



CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION: **Inquest into the death of Elliot Arapita HAIMONA**

TITLE OF COURT: Coroners Court

JURISDICTION: Brisbane

FILE NO(s): COR 2015/374

DELIVERED ON: 10 February 2017

DELIVERED AT: Brisbane

HEARING DATE(s): 12 October 2016; 25 January 2017

FINDINGS OF: Mr Terry Ryan, State Coroner

CATCHWORDS: CORONERS: Death in the course of a police operation; Taser deployment; suicide

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Commissioner of Police:	Ms Belinda Wadley
Constable Leigh Hurley and Senior Constable Daniel Hayes:	Mr Troy Schmidt

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Introduction

1. Elliot Haimona was 23 years of age. Late on 27 January 2015 he suffered self-inflicted injuries that resulted in his death in the early hours of the following morning.
2. Mr Haimona was visiting a friend at a Surfers Paradise motel complex. In a sudden and unexpected departure from his relaxed demeanour earlier in the evening, Mr Haimona refused an invitation to leave shortly before midnight, and began stabbing himself in the head and neck.
3. The Queensland Police Service was called to address. Upon arrival officers found Mr Haimona continuing to stab himself. He stopped only after he was tasered and physically restrained. The injuries he had suffered by this time were such that he could not be saved, despite the prompt arrival of paramedics.
4. These findings:
 - confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death;
 - consider whether any third party contributed to his death; and
 - consider the adequacy of the QPS investigation into the death, as QPS officers were present and restrained Mr Haimona shortly before his death.

The investigation

5. As the death occurred in the course of police operations, the investigation into the circumstances leading to Mr Haimona's death was conducted by Detective Sergeant Jeffrey Gillam from the Queensland Police Service, Ethical Standards Command (ESC), Internal Investigations Group (IIG).
6. After being notified of Mr Haimona's death, the ESC was tasked to attend and an investigation ensued. The investigation was informed by statements and recorded interviews with:
 - police officers involved;
 - attending Queensland Ambulance Service (QAS) staff;
 - the other persons inside the residence in the lead up to the death;
 - neighbours of the residence; and
 - Mr Haimona's next of kin.
7. Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted and photographs were taken. All of the police investigation material was tendered at the inquest.

8. A full internal autopsy examination, with associated testing, was conducted by experienced Forensic Pathologist, Dr Dianne Little. Further photographs were taken during this examination.
9. I am satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The Inquest

10. An inquest was held in Brisbane on 25 January 2017. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.
11. I accepted the submission from counsel assisting at the pre-inquest conference, Mr Johns, that all relevant evidence be tendered and that oral evidence be heard from the investigating officer, Detective Sergeant Gillam, the attending police officers, and Selwyn Yorke (the occupant of the motel unit where the events leading to Mr Haimona's death took place).
12. I consider that the evidence tendered in addition to the oral evidence from these witnesses (except for Mr Yorke) was sufficient for me to make the requisite findings.

The evidence

Personal circumstances and correctional history

13. Mr Haimona was born in Whakatane, New Zealand on 21 September 1991. He is survived by his mother, Brenda, and his younger brother. Mr Haimona had arrived in Australia in 2009 shortly after the apparent suicide of his younger sister. I extend my condolences to Mr Haimona's mother, brother and family.
14. Mr Haimona appears to have stayed in and around Surfers Paradise after arriving in Australia. It is likely that he was homeless for most of this time. He was living on the streets in the two years prior to his death. During that period he regularly spoke about his circumstances with Reverend Jonathon Brook, the coordinator of the Crisis Service operated by the Surfers Paradise Anglican Church.
15. Mr Haimona would often attend the church's drop in centre to use the facilities, get meals, socialise and occasionally obtain transport to seek medical care. Volunteers at the church attempted to help Mr Haimona to find employment, organising appointments and job interviews for him. However, Mr Haimona consistently failed to attend appointments arranged for him.
16. Reverend Brook, a former psychiatric nurse, considered Mr Haimona may have been suffering from depression. However, he had not observed him

suffering from psychosis or any other condition warranting referral for a mental health assessment.

17. The police investigation revealed that Mr Haimona used drugs and consumed alcohol on a social basis. His criminal history was relatively minor, including street offences for public nuisance and contravening directions of police.
18. Police investigations revealed that Mr Haimona had formed a relationship with a woman (Ms S) approximately 8 weeks before his death. He had met Ms S socially in Surfers Paradise, and information provided to police suggested that Mr Haimona had initially been able to hide from her the fact that he was homeless and unemployed. Mr Haimona had led Ms S to believe that he was employed in the finance industry and resided in Merrimac.
19. On 15 January 2015, Mr Haimona overheard a telephone conversation between Ms S and a friend, in which Ms S expressed concerns about the veracity of the information provided to her by Mr Haimona. She also queried him directly about his apparent lack of employment and accommodation. Mr Haimona ended the relationship shortly after this phone call, and Ms S had no further contact with Mr Haimona.
20. Due to his transient lifestyle, the investigating police were able to ascertain very little about his movements between 15 January 2015 and his death on 28 January 2015.

