involuntary treatment order and consideration was given to recommencing him on depot injections, although this does not appear to have occurred. Mr Huynh absconded on 24 September and was returned by the police on 25 September. He absconded again on 28 September 2001. Mr Nguyen returned him to the hospital on 19 October 2001 on account of disorganized behaviour and the fact he had not been taking his medication. The following day he absconded yet again. Dr De Souza-Gomes indicated on his return Mr Huynh should be recommenced on fluxopenthixol in depot form. She requested his case manager contact his flat mate and visit him at his last known address. Attempts in this regard were unsuccessful.

On 31 January 2002, Mr Nguyen took Mr Huynh to the PAH as he was going overseas and therefore could not look after him. On admission Mr Huynh appeared to be pre-occupied with auditory hallucinations. Once again he had not been compliant with his medication. Dr De Souza-Gomes assessed him on 4 February 2002. She was content to continue prescribing him olanzapine 10 mg daily and requested a new case manager be appointed as Mr Huynh had not engaged with the MHS for seven months. Mr Huynh walked out of the ward the following day but voluntarily returned less than 24 hours later. On 21 February his daily dose of olanzapine was increased from 10 to 20 mg and on the following day he was discharged.

Three days later Mr Huynh's case manager visited him at home and gave him the contact details for the Ethnic Mental Health Service. Mr Huynh was reassessed by Dr De Souza-Gomes on 12 March 2002 at which time she reduced his daily dose of olanzapine from 20 to 15mg on account of its sedating side effects. Two weeks later, on 26 March 2002, Mr Huynh's case manager spoke to one of his flat mates and she indicated she did not think he was taking his medication. The case manager saw Mr Huynh the following day and he denied this.

Approximately two weeks later, Mr Huynh was found by his case manager standing and staring at a lady in a coffee shop. He told his case manager she was talking to God and wanted to ask her about her dog. He was admitted to the PAH and on admission he reported auditory hallucinations. It was thought

that yet again his deterioration had been precipitated by non compliance with his medication. He was seen by Dr De Souza-Gomes on 16 April 2002, at which time she decided because Mr Huynh was unable to tolerate depot medication she would increase his daily dose of olanzapine again from 15 to 20 mg, with a weekly review by his case manager. She considered Mr Huynh's flat mates could be asked to assist in monitoring his compliance.

When reviewed in July 2002, Dr De Souza-Gomes reduced his daily dose of olanzapine to 15mg because Mr Huynh reported that he was sleeping sixteen hours per day. In September 2002, Mr Huynh requested his medication be reduced. Dr De Souza-Gomes considered this was reasonable and reduced the olanzapine to 10mg per day which was the dose he had been initially prescribed in October 2000.

The forensic order which had been imposed on 15 July 1999 was revoked on 8 October 2002. This was in recognition of there having been no further re-offending behaviours and the fact he had been apparently compliant with his medication over the previous six months. When one has regard to the incident that precipitated his inpatient admission in April, and his history of non compliance with his prescribed medication, this decision seems questionable.

Treatment as a voluntary patient

However, this improvement was short lived and on 25 October 2002, Mr Huynh admitted he had not been taking his medication and showed his case manager two boxes of untouched olanzapine tablets. It was considered Mr Huynh required inpatient treatment but there were no beds available. Arrangements were made for an interim care co-ordinator to look after him over the weekend and he was taken to the emergency department of the PAH where he was administered 40 mg of fluxopenthixol in depot form and was recommenced on olanzapine 20mg.

Dr De Souza-Gomes assessed Mr Huynh on 29 October 2002 and her plan was to closely monitor Mr Huynh's compliance with medication and to consider administering another depot injection in a further two weeks if his condition had not improved.

On review on 19 November 2002, Dr De Souza-Gomes found Mr Huynh's condition to be much improved and reduced his daily dose of olanzapine to 15mg. She requested his case manager to liaise with a support worker from the Multicultural Centre for Mental Health and Well-being ("the MCMH&W).

For the remainder of November until 5 February 2002, Mr Huynh did not have contact with the MHS. He did not attend an appointment with Dr De Souza-Gomes on 24 December 2002. The support worker from the MCMH&W was unable to find him at home. At a team review meeting on 17 February 2003, it was decided Mr Huynh would need to be allocated a new case manager due to organizational changes within the MHS. This appointment did not take place until mid April 2003, when Ms Bonney became his interim case manager.

On 14 May 2003, Mr Huynh's female flat mate reported to Ms Bonney that Mr Huynh had been physically and verbally aggressive at home. When he gave evidence at the inquest, Mr Nguyen suggested that Mr Huynh had simply been talking loudly as he had done on many previous occasions prior to him being admitted to the PAH. He was admitted to hospital at which time he was annoyed and was considered to have poor insight. It became apparent Mr Huynh had once again not been compliant with his medication. When reviewed by Dr De Souza-Gomes on 15 May 2003, she thought Mr Huynh's decision not to take medication may have been contributed to by the sedative effects of the olanzapine and for this reason she ceased it and decided to trial him on amisulpride, another anti-psychotic.

Mr Huynh absconded on 18 May 2003 but returned later that day. He was discharged on 28 May 2003 with a prescription of 60 x 400mg tablets of amisulpride and was instructed to take two tablets each day.

Less than two weeks later, on 11 June 2003, Mr Huynh was detained by the police after he was reported to be following a woman in the city. When confronted by security officers, he accused them of being evil. The MHS was contacted resulting in inpatient treatment for a week. The admitting doctor spoke to one of Mr Huynh's flat mates, Mr Phan and was told he had not been able to keep him at home as he was agitated and prone to wandering. Mr Huynh was clearly psychotic. During this admission, Belinda Khong, psychologist was appointed as Mr Huynh's case manager as she could converse with him in Cantonese. He was discharged on 18 June 2003 with another box of 60 x 400mg tablets of amisulpride.

Dr De Souza-Gomes reviewed Mr Huynh on 26 June 2003. He was calm and cooperative and claimed to have no recollection of the events leading up to his admission and appeared embarrassed when they were recounted to him.

In September 2003, Mr Huynh told Dr De Souza-Gomes that he was taking his medication and wanted to study maths and astronomy at university. He was concerned he had been unemployed for a number of years and wanted to work as a cleaner but had no real idea how to secure such employment.

On 1 October 2003, Mr Nathan Seefeld, psychologist, replaced Ms Khong as Mr Huynh's case manager. Ms Khong had seen Mr Huynh very regularly over the four month period while she had been his case manager. In taking over this role, Mr Seefeld considered it was his responsibility to assess Mr Huynh's areas of need and work with him with respect to having those needs met.

Mr Seefeld had contact with Mr Huynh on 17 occasions over the following three months until the time of his death. Mr Huynh told Mr Seefeld he had returned to Vietnam in 2001 to get married and Mr Seefeld believed one of the major driving forces in Mr Huynh's life was providing his wife with an opportunity to immigrate to Australia. Mr Huynh understood he needed to get a full-time job in order to sponsor her. Mr Seefeld's efforts with Mr Huynh were directed at assisting him to find employment and a place of his own in which he would be able to live with his wife.

On 8 October 2003, Mr Seefeld visited Mr Huynh at home. He was co-operative, pleasant and responded appropriately to questions. Mr Seefeld asked him about his medication. Mr Huynh showed Mr Seefeld a packet of amisulpride and assured him he was taking two tablets daily after lunch. Mr Seefeld could not recall whether the packet was a box or blister packet. He did not count the tablets in the packet, nor did he seek to ascertain when the packet had been dispensed.

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The following morning, Mr Huynh's flat mate telephoned Mr Seefeld as he had been yelling out during the night and it was apparent his condition had suddenly deteriorated. The notes in the MHS file record the flat mate telling Mr Seefeld she felt concerned for her safety and that of the other flat mates. When he gave evidence, Mr Nguyen recalled Mr Huynh had been yelling out during the night so that no one could sleep. Mr Nguyen was concerned because his wife was pregnant at the time and he thought if he was not home, Mr Huynh might push his wife or continue talking loudly and disturb the unborn baby.

Following the phone call, Mr Seefeld went to see Mr Huynh at his home. Mr Huynh expressed concern about a female neighbour and said he wanted to kill her. He said he had been attacked during the night but gave no further details. In consultation with Dr De Souza-Gomes, Mr Seefeld facilitated his admission to hospital. Mr Huynh cooperated without incident and told the admitting doctor he had not been taking his medication. That evening, Mr Huynh made an unprovoked assault on another patient but apparently no significant injuries were sustained. When reviewed by Dr De Souza-Gomes on 16 October 2003, he denied he had been non-compliant prior to his admission. She noticed a bilateral tremor which she thought was likely to be secondary to the amisulpride which he had been administered while in hospital. Mr Huynh was discharged on 23 October 2003 with the assistance and support of Mr Seefeld. He was given another box of 60 x 400mg tablets of amisulpride. He was placed on an involuntary treatment order ("ITO") with community leave based on the usual conditions he take his medication, receive visits from his case worker and keep the MHS advised of his place of residence, etc.

On 6 November 2003, Mr Huynh secured work for two hours per day cleaning a local bakery in West End. On 11 November 2003, he told Dr De Souza-Gomes he was no longer experiencing auditory hallucinations. She considered his ITO could be ceased, which occurred two days later, the effect of which was to make him a voluntary patient. On this same day, Mr Seefeld visited Mr Huynh and he indicated the job was coming to an end because the business was being sold. Mr Seefeld asked to see his medication and Mr Huynh showed him 70 x 400mg tablets of amisulpride which Mr Seefeld counted. This apparently satisfied him that Mr Huynh was taking his tablets as required.

By 19 November 2003, Mr Huynh had found himself another job as a delivery driver for an Asian food company. He was responsible for assembling orders of imported foods and delivering them to sites around Brisbane. Mr Seefeld discussed this job with Dr De Souza-Gomes and she was somewhat concerned as she thought it might have involved Mr Huynh operating a forklift. She told Mr Seefeld to tell Mr Huynh if he did not take his medication she would have to contact the Department of Transport and have his license taken away.

Mr Seefeld visited Mr Huynh at his home on 3 December 2003. He was getting ready for work. Mr Seefeld discussed with him he was likely to be offered a unit of his own by the Housing Commission. During the course of the visit, Mr Seefeld again counted Mr Huynh's medication. He noted he had 30 of the 70 tablets remaining, which demonstrated to Mr Seefeld he had been compliant with it since he had last counted approximately three weeks earlier on 13 November 2003.

A few days later Mr Huynh moved into his own unit at 8/35 Browning Street, West End. On 12 December 2003, Mr Seefeld made a note in the MHS file to the effect it was apparent Mr Huynh's mental state had deteriorated to some extent on account of his recent move and his new job. Mr Seefeld had been given the impression from Mr Nguyen that Mr Huynh was extremely excited about this change in his living arrangements. However, in retrospect, it is likely this change in conjunction with his new job may have been major stressors for him.

A tri-monthly team review meeting was held on 22 December 2003 at which time the need to monitor Mr Huynh's compliance with medication was discussed. Mr Seefeld took up with him again the following morning when he found him walking to work. He says Mr Huynh was quite disorganized in speech and thought and spoke freely of delusions involving Tony Blair, John Howard, NASA and DNA. Mr Seefeld was concerned he may not have been taking his medication and made a note in the file to check it on his next visit in about a fortnight. He said in evidence he was otherwise not overly concerned with Mr Huynh's presentation because his illness was chronic and even when he was stable he had residual levels of delusions along with unrealistic and over-valued ideas. In fact, Mr Seefeld felt he had not seen Mr Huynh happier. He thought Mr Huynh's presentation could in part, be explained by his change in living arrangements and his demonstrated ability to hold down a job.

Later that day, Dr De Souza-Gomes reviewed Mr Huynh when he came to the MHS at the PA. He had with him a cardboard box full of household items which he said his employer had given to him. He referred to an encyclopaedia type book and pointed to a photograph of the Queen stating she resembled his mother. Dr De Souza-Gomes could find no evidence of persecutory delusions or visual hallucinations. His thoughts were somewhat disorganized and difficult to follow but Dr De Souza-Gomes felt his presentation was consistent with his mental state when stable. Mr Huynh stated he was taking his medication and he had collected a repeat prescription in the previous

week. It seems this prescription was never filled. This was the last occasion on which Mr Huynh was seen by anyone from the MHS.

Events in the days leading up to the death

As mentioned earlier, on 23 December, 2003 Mr Huynh saw both his case worker and his psychiatrist. To both he appeared slightly delusional but on their evidence, this was his usual state, even when adequately medicated. Significantly, he was not observed to be displaying any aggressive or violent behaviour.

At approximately 9.30pm on Christmas Day, Mr Huynh visited his friends Sang Nguyen, his wife Han Luu and Hong Phan in Turin Street where he had lived until a few weeks previously.

His friends were aware of his mental illness and were very supportive and caring of him. On this evening his friends noticed he was carrying a book with him and saying strange things. They instructed him to go home to bed and a short time later he complied with their request and left.

Later that evening Mr Huynh returned to the Turin Street premises. His friends estimated this was between 11.00pm and 12.30am on Boxing Day morning. Mr Phan got up to talk to Mr Huynh. He reported that Mr Huynh talked about the man on the moon and other nonsensical matters.

Mr Phan kindly walked Mr Huynh back to his unit. En route they stopped at a convenience store where they bought milk and bread. Mr Phan then walked home.

He recalls being awoken later in the night by knocking on the door. He ignored the noise believing it to be Mr Huynh and went back to sleep. At about 4.30 am Mr Nguyen got up when Mr Huynh again knocked on the door. He thought Mr Huynh looked very tired and strained. He was talking “nonsense”. After a few minutes, Mr Huynh complied with Mr Nguyen’s request to leave. Mr Nguyen assumed he was going home as he told him to go to sleep. His friends did not see Mr Huynh again.

Events of the day of his death

Psychotic rambling

It seems likely that after leaving his friends place in Turin Street, Mr Huynh did not settle but continued to roam around. One of the residents of the unit block where he lived said she heard someone come and go from unit 8 about half a dozen times during the night and early morning.

At about 4:45am another neighbour heard him calling out loudly. He couldn’t understand what Mr Huynh was saying but the tone of his exclamations is illustrated by that witness’ comment, “*I thought he may have been calling out to a god or something in his own language*”. When challenged by the neighbour Mr Huynh responded appropriately, apologised and stopped calling out.

His compliance was short lived: a few minutes later a woman who lived in a unit at the front of the block, Olivia Varadi, heard him walking up the driveway calling out as he went. She saw him walking on the footpath "*looking to the sky and yelling out 'oi, oi' to the birds or sky or someone up above. I remember thinking at this time that he was loopy".*

Attacks on neighbours

Shortly after 5.30am, George Drougkas was sitting on the front veranda of his unit on the ground floor in the same unit block. His unit also fronted Browning Street. He says he saw a man we now know was Mr Huynh, walk down Browning Street towards Boundary Street and return. He did this three times. When he returned on the third occasion Mr Huynh came up the stairs to the veranda where Mr Drougkas was sitting. When he got very close Mr Drougkas saw him raise his right arm and Mr Drougkas realised he was holding a knife. Before he could move, Mr Huynh then stabbed Mr Drougkas in the throat. Mr Huynh then just turned and ran off.

Mr Drougkas called for help and a number of people came out of their homes and units to attend to him. One of the first neighbours to reach Mr Drougkas was Mary Cosh. While she was consoling him and looking at his wounds, Mr Huynh came up behind her and without warning also stabbed Mrs Cosh. Before she left her unit, Mrs Cosh had told her daughter to ring the police. This call was received at 5.44am.

Another person who came out to lend assistance was Daniel Johnson, the fifteen year old grandson of Mrs Varadi. He and his grandmother went up to Mr Drougkas while he was being comforted on the footpath outside his unit. He saw Mr Huynh coming up the driveway of the unit block and noticing blood on his clothing assumed he too may have been attacked.

However, Mr Drougkas identified him as his assailant. He says Mr Huynh responded to the allegations by saying "*No, no it wasn't me*" but when Mr Johnson challenged that denial by saying, "*You got blood on you*", Mr Huynh produced a knife with his right hand from inside the front of his pants. He came towards Daniel who, when Mr Huynh was about two metres away, tried to run. He says he first shuffled backwards and as he was turning he tripped and fell on his back on the footpath. He says Mr Huynh then got down on top of him and stabbed him in the left shoulder and then in the right side of his chest before Daniel could grab his assailant's right hand and prevent any further wounds. Daniel said Mr Huynh was not very strong and he was able to get up and hold the hand with the knife away from him. He says they were in this position struggling on the road way for some time and he felt his strength ebbing when another neighbour intervened.

Janet Vasie says she picked up a piece of wood from Mr Drougkas' front garden and approached Mr Huynh who was at that stage still struggling with Daniel. She said she raised the wood above her head and called on Mr Huynh to "*let him go*". Mr Huynh complied. It was apparent to Ms Vasie, whose brave and decisive action warrants commendation, that Mr Huynh *"seemed that he*

was not all there". The danger to Mr Johnson was not over however, as while her intervention allowed him to release his grip on Mr Huynh and step back, Mr Huynh then produced another knife and when Mr Johnson turned to flee he was cut on the lower back.

Mr Huynh then walked away down Browning Street. Another neighbour, Robert Swain, followed and saw him turn left into Russell Street and left into Boundary Road. Mr Swain then saw a police car heading towards Browning Street and so ran back to tell the officers what he had seen of the offender and his movements.

The first police officers arrived at the Browning Street address at about 5.49am. An ambulance was already in attendance. Over the next few minutes numerous other police vehicles arrived at the scene and others who had responded to the radio call for assistance were given a description of Mr Huynh and instructed to patrol the area.

The next reported sighting of Mr Huynh was by a woman walking her dog in Vulture Street a few blocks from where he had previously lived. Wendy Brown's attention was drawn to him by the blood she noticed on his feet and about his mouth. He passed her near the intersection of Princhester and Vulture Streets heading east – back towards Browning Street. After they passed each other, she stopped and looked back; concerned he may be seriously injured. She saw him continuing towards the intersection of Boundary and Vulture Streets.

A further stabbing

He was also seen in a similar location by Mark Stokes, a gardening contractor who stopped his truck carrying a water tanker on the opposite side of Vulture Street adjacent to its intersection with Princhester Street. Mr Stokes had not noticed anything unusual about Mr Huynh but as he was in the process of connecting a water up stand to a fire hydrant outlet in the footpath, he noticed a shadow and/or felt the presence of someone approaching him from behind and so he stood up. Before he could turn around he felt the person strike him in the middle of the back. He then turned and saw Mr Huynh with a knife raised and appearing to be intent on again attacking him. He says Mr Huynh's eyes appeared vacant; he said nothing and made no noises; he just attacked. Mr Stokes grappled with Mr Huynh and they both fell to the ground. Mr Stokes called for help and took hold of the knife blade to prevent Mr Huynh from stabbing him in the chest.

It was in this position they were seen by Ms Brown when she looked back in response to the sound of yelling.

The calls for assistance also caused Ms Clarke and her two children to come out onto the balcony of the first floor apartment in the building abutting the footpath immediately adjacent to where the attack was occurring. They all agree that Mr Stokes and Mr Huynh were on the footpath with their heads towards the truck between the front and back wheels. Ms Clarke described how the position of Mr Stokes' hands near his neck and his shaking arms

made her think he was having a seizure. It was only later she realised the shaking was caused by the effort he was exerting in resisting the attempts of Mr Huynh to stab him.

Interaction with police

The attack was also witnessed by Constables Goeths and Hyland as they drove in a westerly direction along Vulture Street towards its intersection with Boundary Street. They had been patrolling the area looking for the person responsible for the stabbings in Browning Street when Constable Goeths saw Mr Huynh run across Vulture Street and recognised he matched the description they had been given. He says he saw Mr Huynh run up behind Mr Stokes and appear to strike him in the back with a two handed blow. Both officers say they then saw the two wrestle and fall to the ground. They then saw Mr Huynh had a knife.

Constable Goeths parked his vehicle nose to nose with the water truck and ran to where Messrs Stokes and Huynh were struggling. He was followed by Constable Hyland who immediately drew her firearm on the basis the safety of Mr Stokes and the two officers was clearly threatened by the actions of Mr Huynh. Both officers say Constable Goeths on two occasions went right up to Mr Huynh and took hold of his neck so he could administer capsicum spray. It had no effect. The officers say while this was occurring they were constantly yelling at Mr Huynh to get off Mr Stokes and to drop the knife.

When these endeavours did not resolve the crisis, at considerable danger to himself and with great courage, Constable Goeths took hold of the back of Mr Huynh's shirt and swung him in a circular motion off Mr Stokes and on to the ground behind the water truck, next to the gutter. Constable Goeths says he then took up a position equally distant from the gutter and about four to five metres west along Vulture Street from Mr Huynh. He drew his firearm. Constable Hyland remained on the footpath but she too moved a few metres further west, in line with the back of the truck.

Both officers say they were pointing their firearms at Mr Huynh and yelling at him to drop the knife and get down. Both say after being flung onto the roadway where he fell onto his hands and knees, Mr Huynh immediately sprang up still clutching the knife which he raised above his shoulder. At this point Constable Hyland fired at him, discharging three shots. As she fired, so did Constable Goeths, firing twice. Mr Huynh fell to the roadway.

When questioned about the shooting, Constable Hyland says when he got up, Mr Huynh raised the knife above his shoulder and she was concerned he was going to stab Constable Goeths who was only a few metres from him. That officer, on the other hand, said when interviewed he thought Mr Huynh was going to re-commence his attack on Mr Stokes. Constable Goeths also said Mr Huynh was "*trying to get up*" and he *"started to get up".* When he gave evidence at the inquest the officer said "*He's got up and he's got the knife in his hand, so I've discharged two to three shots".*

The shooting was also witnessed by two other officers who arrived on the scene just as it occurred; indeed the driver of the vehicle, Constable Sampson, says he stopped the vehicle suddenly to avoid crossing the line of fire after the sound of gunshot and a puff of smoke on the road made him realise he was at risk. He says he saw Mr Huynh "*in a crouched position"* behind the water truck when he was shot.

His passenger, Sergeant Bentham, says when Mr Huynh was thrown to the ground, the knife came out of his hand but he quickly regained it. In the notes he made shortly after the incident he wrote "*the male tried to get up. I heard three shots. Male fell to the ground".* When he was interviewed later on the day of the death he said *"the male person was getting up when he was shot".* By the time he gave evidence at the inquest his recollection was that Mr Huynh had got up and had motioned towards Constable Goeths in a menacing manner before he was shot. After Mr Huynh had been shot he fell to the ground releasing the knife but Sergeant Bentham saw him reaching for it and he ran over and kicked it away. He then saw Mr Huynh roll onto his back and remain still. The officer formed the opinion he was dead.

The Clarke family who, as I mentioned earlier watched the incident from their balcony directly above, give accounts very consistent with those of the officers. They also say when Mr Huynh got up from the road he raised the knife and made a move towards Constable Goeths before being shot.

Other nearby residents heard parts of the incident but none saw the crucial parts. With one exception, none of their accounts conflict with the versions outlined above. That exception is contained in the evidence of Louise Mutton who was asleep in a unit across the road from where the shooting occurred. She gave evidence she thought she heard a person shout "*Don't shoot, don't shoot, put the gun down!".* She had been asleep and it was the shouting that woke her. In those circumstances she readily acknowledged she could have been mistaken about what exactly was said. Her evidence the words were spoken in an Australian accent makes it most unlikely she heard Mr Huynh: his case manager gave evidence his accent was so strong the case manager had trouble understanding him and it became even more difficult when he was acutely unwell. I therefore conclude Ms Mutton made a genuine mistake.

As a result of considering all of the evidence I am satisfied the officers involved were justified in shooting Mr Huynh, even though the number of shots and their placement made his death almost inevitable. He had by then, demonstrated he was capable of inflicting serious injury: It is remarkable none of his victims died. Further, the officer attempted to use less violent means of subduing him without success. Officers in such circumstances can not be expected to wait till they are actually attacked before they resort to the use of their firearms. They were entitled to have regard to the way Mr Huynh had behaved in the minutes before his death and to have concluded they were at great risk of being stabbed, seriously wounded or even killed. They are then entitled to use whatever force was reasonably necessary to remove that risk. That is what they did. As sad as it is for Mr Huynh, his friends, family and the

officers involved, by the time they became involved Mr Huynh's actions probably made his death unavoidable.

Post shooting events

First Aid

As a result of the frenzied stabbing attacks and the police shooting of Mr Huynh, there was understandably pandemonium in the area. The police, who were involved in attending to the two earlier stabbing incidents in Browning Street, together with other police, quickly arrived at the scene of the shooting, after hearing about it on the police radio system. Officers attended to stabbing victim Stokes, while other officers checked the condition of Mr Huynh and placed him in a "recovery position". The QAS arrived on scene very shortly thereafter.

When the paramedics examined Mr Huynh, who was lying on the roadway on his left side in a recovery position, he was unconscious, not breathing and had no pulse. Understandably, the paramedics did not attempt to revive Mr Huynh as he showed no signs of life.

I am satisfied that Mr Huynh rapidly passed away after being shot and any attempt to revive him would have been unsuccessful.

Separation of police

Shortly after the police shooting of Mr Huynh, Constables Hyland and Goeths were separated and transported back to the West End Police Station in different police vehicles. There, they were kept separated and did not communicate with each other prior to being formally interviewed by investigators. They did speak with a lawyer prior to being interviewed.

Guns secured

Once Constables Hyland and Goeths arrived back at the West End Police Station, their service issue Glock pistols, magazines and ammunition were seized for forensic examination. Ballistic examinations were conducted by a police service ballistics expert.

Constables Hyland and Goeths had different types of police service Glock ammunition on issue to them. The bullets Constable Hyland had been issued with had brass cartridge cases and black coated jacketed hollow point projectiles, while Constable Goeths had been issued with nickel plated cartridges and uncoated jacketed hollow point projectiles.