Assessment of mental health

21. The police investigation established that Mr Haimona had very limited medical history recorded with Queensland Health. The records from the Gold Coast University Hospital (GCUH) were tendered, and showed three presentations to the emergency department for various minor, physical injuries.
22. The records suggest that he had no mental health issues or other chronic illness.

Events leading to the death

23. Selwyn Yorke was the last to see Mr Haimona. He gave a statement to police, which was tendered to the inquest. He confirmed that he had known Mr Haimona for about 15 months, having met him through the St John's Anglican Church at Surfers Paradise. Although a summons was issued requiring that Mr Yorke attend at the inquest to give evidence, it could not be served as he could not be located.
24. Mr Yorke recalled that Mr Haimona came around to his unit at the Surfers Paradise Motor Inn, just after 6:00pm on 27 January 2015. Mr Haimona's

visit was unannounced. Mr Yorke poured him a small glass of beer, and Mr Haimona told him about the weekend he had just enjoyed at Tweed Heads.

25. Mr Yorke told police that at around 7:00pm the two men shared a cannabis cigarette. They then shared another one about an hour or so later. David Gammon came around at about this time, and stayed for about 20-30 minutes. Mr Gammon also knew Mr Haimona and Mr Yorke through the church and lived in one of the adjoining units. Mr Gammon said that both men appeared fine to him, and did not appear to be affected by drugs or alcohol. He did not detect any bad feeling or arguments between the men. Mr Gammon left the unit at around 9:00pm and left for a friend's home. He did not return home until 6:30am.¹
26. Mr Yorke reported that Mr Haimona spoke about a girlfriend, and his plans of marrying her someday. He recalled that Mr Haimona seemed to be in a good mood while he was talking about his girlfriend.
27. At about 11:00pm, Mr Yorke started to feel tired and told Mr Haimona it was "*time for him to head off*".² Mr Yorke got the impression that Mr Haimona did not really want to leave, so he let him stay a bit longer. At about 11:30pm, Mr Yorke recalled standing at the door and saying to Mr Haimona "*Come on Bro, I've had enough it's time to go*".³ Mr Haimona walked outside, such that Mr Yorke thought he was leaving. Mr Haimona then walked back inside and said, "*I might just get a drink*".⁴
28. Mr Haimona walked into the kitchen and had a glass of water from the tap. Mr Yorke repeated that it was time for him to go. Mr Haimona then proceeded to walk out again, but stopped, turned, and walked back into the kitchen. He grabbed a steak knife from a plastic jug on the bench, and while looking at Mr Yorke, stabbed himself three times to the right side of the head with the knife.
29. Mr Yorke ran into the bathroom to get a towel. When he returned, Mr Yorke saw a stab wound to Mr Haimona's neck, with blood spurting out. Mr Yorke pushed the towel onto Mr Haimona's neck, and the side of his head. Some degree of a struggle ensued, during which Mr Yorke tried to give Mr Haimona assistance with the towel. During the struggle, the knife moved towards Mr Yorke, and he subsequently went out to the front of the unit to call an ambulance.
30. Once outside, Mr Yorke realised he did not have his phone with him. He went back inside the unit. He saw Mr Haimona standing near the fridge in the kitchen. He was puncturing himself with the knife, stabbing his body and neck. Mr Yorke grabbed his phone, and ran back outside to call 000. The CAD data shows that this call was placed at 11:57pm.

¹ Exhibit B1

² Exhibit B7, paragraph 8.

³ Ibid.

⁴ Exhibit B7, paragraph 9.

31. A first response crew including Senior Constable Daniel Hayes, Constable Leigh Hurley and Constable Robert Sokolinski were dispatched, and they arrived on scene by 12:03am. The QAS arrived shortly after at 12:08am.
32. Senior Constable Hayes and Constable Hurley gave evidence at the inquest. Both officers confirmed that they had no knowledge of Mr Haimona prior to this incident, but that they were familiar with the block of units, having attended there previously in relation to other matters.
33. Senior Constable Hayes joined the QPS in 2009. At the time of Mr Haimona's death he was rostered to work as custody manager from 10:00pm to 6:00am over a period of seven nights. He went to assist with this job as there was no one in custody at the relevant time.
34. Senior Constable Hayes recalled that it was just before midnight, that he was at Broadbeach station, and his colleagues received a call from VKR Police Communications requesting their attendance at a Code 2 priority job. They were informed it was a self-harming incident.
35. Senior Constable Hayes left the station in company with Constable Hurley and Constable Sokolinski and proceeded straight to the incident. Their call sign was GC830. Senior Constable Hayes was the senior officer in this crew. On route to the job, the crew were advised that a male person was stabbing himself.
36. Upon arrival at the scene, Senior Constable Hayes could see a male person pacing around talking on his mobile phone at the unit block. This person was later identified to be Mr Yorke. Senior Constable Hayes noted that Mr Yorke appeared to be hysterical and in shock. He observed blood on Mr Yorke's board shorts and torso. Mr Yorke indicated to Senior Constable Hayes he had smoked some pot with the deceased during the night and they had also consumed some liquor.
37. Constable Hurley was the first officer inside the unit, followed by Constable Sokolinski and Senior Constable Hayes. Senior Constable Hayes activated his body worn video recorder which was mounted on his load bearing vest. I have had regard to that footage in preparing these findings.
38. Constable Hurley's evidence was that when he entered the unit blood splatter was evident over the walls and curtains. He saw Mr Haimona at the end of the bed sitting upright on the floor and holding a knife.
39. Senior Constable Hayes drew his Taser, and he explained in his evidence that this was due to information received that Mr Haimona was armed with a knife. He said that in his assessment of threats the knife was the most obvious risk. Constable Hurley unclipped his firearm and drew it up a small way out of the holster in case Mr Haimona came at them with the knife.

40. Constable Hurley repeatedly called out to Mr Haimona to “drop the knife’, as did Senior Constable Hayes. Senior Constable Hayes stood up on the bed to obtain a better vantage point. Senior Constable Hayes observed Mr Haimona on the ground on the far side of the bed. Senior Constable Hayes asked Mr Haimona ‘what’s your name?’. Mr Haimona looked blankly back at him and resumed stabbing himself in the neck with the knife another two or three times.
41. Senior Constable Hayes can be heard on the body worn camera footage to call out “this is a Taser don’t move, Taser Taser Taser”. After he deployed his Taser, Mr Haimona dropped the knife. Senior Constable Hayes was of the impression that one Taser probe struck Mr Haimona in the shoulder, and the second probe in his torso. Senior Constable Hayes instructed Constable Hurley to handcuff Mr Haimona. Constable Hurley then proceeded to try to place gloves on for protection before doing so.
42. As Constable Hurley retrieved his handcuffs, the five second Taser cycle lapsed. As a result, Mr Haimona regained movement and began to reach for the knife. Senior Constable Hayes again instructed Mr Haimona not to move.
43. Senior Constable Hayes’ evidence was that as he was concerned for Constable Hurley’s safety, he activated his Taser again, giving Mr Haimona another five second cycle. The second activation resulted in Mr Haimona being incapacitated, enabling Constable Hurley to restrain and handcuff him safely. Constable Hurley then kicked the knife under the bed.
44. Senior Constable Hayes then provided a situational report to Police communications that a Taser has been deployed. Constable Hurley commenced providing first aid as it appeared that Mr Haimona was unresponsive. Constable Hurley’s evidence was that he attempted to apply pressure to Mr Haimona’s neck but there were too many wounds to stem the blood flow. He said that it had the texture of a cheese grater. He was actively monitoring Mr Haimona’s breathing and pulse and then started chest compressions.
45. A second police crew from Broadbeach arrived to assist. Constable Hurley and others started moving furniture out of the way so that the QAS would have better access to Mr Haimona. Upon moving the bed, Senior Constable Hayes located a knife underneath it. A second knife was also located on the ground next to Mr Haimona. Senior Constable Hayes placed both knives on a table in the unit.
46. The QAS arrived on scene and commenced treatment. Mr Haimona was subsequently transferred to the GCUH where he was pronounced deceased at 01:15 hours on 28 January 2015.

Aftermath and assessment of use of force

47. The evidence at the inquest confirmed that a crime scene was established. The evidence of the responding officers was that they were separated after returning to the Surfers Paradise Police Station. Service issued accoutrements were also surrendered for examination, in particular the Taser deployed by Senior Constable Hayes. The data from this Taser was downloaded and tendered at the inquest. The body worn camera footage from Senior Constable Hayes and Constable Matthew Vidler was also retrieved and tendered at the inquest.
48. Senior Constable Hayes' evidence with respect to his use of the Taser was that when he first walked in to the unit, Mr Haimona was lying on his left shoulder, facing towards the front door. He was on his back by the time Senior Constable Hayes was on the bed with his Taser drawn.
49. Senior Constable Hayes explained his consideration of use of force options. He drew his Taser because of the presence of the knife. He did not consider his firearm to be appropriate, as he was the last police officer inside the unit, with other police officers in front of him. Senior Constable Hayes did not see Mr Haimona with the knife until such time as he was up on the bed. Mr Haimona was seen to be holding a knife over his chest with a firm grip. It looked like a standard kitchen knife or steak knife, about 150mm long.
50. Senior Constable Hayes recalled that the moment he asked Mr Haimona for his name, he started thrusting the knife into his own neck approximately two to three times. He did this with force, with the blade going in deep, almost to the handle.
51. Senior Constable Hayes confirmed that he had completed Taser training during the week before Mr Haimona's death, involving a very similar scenario. He had been trained not to deploy firearms in cases of self-harm. His approach was to use tactical communications and remain at a distance to minimise risks to officer safety.