The ballistics examination established three brass discharged cartridge cases located at the scene of Mr Huynh's shooting had been fired by the Glock on issue to Constable Hyland and the two nickel plated discharged cartridge cases located at the scene, had been fired by the Glock on issue to Constable Goeths.

Four projectiles were removed by Dr. Ong during Mr Huynh's autopsy. Comparison of these projectiles indicated the two black coated projectiles

were consistent with having been fired by the Glock on issue to Constable Hyland and the uncoated projectiles were consistent with having been fired by the Glock on issue to Constable Goeths.

Capsicum spray

During the fracas with Mr Huynh, Constable Goeths acknowledges he sprayed the contents of his police service issue capsicum spray canister at Mr Huynh. Unfortunately, only Mr Stokes suffered the effects of the capsicum spray, as it did not seem to affect Mr Huynh.

The canister used by Constable Goeths was seized for forensic examination. A swab was also taken from Mr Huynh's face during the autopsy. Analysis of both items revealed the canister was empty and the swab did not contain any detectable quantities of capsicum spray.

Blood samples taken from officers

At interview, Constables Hyland and Goeths consented to providing a sample of blood for analysis, which confirmed neither had any alcohol or drugs in their system.

The autopsy

On Saturday 27 December 2003, Doctor Beng Ong, an experienced forensic pathologist, conducted an autopsy on Mr Huynh's body at the John Tonge Centre.

It was established Mr Huynh had been shot five times, although only four projectiles or fragments thereof were located. Two projectiles had pierced the front of the chest from front to back, with a trajectory slightly left and upwards. The three remaining projectiles were from back to front in an upward direction in the buttock and thigh region. One of these wounds was grazing, while the other two projectiles penetrated the left buttock and thigh respectively.

The gunshot wounds to the chest were severe and would have caused Mr. Huynh to pass away quickly.

None of the gunshot wounds showed "soot staining or powder tattooing", which is consistent with the Glocks being fired from a distance of a metre or more away from Mr. Huynh.

At autopsy, Dr. Ong also located several bruises and grazes on Mr Huynh's elbows and knees; an abrasion on the left foot and a small abrasion on the left eye. These minor injuries can be attributed to Mr Huynh's physical altercation with Daniel Johnson and Mark Stokes, coupled with being flung onto the roadway on Vulture Street, after being pulled away from Mr Stokes by Constable Goeths.

In Dr. Ong's opinion, the mechanism of death was gunshot wound to the chest.

Toxicology analysis of blood and urine taken from Mr Huynh at autopsy revealed no alcohol or illicit drugs in his system. However, before the inquest commenced a request was made for his blood to be screened for amisulpride. This showed the drug was present at a level of 1.0mg/L in blood taken from the chest cavity and 4.8mg/L in blood taken from the femoral artery. A pharmacologist who provided a report to the inquest advised the therapeutic range of the drug was in the vicinity of 1mg/L. He could not explain the high level found in the femoral blood. One possibility was post mortem redistribution which could cause elevated readings. Another possibility is that Mr Huynh was aware he was relapsing and took more of the tablets than he had been prescribed in an effort to reduce his symptoms.

Identification

As a result of being unable to locate any family member to identify Mr Huynh, it was necessary to use fingerprint examination to positively identify him. Of course, identification by way of fingerprints is a well recognised means of formally confirming a person's identity.

On 26 December 2003, a police fingerprint expert formally identified Mr Huynh after comparing inked impressions taken from Mr Huynh's body with records held from previous fingerprint impressions taken from Mr Huynh.

Findings required by s45(2)

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. I have dealt with the last of those matters, the circumstances of death, above. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, I am able to make the following findings in relation to the other aspects.

Identity of the deceased – The deceased was Mieng Huynh

Place of death – Mr Huynh died on the roadway outside 60 Vulture Street, West End

Date of death – He died on 26 December 2003

Cause of death – Mr Huynh died as a result of a gunshot wound to the chest caused by a police officer acting in the course of his duty.

Referral to the DPP

In so far as is relevant to this matter, s48 provides that if information obtained by a coroner while investigating a death leads him/her to reasonably suspect that a person has committed an offence, the coroner must give the information to the director of public prosecutions. In this case it is appropriate to consider

whether such a referral should be made in relation to an offence of unlawful killing.

It is not my role as coroner to decide whether any person is guilty of an offence in connection with the death or indeed, even whether the prosecutorial discretion should be exercised in favour of presenting an indictment and bringing the matter before a jury.

I take "*committed an offence*" to mean that there is admissible evidence that could prove the necessary elements to the criminal standard.

The use of the term "*reasonably suspects*" is redolent of the test applied when a search warrant is sought. In that context it has been held that a suspicion is a state of mind less certain than a belief and to be reasonable it must be based on some evidence, but not necessarily well founded or factually correct and be a suspicion that a reasonable person acting without passion or prejudice might hold.[33][34]

However a search warrant is frequently sought when very little might be known about the circumstances of the suspected offence. In that context it is applied when there has been inadequate opportunity to allow the suspicion to gestate into a belief and authority is sought to take the steps that might enable that to occur. As a result, a relatively low level of certainty is needed to satisfy the test. It would seem incongruous that a similar approach be taken when there has been an extensive investigation and public inquiry in which all relevant witnesses have given evidence under oath and have been cross examined and world renowned experts have provided reports and also given oral evidence. In those circumstances there is little room for uncertainty and reliance on speculation or conjecture would seem unnecessary. The removal of doubt by the forensic process means that for a suspicion to be reasonable it must be well founded. [35]

I consider this potential anomaly can be overcome by construing the subsection as requiring a referral to the DPP only when the coroner considers it likely that the Crown could prove all of the elements of an offence.

Section 291 of the Criminal Code provides that it is unlawful to kill another person unless that killing is authorised, justified or excused by law.

Section 300 of the Criminal Code states that "*any person who unlawfully kills another person is guilty of a crime, which is called murder, or manslaughter, according to the circumstances of the case".*

There are various definitions of murder provided by s.302 of the Code. Most relevant to this case, s302(1) provides that a person who unlawfully kills

[33] For a discussion of the authorities see Tonc K., Crawford C., & Smith D., *"Search and Seizure in Australia and New Zealand",* LBC, Sydney, 1996 at p68

[34]

[35]

another person with the intention of causing the death or doing grievous bodily harm is guilty of the crime of murder.

In this case there is an abundance of evidence indicating that Mr Huynh died as a result of being shot by Constable Goeths and Constable Hyland.

When interviewed by investigators immediately after the shooting, the officers indicated that they had shot Mr Huynh intending to incapacitate him. They gave similar evidence at the inquest. However, these admissions were made after the officers had been given a direction to answer questions pursuant to the *Police Service Administration Act 1990* and s39 of the *Coroners Act 2003 respectively*. The answers were not therefore voluntary and can not be used against the witness in criminal proceedings. However, the intention of an actor can be inferred from the circumstances of the act: the natural and usual consequences of an act will be presumed to have been intended.

In this case, I consider a jury could infer from the deliberate close range shooting of Mr Huynh as witnessed by others that the officers had the intention to kill or do grievous bodily harm. I therefore consider all the elements of the offence of murder can be made out against one of both officers.

Accordingly, the only issue to be further considered is whether the killing was authorised, justified or excused by law. If it was, that is the end of the matter. If not, I must refer the evidence, other than that given after the directions previously mentioned, to the DPP for her consideration.

This requires consideration of any defences open to the officers, because, before a jury could convict either of them, the prosecution would have to exclude the operation of any defences. The two statutory provisions relevant to that issue in this case are s.271 and s.283 of the Criminal Code.

Section 271, short-titled "*Self-defence against unprovoked assault,*" provides that if a person is assaulted in such a way as to cause reasonable apprehension of death or grievous bodily harm, and the person reasonably believes that he can not otherwise protect himself from that, it is lawful for the person to use such force as is necessary for his defence even though that force may cause death or grievous boldly harm. So far as is relevant to this case, "assault" is defined in s.245 to include not only the application of force but also the threatened application of force in circumstances where the person making the threat has an actual or apparent ability to carry out the threat.

It is also important to note that s.283, short-titled "*Excessive force*", provides that *"(i)n any case in which the use of force by one person to another is lawful the use of more force than is justified by law under the circumstances is unlawful".*

I will now apply that law to the facts of this case.

As I have set out earlier, the officers became involved with Mr Huynh in order to prevent his continuing attack on Mr Stokes. When they managed to interrupt that event and momentarily disarmed Mr Huynh, he did not comply with their direction to stay on the ground but rearmed himself and gave every indication that he was going to attack the officers. In those circumstances, I am of the view that Constables Goeths and Hyland reasonably feared that they may suffer serious harm or even death. They could not safely retreat without exposing themselves and/or Mr Stokes to further attack. They were therefore, in my view, justified in shooting Mr Huynh even if it was liely that in so doing they would cause his death.

Both of the police officers involved in these events were placed in a very difficult and at times terrifying situation. None of them is above the law: they are charged with upholding it and protecting the life of even those who are endangering others. However, police are also entitled to the protection of the law. They are entitled to defend themselves and even use deadly force if they can not in any other way secure their own safety. In this case, the officers did not have to wait until one of them was stabbed before using their firearms to neutralise the risk of that happening. When faced with a clearly deranged and violent man armed with a knife and acting in a threatening manner, society can expect no more than its police officers act reasonably. I accept that Constable Goeths and Constable Hyland did that in this case while ardently trying to protect the community by apprehending someone who had shown a potential to be very dangerous.

There is therefore no basis on which to refer any information concerning this matter to the DPP

Concerns, comments and recommendations

Section 46 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. It will be noted those heads of jurisdiction are alternatives and so it is not necessary that the death be preventable before a comment concerning public health and safety or the administration of justice can be made.

The circumstances of Mr Huynh’s death, in my view, raise the following issues for consideration from this perspective:-

- The adequacy of the management of Mr Huynh’s mental illness by the Princess Alexandra Hospital Health Care District, including his medication regime, his status under the Act and the level of care provided to him; and

- The appropriateness of the police response to the emergency.

Management of Mr Huynh's mental illness

Mr Huynh received mental health care from the P.A. MHS for nearly five years. During this time he was initially subject to a forensic order; subsequently he underwent periods of inpatient treatment both under an involuntary treatment order and as a voluntary patient. He was seen by his case worker and his treating psychiatrist only three days before his death and was at that stage suffering delusions.

The circumstances of his death naturally cause consideration of whether the MHS should have treated him differently, and if they had, whether this would have prevented the death.

In particular:

- Should the ITO have been revoked in November 2003?
- Should Mr Huynh have been maintained on depot medication?
- Should Mr Huynh have been hospitalised on 23 December 2003?

In considering these questions, I have had regard to the evidence of the practitioners who were involved in treating Mr Huynh, his friends who were dedicated in their support of him and the opinion of Dr Jill Reddan, the independent expert briefed by this office to critique his care.

Before turning to the three issues I have identified as problematic, I will make some general observations about the care provided to Mr Huynh. It is apparent to me from the evidence of Dr des Arts, Dr De Souza-Gomes and Mr Seefeld the workload of the MHS was very high and Mr Huynh was at times a difficult patient to manage: he had hearing difficulties, language difficulties and little insight into his illness. Notwithstanding these challenges, in my view, these practitioners and others who had contact with Mr Huynh, strived compassionately and professionally to assist him. They accepted the chronic nature of his illness and worked to ameliorate its impact on his life. Mr Huynh was able to undertake a TAFE course, work and live a relatively normal life in the community, largely due to their perseverance and dedication.

Revocation of the ITO

As detailed earlier, in October 2003, after his flat mates became concerned about Mr Huynh's threatening behaviour and he had told his case manager he wanted to kill his next door neighbour, Mr Huynh was hospitalised and made subject to an involuntary treatment order. In the first few days following his admission, Mr Huynh continued to exhibit signs of florid psychosis and assaulted another patient. He had made threats to kill another unknown person a few months earlier. However, then, as on this occasion, he quickly stabilised after being given a bolus dose of anti psychotic medication intravenously, followed by supervised, daily administration of medication taken orally.

He was discharged after two weeks and his ITO was varied to provide for community based treatment. After persuading his treating psychiatrist and his case manager he would adhere to his oral medication regime, the ITO was revoked.

It doesn't seem Dr de Souza-Gomes applied any formal risk assessment process or instrument when she made the decisions to discharge Mr Huynh and to revoke the ITO. Rather it would seem to have been a more organic process; a multi-factorial assessment of various aspects of his case. I understand this aspect of patient case management has now been reformed.

The treating psychiatrist and the head of the unit who reviewed the medical charts after Mr Huynh's death thought by the time he had settled into his usual medication regime, Mr Huynh no longer satisfied the criteria for the continuation of the ITO. Clearly he was not "cured" (and indeed it's unlikely that he ever would be). However, in their view there was insufficient basis for concluding he was a danger to himself or others as the Act requires, if, as is traditionally the case, "harm" is defined to mean physical harm or violence. Further, they were of the view that maintaining Mr Huynh on an ITO would have achieved nothing. He would not have remained an inpatient. His compliance with his oral medication requirements could as easily be checked by his case manager without an ITO being in place because Mr Huynh was always co-operative with this level of management. It was therefore consistent with the governing paradigm of using the least intrusive manner of treating the patient to have Mr Huynh treated as a voluntary patient.

However, Dr Jacinta Powell, a senior Queensland Health psychiatrist who conducted a clinical review of the case after Mr Huynh's death disagreed. She suggested in view of his history of non compliance with medication, his rapid deterioration when not medicated and his tendency to make threats of violence when acutely unwell, it would have been preferable to have maintained the ITO. The benefits of this approach were, according to Dr Powell, the regular review of his case by the Mental Health Tribunal that would have ensued, would have ensured there was in place a well documented treatment plan. This would have identified the signs and symptoms of relapse and provided responses to be utilised when these were noted. It may also have made stringent monitoring of his medication compliance more likely to occur.

I am of the view this case and the others investigated during this inquest, may provide a basis for a review of the criteria on which decisions concerning discharging mental health patients and revoking ITOs are based; an issue I will discuss in part 6 of this report. However, in this case I do not consider it could be demonstrated had Mr Huynh remained on an ITO it would have made any difference to the outcome.

Problems with medication compliance

Mr Nguyen had been a friend of Mr Huynh's for five or six years and had been his flat mate for three years until approximately two weeks prior to his death. He seemed to provide enormous support to Mr Huynh and was clearly very

caring towards him. He took Mr Huynh up to the hospital to get treatment on occasions when his condition had deteriorated. He appeared to have been exceptionally tolerant when Mr Huynh was unwell, when he would talk about *"strange things"* and when he was disturbed and calling out during the night. Mr Nguyen tried to help Mr Huynh take his tablets. It was his understanding that Mr Huynh only needed to take one tablet each night.

In evidence, Mr Nguyen described Mr Huynh as careless and lazy in his attitude towards his medication. He identified a further problem being Mr Huynh would tell him he did not need to take any medication if he felt well. This attitude is consistent with the poor level of insight Mr Huynh was found to have on just about every admission to hospital.

Approximately one week after Mr Huynh was discharged from hospital in October 2003, he told Mr Nguyen he was not taking his medication because he no longer needed to. Mr Nguyen did not see him take any more medication until the time of his death some two months later. The day after he moved into his own unit approximately two weeks before his death, he told Mr Nguyen again he was not taking any medication. This is clearly inconsistent with Mr Huynh's assurances to Mr Seefeld that he was taking it. Conversely, it cannot be discounted Mr Huynh was taking his medication more regularly but denied to his friends doing so or needing to out of embarrassment.

The toxicology analysis of a sample of Mr Huynh's blood taken after his death confirms there was amisulpride in Mr Huynh's blood post mortem. However, it does not resolve the issue as to the regularity with which Mr Huynh was taking it. What is known is that packets of 60 tablets of amisulpride were dispensed on 28 May, 17 June and 21 October 2003. Given that Mr Huynh was supposed to be taking two tablets per day, he only had sufficient medication for 90 days. The number of days between when the first packet was dispensed on 28 May 2003 and the time of his death on 26 December 2003 was 210, of which 21 were spent as an inpatient at PAH. Therefore over this time, he actually lived in the community for 189 days. This raises the issue that Mr Huynh had in fact been prescribed less than half the medication he required, given it was intended to maintain him on 800mg of amisulpride per day.

Considering all the evidence, it seems clear that for whatever reason Mr Huynh frequently failed to take his medication as prescribed and this almost certainly contributed to his deterioration into a florid psychotic state on the day of his death. This was consistent with his habits over the preceding years; all of the instances on which he required emergency admission were preceded by a failure to consistently take his medication as prescribed.

This raises the question of whether enough was done to monitor Mr Huynh's compliance with his medication and/or whether there was more that could have been done to address this problem.

One possible prophylaxis is the use of depot doses. This involves injecting significant amounts of the drug intramuscularly from where it infuses into the

blood stream over days or weeks, obviating the need for the patient to take medication daily. However, many psycho-pharmacotherapy drugs have significant, distressing side effects for many patients when given in bolus, or depot doses. It seems Mr Huynh was such a patient. Dr De Souza-Gomes attempted to find a way of overcoming these adverse effects by varying the quantity of the depot dose, to no avail.

She also trialled him on three different oral medications and varied the doses on a number of occasions in an attempt to achieve an optimum therapeutic level for him. Despite her best endeavours, a satisfactory treatment regime could not be achieved.

Dr Jacinta Powell, psychiatrist, conducted a review of the treatment provided to Mr Huynh while he was a client of the MHS. In a report dated 30 December 2003, Dr Powell questioned whether Mr Huynh should have been trialled on other depot medications apart from fluxopenthixol, which he was administered for only a two month period in late 2000 and on one further occasion in October 2002. The depot medication was ceased in October 2000 because Mr Huynh was requesting to go off it and he was exhibiting significant side effects from it. Dr De Souza-Gomes altered the frequency of the dose from bi-monthly to tri-monthly and reduced the dose from 40mg to 20mg, but to no avail. There is a distinct possibility had she insisted on Mr Huynh continuing to accept depot doses, he may well have severed contact with the service.

Problems of compliance with medication are not limited to patients who have mental illnesses. It remains a significant challenge for all health professionals. However, the management of it is certainly made more difficult when the patient has little insight and the side effects of the medication are not insignificant.

In the circumstances, I do not consider Dr De Souza-Gomes' decisions concerning Mr Huynh's medication regime should be criticised. However, medication compliance is a common problem I shall return to in part 6 of this report.

Should Mr Huynh have been hospitalised on 23 December 2003?

The evidence makes clear that when seen by his case manager and later his treating psychiatrist on 23 December 2003, Mr Huynh was seriously delusional, although he was apparently not hallucinating and was able to communicate reasonably. He told both he was taking his medication and enjoying living in his new abode. Three days later he became floridly psychotic and extremely violent. With hindsight, we know had he been hospitalised on 23 December the events of 26 December would not have occurred. The question is whether the decisions made on 23 December, were reasonable having regard to what was known then.

The behaviour of Mr Huynh on the morning of 26 December 2003 came as a shock to Mr Huynh's treating team. Neither Dr De Souza-Gomes nor any of the other health professionals who cared for him were ever concerned for their

personal safety or the safety of others, although there had been some instances of violence. For example, Mr Huynh apparently assaulted a patient in hospital on 9 October 2003. However, this does not seem to have been significant. Some eight years earlier on 30 January 1995, he came to the attention of the police in West End because he was carrying a bag with items sticking out. A search of the bag revealed a 30cm knife wrapped in a t-shirt. He refused to supply his name and later resisted arrest, but there is no suggestion he used the knife or intended to use it to threaten or harm anyone else. The charges in 1999 for which the Mental Health Tribunal found him to be of unsound mind, were not offences involving violence and arose out of Mr Huynh's delusional belief his then employer was going to harm his wife and he needed to protect her.

Mr Nguyen never saw Mr Huynh behave in a violent, aggressive or threatening manner. He never saw him carry a knife or other dangerous weapon with him. Mr Huynh visited Mr Nguyen's house on three separate occasions on the night before he died. Mr Nguyen was in no way frightened of him and there was absolutely no indication of what was to occur the following morning.

Dr Reddan opined there is no clear explanation as to why Mr Huynh's behaviour changed so dramatically from having harmless delusions to stabbing random strangers in the street. She thought something in his environment may have triggered the violent outburst and in particular, the change in his living arrangements. She also considered that while Mr Huynh needed to be encouraged to work, the reality of his work situation may have been difficult for him.

Regrettably, it is the case that numerous members of the community chronically suffer from thought disorders of various types but the vast majority cause no harm to themselves or others on this account. Of course, tragedies like this one need to be avoided if possible but I do not accept that in attempting to do so everyone suffering delusions should be involuntarily hospitalised.

My Huynh had been admitted as an inpatient on 12 occasions in the period 1999 to 2003; the last period being just two months before his death indicating that this assistance was made available when those treating him thought it necessary.

In all of the circumstances, I do not think Dr De Souza-Gomes should be criticised for not seeking to cause Mr Huynh to be admitted when she saw him for review at the hospital on 23 December. Apparently, he frequently manifested symptoms similar to those seen on that day. According to Dr des Art up to 50% of the P.A. MHS long term patients frequently display similar symptoms; it would obviously be impractical and unwarranted to admit all of them as in-patients. There was no basis for Dr De Souza-Gomes to suspect anything like the terrible events of 26 December were likely to occur and there was no other basis on which Mr Huynh's admission as an in-patient was indicated.

The police response

I have found the shooting of Mr Huynh by the officers who came upon him attacking a council contractor was justified and lawful. They attempted to resolve the matter with less deadly means but were unsuccessful. Mr Huynh ignored repeated demands to put down his weapon and was posing a very great risk to the safety of the officers at the time he was shot. There was at that stage nothing else they could have done to preserve their safety and that of the council contractor. It is sometimes suggested in such situations officers should shoot to wound. For reasons I will expand upon in part 7 of this report I do not accept that.

The only criticism that could be made of their actions was the failure of either officer to warn of their intention to shoot. I do not believe it would have made any difference in this case but the National Guidelines for Use of Lethal Force by Police and the Queensland Police Service Operational Procedures Manual requires it wherever it is practical to do so. In this case the officers say they made repeated demands for Mr Huynh to drop the knife and to get onto the ground. Obviously, therefore, they had time to include a warning they would shoot if he did not comply. This omission occurred in all of the deaths investigated at this inquest. I shall return to it in part 7 of this report.

Finally, I wish to express my admiration for the courage and composure shown by Constables Goeths and Hyland. I recommend the Commissioner consider citing Constable Goeths in particular for his bravery in trying to prevent Mr Huynh from continuing his attack on Mr Stokes; he may well have saved that man’s life.

Part 4 – Findings into the death James Henry Jacobs

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Introduction

In the early evening on 25 March 2005, two uniformed police officers responding to a complaint concerning a man causing a disturbance near the Gold Coast Hospital, saw a person matching the description of the person as they patrolled in the vicinity. They approached the man we now know was James Henry Jacobs, and called on him to stop. He produced a knife from under his clothing and soon after was shot by one of the officers. Mr Jacobs died at the scene. These findings detail the actions of those involved in the death and consider whether changes to police or mental health service practices or procedures could reduce the likelihood of deaths occurring in similar circumstances in future.

The investigation

Scene preservation

Senior police quickly arrived on scene after the shooting and cordoned off the area and secured it to enable investigations to be conducted. A crime scene log was commenced and maintained until the scene investigations were concluded. Constables Nunn and Booker were directed to drive themselves back to the Southport Police Station in the vehicle they arrived in. Not only did this create an opportunity for collusion or the accidental distortion of their memories of the incident, it removed a significant item from the crime scene. It was a mistake that would not have been made had the shooter been a civilian. It should not be repeated.

Fortunately, the Duty Sergeant at Southport Police Station ensured that, in accordance with protocols, once the officers arrived at the station they were separated and did not communicate with each other further prior to being interviewed by investigators.

The position of the car at the scene was not even marked. A car driven to the scene by one of the crews to respond to the emergency was subsequently included in the crime scene photographs and the scale plan of the scene.

Interviews with the officers and witnesses

Detectives from the Homicide Investigation Unit attended the scene and Detective Sergeant Bishop was appointed as the primary investigator of the incident and took control of the investigation.

Inspectors from the Ethical Standards Command and the Crime and Misconduct Commission also attended the scene. These officers undertook

an over-viewing role of the investigation on behalf of their respective organisations.

Constables Booker and Nunn participated separately in tape-recorded interviews with investigators later that evening. The following morning, both officers also participated separately in a video-recorded “walk through” at the scene.

A door-knock was conducted in the vicinity to identify any potential witnesses. Statements were taken from witnesses to the incident.

In order to gain a greater appreciation of the circumstances of this incident, I attended the scene on the following morning and observed the “walk through” interviews with Constables Booker and Nunn.

Forensic experts

Specialist police including scenes of crime officers and scientific officers attended the scene and conducted their respective investigations. Photographs and video-recordings were taken of the scene and of the various items of interest in-situ. Exhibits were seized for forensic examination and evidentiary purposes.

A forensic examination was conducted of Constable Booker’s Glock pistol, the spent cartridge located at the scene and the remains of the projectile located at autopsy.

A survey was conducted of the scene and a scale plan was prepared. It was inadequate as it did not include all data relevant to a compete understanding of the locale.

Apart from the shortcomings I have mentioned, I am satisfied the investigation was thorough and impartial. I commend Sergeant Bishop on his work.

The evidence

Family history

Mr Jacobs was born in Johannesburg, South Africa on 13 October 1975 making him 29 years of age at the time of his death. He was an only child. His parents separated when he was aged two or three. His mother, Mrs Kealton, reported that James’ father was paranoid, delusional and violent and did not receive treatment for his mental illness. He was reported to self-medicate with alcohol. His violence ultimately led to the demise of their marriage.

James continued to live in Durban with his mother until 1988 when his mother remarried and the family migrated to Australia and settled on the Gold Coast.

Throughout his life James enjoyed a strong and supportive relationship with his mother and step-father, Leigh.

Social history

James started grade 8 at Benowa High School in 1989. Midway through grade 8 he transferred to The Southport School (TSS). James excelled in academic and sporting pursuits, notably swimming and rugby union and in grade 11 he received a Duke of Edinburgh award.