Autopsy results

52. A full internal autopsy examination was conducted by experienced forensic pathologist Dr Dianne Little.⁵
53. Examination revealed the presence of a large number of stab wounds to Mr Haimona's head, neck and legs, as well as incised wounds to the face, left wrist and right calf. There were at least 57 stab wounds to the neck, which caused severe damage to the underlying soft tissues of the neck as well as fractures of the larynx and wounds in both the right and left jugular veins and the left common carotid artery.

⁵ exhibit A4

54. Dr Little considered that these wounds would have resulted in significant blood loss. The stab wounds to the neck were the direct cause of death. The other stab wounds to the legs, face and scalp did not pass through any vital structures. Dr Little's opinion was that all of the stab and incised wounds could have been self-inflicted.
55. Dr Little noted red marks on Mr Haimona's wrists consistent with the use of handcuffs, and a Taser barb was embedded in the front of the right shoulder. There was no evidence of significant natural disease to cause or accelerate death.
56. Toxicological analysis detected minor levels of methylamphetamine and its breakdown product, amphetamine. This was not considered to have contributed to the death in any way. Contrary to Mr Yorke's statements to the QPS, toxicology did not reveal the presence of cannabis or its constituents in Mr Haimona's blood.
57. Dr Little determined the formal cause of death to be from stab wounds to the neck.

Investigation findings

58. The ESC investigation relevantly addressed Senior Constable Hayes' use of the Taser. It was confirmed that the Taser had been signed out by Senior Constable Hayes at the Surfers Paradise police station at about 10:00pm on 27 January 2015. The data downloaded from the device after the incident confirmed the deployment of the Taser at an initial 5 second cycle, and then a further five second cycle. This data was consistent with the evidence given by Senior Constable Hayes and Constable Hurley.
59. The ESC investigation found the responding officers attended the incident in a timely manner upon receipt of the job details. Upon entering the unit and observing Mr Haimona stabbing himself in the neck, Senior Constable Hayes and Constable Hurley made a threat assessment, with Senior Constable Hayes choosing the use of force option of the Taser to stop the threat of the knife. This was an appropriate choice in the circumstances. The deployment of the Taser was successful, allowing Constable Hurley to control Mr Haimona's actions, and facilitating his restraint.
60. The ESC investigation concluded that there was no misconduct displayed by any of the officers involved and further concluded that no disciplinary proceedings were required. I accept the conclusions of Detective Sergeant Gillam in this regard.
61. The police officers were separated after they were stood down from duty and after the Regional Duty Officer had examined the body worn camera footage of the incident. I am satisfied that the integrity of the evidence of the officers was suitably preserved.

Conclusions

62. After considering all of the evidence, I conclude that Mr Haimona died as a result of his own actions, after he inflicted multiple stab wounds to his neck and other parts of his body. I find that none of the police officers or other persons at the Surfers Paradise Motor Inn on 27 January 2015 caused or contributed to his death in any way.
63. I am satisfied that the actions and decisions made by the attending police officers in the immediate lead up to Mr Haimona's death were appropriate and timely. Mr Haimona's death could not have reasonably been prevented by the attending officers.
64. I am satisfied that the investigation conducted into Mr Haimona's death by the Ethical Standards Command was appropriate, thorough, and covered all relevant areas of investigation. I am satisfied that the protocols established to investigate deaths in custody in accordance with the *Coroners Act 2003*, and Queensland Police Operational Procedures Manual were complied with.

Findings required by s45

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

Identity of the deceased – The deceased person was Elliot Arapita Haimona.

How he died - Mr Haimona died as a result of his own actions, by way of inflicting a large number of stab wounds to his neck, face and other parts of his body.

Place of death – He died at the Gold Coast University Hospital, Gold Coast in the State of Queensland.

Date of death – He died on 28 January 2015.

Cause of death – Mr Haimona died as a result of stab wounds to the neck.

Comments and recommendations

66. Section 46 of the *Coroners Act*, insofar as it is relevant to this matter, 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.
67. In this case I have found that there are no grounds for criticism of the police officers involved. They responded professionally, and in accordance with their training in relation to appropriate use of force, in a highly charged situation involving a man with a weapon that could have potentially been used upon them.
68. I consider there are no recommendations I could reasonably make to prevent a similar death from occurring in the future.
69. I close the inquest.

Terry Ryan
State Coroner
Brisbane
10 February 2017