In June 1993, James was expelled from TSS for possession of marihuana. He then enrolled at Scots College at Warwick for the final two terms of Grade 12.

After completing school, James worked at various part-time jobs including a coffee shop and helping a family friend with the construction of a house.

In June 1994, James left the Gold Coast to return to South Africa. He had planned to renew contact with his biological father whom he had not seen since he was eight years old. Tragically, his father committed suicide shortly after his return to South Africa and before James could establish contact with him.

It appears this was not James' first experience with bereavement. In 1991, James befriended a young couple who were also staying on Moreton Island for the summer holidays. As the couple departed in their light aircraft they waved to James and attempted to perform a stunt. The plane crashed killing the couple instantly.

Within six months of James' father's death he also lost two other people of great significance to him. His maternal grandfather committed suicide and his uncle, with whom he was living in South Africa, died in a motor vehicle accident.

It was after his uncle's death James started to experience emotional difficulties. These difficulties were observed by his mother's sister, a registered nurse, with whom he went to live following his uncle's death. She ultimately raised her concerns about James' mental state with his mother. In June 1995, James returned to Australia in order to receive appropriate psychiatric treatment.

It appears James was not further employed following his return to Australia although he did perform some voluntary work at a number of charitable organisations and some work for the family business at various times. He was otherwise dependant on the disability support pension.

James successfully completed a Business Management course at a TAFE college in April 2001.

His accommodation varied from living with his parents, to residing in boarding houses, hostels, caravan parks and private, shared rented residences. He also lived for a period of time at Tekapo, a supported accommodation facility run by the Schizophrenia Fellowship.

In early 2004, James commenced a relationship with Bernadette Cannon who also suffered from schizophrenia. In April 2004, James was arrested and remanded into custody at the Arthur Gorrie Correctional Centre. He received bail on 1 October 2004. James then returned to live with Ms Cannon until his death.

Previous interaction with police and criminal history

According to police records, Mr Jacobs' first recorded contact with police occurred on 28 June 1996, when he was 21 years old He was charged with stealing, possession of dangerous drugs and possession of a pipe for smoking a dangerous drug. No convictions were recorded and he was fined for these offences.

He was next before the court in 1998 when he was charged with serious assault of an elderly man and in 2001 he was convicted of receiving property obtained by a crime.

Mr Jacobs had further interaction with the criminal justice system in 2002 and 2003 when he breached his suspended sentence and a bail undertaking. He was not sentenced to any periods of imprisonment on these occasions.

By far, the most serious of these matters was the 1998 assault charge. This charge related to Mr Jacobs seriously assaulting an elderly man at a boarding complex in Southport. The catalyst for the incident was the man had requested him to quieten down. Evidence led at the inquest suggests Mr Jacobs was suffering auditory hallucinations and was yelling in response. Although the matter went before the Mental Health Tribunal, it was found Mr Jacobs was not of unsound mind when the incident occurred and he was fit to stand trial. As a result, on 16 October 2000 he appeared in the Southport District Court on an indictment for assault occasioning bodily harm and was convicted and imprisoned for 2 years which was ordered to be wholly suspended for a period of three years.

At the time of his death, Mr Jacobs was the applicant/aggrieved in a domestic violence order in which his de-facto wife, Bernadette Cannon, was the respondent. This action was taken on 11 March 2005 when police were called to their residence. It was confirmed they had been involved in an argument concerning the state of the residence and Ms Cannon had slashed Mr Jacobs' arm with a pair of scissors which she claimed was "accidental".

Between 1998 and 2004, Mr Jacobs spent time in jail on three occasions. Firstly, he was in the custody of the Department of Corrections on remand from 5 November 1998 to 2 December 1998 in connection with the serious assault. During this time, he underwent a medical examination pursuant to the Mental Health Act at the John Oxley Memorial Hospital.

For the period 9 January 2002 to 28 March 2003, Mr Jacobs' custody in connection with his breach of the suspended sentence was managed by Community Corrections. This was a combination of secure custody and community corrections.

He was next in custody on remand from 23 April 2004 to 1 October 2004 in relation to two offences of demanding property with menace.

Interestingly, records show Mr Jacobs did not become involved in any physical altercation with police during any of his dealings with them. Similarly, there is no record of him becoming involved in any physical altercation with Correctional Officers whilst in their custody.

Issues concerning his incarceration will be dealt with further later in these findings.

Mental health history

As detailed earlier, Mr Jacobs late teens and early 20s were traumatic. Those events seemed to have a significant and ongoing, destabilizing influence on him. After his uncle died, he went to live with his mother's sister who also lived in South Africa. She was a registered nurse and noticed he was becoming psychotic and arranged for him to be assessed by a psychologist in South Africa. The psychologist advised Mr Jacobs required psychiatric treatment.

Initial diagnosis and treatment

He returned to Australia in June 1995 and was seen by Dr Stephen Murphy, a psychiatrist at Southport. Initially the diagnosis was not clear, but as time went on, Dr Murphy considered Mr Jacobs was suffering from a psychotic disorder and prescribed neuroleptic medications. Mr Jacobs' mother requested guidance from Dr Murphy as to how best provide support to her son, but felt such assistance was not forthcoming.

Mr Jacobs stopped seeing Dr Murphy after only a few months. By December 1995, he was reporting to his mother he no longer needed to be on medication and had ceased taking it. In June 1996, following months of deterioration in his behaviour, Mr Jacobs agreed to consult Dr Murphy again and was prescribed further medications. However, his compliance was again poor and his condition deteriorated over the subsequent year.

In early 1997, his mother considered he may have been a danger to himself and others and applied for a Justice Examination Order under the Mental Health Act. The order was granted, but by the time Mr Jacobs was assessed, his presentation had improved and the practitioner who examined him considered there was no basis for making him the subject of an involuntary treatment order.

On 29 July 1997, Mr Jacobs was admitted as an inpatient to the Gold Coast Mental Health Unit under the care of Dr Ziukelis, psychiatrist. He remained an inpatient for two weeks. He was admitted with chronic deterioration in his functioning and reported delusions with religious and persecutory themes. He demonstrated bizarre behaviour by watching television with the sound down and covering the screen with a sheet. He was prescribed Olanzapine, an anti-psychotic, and Fluoxetine, an anti-depressant. At the time of his discharge, he

was reactive and appropriate in affect, had been attending rehabilitation and had been compliant with his leave conditions.

On discharge from hospital, Mr Jacobs was referred to the Southport Adult Mental Health Service (the MHS) and began receiving a disability support pension.

In March 1998, Mr Stuart Loudon, social worker, became Mr Jacobs' case manager. He was responsible for monitoring Mr Jacobs' mental state, arranging and facilitating his attendance at medical appointments, providing support to Mr Jacobs and his family and encouraging his involvement in social and recreational activities. It became readily apparent to Mr Loudon that Mr Jacobs initially found it difficult to accept the validity of his psychiatric diagnosis and thus his response was to try to forget about it.

Forensic orders

When Mr Jacobs was charged over the assault of the old man, he was remanded in custody at the Arthur Gorrie Correctional Centre ("AGCC"). He remained there for a week, before being transferred under s.31 of the Mental Health Act to the John Oxley Memorial Hospital for an assessment of whether he had been mentally balanced at the time of the October 1999 incident and also to determine whether he was fit to stand trial. He then came under the care of Dr Fama, psychiatrist. On 9 November 1998, Dr Reddan assessed Mr Jacobs as Dr Fama was on leave and considered he was suffering from a mental illness that warranted his detention in the hospital.

By this time, it had been decided that because of compliance issues, Mr Jacobs needed to be placed on a depot medication, Zuclopenthixol. On 18 November 1998, Dr Fama diagnosed paranoid schizophrenia which he thought was partly in remission. He referred Mr Jacobs to the Mental Health Tribunal for determination of a likely defence under s.27 of the *Criminal Code*. He further recommended Mr Jacobs be transferred to the Gold Coast Mental Health Unit as soon as possible.

Dr Fama's recommendation was acted upon and on 2 December 1998, Mr Jacobs was transferred to the Gold Coast Hospital under the care of Dr Hamilton, psychiatrist. He remained an inpatient until 30 December 1998 when he was transferred to the Rosewood Unit at Palm Beach. On 2 March 1999, he was assessed by Dr Ziukelis at the request of the Mental Health Tribunal. Dr Ziukelis considered Mr Jacobs was fit to stand trial in relation to the offences for which he had been charged following his involvement in the October 1998 incident. Two days later, Mr Jacobs was discharged from the Rosewood Unit for outpatient follow up treatment.

On 14 April 1999, Dr Fama re-examined Mr Jacobs and thought his psychosis was largely in remission. In relation to the October 1998 incident, he opined that although Mr Jacobs had been affected by paranoid schizophrenia and had been intoxicated, he was fit to stand trial. Dr Reddan re-assessed Mr Jacobs at the request of the Mental Health Tribunal on 12 June 1999 and

concurred with Dr Fama's opinion. In the following month, the Mental Health Tribunal found Mr Jacobs was fit to stand trial.

The charge of attempted murder police had preferred immediately after the incident was downgraded to assault occasioning bodily harm, to which Mr Jacobs pleaded guilty on 16 October 2000. He was sentenced to two years imprisonment to be wholly suspended for three years. Dr Lotz, psychiatrist, provided an undertaking to the court that Mr Jacobs would continue to be a restricted patient of the MHS for a period of at least 12 months. The Crown entered a *nolle prosequi* in relation to the charge of grievous bodily harm.

Mr Jacobs later told a prison psychologist it had been a condition of his suspended sentence he continue to take his prescribed medication for the term of the suspended sentence and he accordingly did so.

Following the October 1998 incident, Mr Loudon found Mr Jacobs became more accepting of the reality of his psychiatric diagnosis and came to the realization he had a role in managing it. Regrettably however, substance abuse continued to complicate his treatment and management. Mr Jacobs' degree of insight and willingness to cooperate with treatment varied over time. When unwell, his ability to live in the community was greatly affected. For example, he had delusional beliefs of a paranoid type about food which would diminish his ability to look after himself. However, when living in stable accommodation and refraining from illicit drug abuse, he functioned adequately.

Between April 1998 and February 2001, he lived within the "Tekapo" supported accommodation program run by the Schizophrenia Fellowship. Mr Loudon maintained regular contact with him except for a six month period commencing in October 2000, when he went on leave and Lesley Anderson worked with Mr Jacobs as his case manager. It seems over this time Dr Trevor Lotz, psychiatrist treated Mr Jacobs. He seemed to function relatively well and was largely compliant with his medication. He participated in a rehabilitation program, part of which included weekly voluntary work with "Meals on Wheels" at Southport and also participation in social and leisure group activities.

When Mr Jacobs moved out of Tekapo, he lived with a flat mate at Labrador and in April 2001 completed a TAFE course in business management. He told Mr Loudon he would also like to do a hospitality course but did not have sufficient money to finance it. He was working in his mother's business performing administrative duties.

On 23 April 2001, Dr Nevin Taylor, senior medical officer with the MHS examined Mr Jacobs at which time he reported he had not heard voices for two years and had not recently experienced delusions. Dr Taylor thought he was managing well and consideration could be given to referring him to a Commonwealth Government pilot program called the General Practice and Psychiatry Partnership Program (GPAPP). The program was implemented in 1999, with the aim of establishing links between mental health workers and

general practitioners to improve the quality and continuity of care of persons with mental illness. Dr Taylor planned to review Mr Jacobs in two months.

For an unknown reason, neither the referral nor the review took place and it was not until late August 2001 Mr Jacobs was seen by any doctor. The record of the relevant consultation indicates Mr Jacobs was assessed by a consultant psychiatrist, the identity of who remains unknown.

Over this time Mr Loudon continued to meet with Mr Jacobs on a regular basis and was clearly a great support to him. However, Mr Jacobs' degree of insight and willingness to co-operate with treatment varied and his increased substance abuse complicated his treatment and management. In August 2001, Mr Jacobs moved out of his accommodation and for the following few months his attendances at the MHS were rather sporadic. At a case review meeting on 21 November 2001, it was decided it was necessary to make regular contact with Mr Jacobs. In January 2002, Mr Jacobs' mother was concerned he was using drugs but he denied it as he had on numerous previous occasions.

Mr Jacobs was not seen by a doctor between August 2001 and 19 April 2002, at which time he told Dr Taylor whilst he was having some thought disorder and was a little edgy, he was generally well. Over the following month he reported having auditory hallucinations, he was paranoid and his head "felt explosive". On 14 May 2002, he admitted to having heavily abused substances the week before and in mid June 2002 he was having trouble paying his rent as he had spent his money on drugs. On 5 July 2002, Mr Jacobs did not demonstrate or report any psychotic symptoms and Mr Loudon discussed with him the plan to refer him to a general practitioner.

There were a number of concerning aspects to the management of Mr Jacobs whilst he was a client of the MHS. For example, no psychiatrist seems to have had any input into decisions being made concerning Mr Jacobs treatment. The MHS file indicates Mr Jacobs was not assessed by a psychiatrist in the 10 months prior to his care being transferred to Dr Kelly. Further, although Dr Taylor was Mr Jacobs' treating doctor in the 15 months prior to his care being transferred to Dr Kelly, he only saw him on 3 occasions, being 23 April 2001, 19 April 2002 and 30 April 2002.

Although team meetings to review Mr Jacobs' case were supposed to be held every three months, no such meeting was held in the eight months prior to his discharge from the MHS. It is also of concern discussions at the team meetings were not adequately documented to identify the significant management decisions made at these meetings and little formal guidance seems to have been provided by the MHS generally with the result Mr Loudon had a great degree of autonomy as far as management of Mr Jacobs was concerned. On the other hand, it does seem Mr Loudon was a very experienced and committed mental health care worker and I have no doubt he devoted himself to assisting Mr Jacobs to the extent his heavy workload allowed.

Discharge from the MHS

Notwithstanding Mr Loudon's dedication, the facts remain the plan to refer Mr Jacobs to Dr Kelly was made in April 2001 and not implemented for some 15 months, during which time there was little medical input or discussion at case review meetings as to the appropriateness of this management decision. It is also noteworthy Mr Loudon had reservations about transferring Mr Jacobs' care to Dr Kelly but felt because of insufficient resources there was no alternative.

It was Mr Loudon's understanding Mr Jacobs was being referred to Dr Kelly as part of the GPAPP scheme referred to earlier. However, Dr Kelly thought the program had ceased to function by July 2002. Certainly the assistance of a psychiatrist to review and advise on the patient's progress was an integral part of the program which did not occur in Mr Jacobs case.

Mr Loudon thought Dr Kelly was provided with information relevant to Mr Jacobs' management in a Mental Health Assessment Form but Dr Kelly's evidence was she did not receive such a form. A copy of the form was not in either the MHS or the Southport Medical Centre files and it seems unlikely Dr Kelly received it. Mr Jacobs was introduced to Dr Kelly through a referral letter dated 16 July 2002 in which she was told:

- Mr Loudon had been Mr Jacob's case manager;
- Dr Nevin Taylor had been his doctor;
- Mr Jacobs had a history of schizophrenia which had required inpatient treatment in March 1999;
- Mr Jacobs' mental illness was well managed with fortnightly 300mg of depot Zuclopenthixol ;
- the experience of the MHS had been that Mr Jacobs had been mostly reliable in attending his appointments; and
- Mr Jacobs was able to self monitor and would advise her if he had any suspicion he was becoming unwell.

Unfortunately, due to a break down in communication, Dr Kelly was not told:

- Mr Jacobs had not been assessed by a psychiatrist for 8 months or by any doctor for 3 months;
- of the circumstances surrounding the inpatient admission in early 1999, including the cause for the deterioration in Mr Jacobs' condition;
- whether Mr Jacobs had required another inpatient treatment;
- of Mr Jacobs' forensic history;
- Mr Jacobs could be physically violent when psychiatrically unwell; or
- of the symptoms Mr Jacobs typically presented with when psychiatrically unwell.

Dr Kelly was Mr Jacobs' treating doctor between July 2002 and March 2004. She initially reduced his dose of Zuclopenthixol from 300mg to 200mg as it was her understanding he had been previously stable. In approximately November 2002, Dr Kelly prescribed Risperidone after discussion with Mr

Loudon, as there had been a deterioration in Mr Jacobs' condition. On a few occasions, Mr Jacobs presented to the Gold Coast Hospital Emergency Department complaining of psychotic and depressive symptoms in the context of increased substance abuse. Dr Kelly was not aware of these attendances. There was apparently a system in place at the time to enable the exchange of information between the Gold Coast Hospital and the MHS. For a reason which is not clear, this line of communication does not appear to have been utilized following Mr Jacobs' presentations at the hospital.

Dr Kelly last saw Mr Jacobs in January 2004. At that time he seemed to her to be managing well and to be taking his medication, although he had been requesting increased prescriptions of Valium. Dr Kelly questioned him about the use of this medication and warned him about the potential adverse effects of over use.

In March 2004, Mr Jacobs telephoned the Southport Medical Centre and informed a receptionist he would no longer be attending for treatment by Dr Kelly because in his view, he did not require further treatment. Dr Kelly had no further contact with Mr Jacobs and did not advise the MHS of Mr Jacobs' cessation of treatment, nor did she call him and seek to persuade him to reconsider the decision.

Mr Jacobs re-offends

In the early hours of the morning on 22 April 2004, Mr Jacobs went to a service station at Broadbeach and demanded a packet of cigarettes from the attendant. He was carrying a length of metal chain. The police were called and when they arrived they found him sitting in a gutter across the road from the service station. While Mr Jacobs was being transferred to the Southport watch house, the police were informed he committed the same offence a few hours earlier at another nearby service station. He was initially charged with two offences of demanding property with menace but these charges were later upgraded to armed robbery.

The following day, Mr Jacobs was transferred to the Arthur Gorrie Correctional Centre ("the AGCC") where he was remanded in custody until 1 October 2004.

On admission he was seen by an RN and told her of his earlier diagnosis, his cessation of medication and his illicit drug use. A plan was made for him to be reviewed by a psychiatrist.

Three days later, Mr Jacobs was assessed by a psychologist, Ms Tamara Smith. Ms Smith also recommended Mr Jacobs be assessed by a psychiatrist.

Psychiatric care in Arthur Gorrie CC

Dr Aleksandra Isailovic, was a psychiatrist employed by Queensland Health at the Park Centre for Mental Health at Wacol. She was also responsible for assessing and treating inmates at the AGCC and the Wacol Correctional Centre, who prior to their incarceration, had resided or been apprehended in the Gold Coast area. She would usually attend the AGCC weekly for half a

day and review prisoners who had been assessed by prison staff as needing such attention.

On 4 May 2004, Dr Isailovic saw Mr Jacobs for the first time. He told her:-

- in 1996 he had had a psychotic episode which was not drug induced but resulted in thought disorder lasting for two to three years;
- he had had a relapse in 2000 which had required inpatient admission at the Gold Coast Hospital
- between 2000 and 2003 he had taken Clopixol (Zuclopenthixol) 250mg fortnightly;
- he had taken no medication for approximately 5 months, since December 2003; and,
- he had been seeing Dr Kelly at the Southport Medical Centre.

On account of Mr Jacobs' previous psychiatric history and his reported non compliance with medication over the previous few months, Dr Isailovic was suspicious Mr Jacobs had minimized to her the nature and extent of his past psychotic experiences. She prescribed 100mg of Seroquel, an atypical anti-psychotic, which Mr Jacobs had not taken before. The plan was to review him the following week so Dr Isailovic could monitor any side effects of the medication.

For an unknown reason, that review did not take place as had been planned. The usual process was the coordinator of the Mental Health Services at the AGCC would have follow up with inmates who had not attended for scheduled psychiatric appointments, but it seems Mr Jacobs "*fell between the cracks*".

On 3 June 2004, Mr Jacobs was seen by a registered nurse. He reported visual hallucinations and felt he was paranoid, anxious and agitated. Dr Isailovic re-assessed Mr Jacobs on 13 July 2004 and unfortunately at this time, she did not know of the difficulties he had reported to the registered nurse some 10 days earlier. At the time of the assessment, Mr Jacobs denied experiencing hallucinations or delusions. She thought he was generally managing well and titrated his daily dose of Seroquel to 300mg with a plan to review him the following week.

Later that day, Dr Isailovic had a telephone conversation with Mr Jacobs' mother due to concerns raised by Mrs Kealton with staff at the AGCC. When she visited him, Mrs Kealton had noticed deterioration in her son's behaviour over the previous two weeks. Her son appeared to be preoccupied with bizarre themes and told her he was frightened to talk to anyone else because he believed they would hurt him. Given that Dr Isailovic had earlier that day increased Mr Jacobs' medication, she did not consider it necessary to re-assess him despite the information which had been provided by his mother.

The side effects of the increased dose of Seroquel caused Mr Jacobs to feel dizzy on occasions. He reported this to a registered nurse on 18 July 2004 and was again seen by Dr Isailovic some two weeks later on 3 August 2004, at which time she altered his medication slightly.

The last occasion on which Dr Isailovic saw Mr Jacobs was on 31 August 2004. Mr Jacobs reported feeling empty, detached and disinterested. He indicated he had a court hearing date in two weeks time and was concerned he had nowhere to live once he was released. Dr Isailovic considered Mr Jacobs had poor insight and there was a significant risk he would not continue taking the Seroquel or any other anti-psychotic medication once he was released. This concerned Dr Isailovic because it was clear to her he had chronic schizophrenia which was likely to relapse in the absence of medication. For these reasons, Dr Isailovic was of the opinion follow up support in the community was essential. In order to facilitate this referral, Dr Isailovic attempted unsuccessfully to contact Mr Jacobs' solicitor in the hope a condition of his bail would require him to seek the appropriate medical attention.

There was some question about whether Mr Jacobs took the medication he had been prescribed while an inmate at the AGCC. The medication chart confirms he was given the medication but this does not prove he took it. Ms Bernadette Cannon was Mr Jacobs de facto partner for the 15 months prior to his death. She is now middle aged and has had schizophrenia since her late teens. She did not give evidence but provided a signed statement to the effect Mr Jacobs told her on his release from prison he had not taken his medication and he had either spat it out or exchanged it for tobacco with other inmates. However, Mrs Kealton visited her son in prison on a weekly basis and it was her impression he was taking it most of the time. Further, Dr Isailovic altered the dose of the medication on a few occasions due to complaints made by Mr Jacobs of its sedative effects.

Her attempts to arrange for follow up support in the community was complicated by the fact Dr Isailovic did not know the date on which Mr Jacobs was to be released. The AGCC had no mechanisms in place to facilitate transfer of an inmate from the prison to the Community Mental Health Service in these circumstances. It was the responsibility of the prison mental health co-coordinator and not Dr Isailovic to arrange follow up support.

Mr Jacobs was released following a successful application for bail on 1 October 2004. He was not assessed by a psychiatrist in the month prior to his release, even though Dr Isailovic had planned to review him in mid September 2004.

Release from prison with no mental health care plan

On his release from the AGCC in October 2004, Mr Jacobs resumed cohabiting with Ms Cannan until his death in March 2005. He did not take any medication or seek any treatment for his mental illness over this period of time. She noticed his behaviour had markedly changed. He began showing an interest in knives and other weapons. He would carry knives around the house and on occasions when he was withdrawing from amphetamines, he would become violent and damage property.

Over this five month period Mr Jacobs and Ms Cannan were regularly using illegal substances, particularly amphetamines. His mother felt he was aware of the impact of his substance abuse on his health and was at a loss to explain why he continued doing it.

Less than three weeks before his death, police were called to a domestic disturbance between Mr Jacobs and Ms Cannan, at which time Mr Jacobs informed police he had been inhaling the fumes of paint.

In late February 2005, Mr Jacobs telephoned his mother and said he was concerned there were "bad people around" and asked her to come around to his house urgently. When Mrs Kealton arrived at his residence, it was immediately apparent to her he was mentally unwell. He agreed with her he needed to seek ongoing treatment for his illness and told her he would probably go to Ms Cannan's general practitioner. Unfortunately, further treatment was not sought.

Events on the day of the shooting

There are considerable gaps in what is known about Mr Jacobs's movements on the day of his death.

Ms Cannan advises in the days preceding the shooting they had ingested considerable quantities of amphetamines. Mr Jacobs had received his social security payment on 22 March 2005 and spent $400 to buy two grams of "speed". She said it was very strong and, consistent with his recent behaviour when Mr Jacobs was "*coming down*," he acted violently, doing such things as stabbing the walls of their house.

She also says in the months prior to his death Mr Jacobs had regularly carried around a knife with which he would threaten her and stab into the walls and furniture in their house.

By Thursday 24 March 2005, they had used all of the amphetamines he had purchased. On that morning he told his partner he was going to Southport to buy some more. Before he went Mr Jacobs showed her he had found a wheel nut spanner she had previously hidden after he had become violent with it.

He left the house at about 9.00am in the morning and she never saw him again.

She was however able to advise the police associates she spoke to after Mr Jacobs's death told her that late in the afternoon of the 24 of March 2005 he had taken more speed in their company. She also reported these people said the drug was very pure and, consequently, strong. The former partner would not name these people when interviewed by police and in view of her long history of mental illness and continuing psychiatric problems it was not considered appropriate to compel her to give evidence in these proceedings.

There is also evidence concerning Mr Jacobs's conduct at about 6:30pm on the day in question. At that time he approached an elderly couple who were in

their car and preparing to drive off from outside the Gold Coast Hospital where the woman had been receiving treatment. A man we now know was Mr Jacobs rocked the car by pressing on the boot. This caused the male driver to alight to see what was going on. It soon became apparent Mr Jacobs was not in a rational state of mind. He directed the driver not to get back into the car and told the driver's wife she should go into the hospital for treatment. When the driver sought the assistance of two passers-by, Mr John Rixon and his son Michael, Mr Jacobs was equally irrational in his responses to them.

It seems Mr Jacobs wanted to use the car to go to Nerang. However, he did not use any violence to further this end and even when he had an opportunity to get into the car and drive off, he didn't. Nor, when he was told the police had been called, did he decamp. Instead he stayed around for a period of time variously estimated to be between five and twenty minutes until the elderly couple were able to re-enter the car and drive off. Mr Jacobs was still simply leaning against the fence when they did this and only after the two Rixons left the scene did he also walk away from the hospital in a westerly direction.

The four people involved in this incident with Mr Jacobs all indicate he was not acting normally. However, their observations are equally consistent with his being intoxicated by drugs, suffering a drug induced psychosis, suffering a psychotic episode as a result of mental illness or a combination of any or all of these conditions. The elderly motorist said in his statement Mr Jacobs *"appeared like he had mental problems".* His wife thought Mr Jacobs "*must have been drunk or under the influence of drugs".* Mr Michael Rixon noticed *"his eyes were twitchy and glazy".* His father thought Mr Jacob's "*demeanour appeared strange, he seemed drugged or drunk and he didn't seem to be making sense".*

Very soon after becoming involved in the incident, the younger Rixon called police and told them of the incident.

At 6.39pm this call was taken by a uniform constable at the Southport Police Station. There is no record of exactly what that officer was told. However, he contacted a civilian communications centre officer and asked her to enter the job on the computer dispatch system. The transcript of that conversation was in evidence. The constable told her he had been informed a male person was trying to get into a car while there was an elderly lady in the passenger seat. The constable also told the communications centre officer the subject was intoxicated "*from something".*

When the radio operator broadcast the job over the police communication system she erroneously added the elderly female was "*refusing to open the door".* This misinformation was also typed into the computer dispatch system. No information was given about Mr Jacobs' mental state or the possibility he was affected by drugs or alcohol.

It is apparent from the transcript and computerised job card that was generated there was some miscommunication in relation to aspects of this

incident. I do not consider the errors had any bearing on the outcome of Mr Jacobs' subsequent interaction with police. It is of concern however, that more care was not taken to precisely record what the informant reported to police and to ensure what was conveyed to officers detailed to respond was correct. In other circumstances this laxness could have serious repercussions.

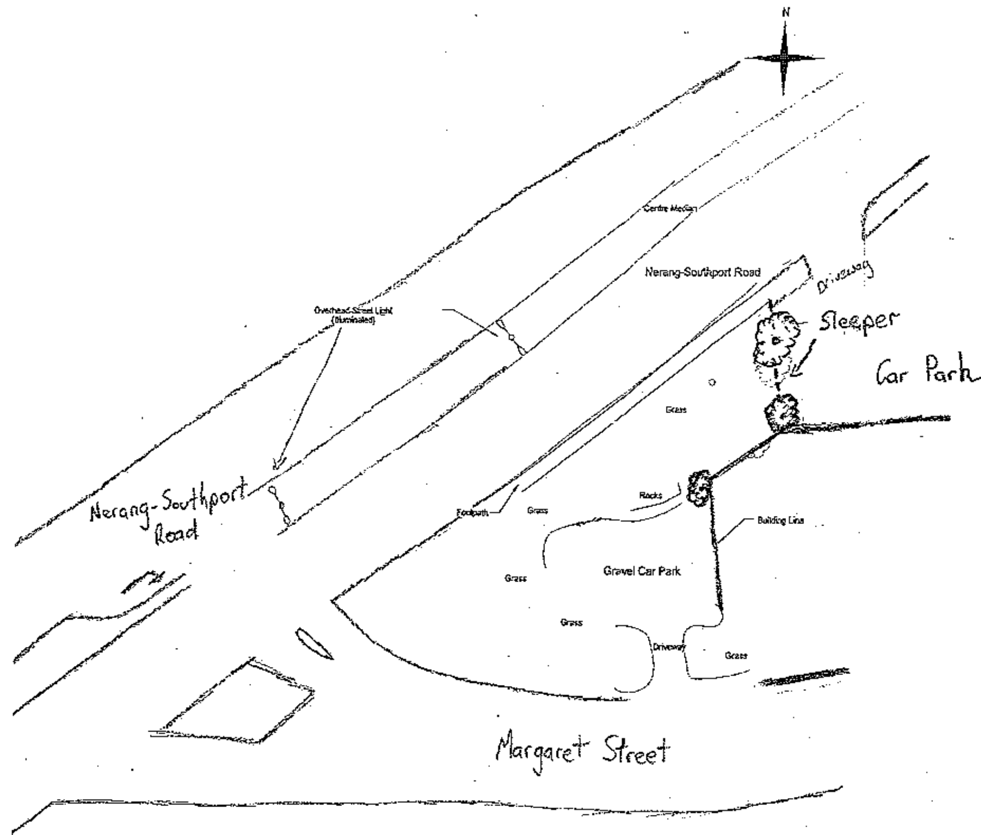
Constable Nunn was patrolling with Constable Booker when this job was broadcast. At 6.44pm they took the details and indicated they were proceeding to Queen Street Southport where the incident had occurred.

Before they could get there, another police car passing the hospital was flagged down by Mr Rixon Jr. They had heard the job allocated over the police radio system and so knew what he was talking about when he told them the subject person had left the scene heading west along Queen Street. Mr Rixon also gave them more details about Mr Jacobs' appearance. That information was passed to the communications centre operator who relayed it to Constables Nunn and Booker.

As a result those two officers patrolled west along Queen Street and then west along Nerang Street.

After going only a couple of blocks they came upon a person Constable Booker considered fitted the description they had been given. He was walking on the footpath adjacent to 194 Nerang Street, a commercial premises set back from the road.

A description of the area may help an understanding of the evidence. Nerang Street at this point has a northeast/southwest alignment. It has two lanes in each direction separated by a concrete median strip. Margaret Street, which runs east/west, runs behind the commercial building and intersects with Nerang Street, forming a triangle of open land to the front and west of the building. It is in this area in front of the building the incident unfolded. Refer to below sketch plan, but note it is not to scale.



The building is set back approximately 10 metres from the footpath. The driveway to the building meets it at a point where the front wall has a slight obtuse angled corner. To the southwest of the driveway, the land slopes downwards. On the street end of the driveway, there is a bushy Poinciana tree; where it meets the building there is a small red shrub. At the end of the wall that runs south-west from the driveway there is a more voluminous bush and a rock retaining wall. The south-western side of the driveway is retained by a single sleeper.

The interaction between the police and Mr Jacobs all occurred in this space bordered by the driveway to the north-east, the building to the east and the footpath to the west.

Constable Booker says he first saw the man we now know was Mr Jacobs walking in a south westerly direction on the footpath of Nerang Street near the driveway or the Poinciana tree. He alerted Constable Nunn who drove past Mr Jacobs before pulling over and parking the police vehicle some thirty to fifty metres past where Mr Jacobs was walking. He activated the flashing blue and red bar lights on the vehicle.

Both officers alighted and began walking back in the direction they had come. Constable Nunn was nearer the footpath while Constable Booker was closer to the alignment of the building. There are some differences in the fine detail of what they say happened next but their versions are largely consistent and

are generally corroborated by an independent civilian witness who viewed the events from a nearby intersection.

Both officers say as soon as they alighted they saw Mr Jacobs divert off the footpath at about 90 degreis to his previous path and head towards the commercial building. He went below the Poinciana and then headed back up hill slightly but never went onto the driveway.

Constable Nunn says he noticed nothing unusual about Mr Jacobs. Constable Booker on the other hand claims as soon as he saw Mr Jacobs he could tell from his eyes he was either affected by drugs or mental illness.

They agree as soon as they commenced to approach Mr Jacobs, he made it clear he was intent on avoiding them by his diversion. They also agree Constable Nunn called out, identifying himself as a police officer and directing Mr Jacobs to stop. Constable Nunn says Mr Jacobs looked at him and kept walking and so he repeated the direction. He says he told Mr Jacobs they just wanted to talk to him.

Both officers says they fanned out – "*triangulated*" in police jargon – so they were closing in on Mr Jacobs from slightly different angles as they moved up the slight incline. They did this to cut down his paths of escape and to reduce the opportunity for him to attack them both. Constable Booker also says he increased his pace when Mr Jacobs did not stop, agreeing with Constable Nunn's aside that Mr Jacobs appeared as if he may flee.

They also both say Mr Jacobs continued walking until he reached the corner of the commercial building, near the red shrub and the proximal end of the driveway. He then hesitated and appeared to be under the apprehension his path away from the officers was blocked by the building and/or some shrubbery. They agree at this stage Mr Jacobs turned to face them and lifted up his shirt, revealing a long bladed knife tucked through his belt. He drew it out and lifted it above his right shoulder.

Constable Booker says after doing this, Mr Jacobs first looked directly at him, took a step backwards and then shuffled a few steps back towards the road. Both officers immediately drew their firearms and yelled at him repeatedly to drop the knife. They both retreated a couple of steps and Constable Nunn moved a little closer towards Constable Booker. They say Mr Jacobs then did nothing decisive for some 15 to 30 seconds, while the officers continued to shout at him. According to Constable Booker, Mr Jacobs was only a few metres from Constable Nunn at this stage. He then charged at Constable Nunn and when he was a couple of steps from Constable Nunn, Constable Booker fired fearing Constable Nunn was about to be stabbed. He said he fired to incapacitate Mr Jacobs and believed there was no other action he or Constable Nunn could have taken which would have protected Constable Nunn.

Constable Nunn's version varies slightly. He says after pulling out the knife, Mr Jacobs turned to face the road and walked three or four paces back

towards the Poinciana tree, moving parallel with the sleeper referred to earlier. At that stage Mr Jacobs was 10 metres or more from Constable Nunn. He then moved slowly towards Constable Nunn until he was about 5 metres away and then suddenly quickened and was shot by Constable Booker when he was about four metres away from Constable Nunn.

A student, Andrew Little, who was riding his moped home from university also witnessed the incident from the intersection of Margaret and Nerang Street. He was waiting to turn across Nerang Street into Margaret Street and was therefore looking directly at the scene of the shooting. His attention was drawn to the officers by the bar lights flashing from the top of their patrol car. He saw them moving up the incline from their vehicle and noticed a civilian closer to the commercial building. Mr Little says he saw the officers walking towards the civilian who was clearly trying to avoid them. He says after getting near to the building, the civilian turned and walked slowly back towards the police. Mr Little then saw the officers start to move backwards and draw their guns. He then heard loud voices but couldn't say who was yelling or what they were saying.

At this stage Mr Little drove across Nerang Street and had a good view of the scene from Margaret Street. He says he saw the civilian advance towards the officer closest to Nerang Street and raise his right hand above his head. He could see something in the civilians hand and saw him lunge at the officer. He heard a loud bang and saw the civilian collapse on the ground.

There are obvious differences in these three versions as one would expect from witnesses seeing and/or participating in such a frightening and volatile incident. I do not believe it is possible to reconcile those differences or determine which account is most accurate; indeed it is likely there are aspects of each account that are accurate and parts that are not. The differences in my view however do not detract from the collective effect of the evidence I consider demonstrates that when he was shot, Mr Jacobs was presenting a very real danger to Constable Nunn such that had Constable Booker not fired it is likely Constable Nunn would have suffered serious injury or death. I discuss later in these findings whether the officers could have prevented such a dangerous situation from arising. However, at this point it is appropriate to acknowledge that when it did arise, the brave and purposive actions of Constable Booker saved his partner from serious injury or worse.

Post shooting events

After Mr Jacobs was shot, Constable Nunn moved to apprehend him. He first kicked the knife from Mr Jacob's grasp. Mr Jacobs then produced from his trousers the wheel nut spanner Ms Cannan had seen him with earlier in the day and attempted to strike at the officer with it. Constable Nunn wrenched it away from him and handcuffed him. The officer said he did this even though the blood soaking through Mr Jacob's shirt made him aware he was seriously injured, the officer could not see the knife and was worried that if Mr Jacobs got hold of it, further violence might ensure.

While Constable Nunn was doing this, Constable Booker was attempting to make radio contact with his superiors and to summon an ambulance. Numerous other police officers arrived very soon after the shooting and one of them removed the handcuffs and placed Mr Jacobs in the recovery position. It seems none of the officers attempted to provide any first aid by checking his airway or attempting CPR. All seem to have been involved in erecting crime scene tape and looking for exhibits. There is no evidence in this case first aid would have made any difference to the outcome. However, it should always be an officer's first priority.

Two ambulance crews were despatched to the scene with the first paramedic team arriving at 7.03pm. At this time, Mr Jacobs was on the ground in a "recovery position". The paramedics examined him and commenced cardiopulmonary resuscitation. It was obvious to them he was seriously injured. The paramedics left the scene with Mr Jacobs at 7.12pm and travelled a short distance to the Gold Coast Hospital.

Mr Jacobs was examined there and provided with emergency medical treatment. At 7.30pm, a decision was made to cease resuscitation attempts when it became apparent Mr Jacobs had died.

Significantly, no medications were administered to Mr Jacobs after the shooting and so the drugs found in his blood when it was analysed after his death must have been consumed by him.

Ballistics evidence

The Police Service Glock 40 calibre pistols, together with the associated magazines and ammunition issued to Constables Booker and Nunn, were seized and secured. These items were later subject to forensic examination by a ballistics expert, Sergeant Clark of the Brisbane Scientific Section. An examination of the projectile recovered from Mr Jacobs' body at autopsy showed it was consistent with the type issued to members of the Police Service and the markings on it were also consistent with it having been fired by a Glock pistol. An inspection of the discharged cartridge, which had been located at the scene of the shooting, established it had been fired by a pistol, similar to that on issue to Constable Booker.

Breath and blood tests

At interview, Constables Booker and Nunn consented to providing a sample of their breath on a roadside breath testing device; both of which proved negative. Furthermore, both officers consented to provide a blood sample for toxicology analysis, the results of which confirmed neither officer had alcohol or drugs in their system.

The autopsy

On 25 March 2005, an experienced forensic pathologist, Doctor Beng Ong, performed an autopsy on Mr Jacobs' body. He found a wound caused by a projectile entering the outer front left of the abdomen about level with the umbilicus. The gunshot wound was directed from left to right in a slightly downwards and backwards direction. It punctured the small intestine and the

descending colon and perforated the fifth lumbar vertebra. The projectile lodged in the lumbosacral joint from where it was recovered.

The wound entrance had no powder markings, suggesting the firearm had been discharged from at least one (1) metre away from Mr Jacobs. The wound caused massive haemorrhage within the abdomen.

Analysis of blood taken from Mr Jacobs found the presence of methylamphetamine [0.11 mg/kg] and its metabolite, amphetamine [<0.03 mg/kg]. According to Dr. Ong, the level of methylamphetamine was significant and would have influenced the behaviour of Mr Jacobs. Additionally, the effects of methylamphetamine on the heart may hasten death by increasing the amount of bleeding due to its hypertensive and sympathomimetic (increase in heart rate effect). Also found was morphine [0.02 mg/kg] and a metabolite of cannabis. Dr. Ong advised the morphine appeared to be taken some hours prior to death as the ratio of morphine and morphine glucuronides [0.11 mg/kg] was low.

In Dr. Ong's opinion, the mechanism of death was internal haemorrhaging caused by a gunshot wound to the abdomen.

The identification

Initially, identification of Mr Jacobs was confirmed by comparing his fingerprints with records held on the National Fingerprint Database.

Later, at 12.50am on Friday, 25 March 2005, Mr Jacobs' mother was transported to the Gold Coast Hospital, where she positively identified her son to police.

Findings required by s45(2)

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. I have dealt with the last of those matters, the circumstances of death, above. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, I am able to make the following findings in relation to the other aspects.

Identity of the deceased – The deceased was James Henry Jacobs

Place of death – Mr Jacobs died at 194 Nerang Street, Southport

Date of death – He died on 24 March 2005

Cause of death – Mr Jacobs died from internal haemorrhage due to a single gunshot wound to the abdomen

Referral to the DPP

In so far as is relevant to this matter, s48 provides that if information obtained by a coroner while investigating a death leads him/her to reasonably suspect that a person has committed an offence, the coroner must give the information to the director of public prosecutions. In this case it is appropriate to consider whether such a referral should be made in relation to an offence of unlawful killing.

It is not my role as coroner to decide whether any person is guilty of an offence in connection with the death or indeed, even whether the prosecutorial discretion should be exercised in favour of presenting an indictment and bringing the matter before a jury.

I take "*committed an offence*" to mean that there is admissible evidence that could prove the necessary elements to the criminal standard.

The use of the term "*reasonably suspects*" is redolent of the test applied when a search warrant is sought. In that context it has been held that a suspicion is a state of mind less certain than a belief and to be reasonable it must be based on some evidence, but not necessarily well founded or factually correct and be a suspicion that a reasonable person acting without passion or prejudice might hold.[36][37]

However a search warrant is frequently sought when very little might be known about the circumstances of the suspected offence. In that context it is applied when there has been inadequate opportunity to allow the suspicion to gestate into a belief and authority is sought to take the steps that might enable that to occur. As a result, a relatively low level of certainty is needed to satisfy the test. It would seem incongruous that a similar approach be taken when there has been an extensive investigation and public inquiry in which all relevant witnesses have given evidence under oath and have been cross examined and world renowned experts have provided reports and also given oral evidence. In those circumstances there is little room for uncertainty and reliance on speculation or conjecture would seem unnecessary. The removal of doubt by the forensic process means that for a suspicion to be reasonable it must be well founded. [38]

I consider this potential anomaly can be overcome by construing the subsection as requiring a referral to the DPP only when the coroner considers it likely that the Crown could prove all of the elements of an offence.

Section 291 of the Criminal Code provides that it is unlawful to kill another person unless that killing is authorised, justified or excused by law.

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[36] For a discussion of the authorities see Tonc K., Crawford C., & Smith D., *"Search and Seizure in Australia and New Zealand",* LBC, Sydney, 1996 at p68

[37]

[38]

Section 300 of the Criminal Code states that "*any person who unlawfully kills another person is guilty of a crime, which is called murder, or manslaughter, according to the circumstances of the case".*

There are various definitions of murder provided by s.302 of the Code. Most relevant to this case, s302(1) provides that a person who unlawfully kills another person with the intention of causing the death or doing grievous bodily harm is guilty of the crime of murder.

In this case there is an abundance of evidence indicating that Mr Jacobs died as a result of being shot by Constable Booker. It was witnessed by Constable Nunn who gave evidence of the shooting.

When interviewed by investigators immediately after the shooting, Constable Booker indicated that he had shot Mr Jacobs intending to incapacitate him. He gave similar evidence at the inquest. However, these admissions were made after the officer had been given a direction to answer questions pursuant to the *Police Service Administration Act 1990* and s39 of the *Coroners Act 2003 respectively*. The answers were not therefore voluntary and can not be used against the witness in criminal proceedings. However, the intention of an actor can be inferred from the circumstances of the act: the natural and usual consequences of an act will be presumed to have been intended.

In this case, I consider a jury could infer from the deliberate close range shooting of Mr Jacobs that the officer had the intention to kill or do grievous bodily harm to him. I therefore consider all the elements of the offence of murder can be made out against Constable Booker.

Accordingly, the only issue to be further considered is whether the killing was authorised, justified or excused by law. If it was, that is the end of the matter. If not, I must refer the evidence, other than that given after the directions previously mentioned, to the DPP for her consideration.

This requires consideration of any defences open to the officer, because, before a jury could convict him, the prosecution would have to exclude the operation of any defences. The two statutory provisions relevant to that issue in this case are s.271 and s273 of the Criminal Code.

Section 271, short-titled "*Self-defence against unprovoked assault,*" provides that if a person is assaulted in such a way as to cause reasonable apprehension of death or grievous bodily harm, and the person reasonably believes that he can not otherwise protect himself from that, it is lawful for the person to use such force as is necessary for his defence even though that force may cause death or grievous boldly harm. So far as is relevant to this case, "assault" is defined in s.245 to include not only the application of force but also the threatened application of force in circumstances where the person making the threat has an actual or apparent ability to carry out the threat.

Section s273 provides that if it is lawful for a person to use force to defend himself it is also lawful for any other person acting in good faith in aid of the first person to use a like degree of force.

I will now apply that law to the facts of this case.

As I have set out earlier, the officers became involved with Mr Jacobs when responding to a complaint that he had menaced people at the hospital. The officers confronted him and quite reasonably required him to stop and speak with them. Soon after, he rushed at Constable Nunn while brandishing a knife. In these circumstances I am satisfied that Constable Nunn reasonably feared for his life and concluded that he could only protect himself by shooting Mr Jacobs. Constable Booker was of the same view; he acted more quickly and was entitled to use deadly force to protect Constable.

Both of the police officers involved in these events were placed in a very difficult and dangerous situation. None of them is above the law: they are charged with upholding it and protecting the life of even those who are endangering others. However, police are also entitled to the protection of the law. They are entitled to defend themselves and even use deadly force if they can not in any other way secure their own safety. In this case, the officers did not have to wait until one of them was stabbed before using their firearms to neutralise the risk of that happening. When officers are faced with a man armed with a knife and acting in a threatening manner, society can expect no more than its police officers act reasonably.

There is therefore no basis on which to refer any information concerning this matter to the DPP

Concerns, comments and recommendations

Section 46 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. It will be noted those heads of jurisdiction are alternatives and so it is not necessary the death be preventable before a comment concerning public health and safety or the administration of justice can be made.

The circumstances of Mr Jacobs' death, in my view, raise the following issues for consideration from this perspective:-

- The treatment/management of Mr Jacobs' mental illness by the Southport Adult MHS, the Gold Coast Hospital and the prison health system; and

- The response of officers Booker and Nunn when they confronted Mr Jacobs.

Mental health care

Continuity of care is widely regarded as an essential characteristic of a successful therapeutic relationship. Unfortunately for Mr Jacobs, this was almost completely absent from the management of his mental health needs throughout the time he sought assistance from the Gold Coast Mental Health Service.

After his initial discharge from an inpatient stay at the Gold Coast Hospital, he was fortunate to have Mr Louden as his case manager but the doctors on whom he was reliant for psychiatric input changed frequently and saw him rarely. Long periods passed during which he had no psychiatric review.

Both Dr Redan and Dr Kingswell were critical of the lack of coordinated medical leadership.

During times of crisis Mr Jacobs and/or his mother attended at the emergency department of the Gold Coast Hospital where little was done to assist them. No regard appears to have been had to his extensive clinical history; each episode was viewed in isolation. Indeed, these crises were not even reported to the MHS.

It is clear Mr Jacobs had little insight into his condition. Like many people suffering mental illness he did not appreciate the chronic nature of his condition and was therefore not medication compliant. Equally common was his tendency to abuse illicit drugs.

Unfortunately, the MHS seemed unable or unwilling to actively engage with the challenges these tendencies presented. Mr Jacobs was simply advised to seek assistance from ATODS and urged to continue to take his medication.

When his care was transferred to a private practitioner, there was no follow up from the MHS and it was not advised when he ceased attending for his depot medication, even though this almost guaranteed Mr Jacobs would relapse. The next month he committed criminal offences in circumstances that strongly suggest he was psychotic at the time.

When he was imprisoned as a result, Mr Jacobs received reasonable psychiatric care. However, even though his treating psychiatrist accurately foresaw he would not remain medication compliant upon release and he would suffer a relapse of his mental illness as a result, there were no mechanisms available to her to respond to these looming problems. Consequently, upon release Mr Jacobs did not seek mental health care, did not obtain any medication, abused illicit drugs and was dead within five months.

Each of these failings is symptomatic of the weakness in the mental health care system. Some of them have been addressed. I shall return to them in part 6 of this report.

The police response

It is apparent officers Booker and Nunn approached and interacted with Mr Jacobs without making any allowance for his mental illness. It could be argued a more careful assessment of the information conveyed to the QPS by the members of the public who reported Mr Jacobs' strange behaviour outside the hospital, could have alerted the officers to the likelihood he was delusional. It is unlikely, however, that would have made any difference to the outcome.

It is highly likely mental illness and or the drugs Mr Jacobs had taken influenced his reaction to the officers. It is probable when they confronted him in a confined space and yelled directions at him he panicked. His running at officer Nunn was more likely an attempt to escape than an attack but of course the officers could not risk allowing him to get any closer to them in the circumstances. In particular, the darkness, the uneven ground, the uphill position Mr Jacobs commanded and, of course, the large knife he was brandishing, meant Constable Booker had little choice other than to shoot as he did.

I accept members of Mr Jacobs' family and his mental health case worker had on other occasions, managed to defuse Mr Jacobs' aggression when he was manifesting paranoid delusions but the circumstances in which this had been accomplished were far different from those prevailing on the night of his death, when the two officers who had no prior dealings with him came upon him suddenly and provoked a violent response. I do not believe the officers could reasonably have retreated. To do so would have posed too great a risk in that Mr Jacobs, having a running start from an uphill position could have run them down. Further, if he'd escaped and harmed a member of the public, the police would have been criticised for not using more decisive means to take him into custody when they had the chance.

Suggestions that officers in such cases should "shoot to wound" are misconceived. I will deal with that more fully in part 7.

I am therefore of the view the officers involved discharged their responsibilities appropriately. Sadly, there was nothing they could reasonably have done that would have made Mr Jacobs' death less likely.

Part 5 – Findings into the death of James Michael Gear

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Introduction

Late in the evening of 24 February 2006, neighbours of James Gear called police when they became concerned by his bizarre and threatening behaviour.

When approached in his backyard by the officers, Mr Gear reacted in an aggressive and threatening manner. After a brief struggle he fled into his house. Shortly afterwards, three officers went into the house. Mr Gear ran at one with a knife and he was shot dead.

These findings explain how that happened and consider whether any changes to the policies, procedures or practices of the local community mental health service or the police service could improve public health or safety or reduce the likelihood of deaths occurring in similar circumstances in the future.

The investigation

Investigators from the Homicide Investigation Group, Ipswich District Criminal Investigation Branch and the Ethical Standards Command attended at the scene within two hours of the shooting. Detective Inspector Reeves of the Ethical Standards Command was appointed to take charge of the investigation.

An interactive crime scene recording was undertaken by officers from the police photographic section. Video-recordings and photographs were taken of the scene and items of interest. A scale plan of the scene was prepared.

Police scenes of crime and scientific officers attended and conducted their respective investigations. Relevant exhibits were photographed, recorded and seized for forensic examination. Ballistic examinations were conducted by a police ballistics expert.

Regrettably there was a flaw in the scene preservation process in that a knife thought to have been wielded by Mr Gear was noticed on the floor in the room in which he was shot by one of the first officers to enter the house after the shooting. That officer picked it up and placed it in the boot of his car. He said he did this because he was concerned it would be stepped on by the ambulance officers who were passing through that room when treating Mr Gear. It was not photographed in situ nor was its position marked. I don’t consider this failing negatively impacted upon the investigation but it should not have occurred.

Investigators conducted a "door knock" in the vicinity of the incident premises in an endeavour to locate potential witnesses.

The officers who witnessed the shooting were separated and interviewed as soon as possible after the event. A video re-enactment was undertaken at the scene with the officers who were present when the shots were fired.

In order to gain a greater understanding of the scene and the circumstances of this complex incident, I attended the scene later that day and also observed the "walk through" interview with the officer who shot Mr Gear.

I am satisfied the investigation in this case was thorough and carried out in a competent manner. Detective Inspector Reeves and those who assisted him are to be complimented on their work.

The evidence

Family History

Mr Gear was born in Ipswich on 5 September 1982 making him 23 years of age at the time of his death. He was the youngest of three children. He had a good relationship with his siblings, Adam and Meagan. Adam also suffered from schizophrenia but his condition has been well managed since his early twenties.

James' parents separated in 1990 after twenty years of marriage. He was eight years of age at the time. James' mother suffered from panic attacks and depression. His father was a Vietnam veteran who also suffered from anxiety and apparently became unstable if he drank too much.

Following his parents' separation James continued to live with his mother and had only sporadic contact with his father.

James enjoyed a strong and supportive relationship with his mother. Contact with his father was infrequent however his father remained concerned and supportive of his son and assisted him when he could.

Social History

James was popular at school but his educational history was characterised by truancy and suspensions. Not surprisingly, his grades suffered as a result. He left school after completing year 10.

He then worked intermittently in a number of semi-skilled positions. He was, however, unable to secure long term employment. Although often motivated to work, he was unable to secure permanent employment due to becoming stressed and anxious by the work. This in turn increased his paranoid thinking and auditory hallucinations which resulted in increased alcohol consumption, compromising his ability to work for any length of time.

In October or November 2001, he was asked to leave his employment in a factory for allegedly stalking a female co-worker.

In mid 2002, James' mental state began to deteriorate again and he had a number of brief hospitalisations for treatment.

Between December 2003 and April 2004, James was able to secure casual work with an employment agency, Manpower.

In about September or October 2005, James commenced employment with Vast Interiors, a furniture factory, working to load and unload delivery trucks. He enjoyed this work. Unfortunately he was made redundant just prior to Christmas in 2005 as the factory had no further work for him. The loss of this employment upset him greatly.

It was following this time James' mental state began to deteriorate and his mother reported concerns he was becoming more and more isolated.

For the most part, James lived with his mother in the house at Harlin Road. However, for briefer periods he lived with other members of his family including his father, Peter, his sister, Meagan, his brother, Adam and his wife, Leanne.

Contact with police

Mr Gear had no criminal history. There is no record of him being involved in any physical confrontation with the police or being charged with any criminal offences.

A check of the Ipswich Police District Information Management System (IMS), which is maintained at the Police Communications Centre, reveals five entries relating to Mr Gear's residence at 71 Harlin Road, Coalfalls.

Incident 1 – 10 May 2002

Mrs Gear phoned the police complaining that James had been smoking dope and sniffing paint and was causing a disturbance at their residence at 71 Harlin Road, Coalfalls. Police attended the scene. Mrs Gear had asked James to leave the premises. He was collected by his brother while the police were in attendance. No offences were detected by police and no further action was taken by the police or other authorities.

Incident 2 – 3 June 2002

A triple "O" call was received from a male at 71 Harlin Road, Coalfalls who advised persons were *"pushing drugs*" through his neighbourhood. The identity of the male is not known. The operator advised the caller to contact the Yamanto police with his information. No further action was taken by the police.

Incident 3 – 16 June 2002

A telephone call received from "James" at 71 Harlin Road, Coalfalls advising he wanted to report "*a home invasion*". When he was queried for more information, James advised it was a matter between himself and his brother and he wanted to change his mind and not report the matter to police. Police attended the address; however no further action was taken by them.

Incident 4 – 12 July 2002

Mrs Gear informed police she was having problems with James. He was demanding money and was high on drugs and alcohol.

Police attended the address and spoke with Mrs Gear and James. It was established that James' mental health was deteriorating. He was not taking his medication and had been drinking alcohol. His behaviour was described by police as "*not too bad*". The police gave advice to Mrs Gear about the processes involved in having James "*regulated*". Police left the scene reporting *"all calm*".

As a result of this attendance an entry was made on the QPS computer system under the heading "Danger/Intelligence at Incident Address": -

> *12/7/02. If James Gear goes off again, send 2 units, if possible. James is a big lad and may not like police presence.*

Incident 5 – 2 February 2006

A telephone request was received from the Ipswich Integrated Mental Health Unit (MHU) for police assistance for a Justice Examination Order (JEO) for James Michael Gear at 71 Harlin Road, Coalfalls. The reason provided for police assistance was "*potential violence when unwell*". At 5.01pm a call was made to MHU however, they were not available to attend and the matter was put "on hold" until the following day.

Police attended on 8 February with two mental health nurses. No action was required by them.

Mental health history and treatment

Initial diagnosis

When James was approximately 15 years of age, his mother noticed his behaviour becoming unusual and verbally abusive. He was referred by the family's general practitioner to a private psychiatrist in Ipswich for treatment. She saw Mr Gear on three occasions. He presented with symptoms of auditory hallucinations and paranoid delusions. He told her he had experienced these symptoms for several years and they intensified with illicit drug use. The psychiatrist prescribed olanzapine, an anti-psychotic medication.

In August 1999, when Mr Gear was nearly 17 years of age, the private psychiatrist who had been treating James was leaving the Ipswich area and at

his request she referred him to the West Moreton Child and Youth Mental Health Service ("CYMHS") at Ipswich.

On 23 August 1999, Mr Graeme Rawson, a psychologist at the CYMHS performed an initial assessment of him. The notes of the assessment record Mr Gear as having told Mr Rawson he had been hearing voices since he was 13 or 14 years of age and had started taking drugs including amphetamines, heroin and LSD when he was approximately 15 years of age. He also told Mr Rawson he had been previously diagnosed with paranoid schizophrenia. Mr Rawson became Mr Gear's case manager.

For the next four months, Mr Gear attended at the CYMHS for assessment and treatment of psychotic symptoms, including auditory hallucinations and persecutory and paranoid thinking. Mr Rawson saw him on average, four times per month. Dr Sanjay Patel, a psychiatric registrar, was Mr Gear's supervising clinician and continued him on olanzapine. Dr Patel assessed Mr Jacobs on 13 September 1999, and diagnosed an "*unspecified psychotic disorder*". This was the primary diagnosis although Dr Patel could not discount paranoid schizophrenia.

By January 2000, Mr Gear was apparently finding it difficult to attend therapy sessions due to work commitments. He did not respond to numerous requests to contact the CYMHS. In late April 2000, Mr Rawson wrote to Mr Gear and expressed concern he had not been seen by the CYMHS for five months and indicated if he did not contact the CYMHS within two weeks his file would be closed. Mr Gear did not respond and on 27 June 2000, he was discharged as a client of the CYMHS.

Relapse in 2002

In April 2002, Mr Gear's father contacted the West Moreton Integrated Mental Health Service ("the WMMHS") as he was worried about the deterioration of his son's mental state over the previous six months. Mr Gear agreed to attend the clinic. On 5 April 2002, he was seen by Dr Gnanambikai Mackinnon, psychiatrist and supervising clinician of the Rural Continuing Care Team ("the rural team"). Mr Gear told Dr MacKinnon he had lost his job in late 2001 for stalking a female employee and he felt angry towards her and wanted to *"smash people's heads in"*. He indicated he had been smoking marijuana for some time but had given it up six weeks earlier. Dr Mackinnon diagnosed Mr Gear as suffering a relapse of his previously diagnosed chronic paranoid schizophrenia and prescribed him Risperidone, an antipsychotic and Fluvoxamine, an antidepressant.

Approximately six weeks later, Mr Gear's father telephoned Dr Mackinnon as he was concerned about the continuation of his son's aggressive behaviour. He reported his son was abusing drugs and sniffing petrol. An appointment was scheduled for the following day but Mr Gear did not attend and Dr Mackinnon sent him a letter asking him to contact the WMMHS if he required another appointment.

Mr Gear's sister took him to the WMMHS on 26 June 2002 and he was reviewed by Dr Mackinnon. Mr Gear told her he was living with his sister and taking his medication. He admitted to continuing use of marijuana but denied using any other illicit substances. Dr Mackinnon thought Mr Gear's mental state had improved since he had commenced taking the medication.

On 15 July 2002, Mr Gear's father again telephoned the WMMHS and indicated his son had stopped taking his medication resulting in a deterioration in his mental state. He was concerned as his son had almost burnt down the house on three occasions and had been found cooking petrol in the frying pan and eating the residue. He also indicated his son had accused his wife of hiding his imaginary girlfriend "Debbie". Mr Gear's mother was so terrified of him she was locking herself in the bedroom at night.

Mr Gear was reviewed at the WMMHS on 17 July 2002. He denied the accusations made by his father and refused to accept he had a mental illness. He was diagnosed with an exacerbation of chronic schizophrenia secondary to petroleum abuse. It was decided he should be admitted to hospital but he absconded prior to admission. He was detained by police later that day and was admitted to the Ipswich Hospital where he remained a patient under an Involuntary Treatment Order ("ITO") until 29 July 2002.

Whilst an inpatient, Mr Gear initially presented as hostile, irritable and aggressive, particularly to family members but after a few days he settled and became co-operative. He admitted to not having taken any medication for two months. Dr Mackinnon reviewed Mr Gear on 18 July 2002. He stated he had been burning petrol and eating the residue and he was also experimenting with "acid". His explanation for this behaviour was *"why buy it when you can make it at home".* He also said "*I shot someone a month ago and now I'm connected"* and he was connected by a *"visionary tube"* to "Debbie", his imaginary girlfriend. He responded to treatment and on discharge his ITO status was downgraded to a limited community treatment order, on condition he attend the WMMHS, take his medication, abstain from illicit drug use and display appropriate behaviours. He was given the 24 hour help line number for the Alcohol Tobacco and Other Drugs Service ("ATODS"). During this inpatient admission, Ms Xuan Luong became Mr Gear's case manager. She remained in this position until January 2005.

Not surprisingly, Mr Gear's mother was quite anxious about the prospect of her son being discharged from hospital. She was fearful he would cease taking his medications and return to using drugs. However, on his discharge Dr Mackinnon noticed Mr Gear was more willing to accept treatment. Ms Luong made arrangements to refer him to the Young Peoples Group, a rehabilitation group for young people with mental illnesses between the ages of 18 and 26. The group was run by the Active Recovery Team, which was a team within the WMMHS. Ms Luong in consultation with Dr Mackinnon thought such a referral would be beneficial in increasing Mr Gear's social networks, social skills and confidence to enable him to manage his symptoms and generally participate in the community.

Continuity of care – a stable course

Throughout the balance of 2002 and into 2003, Mr Gear's clinical course fluctuated but he was generally more stable. He continued to experience auditory and visual hallucinations which largely centred on "Debbie". Dr Mackinnon varied his medications as required and by mid February 2003, Mr Gear was reporting he was not as troubled by the hallucinations. Ms Luong had contact with Mr Gear on 22 occasions between August 2002 and mid February 2003. On 25 February 2003, Dr Mackinnon revoked Mr Gear's ITO, rendering him a voluntary patient.

Ms Luong and Dr Mackinnon continued to have regular contact with Mr Gear. It was apparent he was drinking to excess and he was encouraged to reduce this. In September 2003, Mr Gear told Ms Luong he would prefer to have telephone contact with her rather than home visits, as he felt he was managing his symptoms and was feeling better within himself. This request was accepted by Ms Luong after consultation with Dr Mackinnon and Mr Gear's mother. Mr Gear's mother felt her son and Ms Luong had a good relationship. She felt that although Ms Luong was firm with him, she showed a genuine interest in him.

In April 2004, Dr Mackinnon conducted her tri-monthly assessment of Mr Gear. He denied excessive alcohol intake and stated he had not used illegal drugs for in excess of two years. He reported auditory hallucinations but appeared generally relaxed. He expressed frustration about not being able to find work.

On 19 May 2004, Mr Gear reported to Ms Luong he had suffered a relapse a couple of weeks earlier. He assured Ms Luong he had been compliant with his medication but stated he had been drinking up to half a carton of beer each day. Ms Luong explained to Mr Gear that alcohol consumption reduced the efficacy of his medication. She encouraged him to reduce his intake of it.

When reviewed by Dr Mackinnon three weeks later, Mr Gear presented as depressed and troubled by auditory hallucinations. His dose of antipsychotic medication was increased. Mr Gear told Dr Mackinnon at his next review about one month later, that he had worked for Manpower between December 2003 and April 2004 and the stress of work had made him unwell. He explained when he had concentrated at work the auditory hallucinations had increased.

For the next few months, Mr Gear continued to feel depressed, with Debbie's voice bothering him. He felt anxious and panicked at the thought of work. He continued to take his medications as prescribed.

Mr Gear's mental state remained at this level until August 2004 when his mood improved. He continued to hear voices but was able to cope with these more effectively. Mr Gear attributed this improvement to an increase in his medication. He continued to search for work but stated the thought of it made him anxious. He was unable to identify the source of this anxiety.

On 12 November 2004, Mr Gear told Dr Mackinnon he was drinking heavily but did not see this as a problem. He was reluctant to seek treatment for this. He had lost interest in seeking employment.

In January 2005, Ms Luong ceased being Mr Gear's case manager as she was seconded to another position. On 7 January 2005, Mr Gear told Dr Mackinnon that while he was doing well he was concerned he would not be able to get or keep a job. He told her he did not want to receive assistance from the Active Recovery Team which had previously been arranged for him in July 2002 as he did not want to associate with *"nuts".*

Discontinuity of care – a breakdown of the therapeutic relationship

The following month, Ms Rochelle Matjac, psychologist took over as Mr Gear's case manager. She only performed this role for 8 weeks and made contact with Mr Gear on five occasions. She ceased her responsibilities in April 2005 when she left her employment with the WMMHS.

Mr Gear was not seen by a case manager for the next three months. In July 2005, Boyana Tatarevic, occupational therapist took over this position and became a member of the rural team. She had only graduated from university some three months earlier and her only relevant employment history was limited to a four week locum position at Mt Olivet Hospital caring for terminally ill patients. Ms Tatarevic did not have any experience in managing clients with mental illnesses and was provided with no training. She simply relied on the informal guidance of more experienced staff.

As Mr Gear's case manager, Ms Tatarevic considered it was her responsibility to:-

- assess his mental state, which included identifying a deterioration related to hallucinations, paranoia, substance abuse and depression;
- ensure he was compliant with his medication;
- help him find and keep employment and ensure he was voluntarily participating in employment;
- assess his self-care, leisure, recreational and vocational needs;
- assess his social support network and familial network;
- assess his adjustment to his illness and his coping skills; and
- provide assistance with interpersonal skills such as appropriate communication with others.

On 1 August 2005 Ms Tatarevic telephoned Mr Gear to introduce herself and to arrange a home visit for later that day. He declined the offer and told her he was not feeling well. She telephoned him two days later and received the same response. For these reasons it was not until 11 August 2005 that Ms Tatarevic met Mr Gear at his home. His mother was present. Mr Gear told her:

- he was taking his medication;
- he had no suicidal thoughts;
- he had no hallucinations;

- he was hearing voices but they were not as annoying as they had been previously;
- he had not used illicit drugs for two years;
- he was drinking a carton of beer a week;
- his main problem was boredom because he was not working;
- he had difficulty keeping a job as work tended to exacerbate his auditory hallucinations; and
- he had been on the waiting list for housing commission accommodation for four years but preferred to live with his mother.

A case review meeting of the rural team was held on 15 August 2005. It was decided to continue providing support as needed and to encourage Mr Gear to participate in recreational activities. Less than two weeks later, Mr Gear was reviewed by Dr Mackinnon. She thought that while he continued to be troubled by voices his mood was stable. Mr Gear mentioned he became anxious when he worked and she discussed breathing and other anxiety management techniques with him.

Ms Tatarevic telephoned Mr Gear on 13 September 2005 and he reported he was starting full time work on the following day. She advised him to contact the WMMHS immediately if he experienced an increase in the frequency or severity of his auditory hallucinations or anxiety. It appears that Mr Gear was not able to manage this employment. On 7 October 2005, he attended for an appointment with Dr Mackinnon. Ms Tatarevic was present. Mr Gear reported he had become so anxious at the thought of going to work he had not been able to attend. This had caused him to become depressed and drink to excess. Dr Mackinnon provided Mr Gear with some relaxation techniques and a relaxation tape and gave him a script for diazepam, a sedative.

On 4 November 2005, Mr Gear telephoned Dr Mackinnon to tell her he could not attend his appointment with her that day as he was unwell. Ms Tatarevic visited Mr Gear at his home on 19 November 2005. He told her that approximately a week earlier he had started a job labouring in Ipswich. Mr Gear's mother recalled this work was for Vast Interiors and her son was required to help unload trucks of furniture. Mr Gear told Ms Tatarevic up until the previous two days, he had been hearing voices every two hours. He reported he was taking his medication but was still drinking a carton of beer per week.

The rural team met to review Mr Gear's case on 21 November 2005. Mr Gear did not attend his scheduled appointments with Dr Mackinnon on 24 November or 2 December 2005. Therefore she had not seen him since early October 2005 and did not see him again as she left the WMMHS at the end of the year.

Dr Drew Richardson replaced Dr Mackinnon as Mr Gear's treating psychiatrist in mid January 2006. There was no formal handover and Mr Gear was simply placed on Dr Richardson's list of clients. Dr Richardson did not ever assess Mr Gear but had input into his treatment. Dr Richardson had a demanding

case load that included inpatient and outpatient clinics, supervision of junior doctors and private practice. He considered his case load was considerably heavier than the typical consultant psychiatrist's case load at the bigger teaching hospitals in Brisbane. Mrs Gear was not told her son's psychiatrist had changed until after his death.

This change of psychiatrist coincided with Ms Tatarevic reducing her work load from full time with a case load of 29, to two days per week with a case load of 14. Ms Tataraevic considered this reduced part-time load was difficult to manage and felt it was necessary to prioritize the clients. As Mr Gear was not on an ITO and had been reasonably stable when he had last been seen by her in November 2005, she made the decision he was of a relatively low priority in terms of the frequency with which he required contact with the MHS.

By the end of January 2006, Ms Tatarevic had not seen Mr Gear for in excess of two months and neither had any other person from the WMMHS. Ms Tatarevic was aware Mr Gear had not been seen by a psychiatrist for in excess of three months and had missed his last three scheduled appointments but she did not bring this to Dr Richardson's attention.

Mrs Gear telephoned Ms Tatarevic on 30 January 2006 to report:

- her son's mental health had deteriorated;
- she thought he had stopped taking his medication in November 2005 and had commenced using illicit substances again;
- he had not been eating or sleeping regularly for the previous week;
- he had been laughing and cursing in his room which she thought was in response to auditory hallucinations;
- he had been verbally abusive towards her;
- he had been withdrawn in his room; and
- he had not left the house for two days.

Mr Gear refused to respond to Ms Tatarevic questions and abused her. At the request of his mother, Ms Tatarevic went to their home later that day. He appeared agitated and Ms Tatarevic was afraid of him. Mr Gear's mother confirmed he was verbally abusive and intimidating. Having seen this behaviour, Ms Tatarevic decided Mr Gear needed to be assessed by a psychiatrist as she thought he may have required inpatient treatment.

Ms Tatarevic returned to the WMMHS and raised her concerns with Dr Richardson. A team meeting was held at which time it was known Mr Gear had:

- not been taking his medication since November 2005;
- a short time earlier been abusive towards Ms Tatarevic;
- refused to be interviewed; and
- appeared paranoid and was possibly hearing voices.

Dr Richardson considered that based on the information he had available to him, it seemed Mr Gear's psychosis had relapsed possibly in the setting of non-compliance with medication and probable substance and alcohol abuse.

It was decided as there was no imminent risk of harm to his mother, Mrs Gear should be advised to take out a Justice Examination Order ("JEO").

Failure of the Justice Examination Order process

On the advice of Ms Tatarevic, Mrs Gear applied for a JEO and the order was granted by a justice of the peace on 2 February 2006. The order was then forwarded to the WMMHS. The JEO required a doctor or an authorised mental health practitioner ("AMHP") as provided for under the *Mental Health Act* 2000, to examine Mr Gear to determine whether a compulsory mental health assessment by a psychiatrist should be ordered.

Unfortunately, no members of the rural team were AMHPs and for this reason Mr Forward and Mr Cosgrove, both clinical nurses and AMHPs from the Crisis Assessment and Treatment Team ("CATT") were asked to perform the assessment. It was undertaken at Mr Gear's home on 8 February 2006. Mr Forward had not met Mr Gear before but Mr Cosgrove had provided nursing care to Mr Gear when he had been an inpatient at the Ipswich Hospital in July 2002. It had been decided on account of Mr Gear's behaviour on 30 January 2006, a police presence was required while the assessment was undertaken. Mr Forward had requested Ms Tatarevic attend the assessment but this did not eventuate.

Prior to undertaking the assessment, Mr Forward and Mr Cosgrove had been provided with a copy of Mrs Gear's application for the JEO, which informed them Mr Gear:

- had suffered from schizophrenia for a number of years;
- had been withdrawn;
- had been eating very little;
- had been laughing, talking and swearing loudly in his room;
- had not been taking his medication since the end of November 2005; and
- had been verbally abusive in short outbursts.

It seems unlikely they had available to them the notes Ms Tatarevic had made of her conversation with Mrs Gear on 30 January 2006 or of her visit to the home later that day, as the notes were inserted in the file at a subsequent time. Mr Forward could not recall having read them. Further, it was not drawn to their attention that Mr Gear had not been assessed by a psychiatrist for four months.

At the time of the assessment Mr Cosgrove and Mr Forward thought Mr Gear presented as a mentally healthy young man with no evidence of psychosis, depression or aggressiveness. He told them he had not heard voices for four months and justified his aggressive behaviour towards Ms Tatarevic on the basis he was annoyed because she had woken him up. It seems the presence of the police probably impacted upon the preparedness of Mr Gear to openly participate in the assessment and in fact, he indicated as much in response to questions regarding his use of illicit substances. Towards the end of the 30 minute assessment, Mr Gear reluctantly accepted the offer made by Mr Forward for arrangements to be made for him to be seen by a psychiatrist,

although Mr Forward had the impression Mr Gear would not turn up for any scheduled appointment.

Mr Forward conceded that based upon the information contained in Mrs Gear's application for the JEO, it was apparent Mr Gear's mental illness had relapsed. However, he considered in performing the assessment on 8 February 2006, he was required to primarily focus on Mr Gear's presentation on the day of the assessment, even though this was significantly at odds with the collateral information provided by his mother. He was of the view unless Mr Gear appeared to him on the day of the examination to be psychotic he could not order a compulsory psychiatric assessment.

Both Drs Mackinnon and Richardson thought if either of them had undertaken the assessment, greater weight would have been placed on Mr Gear's longitudinal history and the recent concerns expressed by his mother.

Ms Tatarevic telephoned Mrs Gear the following day to inform her the assessment had taken place and her son had been found to be mentally well. Mrs Gear did not agree with this. Both Drs Mackinnon and Richardson considered even though it was arguable Mr Gear did not require hospitalization on 8 February 2006, it was reasonably clear Mr Gear was not well and had relapsed, particularly in circumstances where he had willingly told Mr Cosgrove and Mr Forward he had stopped taking his medication because he thought he no longer required it.

The day following the assessment, a CATT team meeting was held. Unfortunately, because the discussion that took place and the treatment decisions made were not documented, it is not known whether any immediate options for re-engaging Mr Gear with the WMMHS were explored. Further, the exchange of information between the CATT team and the rural team was on an informal ad hoc basis at best.

Ms Tatarevic was surprised Mr Gear had presented to Mr Forward and Mr Cosgrove as mentally well but accepted the assessment and subsequent to this she considered Mr Gear's behaviour was a reaction to her rather than a sign of deterioration in his mental health.

An appointment was made for Mr Gear to be assessed by Dr Richardson on 7 March 2006. On 13 February 2006, Ms Tatarevic telephoned Mr Gear to inform him of this scheduled appointment with Dr Richardson and he indicated he was prepared to attend. He said he was *"doing fine"* and he had been listening to music.

The following week on 21 February, Ms Tatarevic and John Thomson, social worker went to Mr Gear's home for a visit. Upon arrival, Mrs Gear met them at the front door and ushered them inside. Her son was in the kitchen with his back towards them and made no attempt to acknowledge their presence. He then began yelling at Ms Tatarevic and asked her whether she had brought the police with her. He then walked towards her shouting and behaving generally aggressively. The situation was clearly volatile with a potential for

escalation and for this reason, Ms Tatarevic and Mr Thomson immediately left.

Ms Tatarevic returned to the WMMHS and telephoned Mrs Gear. She told her to apply for another JEO or contact the police if she feared for her safety or the safety of anyone else. Mrs Gear apologised for her son's behaviour and provided an explanation for it on the basis he had associated her with the police. Ms Tatarevic informed Mrs Gear she planned to discuss her son at the next team meeting. Neither Mr Gear nor any member of his family had any further contact with the WMMHS.

After her son's death, Mrs Gear explained to the police she did not apply for another JEO because shortly after Mr Gear's outburst on 21 February 2006, a council employee had visited the neighbour's house and she had observed her son speaking to him quite sensibly. Mrs Gear concluded he may well behave sensibly if he was to be again assessed under a JEO and the order would not be granted.

Events on the day of the shooting

A normal day

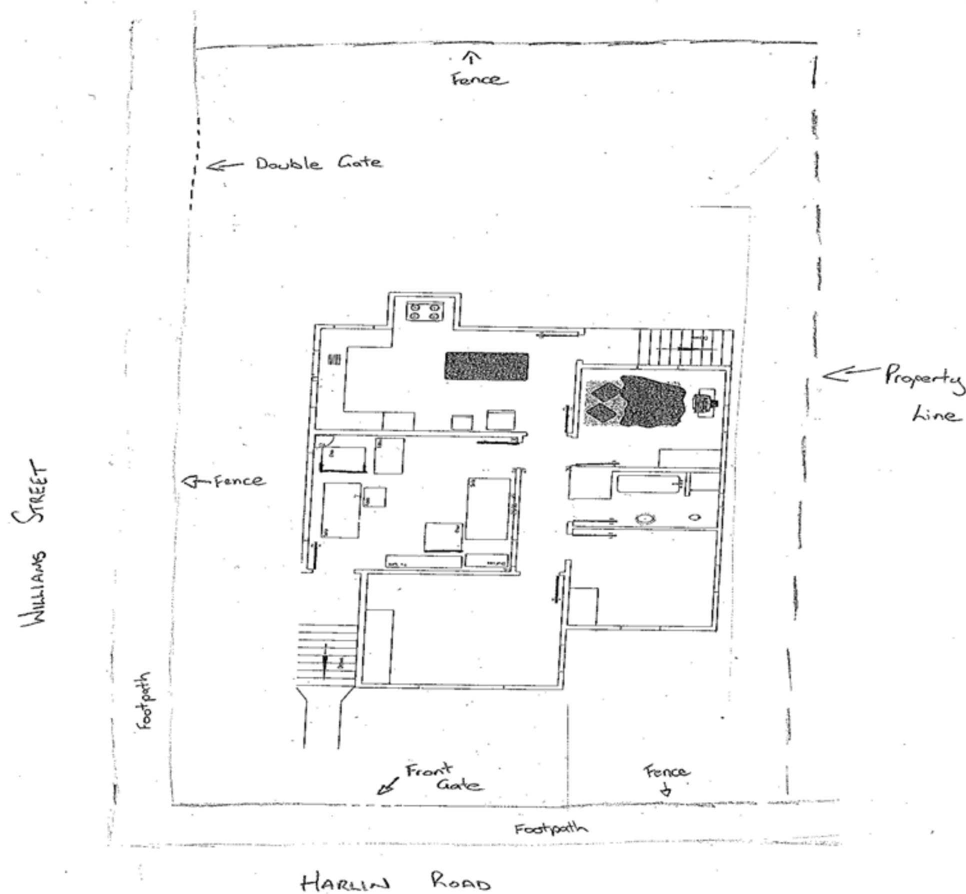
Marie Gear, James' mother says as far as she is aware nothing unusual happened during the day of 24 February 2006 that would in anyway explain what happened later that night. She said in evidence it was apparent to her James was very unwell on this day, and had been for the preceding few weeks. He had been very reclusive, spending all his time in his room. He was apparently having difficulty with his short term memory – "*he kept asking me the same thing over and over*" and generally he was, according to her, relapsing in the way she had witnessed in 2002. Mrs Gear says this was apparent to her whenever she looked into his eyes: he was just "*not there".* However, his condition did not seem acutely worse on the day of his death; he was communicating with her and acting in a relatively normal manner.

As far as she recalls, James only left the house briefly in the afternoon although she acknowledges she was not at home for a few hours in the morning. They had dinner at around 6.00 or 6:30pm. James then went into his bedroom and his mother went to bed around 7:30pm.

Nothing is known of what Mr Gear did after his mother went to bed, but later in the evening he had an interaction with neighbours that led to the police being called.

The location of the incident

A description of the location may assist an understanding of what transpired. The Gears' house at 71 Harlin Road is on the corner of William Street which runs in an east/west alignment along the side of the house. The block slopes down from the front. There is a double gate behind the house which allows vehicular access to the yard from William Street. A sketch of the floor plan of house is set out below.



The police are called

At around 10.00pm, the dogs belonging to the neighbours at the back of the Gear residence were barking incessantly. This caused Jacob Foster to go out into his front yard where he saw, but did not immediately recognise, James Gear standing on the footpath outside his fence.

Mr Foster said to the person, "*Can I help you?"* The person replied with words to the effect of "*This is my place; you've raped several white women".* Understandably, Mr Foster was shocked by these bizarre allegations and he says he attempted unsuccessfully to calm the man whom he soon recognized as his neighbour.[39] Suddenly, Mr Gear shot out a hand and tried to grab a hold of Mr Foster's neck or head. Mr Foster jumped back and after some more strange conversation realised something was wrong with Mr Gear. "*He didn't seem drunk and he didn't seem like he was on drugs. He seemed pretty calm like he was aggravated about something but he seemed pretty focused. He wasn't rambling crap*", Mr Foster said when interviewed. At one stage Mr Gear tried to open the gate as if he was going to enter the yard but the growling of the dogs caused him to desist. Understandably, neither of the neighbours is

[39] When giving evidence Mr Foster seemed unsure if or when he realized the person was his neighbor. However, the log of the telephone calls he and his partner made to police, clearly indicate they knew the person disturbing them lived next door.

able to say with any certainty exactly what was said, but both are adamant Mr Gear was repeatedly making bizarre claims and assertions.

Early in the encounter, Mr Gear's conduct so alarmed Mr Foster he asked his partner, Kerri McCartney to call the police and request they attend to deal with the matter. This call was received at the Ipswich communications centre at 10.12pm.

Mr Foster told Mr Gear the police had been called but this didn't cause him to go away immediately. First, Mr Gear sat down on the footpath near the gutter and apparently stayed there for something like half an hour. Mr Foster went inside and while in there saw Mr Gear walk back to his house and go up the back stairs. He remained inside for a short time and then came back out and went downstairs. He seemed to be somewhere in the back garden of his house. During this time the neighbours made two further calls to police to ascertain when they would arrive.

Mr Foster and Ms McCartney waited inside their house until the police arrived shortly before 11.00pm.[40] When the two first response officers, Constable Dixon and Constable Stephens, had been allocated the job, they were given a computer print out from the QPS information management system (IMS) that told them it concerned a "*male person outside informants' house appears to be mental or drug. He is abusing informant and her husband*".

When they arrived at the scene, the officers first went to the complainants' house and spoke to them about their interaction with Mr Gear. Mr Foster and Ms McCartney told them what had happened earlier in the evening and they had had problems with their neighbour in the past.

Violence erupts

The officers then walked up the footpath of Williams Street. They saw Mr Gear sitting in the middle of the back yard and they played their torch beams on him. He stood up and as the officers came closer he challenged them by calling in an aggressive manner, "*There's the gate*," and similar things on a number of occasions. He was also heard to ask the officers whether they had a warrant. The officers noticed Mr Gear was carrying a stubbie. Constable Dixon said he was concerned about the way in which Mr Gear was holding the bottle and asked him what he was going to do with it. He says Mr Gear responded with words to the effect "*I am going to crack it over your head".* As he said this he began moving towards them.

Understandably, this led Constable Dixon and Constable Stephens to believe they were about to be assaulted. Rather than retreating or seeking to dissuade Mr Gear from this action, both instead immediately took out their capsicum spray. Constable Stephens says when Mr Gear was three to five metres away and advancing, he discharged a jet of spray at Mr Gear's face.

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[40] The transcript of the radio communication between those officers and the QPS Ipswich communications centre has them "booking off the air" at 22.54 but both explained in evidence this message was sent when they erroneously thought they had arrived at the job address. In fact they arrived a few minutes later.

Constable Dixon then did the same. Both officers said in evidence the spray did not seem to have any effect, a comment they had made a number of times to other officers on the night of the shooting, but curiously both also said after being sprayed, Mr Gear ceased advancing towards them and turned and began moving back towards his house. Constable Stephens took out his extendable baton and when he noticed Mr Gear was turning away and bending over, possibly wiping spray from his face, he went quickly into the yard and struck him on his right thigh with the baton. Mr Gear responded by hitting Constable Stephens on the head with the stubbie. Constable Stephens first retreated back onto the footpath while Mr Gear immediately made for the back door. As he was doing so Constable Stephens says he pursued him and struck him "*a couple more times*" in the hope of getting him onto the ground.

Constable Stephens then followed Mr Gear to the back steps but thought better of trying to apprehend him on the stairs where Mr Gear's extra size and elevation would have made that difficult and so let him enter the house unimpeded. In the meantime, Constable Dixon came into the yard. He had accidentally sprayed himself in the eye with the capsicum spray and was therefore delayed slightly. This injury may also explain why he thought he saw Constable Stephens struggling with Mr Gear on the stairs. Realising he would not be able to assist in such a confined space Constable Dixon thought it appropriate to throw his torch at Mr Gear. It is not clear what the officer hoped to achieve by this but, fortunately, it struck no one and just hit the side of the house.

Constable Dixon radioed for assistance and then called again to advise Constable Stephens had been assaulted. These broadcasts were logged at 11.02 and 11.05pm. While they were waiting for that assistance to arrive, Constable Dixon went back to Mr Foster's house and used a hose to wash the capsicum spray from his eye. He also examined Constable Stephens head and noticed an acute lump behind his left ear. Both officers then returned to the Gear residence.

Constable Dixon took up position at the bottom of the back steps and Constable Stephens went to the front diagonally opposite corner so that they could keep an eye on the premises while waiting for further assistance to arrive. Constable Dixon says by that stage he was already contemplating a forced entry to the house in order to arrest Mr Gear for the assault on Constable Stephens. Constable Stephens was feeling unsteady due to being hit with the bottle. He was anxious for assistance to arrive and radioed in clarification of their location so the other crews wouldn't make the same mistake finding the place that he and Dixon had made. Checks were also requested as to the ownership of vehicles in the yard. It is apparent from the IMS system Mr Gear's identity was ascertained at some stage between 11.05 and 11.10 and it was established he was not wanted for anything and had no weapons registered in his name. Other checks that could have informed police Mr Gear had a history of mental illness were not undertaken.

Back up arrives

Four other officers then arrived in two cars in quick succession. They did not undertake any group assessment or endeavour to develop a plan of how to approach the situation or even discuss it together. As might be expected, their versions of what transpired as each officer set about doing whatever he thought was best to resolve the situation are inconsistent in some parts but I do not consider this indicates an attempt to conceal the truth: rather it is an unavoidable outcome when people try and recall detail of such a volatile and traumatic set of events. As best as I can work out, the incident unfolded in the following sequence.

Constable Reis and Senior Constable Russell arrived first. They spoke to Constable Stephens out the front of the house, probably on the footpath near the letter box and apparently realised he was incapacitated. Senior Constable Russell stayed with him at the front of the house for a short time while Constable Reis went around the back to assist Constable Dixon. Senior Constable Russell then also went into the yard but stayed mainly at the front and the side of the house.

Very shortly afterwards, Constable Olsen and Constable Campbell arrived. Both of them after briefly speaking to Senior Constable Russell, went to the back and took up with officers Dixon and Reis.

Mr Gear came to a window in the front of the house. He was seen there by Constable Stephens who called to Senior Constable Russell who came around into the front yard and spoke with Mr Gear briefly through the window. He asked Mr Gear to open the front door. Mr Gear answered him by providing his name but did not open the door as requested. He then was seen to move away from the window. It seems likely at this stage he went into the kitchen.

A short time later the front door was opened by Mrs Gear who awoke and saw the police flashing lights. She got up and says when she opened the front door there were three officers on the stairs. Senior Constable Russell supports this account. He says he called to the officers at the back over the radio and Constables Reis and Dixon came to the front and were with him when Mrs Gear opened the door.

However, the recording made by Constable Olsen on a digital recorder he activated when he arrived on the scene seems to indicate that when Senior Constable Russell requested Constable Reis to come back to the front yard, Mrs Gear was already in the kitchen. This is also supported by Constable Stephens who says when Mr Gear moved away from the window, Senior Constable Russell went back around to the side of the house out of his view. He says he then saw Mrs Gear open the door from his vantage point on the footpath and there were no other officers present at that time.[41]

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[41] Russell would not need to broadcast the fact the door was open if Reis and Dixon were with him when it happened. Further, this reconstruction is also more consistent with the timing of later events; it seems about 40 seconds elapsed from the time Russell broadcast the front door was open until the shooting and all agree they are in the house for only a few seconds before this occurs.

Meanwhile, Constable Olsen went up the back stairs and looked through the glass pane in the back door. He could see clearly into the kitchen as it was well lit. He was trying to attract Mr Gear's attention in the house by asking his name and asking him to come outside.

Almost as soon as Mrs Gear came into the kitchen, after having opened the front door, she also opened the back door but her son quickly closed it. She says he looked frightened. It is at this stage Senior Constable Russell called on the radio requesting the officers to join him at the front of the house. This left Constables Olsen and Campbell on the back steps. Constable Dixon may have also remained with them for a short time. A short time later, Senior Constable Russell can be heard to say over the radio "*You guys the door's open here": –* presumably Reis and Dixon had not reached him yet. At about the same time, Constable Olsen can be heard directing Mr Gear to put down a knife he says he saw him pick up from the bench in the kitchen.

Mr Gear did not comply with this direction which was repeated a couple of times and he can be heard on the recording to say ominously with unintended irony "*You're gunna have to fuckin' shoot me mate".* Soon after this exchange Mrs Gear was encouraged and physically assisted by Constable Olsen to leave the kitchen via the back door. She was helped down the steps and told to go into the back yard. Constable Olsen then sought to contain Mr Gear by closing the screen door and putting his foot against it. Mr Gear demonstrated he was not intending to leave the house by slamming closed the back door.

Constable Olsen then broadcast over the radio the fact Mr Gear had a knife and is "*barricaded in the house*" but it seems the officers who were most meant to hear this message, namely those at the front of the house were just about to, or indeed already had, learnt this fact from their own observations.

Three officers enter the house

When Constables Dixon and Reis joined Senior Constable Russell at the front door they decided to enter the house but did not discuss what they would do once inside or why they were going in. Senior Constable Russell said in evidence he wanted to get into the house as quickly as possible to build upon the rapport he thought he had established during the conversation with Mr Gear through the front window. Constable Dixon on the other hand thought they should go in to provide "*back up*" for the officers at the back steps. He suggested the possibility there might be weapons in the house as a justification for entering quickly. Constable Reis was able to offer no insight into how the decision to enter was made or what was hoped to be achieved. Senior Constable Russell was armed with his mag light torch; Constables Dixon and Reis drew their extendable batons. They entered in that order.

The front door opened onto the lounge room. It gave access to the rest of the house through a door way in the diagonal corner that led to a hallway with immediate access to the kitchen and Mr Gear's bedroom. The three officers headed towards that doorway. Senior Constable Russell says he had only taken a few steps in that direction before stopping and calling to Mr Gear who

he then saw in the hallway leading to the lounge room. He could see Mr Gear had a knife in his hand and saw him enter the lounge room. Senior Constable Russell shouted a warning to his colleagues and rushed out of the room followed very closely by Constable Reis. As they were on the stairs, screaming from the house alerted them Constable Dixon was still inside.

Shots are fired

Displaying great bravery, Constable Reis then re-entered the house. He says when he did so he saw Constable Dixon was lying back across some furniture in the north eastern corner of the room. He had his feet raised and Mr Gear was standing very close in front of him. This corroborates Constable Dixon's account that after the other two officers fled, Mr Gear turned his attention to Constable Dixon who had been behind and to the left of Senior Constable Russell as they advanced. As a result he was unable to exit through the front door because furniture along the northern wall blocked the direct path and Mr Gear's position in the middle of the room prevented a more circuitous route.

Constable Dixon says as Mr Gear advanced towards him he backed away until he stumbled and fell back onto some furniture. He then sought to keep Mr Gear at bay by kicking out with his feet and waving his baton at Mr Gear's upper body. He says while this was happening, Mr Gear was slashing at his legs and groin with the knife. Constable Dixon says he was expecting to be stabbed and couldn't escape. Constable Reis did not see the knife when he re-entered the house but assumed Mr Gear still had it and was convinced he would stab Constable Dixon as he was very close to the prone officer. He therefore went forward and slammed his baton across Mr Gear's back before jumping back.

It seems this may have provided Constable Dixon with an opportunity to draw his gun, as he says at one stage he noticed Mr Gear turn away momentarily. He took this chance and immediately fired a string of shots into Mr Gear's upper body. Constable Dixon claims he then reassessed the situation and seeing no change in Mr Gear's behaviour, fired another group of shots, one of which at least, he saw strike Mr Gear in his upper left chest area. The officer claims when this occurred, Mr Gear was spun or turned away to his left. He says *"it was as if he was going to come back to me and present himself again and then I fired the last string of shots at his side".* He says Mr Gear then turned away and went into his bedroom.

Other officers support this account to some extent. Constable Reis says after he struck Mr Gear and stepped back, he heard three or four shots fired, saw the deceased take a few steps back and then turn and go out of the room through the door into the bedroom across the hallway. He said it was possible Mr Gear had turned while the shots were being discharged but he also said *"it all happened so fast, I don't know".* He was sure the shooting had stopped before Mr Gear left the room and the bullets were all fired in a single stream with no discernable break.

Senior Constable Russell followed Constable Reis back into the lounge room. He says he is unable to recall anything of the actions of Mr Gear and

Constable Dixon, except that very soon after entering he saw a muzzle flash and heard a number of shots fired in rapid succession. He then saw Mr Gear move into the bedroom in the south east corner of the house.

The recording made by Constable Olsen does not support Constable Dixon's claim he fired three groups of shots and reassessed the need for further shots after each group had been fired. Rather, the tape recording evidences a single rapid discharge of nine shots, with no discernable break that took about three seconds in total. His shrill screaming that can be heard before and after the shooting indicates the officer's account of a calculated assessment of risk and response is unlikely to be accurate.

Constable Dixon's screaming and the sound of furniture banging also prompted Constable Olsen to enter the house via the back door. He was moving quickly towards the lounge room when the sound of gunfire caused him to prop, narrowly averting a headlong rush into the path of Constable Dixon's bullets. He was at the door way from the kitchen to the hallway when Mr Gear came out of the lounge room and crossed the hallway to his bedroom. Constable Dixon next came into the hallway with his gun drawn yelling "drop the knife!" repeatedly. The two officers entered the bedroom where they found Mr Gear slumped across the bed. Constable Olsen was able to reassure Constable Dixon that Mr Gear was no longer a threat. He advised the communications centre that shots had been fired and requested an ambulance urgently. The fact of the shooting was entered onto the IMS at 23.11pm.

Post shooting events

First Aid

Police officers at the scene provided Mr Gear with first aid in the form of Expired Air Resuscitation [EAR] and Cardio Pulmonary Resuscitation [CPR], pending the arrival of the paramedics. This is confirmed by the paramedics, who found the police conducting first aid when they arrived on scene at 11.20.

The paramedics found that Mr Gear was in a critical condition as a result of several bullet wounds. He had lost a lot of blood and they could not find a pulse. He was not breathing and was unconscious. They rushed him to the Ipswich Hospital; however Mr Gear could not be revived.

I commend the police officers and the QAS paramedics involved in endeavouring to save Mr Gear.

Scene secured

Shortly after the incident, as is required, the scene was cordoned off and secured. A crime scene warrant was taken out to facilitate the conduct of investigations at the scene of the shooting. A crime scene log was maintained.

Accoutrements secured

Accoutrements on issue to Constable Dixon including his service issue Glock pistol, magazines and ammunition, as well as his police issue oleoresin

capsicum canister were seized for forensic examination. Constable Dixon's police shirt and boots were also seized for forensic examination.

Breath and blood sample taken from officer

At 12.05am on 25 February 2006, Senior Constable Dixon provided a sample of his breath for analysis on an "alcotest" which proved negative. Later that morning, Senior Constable Dixon consented to supplying a blood sample for analysis, which proved negative for alcohol and drugs.

Directions to police

The principal investigator, Detective Inspector Reeves, confirmed during his evidence that the police involved in the incident were kept separate "as best as humanly possible". They went to two different police stations and were not permitted to communicate amongst themselves, prior to being interviewed. They were represented by a lawyer during their interviews.

The autopsy

On 25 February 2006, an experienced forensic pathologist, Doctor Alex Olumbe, conducted an autopsy on Mr Gear's body at the John Tonge Centre. Dr Olumbe describes Mr Gear as being 187cm in height and weighing 126 kilograms.

Doctor Olumbe located four bullet entry wounds to the front of Mr Gear and four bullet entry wounds to his back. He located six projectiles in Mr Gear's body. The located entry wounds are as follows –

1. Upper chest.
2. Back of right hand.
3. Back of left upper arm.
4. Front middle section of the left upper arm.
5. Right mid-back.
6. Right mid-back.
7. Lower left back.
8. Lower left back.

The projectile causing the number 5 entry wound – right mid-back - damaged the heart and lungs and is considered to be the most lethal of the wounds.

None of the entry wounds had skin blackening or tattooing indicating all were fired from more than a metre away from Mr Gear.

Additionally, Doctor Olumbe found bruises on the left upper back and left forearm. The bruises on the left upper arm were consistent with having been inflicted by a blunt object such as a police baton. The two bruises on the upper part of the left back may have been as a result of a fall on a blunt object, however it was not possible to rule out they may have been caused by a blunt object such as a police baton.

Samples of blood and urine were taken at autopsy for toxicology analysis, as were swabs of the nasal, mouth and eye areas. Analysis of the blood sample revealed the following:–

> Alcohol – 14mg/100ml (0.014%). This reading is considered very low and is indicative of either very low consumption or the alcohol consumed had been metabolised at the time of death.
>
> Norfluoxetine – 0.04mg/kg. Norfluoxetine is the metabolite of fluoxetine which was not detected in the analysis which suggests that Mr Gear had not been taking fluoxetine recently, but that he had stopped taking it several days prior to his death and possibly up to a few weeks.
>
> No quetiapine was detected. This means that Mr Gear must have ceased taking it at least four days prior to his death.
>
> Tetrahydrocannabinol-9-carboxylic acid. This is a metabolite of cannabis. Its presence indicates the recent presence of tetrahydrocannabinol but the time frame in which the drug has been ingested can not be accurately calculated. The metabolite is pharmacologically inactive and is not believed to contribute to the effect of marijuana after smoking. This suggests Mr Gear was not affected by marihuana at the time of his death.

Doctor Olumbe considered the cause of Mr Gear's death was *"multiple gunshot wounds".*

Ballistics

A forensic examination was conducted of Constable Dixon's Glock pistol, the spent cartridges located at the scene and the projectile remains located at autopsy.

The evidence is that nine bullets were discharged during the incident. Six bullets were located in Mr Gear's body at autopsy and two bullets were located within the lounge room of the residence, with the remaining bullet hitting a door frame.

Forensic examination revealed the nine bullets had been discharged from Senior Constable Dixon's Glock pistol.

The holes and powder residue located on Mr Gear's shirt were consistent with Glock 40 calibre bullets being fired from close range. It was not possible to determine the distance with any precision.

The identification

On 26 February 2006, Noel John Gear, the father of James Michael Gear, formally identified the body of his son to Inspector Reeves at the John Tonge Centre.

Findings required by s45(2)

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. I have already dealt wih this last aspect of the matter; the circumstance of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, I am able to make the following findings in relation to the other aspects.

Identity of the deceased – The deceased was James Michael Gear.

Place of death – Mr Gear died at 71 Harlin Road Coalfalls in Queensland.

Date of death – He died on 24 February 2006.

Cause of death – Mr Gear died from multiple gunshot wounds to the chest and abdomen as a result of being shot by a police officer.

Referral to the DPP

In so far as is relevant to this matter, s48 provides that if information obtained by a coroner while investigating a death leads him/her to reasonably suspect that a person has committed an offence, the coroner must give the information to the director of public prosecutions. In this case it is appropriate to consider whether such a referral should be made in relation to an offence of unlawful killing.

It is not my role as coroner to decide whether any person is guilty of an offence in connection with the death or indeed, even whether the prosecutorial discretion should be exercised in favour of presenting an indictment and bringing the matter before a jury.

I take "*committed an offence*" to mean that there is admissible evidence that could prove the necessary elements to the criminal standard.

The use of the term "*reasonably suspects*" is redolent of the test applied when a search warrant is sought. In that context it has been held that a suspicion is a state of mind less certain than a belief and to be reasonable it must be based on some evidence, but not necessarily well founded or factually correct and be a suspicion that a reasonable person acting without passion or prejudice might hold.[42][43]

However, a search warrant is frequently sought when very little might be known about the circumstances of the suspected offence. In that context it is applied when there has been inadequate opportunity to allow the suspicion to

[42] For a discussion of the authorities see Tonc K., Crawford C., & Smith D., *"Search and Seizure in Australia and New Zealand",* LBC, Sydney, 1996 at p68
[43]

gestate into a belief and authority is sought to take the steps that might enable that to occur. As a result, a relatively low level of certainty is needed to satisfy the test. It would seem incongruous that a similar approach be taken when there has been an extensive investigation and public inquiry in which all relevant witnesses have given evidence under oath and have been cross examined and world renowned experts have provided reports and also given oral evidence. In those circumstances there is little room for uncertainty and reliance on speculation or conjecture would seem unnecessary. The removal of doubt by the forensic process means that for a suspicion to be reasonable it must be well founded.

I consider this potential anomaly can be overcome by construing the subsection as requiring a referral to the DPP only when the coroner considers it likely that the Crown could prove all of the elements of an offence.

Section 291 of the Criminal Code provides that it is unlawful to kill another person unless that killing is authorised, justified or excused by law.

Section 300 of the Criminal Code states that "*any person who unlawfully kills another person is guilty of a crime, which is called murder, or manslaughter, according to the circumstances of the case".*

There are various definitions of murder provided by s.302 of the Code. Most relevant to this case, s302(1) provides that a person who unlawfully kills another person with the intention of causing the death or doing grievous bodily harm is guilty of the crime of murder.

In this case there is an abundance of evidence indicating that Mr Gear died as a result of being shot by Constable Dixon.

When interviewed by investigators immediately after the shooting, the officer indicated that he had shot Mr Jacobs intending to incapacitate him. He gave similar evidence at the inquest. However, these admissions were made after the officers had been given a direction to answer questions pursuant to the *Police Service Administration Act 1990* and s39 of the *Coroners Act 2003 respectively*. The answers were not therefore voluntary and can not be used against the witness in criminal proceedings. However, the intention of an actor can be inferred from the circumstances of the act: the natural and usual consequences of an act will be presumed to have been intended.

In this case, I consider a jury could infer from the deliberate close range shooting of Mr Gear as witnessed by others that the officer had the intention to kill or do grievous bodily harm. I therefore consider all the elements of the offence of murder can be made out against one of both officers.

Accordingly, the only issue to be further considered is whether the killing was authorised, justified or excused by law. If it was, that is the end of the matter. If not, I must refer the evidence, other than that given after the directions previously mentioned, to the DPP for her consideration.

This requires consideration of any defences open to the officer, because, before a jury could convict him, the prosecution would have to exclude the operation of any defences. The two statutory provisions relevant to that issue in this case are s.271 and s.283 of the Criminal Code.

Section 271, short-titled "*Self-defence against unprovoked assault,*" provides that if a person is assaulted in such a way as to cause reasonable apprehension of death or grievous bodily harm, and the person reasonably believes that he can not otherwise protect himself from that, it is lawful for the person to use such force as is necessary for his defence even though that force may cause death or grievous boldly harm. So far as is relevant to this case, "assault" is defined in s.245 to include not only the application of force but also the threatened application of force in circumstances where the person making the threat has an actual or apparent ability to carry out the threat.

It is also important to note that s.283, short-titled "*Excessive force*", provides that *"(i)n any case in which the use of force by one person to another is lawful the use of more force than is justified by law under the circumstances is unlawful".*

I will now apply that law to the facts of this case.

As I have set out earlier, Mr Gear was shot when three officers rushed into his house and he confronted them while armed with a knife. Two of the officers managed to escape but the third, Constable Dixon, fell against some furniture and was attacked by Mr Gear. In those circumstances, I am of the view that Constable Dixon reasonably feared that he may suffer serious harm or even death. He could not escape even when another officer bravely entered the room and struck Mr Gear with his baton. Constable Dixon was therefore, in my view, justified in shooting Mr Gear even if it was likely that in so doing he would cause his death.

There is therefore, no basis on which to refer any information concerning this matter to the DPP

Concerns, comments and recommendations

Section 46 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. It will be noted that those heads of jurisdiction are alternatives and so it is not necessary the death be preventable before a comment concerning public health and safety or the administration of justice can be made.

The circumstances of Mr Gear's death, in my view, raise the following issues for consideration from this perspective:-

- Was the care provided by the West Moreton Mental Health Service of an appropriate standard?

- Did police respond appropriately to the situation on the night of Mr Gear's death?

Mental health care

As detailed earlier, Mr Gear suffered from mental illness since his early teens. As with many people suffering from many different illnesses his willingness to receive treatment fluctuated. The added difficulty for those suffering mental illness is, however, their judgment about their need for treatment is often warped by their illness. For that reason, there is a responsibility on those who are aware of their illness and can give them care, to persevere in trying to do so even when their offers of help have been rebuffed. Indeed, the Mental Health Act provides for compulsory treatment if the patient meets the criteria for an involuntary treatment order.

It is against that background the mental health care provided to Mr Gear must be judged.

Initially in his teen years James Gear received assistance from the West Moreton Child and Youth Mental Health Service. It seems they provided him with assistance over a couple of years until he ceased attending in 2000. No doubt this service was entitled to expect his parents would contact them if James' needs were acute and those practitioners should therefore not be criticised for simply allowing him to discontinue attending.

A couple of years later just this happened when James' father contacted the West Moreton Integrated Mental Health Service (WMMHS) expressing concern about James' deteriorating mental condition. These concerns were taken seriously and Mr Gear was made the subject of an ITO in July 2002. It became apparent in addition to being noncompliant with his medication he was also abusing illicit drugs.

When the ITO was downgraded to a limited community treatment order with a condition he attend the WMMHS, take his medication and abstain from illicit drugs, the service did nothing of significance to advance this last and most important condition, other than to give Mr Gear a phone number of ATODS. Unsurprisingly, he did not contact the service.

Throughout 2003 and 2004, Mr Gear's condition seems to have been relatively stable and he was in regular contact with his case manager, Ms Luong, and his psychiatrist, Dr McKinnon. Unfortunately, this productive therapeutic alliance ceased when Ms Luong left WMMHS in January 2005. Her replacement, Ms Matjac, only remained with the service for a few months. Mr Gear was then not seen by a case manager for approximately four months. His next case manager, Ms Tatarevic, had no practical experience, limited educational qualifications of relevance and received no training for the position. Throughout the rest of 2005, Ms Tatarevic struggled to provide assistance to Mr Gear. There is no doubt he may have been a difficult patient to manage; but it is equally clear her inexperience ill equipped her for the task.

As had always been the case, Mr Gear continued to abuse alcohol and drugs and still did not receive any active treatment for this exacerbating feature.

His situation worsened at the end of 2005 when his treating psychiatrist, Dr McKinnon left the service. There was no formal handover to her replacement, Dr Richardson and the change of psychiatrist coincided with the case manager, Ms Tatarevic reducing her workload from full time to two days per week. Throughout this period it was apparent Mr Gear suffered a serious lapse. He was not seen by a psychiatrist in the five months prior to his death and attempts by his mother to cause this to happen were frustrated by inadequacies in procedures that should have assisted her to this end.

Despite the case manager, Ms Tatarevic being chased out of the house and his mother reporting Mr Gear was exhibiting signs of severe psychosis; the Justice Examination Order process which could have caused him to be seen by a psychiatrist misfired.

Part of that was to do, in my view, with the unduly restrictive approach to the task by the authorised mental health practitioners who undertook the assessment. Their assessment, only 16 days before the shooting, that he was "*a mentally healthy young man"* could only have been made if the persons making it completely disregarded his clinical history, the eye witness accounts of his case worker and his mother, and his mother's opinions based on her longitudinal observations of him.

Just three days before his death, Mr Gear was manifesting such instability his case manager and her co-worker again left after a few minutes of attempting to engage with him. Their only response to his rapid deterioration was to advise this mother to apply for yet another Justice Examination Order.

In my view, the treatment of Mr Gear provided by the WMMHS was inadequate after Dr McKinnon and Ms Luong left the service. Not enough effort was made to encourage Mr Gear to engage with the service: in particular his case manager was ill equipped to discharge her duties and psychiatric review was too infrequent. Insufficient attention was given to resolving his illicit drug and alcohol abuse problems. When his mother reported his condition was seriously deteriorating, insufficient weight was given to her views and Mr Gear's clinical history. The inexperience of his case manager contributed to these oversights. It is quite possible had appropriate regard been had to Mr Gear's mother's valid concerns, he would have once again been made the subject of an ITO and would not have become involved in the dispute that precipitated his death.

The police response

When the police were called to respond to complaints by Mr Gear's neighbour on the night of 24 February 2006, they were told at the outset the subject of the complaint "*appears to be mental or drug*'. Just two weeks before, officers from the same station had attended Mr Gear's residence with mental health workers to undertake a Justice Examination Order assessment.

Had the first response officers made enquiries with the station or even more closely questioned the neighbours, they could have readily ascertained it was likely Mr Gear was suffering from a mental illness. That should have alerted them to the need to proceed with more caution.

Had they done so, when Mr Gear made verbal threats and advanced towards them on the footpath, the officers may have considered tactically withdrawing. They were given further opportunity to do so after they administered OC spray and Mr Gear, without doing any violence to the officers, retreated into his yard. Rather than taking that opportunity to seek advice or to consider less confrontational ways of proceeding, the officers did the opposite. One of them ran into the yard behind Mr Gear and struck him with a baton. Not surprisingly perhaps, Mr Gear responded by striking the officer. From that moment on the incident continued to escalate with no thought apparently being given by the officers as to how it might better be managed.

The arrival of more officers unfortunately did little to advance the consideration of a constructive and measured response to the problem presented by Mr Gear.

Surprisingly, there was no discussion or planning among the six officers involved in the incident. Even when Mrs Gear was removed from the house they failed to take stock. She could have easily and quickly assured them no one else was in the house who might have been at risk and that there were no firearms in the premises. In those circumstances, the most obvious appropriate response would have been to seek to persuade Mr Gear to leave the house. There was no need to enter the house; that was clearly a dangerous thing to do. There were many options that may have allowed the incident to be resolved without resort to deadly force. Mr Gear could have been contained in the house until those options were explored and/or it was clear that he was not a threat.

However, when the officers charged in, I accept the threat Mr Gear then presented to Officer Dixon was such, the officer had little option other than to discharge his firearm. I accept in the immediate circumstances of the shooting, the officer quite reasonably feared for his safety and he had no other reasonable means of defending himself. However, so uncoordinated was the response that Officer Olsen was extremely lucky not to be shot also as he charged through the kitchen towards the living room as Constable Dixon fired off a stream of 9 shots.

I accept that the officers believed they were doing the right thing. However it concerns me that none of them seems to have sufficiently considered the situation. I am of the view with better management of this incident by the officers involved; Constable Dixon would not have been placed in a position where he had no option other than to shoot Mr Gear. This death may have been avoided.

Part 6 - Mental health issues and recommendations

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The move away from in-patient treatment

The deinstitutionalisation of patients suffering from mental illness has been a continuing trend in the western world since the mid 1980s.

Driven by public outcries at repeated scandals concerning inhuman treatment in closed institutions; aided by advances in pharmacotherapy such as improved anti-psychotic drugs and inspired by the belief that patients could be better cared for in their families' homes or small group homes, the movement led to the closing of numerous stand-alone mental health institutions.

In Australia, this approach was endorsed by the National Mental Health Policy 1992 and the National Mental Health Plan 1992 and has been actively pursued since.

Buttressing this approach is the principle embedded in the *Mental Health Act 2000* to the effect that the powers and functions conferred or created by the Act will be performed in the way least restrictive to the rights and liberty of the patient.[44]

These developments have resulted in those with most forms of mental illness spending far less time as in-patients than would have been the case previously. In theory, this should minimise disruption to their lives and allow greater opportunity for the sufferers of mental illness to maintain more connection with family, friends, employment and other social activities. There is also growing evidence that psychosocial interventions available to non institutionalised patients can enhance re-integration into the community and reduce relapse rates and improve social functioning.[45] Studies also report a preference among patients for community based treatment. However, as these four cases demonstrate, community based care undoubtedly places greater demands on family and friends.

Further, the success of this approach is dependent upon the existence of adequately funded and staffed community based services, supported by psychiatric units within general hospitals. It seems likely that the real costs of the changes were not initially appreciated.

In an institution, all of a patients needs can be catered for. Not just medical needs such as diagnosis, medication, medication compliance and psychotherapy; but also things as diverse as recreation, housing, education, security and nutrition. In a deinstitutionalised regime some other persons or agencies have to attend to all of these needs to a greater or lesser extent depending upon the competence of a particular patient. It is not reasonable to expect mental health services to satisfy all of these needs but nor are other mainstream agencies well equipped to assist the mentally ill.

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[44] Mental Health Act 2000 s9 and s14(e)
[45] Harvey C A and Fielding J M, "The configuration of mental health services to facilitate care for people with schizophrenia", eMJA 2003:178

Only a whole of government approach that looks forward to anticipate these needs, rather than just responding when a failure to provide them leads to crisis, is likely to lead to improved outcomes.

It seems likely that governments did not initially appreciate that economies of scale made caring for a large cohort of patients in one place far more economical than caring for the same cohort dispersed throughout the community. Under funding was, as a result, endemic.

It also seems likely that the mental health managers underestimated the challenges in recruiting, training and supervising case managers expected to work with minimal supervision in circumstances where consultant psychiatrists had little opportunity to directly interact with the patients. Consequently, caseloads were frequently unreasonably high, staff members were often inadequately trained and high levels of staff turnover was and remains prevalent.

Doctors treating patients with whom they have little or no direct contact by relying on information conveyed through allied health care staff is a major reconfiguration of the doctor – patient relationship.

This inquest has heard evidence of all of these difficulties. The management of the mental health care of each of the four men whose deaths were investigated shows to varying degreis and from different perspectives the community based approach can readily result in a patient's needs not being adequately met.

Each of the men had been in-patients in a mental health ward or institution at some stage. Undoubtedly, had they remained in-patients they would not have died in the way they did. In that sense, there is a direct connection between their community based care and their death. However, that does not provide a basis to conclude that deinstitutionalisation as a general policy is flawed. Rather, in my view, it requires a careful consideration of how their mental health care could have been better managed in the community and whether the triggers for readmission to in-patient treatment, either on a voluntary or involuntary basis, are appropriate.

In particular, the issues which these deaths draw into focus are:-

- The evidence base for mental illness assessments;
- The criteria for involuntary treatment;
- Responding to the needs of mental health service patients with a dual diagnosis;
- Continuity of care for released prisoners; and
- Mechanisms for monitoring or improving compliance with medication regimes.

The evidence base for mental illness assessments

Each of the men was suffering a severe psychotic episode at the time he was shot. Three of them, Mr Waite, Mr Huynh and Mr Gear had been assessed by

mental health workers shortly before the fatal incidents and found not to be in need of in-patient treatment. Mr Waite was discharged as a patient by the Logan and Beaudesert Community Mental Health Service one month before he went on a psychotic rampage after the Acute Care Team concluded that he was not suffering from any mental illness. Mr Huynh was seen by his psychiatrist at the Princess Alexandra Mental Health Service three days before he stabbed three people unknown to him. He was not admitted as an in-patient on the day he was seen by his psychiatrist because, despite being delusional, she did not think he was a risk to himself or anyone else. Mr Gear was assessed by an authorised mental health practitioner as being "*mentally well*" 16 days before his bizarre behaviour caused neighbours to call the police. Soon after the officers arrived he charged at one with a knife.

While it seems clear that the mental state of each of these men deteriorated after they were last seen by a mental health worker; the failure of that contact to result in more intensive treatment raises concern.

In at least two of those cases, the assessing health care workers disregarded information from the parents of the dead man that his condition was seriously worsening and in the case of Mr Waite, police also informed an assessing psychiatric registrar of violent delusional behaviour two months before the shooting.

It is troubling that at various times during the treatment of all of the deceased men, critical decisions concerning their treatment were made by para-medics and/or psychiatric registrars and not reviewed by a physiatrist.

Once a confirmed diagnosis of schizophrenia has been made it is likely that there will need to be prolonged treatment that is not terminated on some spurious or procedural basis such as the failure of the patient to attend appointments or continued drug or alcohol abuse. I don't believe that any reasonable psychiatrist could have concluded that any of these four men was "cured". It was obvious that each of them was going to need on going treatment; yet there seemed many instances of mental health workers seeking to discharge them for the CMHS or in some other way withdraw or reduce treatment. I do not believe these decisions had an adequate evidence base and I do not believe they would have been made had the men been private patients not dependant on the public health system.

In this and other inquests, I have heard evidence from mental health professionals that they consider that the Mental Health Act requires them to base their assessments on solely what they observe at the time of making the assessment. I don't believe that is a correct interpretation of the provisions of the Act but as it evidentially impacts upon assessments it needs to be addressed.

It is essential in my view, that mental health assessments have due regard to the valuable information family members, who frequently have observed the patient at close quarters over many years, can provide. In this inquest the mothers of Mr Jacobs and Mr Waite both gave evidence that they had

observed their sons over many years and were very familiar with symptoms indicating deterioration in their mental state but that mental health workers did not accept their views in this regard. Similarly, information from police officers who took Mr Waite for a mental health assessment was dismissed or explained away.

It may be this misinterpretation of the statutory requirements of a finding of mental illness warranting involuntary treatment is contributed to or exacerbated by the lack of formal, standardised and documented assessment processes. While I am not denying the importance of clinical decision making, the National Standard for Mental Health Services stipulates that assessments should be conducted using "*accepted methods and tools*" and cites as examples family interviews and standardised documentation.[46] These guidelines were not followed in these cases.

Similar deficiencies were also noted in the *Queensland Review of Fatal Mental Health Sentinel Events* that reported in March 2005 and recommended, among other things, that a suite of standardised assessment tools be developed. The submission of the Director of Mental Health assures that these recommendations are being implemented and that this process is advanced and continuing (as one would hope, after three years). The mistakes evidenced in the cases examined in this inquest should inform that process.

Recommendation 1 – Standardised assessment instruments

I recommend the Director of Mental Health develop standardised processes and assessment tools that do not seek to replace clinical judgment but which do introduce more objectivity into mental health assessments and which address the tendency of mental health workers to give insufficient weight to relevant information other than that gathered from the patient during the assessment.

Recommendation 2 – Retention and auditing of assessment instruments

I recommend that mental health practitioners be required to complete and retain the standardised documentation used to undertake mental health assessments and that compliance with these processes be audited as a quality measure.

Recommendation 3 – Review of assessment decisions

I recommend that the processes include mechanisms for supervision or overview so that whenever someone other than a psychiatrist decides:-

- *not to order a psychiatric assessment following an examination pursuant to a Justices Examination Order; or*
- *not to admit as an inpatient following an examination pursuant to an Emergency Assessment Order; or*

[46] See paragraph 11.3.6

- *to discharge a patient previously assessed as suffering from mental illness warranting involuntary treatment;*

that decision be reviewed by a psychiatrist as soon as possible.

The criteria for involuntary treatment

If stipulated criteria are met, the *Mental Health Act 2000*, authorises a medical practitioner to compel a person suffering from mental illness to undertake treatment, even if the person does not consent to the treatment. However, for the reasons set out below, I consider the circumstances in which this can happen to be unduly circumscribed. As a result, in some situations, in my view they result in people in need of treatment not receiving it in circumstances where the mental illness has deprived the person of the capacity to make informed decisions in his or her own best interests.

A mental health practitioner must be satisfied that a person is suffering from mental illness and that there is an "*imminent risk*" that the person may cause harm to himself or another before non consensual treatment can be ordered.[47]

None of the four men whose deaths were investigated by this inquest was subject to an involuntary treatment order at the time of his death because none of them was assessed as meeting this criterion. The circumstances of each of those deaths calls into question the validity of those assessments – at the time of each death the dead man was clearly very dangerous. It is therefore appropriate to consider whether the criteria for involuntary treatment should be varied.

Queensland is not unique in this regard; indeed the equivalent legislation in all states other than South Australia has similar requirements. The policy underpinning is the desire to balance the rights of the mentally ill with the need to protect the public; only when the illness puts the patient or others at risk of harm can over riding the patient's free will to refuse treatment be justified.[48] However, when it prevents the provision of non consensual treatment even when mental illness deprives a person of the capacity for informed consent or the person unreasonably refuses treatment, the benefit of such "rights" must be questionable.

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[47] Section 108 of the Mental Health Act provides that before a doctor can make a mentally ill patient the subject of an involuntary treatment order the doctor must be satisfied that all of the "treatment criteria" exist in relation to the patient. These are defined by s14 to include the imminent risk of harm. Indeed the person can not even be assessed without her consent unless an authorised person is persuaded they are at risk or pose a risk, although strangely, in the case of assessment, the risk of harm need not be imminent.

[48] Large M.M., Nielssen O. et al, "*Mental health laws that require dangerousness for involuntary treatment admission may delay the initial treatment of schizophrenia"*, Social Psychiatry and Psychiatric Epidemiology, DOI 10.1007/s00127- 007 - 0287 – 8, November 2007, p4

When a person lacks capacity to consent to treatment because of a physical injury or condition, for example by being rendered unconscious in a motor vehicle crash, the law recognises the right of others to do things to them that if done without consent would usually be unlawful. In those circumstances, it is sufficient that the incapacitated person would benefit from the treatment or assistance that is provided. Why then should someone whose incapacity is caused by mental illness be denied treatment unless it can be shown that they are at risk of harming themselves or another?

The validity of the imminent risk requirement is further undermined by the unreliability of predictions of violence or self harming as these four death exemplify. In an as yet unpublished submission, a group of eminent experts review the literature on this issue and cite studies demonstrating that "*the most sophisticated prediction tool available has only very modest utility in determining decisions about admission"* based on a risk of the patient harming others. They note that the ability to predict who will commit suicide is even more problematic and conclude that:-

> *These studies serve to underline what clinicians already know - even in ideal circumstances, physicians, even specialist psychiatrists, are not able to make accurate or precise predictions for individual patients about their risk of harm to self or others.*[49]

Because clinicians and tribunals are inclined to err on the side of safety, this means that people who *might* becomes dangerous are frequently likely to be unnecessarily detained; whereas this inquest shows that this approach is equally likely to result in persons who do in fact become dangerous, not receiving sufficiently intensive treatment.

Accordingly, I agree with the learned authors referred to earlier who suggest that the risk of harm criterion should be reviewed. An assessment that a person has a mental illness that requires immediate treatment which has deprived the person of the capacity to consent to treatment or has led him or her to unreasonably refuse such treatment should be sufficient basis for an involuntary treatment order in my view.

Recommendation 4 – Criteria for involuntary treatment

I recommend that consideration be given to removing the risk of imminent harm criterion from the "treatment criteria" contained in the Mental Health Act so that an involuntary treatment order can be made whenever a person has a mental illness that requires immediate treatment and the illness has deprived the person of the capacity to consent to the treatment or the person has unreasonably refused treatment.

[49] Ryan C., Large M., Nielssen O., Hayes R., "*A proposal for uniform, ethically informed and evidence based mental health law reform in Australia*", A submission for consideration at the 2020 Summit, p.13

Responding to dual diagnosis

Estimates of the percentage of people suffering from schizophrenia who also abuse illicit drugs range as high as 80%.[50] It has long been recognised that those with this dual diagnosis present a set of complicated problems relating to the exacerbating effect of such drugs on the patient's mental state and the added barriers mental illness may create for the usual approaches to responding to alcohol and drug abuse.

Despite these complications long being recognised, the two service providers, community mental health (CMHS) and alcohol, tobacco and other drugs (ATODS), continue to operate in separate silos with very limited effective integration.

In three of the four cases examined during this inquest, dual diagnosis was a dominate feature. In none of them was the co-morbidity adequately managed in an integrated fashion. In each of these cases the CMHS sought to send the illicit drug problem away. In Mr Waite's case he was discharged from the mental health program on the basis that he could not be offered any assistance for his mental illness until he took responsibility for his illicit drug issues. A few weeks later he died while suffering an acute psychotic episode. Mr Jacobs and Mr Gear were treated in a similar manner.

In my view it is unreasonable and counter productive to expect consumers of CMHS to navigate between those services and ATODS. Conversely, in view of the high and increasing incidence of dual diagnosis there seems no good reason why CMHS, which claim to offer integrated, multi disciplinary therapies and services should not include alcohol and drug abuse management among their panoply of treatments.

The committee which produced the *Achieving Balance* report in 2005 seems to have been of a similar view and recommended transferring responsibility for alcohol and drug treatment to mental health services. This was not actioned after the Forster Review recommend against it. Instead, it was determined to improve integration between the two areas of service. This was defined as the coordination of interaction and relationships within and across both services.

The submission of the Director of Mental Health advises that in 13 of the 20 health service districts dual diagnosis coordinators have been employed and the remaining seven positions are intended to be funded soon. Two state wide dual diagnosis project officers have been appointed. A draft dual diagnosis policy has been developed. A pilot of integrated service provision is being trailed in six sites. A training package for mental health clinicians is expected to be operational by June 2008.

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[50] The *Achieving Balance* report, Queensland Health 2007, found that 75% of the deaths of MHS patients reviewed involved illicit drug abuse. Dr Ken Minkoff, Department of Psychiatry, Harvard Medical School, speaking on the Health Report on ABC radio, 10 December 2007, referred to a study finding 80% of schizophrenia sufferers had abused illicit drug during the previous year.

I readily accept the submission of the Director of Mental Health indicating that the department has given a high priority to addressing this pressing problem. I trust he accepts the bewilderment of outsiders as to why these issues have been allowed to fester for so long and the scepticism as to whether the inertia of the past has been overcome.

Since 1996, the *National Standards for Mental Health Services* have stipulated that "*The mental health service is integrated and coordinated to provide a balanced mix of services which ensure continuity of care for the consumer.*"[51]

In paragraph 11.4.7 the standard provides that "*The MHS ensures access to a comprehensive range of treatment and support services which are wherever possible specialised in regard to duel diagnosis…*". In the example under that paragraph it is suggested "*dual case management with alcohol and other drug services, collaborative treatment with other service providers*" should be the norm.

I am yet to be persuaded that Queensland Health has implemented these philosophies. Certainly there was no continuity of care for the dual diagnosis sufferers whose deaths this inquest investigated. It is difficult for an outsider to understand why, when so many clients of community mental health services suffer from dual diagnosis, it would not be more appropriate to employ alcohol and drug therapists within CMHS, up skill CMHS employees so that they could provide alcohol drug abuse therapy or at least co-locate the two services.

However, in view of all of the activities being undertaken by the department in relation to these problems a recommendation by a mere coroner to that effect is unlikely to have any impact. Evaluation and monitoring of these new activities is however essential. It will be necessary for Queensland Health to be able to demonstrate that it is being more successful in responding to the needs of the growing cohort of consumers with a dual diagnosis.

Recommendation 5 – Evaluation of treatment provided to CMHS patients with dual diagnosis

I recommend that as a matter of priority and on a regular and continuing basis, the Director of Mental Health cause to be undertaken an evaluation of the impact of policies designed to more effectively respond to the needs of CMHS patients with a dual diagnosis. This evaluation should clearly demonstrate whether the alcohol and drug abuse problem of CMHS consumers is being appropriately managed.

Continuity of care for released prisoners

A significant proportion of prisoners suffer from mental illness. Late last year, a senior corrective services official giving evidence in another inquest,

[51] National standards for mental health section 8.1

acknowledged that *"Historically, minimal services have been provided for prisoners with mental illness."*[52]

It is not surprising then that Mr Jacobs was only seen by a psychiatrist on four occasions during the five months he was incarcerated in the Arthur Gorrie Correctional Centre in 2004. The psychiatrist who assessed him was aware that he was likely to be released in the near future but she did not know when that would occur. She considered that he would continue to need treatment for his mental illness and she also considered that without close monitoring he was unlikely to continue to take his medication which was essential for his wellbeing. However, there were no procedures by which she could cause him to be linked with a CMHS after he was released. The psychiatrist tried unsuccessfully to cause this to happen by contacting Mr Jacobs' solicitors to suggest that attendance at a CMHS be made a condition of his bail. It transpired that he was released without the psychiatrist even being informed this was to happen and without any arrangements being made for Mr Jacobs to be seen by anyone from a CMHS.

In the five months between Mr Jacobs' release from prison and his death he ceased taking his antipsychotic medication, he abused illicit drugs, he was involved in a violent domestic relationship and he received no treatment for his mental illness.

The Director of Mental Health contends that changes made since this death have significantly improved the situation. In summary, the director says since Mr Jacobs' death the Prison Mental Health Service has received significant funding increases. In the 2006 – 2007 financial year this enabled recruitment to an additional 15.5 full time equivalent positions; expanding the service provided in Brisbane prisons as well as enhancing services in prisons in Maryborough, Rockhampton, Townsville and Mareeba. Funding was also provided for an additional twelve new positions within the court liaison service. Both of these groups of mental health workers will be overseen by the State Director of Forensic Mental Health.

These workers will also participate in the Transitional Case Management program which, as the name suggests, is designed to facilitate a continuity of care in the transition from prison custody to community living. It is planned that corrective services case managers will liaise with district hospitals, community mental health services, community case managers, court liaison officers and other mental health services to co-facilitate the provision of mental health services. Those case managers will continue to interact with prisoner/patients for two weeks post release.

These processes will be augmented by five support workers employed by the Richmond Fellowship of Queensland. They will take up with a patient on release and for six weeks manage the transition back to the community in conjunction with the prison mental health service workers. I am advised they

[52] Statement of Dr Grant, State Director Queensland Forensic Mental Health Services, in the inquest into the death of Samuel John Mills, exhibit G7 p1

will take a holistic approach addressing issues such as housing, employment and finances and intended to provide an intensive supervision/management of the prisoner/patient's transition.

The experts who gave evidence at the inquest were very supportive of these initiatives. They were cautious however about their success indicating that the functions were very resource intensive. As Queensland's prison population is expected to double in the next ten years, ongoing budget increases will be essential if the goals of these programs are to be delivered.

It is essential therefore that the adequacy and effectiveness of these programs be rigorously evaluated. All instances of prisoners suffering from metal illness failing to connect with community metal health services should be investigated and the reasons for that analysed. It is obviously in the interests of the person with mental illness that these services be maintained. It is also in the community's interest that those likely to suffer a relapse of chronic mental illness are provided with services that make their deterioration and hence offending, less likely.

Recommendation 6 – Evaluation of post release programs

I recommend that as a mater of priority and on a regular and continuing basis, the Director of Mental Health cause to be undertaken an evaluation of the impact of policies designed to more effectively link prisoners suffering from mental illness with CMHS after their release from prison.

Medication non-compliance

In each of the four cases investigated by this inquest, the deceased person had been prescribed antipsychotic medication, but in each case it was only taken sporadically. Family members said that when the pharmacotherapy was adhered to as prescribed the patient's condition improved. Significantly, each of the men was not adhering to his medication regime at the time of his death.

Each man's case manager attempted to address this tendency by various non invasive methods such as reminding the patient of the need to take his medication and counting tablets. There was however no regular or systematic approach to this crucial issue. The outcomes indicate that relying on adherence to flow from a therapeutic alliance was misplaced.

Depot doses of medication were used for only a limited time with three of the patients. Some of the patients suffered severe side effects when receiving medication by this route but limited attempts were made to trial other anti-psychotics as they became available. No blood or urine testing was undertaken in any of the cases. Mr Jacobs manifested a capacity to adhere to medication requirements when it was an element of a suspended sentence, highlighting the need not to assume the extent to which mental illness masks insight or prevents compliance.

Failure to adhere to a medication regime is not uncommon among the general population. One literature review found that the mean compliance rate for

patients with a physical ailment was 76% with a range from 62% to 90%. Among patients prescribed antipsychotics, an average of only 58% of the recommended amount of medication was taken.[53] A study focussing specifically on sufferers of schizophrenia found the adherence rates depended on the drug prescribed but for the most commonly used, haloperidol, 68% of the patients ceased taking it within a year of it being prescribed.[54]

The degree to which a patient follows medical advice will of course almost always be of interest to a treating doctor. However, in the case of patients suffering from mental illness there are aggravating factors of concern. It may be that the illness prevents the patient from making a rational choice. Further, the consequences may range from re-admission to hospital to uncontrolled, florid episodes with concomitant impact on others. The potential for fatal outcomes so graphically demonstrated by these cases means the considerations that mandate that patients be free to choose whether to follow medical advice needs to be questioned when the patient is suffering from some forms of mental illness.

It was for those reasons that during the inquest I sought the views of experts as to how medication compliance or adherence could be improved and whether blood or urine testing should be utilised in more cases. The effect of that evidence was:

- Only some therapeutic drugs can easily be tested for in blood or urine.
- Most tests only evidence very recent medication ingestion.
- Testing is very expensive.
- Testing will often damage the therapeutic relationship between the patient and therapist.

I accept that these are valid reasons for not instituting a program of general blood or urine testing of mental health patients. However, I remain of the view that more needs to be done to increase the likelihood of medication compliance than was evidenced in these cases.

As with most complex problems, identification of the causes and examination of the possible options seems the most appropriate way to proceed. In this case that would require an understanding of why patients might not consistently take the antipsychotic medication that they are prescribed and what can be done to counter those factors.

Considerable work has been done to address these questions.[55] Some of the challenges it identifies are:-

[53]Cramer, Joyce A., Rosenheck, Robert, "*Compliance With Medication Regimens for Mental and Physical Disorders"* Psychiatr Serv 1998 49: 196-201

[54] Rosenheck R., Cramer J.,Wu W., et al, "*A comparison of clozapine and haloperidol in hospitalised patients with refracted schizophrenia*." New England Journal of Medicine, 1997, 337, 809 - 815

[55] See Mitchell A. J. & Selmes T., *"Why don't patients take their medicine? Reasons and solutions in psychiatry",* Advances in Psychiatric Treatment, 2007; vol 13: 336-346

- The need to distinguish between intentional and non intentional adherence. There are indicators that can enable a therapist to predict which causative factor is more likely to manifest. Obviously, the responses will differ.

- The identification of specific side effects is important because apparently, the likelihood of their motivating non compliance varies. Some are more readily apparent, for example weight gain as distinct from say, sexual dysfunction.

- The level of a patient's knowledge of her disease and an understanding of how the prescribed medication can help alleviate its symptoms may influence whether the patient takes the drugs. Studies have shown that doctors frequently over estimate what they have conveyed to their patients about these issues and the extent to which the patient understands them.[56]

- There is a need to distinguish between those patients whose cognitive ability allows them to appreciate the significance of non compliance, including the likelihood of involuntary hospitalization for intentional non compliance and those where this is unlikely to be feasible.

In summary, it is apparent that the rates of compliance vary, depending upon the diagnosis; the drugs prescribed; the nature of the side effects; the quality of the therapeutic relationship; and the level of understanding and attitude the patients has to pharmacological treatment.

All of these issues can be considered and gauged as part of the case management of a mental health patient. Undoubtedly, some of them were during the care provided to Messrs Waite, Jacobs, Huynh and Gear. But I received no evidence indicating that these issues are systematically assessed as part of standard case management processes. In my view they should be. Nor were other non invasive monitoring measures such as requiring the patient to take the drugs in the case manager presence attempted.

Further, I do not accept that drug screening can not be improved upon. I am aware that new drug screens are regularly developed for forensic purpose. If the authorities can justify developing new tests to ensure bicycle riders aren't drug cheats they can surely apply the same science to protecting mental health patients.

Recommendation 7 – Development of prescription drug screens

I recommend the Director of Mental Health engage the toxicologists at Queensland Forensic and Scientific Services to develop blood and urine tests for the drugs commonly prescribed for the management of schizophrenia.

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[56] Ibid.

Recommendation 8 - Protocol for medication compliance

I recommend the Director of Mental Health cause to be developed a standardised protocol to assist case managers more systemically address the issue of medication compliance. It should reflect the extensive literature on the issues involved. The protocol should have regard to the risks posed by a patients failing to take medication and in appropriate cases provide for blood or urine testing.

Part 7 - Policing issues and recommendations

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Introduction

This inquest has closely examined the circumstances of four unrelated incidents during which a police officer shot and killed a young man suffering from mental illness. I have found in each case the police officer reasonably believed that the deceased posed an imminent threat and that there was no other way for the officer to protect himself or another from serious injury or death. For that reason, in each case the shooting was justified and was not unlawful.

However, an object of the *Coroners Act 2003* is to help reduce preventable deaths by allowing coroners to comment on matters connected with a death investigated at inquest that relate to public health or safety or the administration of justice.[57] Therefore, it is appropriate that I consider whether any changes to police service policy, training or procedures could contribute to a reduction in incidents that end as these did.

The challenges inherent in the interaction between police officers and citizens suffering from mental illness continue to confront policing organisations around the globe. Consequently there is an abundance of international experience and research to draw upon. I readily acknowledge and commend the Queensland Police Service for its willingness to inform itself with reference to this material.[58]

The magnitude of these challenges was highlighted by evidence indicating that mental illness is the precipitating factor in over 18,000 incidents dealt with by QPS officers annually.[59] While many of these are quite minor, their ability to rapidly escalate and result in violent death justifies the significant lengths the QPS has taken to equip its officers to manage these interactions safely. These deaths highlighted, however, that there remains room for improvement.

In particular the issues which in my view warrant further attention are:-

Collaboration between QPS QHealth and the QAS

Collaboration between the QPS and QHealth has been a feature of the Mental Health Partnership project since 1998. In July 2000 this was formalised with the establishment of an interdepartmental steering committee. In May 2001 a memorandum of understanding was entered into with a view to developing a broad information exchange strategy. It was reviewed and updated annually. In 2005 its objectives were expanded to include the "*preventing and responding to mental health crisis situations and the development of information sharing guidelines."*

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[57] See s3 and s46

[58] For example in 2003 the QPS joined with Queensland Health and the Queensland University of Technology to convene a conference on policing the mentally ill that was attended by policing experts from the U.S.

[59] Evidence of Superintendent Pittman T p214 16/05/07. These range from persons disorientated needing assistance to the most serious matters the subject of this inquest.

These developments resulted in a major initiative, the Mental Health Intervention Project (MHIP) which also commenced in 2005. That project sought to ensure that police responding to incidents involving people suffering mental illness had specific training in handling such matters and had access to all relevant information. It involved the development of a suite of strategies modelled on the "Memphis Model" of policing but adapted to Queensland conditions. It sought to engage police, CMHS workers and local QAS officers in collaborative planning for and responding to the needs of the mentally ill living in the community.

An important feature of the MHIP is the four training courses developed for first response officers, district mental health intervention coordinators, regional mental health intervention coordinators and communications centre personnel respectively. This training seeks to equip officers with sufficient information to enable them to recognise mental illness and react with some sensitivity and understanding with the aim of deescalating potentially volatile situations. The independent expert psychiatrist who gave evidence to the inquest, Dr Jill Reddan, was complimentary of this focus.

By April 2007, over 3500 officers had undertaken specific training programs under the umbrella of the MHIP. Further, the operation skills training which all officers undertake on a regular basis has complimentary components such as the tactical communication skills course. This training fits within a suite of courses designed to equip officers make decisions consistent with the situational use of force model adopted by the service.

The QPS is to be commended for the commitment it has demonstrated in responding to the training needs of officers who can be expected to interact with persons suffering from mental illness.

While information sharing is a principle driver of the interdepartmental arrangement, its efficacy is limited by the statutory provisions restricting it. Unless a patient has given a "standing consent" for information to be released to nominated persons or organisations, the Chief Executive of the Department of Health needs to authorise the release in writing after being satisfied that it is in the public interest or is necessary to avert a serious risk to the life, health or safety of someone.[60] Clearly this is impracticable when a crisis is developing.

The utility of the arrangement is further negatively impacted by the absence of a Queensland Health central database that would enable police to contact a single point in relation to an address or individual. While the Director of Mental Health assures that such a database will be developed there is no other basis for confidence that this will happen in the near future.

I am of the view that until the development by QHealth of a central data base makes these arrangements functional, the restrictions need to be relaxed so that local mental health services can advise local police whether attendance at a given address or contact with a nominated individual is likely to involve

[60] See the *Health Services Act 1991* s62F and s62I

them in having to interact with someone who may be suffering from mental illness. Such a system would also increase the likelihood of police managing such interactions with the assistance of a mental health worker who is likely to have knowledge of and may have rapport with the patient.

Recommendation 9 – Dissemination of information concerning mental health patients in crisis to QPS officers

Pending the development of a central data base able to provide access to information from all health services state wide, I recommend that the statutory restrictions on the provision of information to the QPS by QHealth concerning mental health patients in crisis be reviewed with the aim of enabling local CMHS to provide to police information relevant to police interaction with such patients.

An admirable aspect of the interdepartmental protocols established under the MHIP includes provision for pre-crisis planning which enables consumers of mental health services to actively contribute to plans for their management by family members, CMHS workers, QAS officers and, if necessary, police officers in times of psychotic episodes. Regrettably, these seem to have been largely under-utilised. In my view more effort should be directed to developing such plans with special emphasis being given to patients on forensic orders and involuntary treatment orders who are not being treated as in-patients.

Recommendation 10 - Greater use of pre-crisis planning

I recommend that QPS district mental health intervention coordinators collaborate with local CMHS officers and QAS officers to make greater use of pre-crisis planning, and in particular that consumers on forensic orders and involuntary treatment orders who are not undertaking in-patient treatment be encouraged to participate in such planning.

National guidelines for use of lethal force by police – warning of intention to shoot

The National Guidelines for Use of Lethal Force by Police provide, among other things, before shooting police shall "*where the circumstances permit give a clear warning of their intent to use fire arms*". In none of the four cases here under investigation was such a warning given. In each case other than that involving Mr Gear, the circumstances would have permitted such warning. The inspector in charge of operational skills training at the academy gave evidence that officers are trained in these requirements. One can only conclude that this training has been ineffective.

There is no basis for concluding in the three cases where the warning could have been given that the giving of it would have made any difference. However, it is easy to envisage circumstances when such a warning would cause a person to desist from conduct that had made the use of deadly force imminent. Accordingly, this needs to be addressed.

Recommendation 11 – Review of training regarding warning to shoot

I recommend that the Queensland Police Service review the training it provides to officers regarding their obligation to warn before using firearms.

Blood testing of officers involved in a critical incident

The *Police Service Administration Act 1990* in section 5A.13(1)(a)(i) enables an officer involved in a critical incident to be required to provide a specimen of urine for testing. Blood testing is more effective for determining whether an officer may have been under the influence of a drug at the relevant time. I stress there is no basis to suspect that any of the officers involved in these four shootings was in any way affected by illicit substances but that is an issue that should be scientifically determined in all cases.

Recommendation 12 - Blood testing of officers involved in a critical incident resulting in death

I recommend that the Police Service Administration Act 1990 be amended to create a requirement for police officers involved in critical incidents resulting in death to provide a specimen of blood for analysis as soon as reasonably practicable after the incident.

Use of tactical withdrawal

A situational use of force model has been adopted by the QPS to assist its officers determine how best to respond to any given situation in which the use of force may be required. The options range from mere presence and tactical communication through to the use of firearms. Police trainers who gave evidence stressed that these options should not be seen as a hierarchy of ever increasing force through which an officer would necessarily progress until a situation was resolved. Rather, all of the options within an officer's panoply skills should be considered as the situation evolves and new risks or opportunities to resolve the incident present.

Tactical withdrawal is one of the options. It appears however there is no training specifically directed to teaching how tactical withdrawal can be used as a means of deescalating a situation. In my view, the incident involving Mr Gear provided on opportunity for tactical withdrawal and the failure of the officers to consider it indicates a gap in their training. It will be recalled that after they initially engaged with Mr Gear, he advanced towards the officers in a threatening manner. They sprayed him with capsicum spray which caused him to turn and retreat into his yard. Rather than reflecting on how the situation could then best be resolved or seeking advice from a more experienced officer, one of the constables immediately pursued him into the yard and struck him with a baton across the back. Not surprisingly, this provoked violence from Mr Gear and the incident escalated from there to its fatal conclusion.

It is easy to appreciate how tactical withdrawal could be particularly apposite to incidents involving people suffering from mental illness. It would give

officers an opportunity to break close contact with the person whose anxiety may be exacerbated by their close presence; it would give officers an opportunity to seek input from mental health professionals or to otherwise seek advice. I am of the view that specific training on the use of tactical withdrawal should be developed.

Recommendation 13 - Development of training in tactical withdrawal

I recommend that the Queensland Police Service review the operational skills training provided to officers to ensure that tactical withdrawal is more likely to be used in appropriate cases.

Critical incident review

Despite the earliest of these shootings occurring four years ago, no review of the incidents has been undertaken by the QPS to consider the conduct of its officers or the suitability of its policies and procedures. The deaths were investigated and a report provided to the coroner. However, no feed back has been provided to the officers involved and no opportunity for organisational learning has been utilised.

It is appropriate that such incidents are subject to an inquest so that the families of the deceased and the public at large can be assured that those involved in the incident are held accountable and that any legislative or procedural changes that are warranted are recommended. However, this does not mean that the QPS should take no action in the intervening period. Rather, I am of the view that as soon as possible after such an incident, a senior officer independent of the establishment from which the officers involved in the incident are attached, should review the incident and consider whether any urgent steps need to be taken even in relation to police service policy and procedures or remedial action in relation to individual officers.

I recognise that this will require some careful management to ensure that this process does not cut across or undermine the investigation being undertaken on behalf of the coroner. These difficulties are not insurmountable. For example, QHealth undertakes a sentinel event review and a route cause analysis in many cases that subsequently go to inquest.

Similarly, I consider it that the police service should, as soon as possible, consider whether any disciplinary action should be taken in relation to the actions of its officers. In my view, it is not appropriate that those issues are postponed pending decisions by external agencies such as the Coroner's Court. The police service is primarily responsible for the actions of its members and for its own policies and procedures. In my view, it is appropriate that it considers the adequacy of both as soon as possible after a critical incident.

Such an approach would be consistent with the National Guidelines for Incident Management, Conflict Resolution and Use of Force which provide that "*the effectiveness of incident management should be continually*

evaluated and monitored with a view to ongoing improvement in officer and public safety and recognition of good practice".

It is likely that an experienced officer could have suggested improvements in the way in which each of the four incidents were handled. This would obviously benefit the officers directly involved and also provide an opportunity for organisational learning.

Recommendation 14 – Development of a critical incident review policy

I recommend that Queensland Police Service develop a procedure for reviewing critical incidents whereby the appropriateness of the actions of its officers and its policies and procedures can be expeditiously considered and remedial action taken if necessary.

Assessing impact of shooting on an officer's effectiveness

Each of the officers involved in these shootings was offered trauma counselling. There is little compelling evidence that counselling in these circumstances is generally of much benefit and some evidence that it is actually counter productive. However, post incident trauma counselling is now so firmly entrenched in Western culture that were the QPS fail to offer it, resentment among its officers is likely.

It is also likely that being directly involved in a life threatening and life taking incident will affect the way an officer responds in similar incidents in future. An officer may be more or less inclined to shoot, depending upon how the officer processes his or her response to the initial incident. Either inclination could have serious, negative consequences. I am therefore of the view that after every incident in which an officer is shot or shoots someone, the QPS should undertake an assessment of any impairment of the officer's operational decision making.

Recommendation 15 - Review of operational decision making capacity

I recommend the QPS develops a process by which, whenever an officer is involved in an incident in which someone is shot, it can assess any resulting impairment of the officer's operational decision making capacity.

Incident command training

Frequently, junior officers will be the first to respond to incidents involving a person suffering a psychotic episode. That is what happened in each of these four cases. In each of them, other than that involving Mr Waite, the incident was concluded before more senior officers could attend. The gross errors of judgment made by the five officers involved in the Gear matter indicate that it is essential that junior officers are adequately trained to manage such incidents.

Currently incident command courses are the only provided to officers of the rank of senior sergeant and inspector. It would be relatively unusual for

officers of that rank to be among the first response officers to a critical field incident. While targeting this group of officers may have been motivated by the belief that they could provide guidance over the radio or the telephone, I consider that these deaths show that to have been misplaced.

I am of the view that greater emphasis should be given to training the officers who are most likely to be most directly involved in such incidents. I recognise that the training curricula for junior officers are crowded and that their numbers make the provision of training expensive. However, it is difficult to imagine training that could be more vital to their safety and that of the community.

Recommendation 16 – Critical incident command training for first response officers

I recommend that critical incident command training be extended to all operational police with particular emphasis given to general duty officers in operational positions.

The use of tasers

Tasers are an electroshock weapon that can be used to disable a person. A taser fires two small dart-like electrodes, connected to the main unit by conductive wire down which currents of electricity are pulsed, causing the target to lose muscle control and drop to the ground.

It is likely that if the officers involved in these four incidents had access to a taser gun they would have been deployed. If it occurred, such deployment may have resulted in each of the incidents being resolved without anyone being killed.

However, there is also considerable controversy surrounding their use in other jurisdictions and some suggestions that tasers have been associated with numerous deaths.

The Crime and Misconduct Commission is currently undertaking an evaluation of a limited trial of tasers by Queensland police officers. Presumably the CMC will have regard to the concerns referred to earlier when framing its recommendations. The QPS will then be appropriately informed as to the circumstances in which tasers should and should not be used.

Notwithstanding the recent decision of the Minister for Police and Corrective Services to provide tasers to all operational police prior to the completion of the CMC evaluation, I understand it will continue. Its findings should inform future decisions about the distribution of tasers among police and the framing of regulations to govern their use.

Recommendation 17 – Continuing evaluation of taser use

I recommend that the trial of tasers continues and that the evaluation by the CMC have regard to international experience in the use of these implements.

When the results of the trial and the CMC evaluation are made known the QPS should review its policy in relation to the use of tasers.

Shoot to wound

In each of these cases, the police officers involved intentionally shot the victim in a manner that made it almost certain that he would die. This was in accordance with Queensland Police Service policy and the training given to officers. Evidence given by firearms training officers was to the effect that officers are taught to fire at centre of the body mass with the intention that this will most speedily incapacitate the target. While those trainers denied that this was a “shoot to kill policy” I am of the view that this is what it amounts to.[61]

This necessarily requires consideration of whether police should instead be instructed and taught to shoot to wound in the hope that incidents involving armed and/or deranged citizens could be resolved without death. Obviously, this would be highly desirable but for the reasons set out below I am convinced that any such change to practice would be counterproductive.

First, contrary to what television programs and movies might lead one to believe, it is very unlikely that police officers could develop sufficient accuracy to enable them to deliberately shoot someone in an arm or a leg, particularly in the dynamic and volatile circumstances which will usually prevail when shooting is contemplated. The effect of unsuccessfully attempting to do so may well be that the offender is not incapacitated and the police officer or someone else is therefore injured or killed. There is also a danger that when attempting to shoot at peripheries, the bullet will miss the target all together and strike someone else.

Second, if the policy is varied so that the use of firearms does not necessarily involve the use of fatal force, but merely the wounding of a target, it is likely that firearms will be used in more situations where the death or serious injury of an officer or another person is not necessarily apprehended. For the reasons set out above, it is likely that more shootings would then result in more deaths.

I am therefore firmly of the view that the current policy in relation to the use of firearms should not be changed, that a change to “shoot to wound” would be counter productive and could lead to more deaths.

[61] At law one is taken to intend the likely and natural consequences of one’s actions. Therefore as a matter of law, the officers complying with the policy would be found to have intended to kill the victim.

Part 8 Summary of general findings

Each of the four deaths was legally justifiable in that at the time of the shooting the police officer concerned reasonably believed that he or someone else was at risk of serious injury or death and that shooting the person who died was the only reasonable way in which that could be avoided.

In three of the cases there was nothing the police officers could have done to better manage the situation so that the need to shoot did not arise. The situations in which the officers found themselves in those cases were very dangerous and volatile. I consider the officers generally demonstrated courage and professionalism. I have no doubt that being required to take the life of another caused them considerable anxiety and distress.

The incident involving Mr Gear, was not so well managed. It is possible that had it been, the need to shoot may not have arisen.

Each of the men killed had, for many years, received assistance from dedicated and compassionate staff of various Queensland Health mental health services. In each case aspects of that care could have been handled more appropriately. In some instances, systemic issues such as legislative impediments, unduly rigid professional practices, poorly coordinated service delivery or lack of clinical leadership contributed to sub optimal levels of service. In other instances errors of judgements were made. In no case was there any indication of deliberate neglect or professional misconduct.

The recommendations contained in the findings are designed to reduce the likelihood of similar deaths occurring in future by better equipping police to respond to incidents involving people suffering from mental illness and improving the capacity of mental health workers to respond appropriately to the needs of their patients. They are not intended to attribute blame or apportion responsibility for the deaths: that is not the function of the coronial system.

Finally, I want to convey my sincere condolences to the families of the dead men. It would be presumptuous of me to make observations about the challenges they confronted as they strove to help their sons deal with mental illness. Nor could I fully appreciate the pain of having a loved one die in this manner. Yet, having read their statements and seen them given evidence I have some understanding of their endeavours and their suffering. They have my deepest sympathy.

Michael Barnes
State Coroner
Brisbane
17 March 2008