QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

RECOMMENDATIONS FROM INQUEST

CITATION:	**INQUEST INTO THE DEATHS OF ANTHONY WILLIAM YOUNG; SHAUN BASIL KUMEROA; EDWARD WAYNE LOGAN; LAVAL DONOVAN ZIMMER; AND TROY MARTIN FOSTER**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane, Maroochydore, Southport
FILE NO(s):	COR 2013/2988; 2014/3598; 2014/4321; 2014/4239; 2014/4357
DELIVERED ON:	20 October 2017
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FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Deaths in custody, police shootings, s 46 comments from inquest, use of force model, police training, mental illness, police officer welfare, investigation methodologies, body worn cameras, replica firearms, nuisance callers, information sharing.

REPRESENTATION:

Counsel Assisting:	Mr Stephen Keim SC and Miss Emily Cooper
Commissioner of Police:	Mr Michael Nicolson (instructed by Public Safety Business Agency)
Police officers who discharged weapons:	Mr Troy Schmidt (instructed by Gilshenan and Luton)
Other police officers:	Mr Adrian Braithwaite (instructed by QPUE Legal Group)
Queensland Police Union of Employees:	Mr Calvin Gnech (instructed by QPUE Legal Group)
Family of Laval Zimmer:	Mr Kevin Kelso (instructed by McKenzie Mitchell)
Family of Troy Foster:	Mr Damian Walsh (instructed by Hannay Lawyers)
Gold Coast Hospital and Health Service:	Mr Christopher Murdoch QC (instructed by Kaden Borriss Legal)
Metro North Hospital and Health Service:	Mr Aaron Suthers
Queensland Advocacy Incorporated (s 46 public interest):	Mr Steven Jones (instructed by QAI)

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Introduction

1. Between August 2013 and November 2014, officers from the Queensland Police Service (QPS), acting in the course of their duties, shot and killed five men in unrelated incidents. The incidents occurred at the Sunshine Coast, Brisbane, and the Gold Coast. In particular, three of the deaths occurred over the period of one week, from 18 November 2014 – 24 November 2014.

2. Findings have previously been made in relation to each of the deaths pursuant to s 45 of the *Coroners Act 2003.*

3. Any recommendations connected to these deaths must be considered in the context that in each case I have found that the relevant QPS officers acted appropriately in discharging their weapons. I have also found that the investigation conducted into each death by the Queensland Police Service Ethical Standards Command Internal Investigations Group was adequate.

4. As noted in my previous findings in relation to each of these deaths, the community has high expectations of police, particularly during a crisis. While operational police are trained in "use of force" options, including lethal force, the community expects that they will act lawfully and professionally in the exercise of their duties, and in accordance with operational policies and training.

5. The use of firearms by police, particularly when that use results in a death, has the capacity to fundamentally shift the trust and confidence that the community has in the police. As the Taskforce Bletchley Report[1] explained:

> *National and international research has shown that the way in which front-line, operational police officers interact with the public during interventions "is important for promoting citizen satisfaction, compliance and cooperation with the police", and that police can achieve positive changes in members of the communities' attitudes towards them by behaving in a procedurally just and legitimate manner.*

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

7. Recognising that involvement in a fatal shooting can lead to significant trauma for the police officers involved, the inquest has also considered the impact of such deaths on those officers. This included issues such as balancing the need for a thorough investigation of the use of lethal force with officer welfare, and the return of involved officers to active duty.

[1] Exhibit R36.5
Recommendations of inquest into the deaths of Anthony William Young; Shaun Basil Kumeroa; Edward Wayne Logan; Laval Donovan Zimmer; and Troy Martin Foster

8. It is important to note that the QPS has not waited until the conclusion of this inquest before reviewing its policies and procedures on the use of force, and implementing changes where it was considered necessary. As the submissions on behalf of the Commissioner of Police noted, the QPS has been actively developing strategies and policies with a view to improving the way police conduct the business of policing in Queensland.

9. In November 2014, the Commissioner initiated the Violent Confrontations Review.[2] This was a review of QPS policy, procedures and training involving violent confrontations. The review was a direct response to the three shootings that occurred in November 2014 that were investigated in this inquest. Similarly, Taskforce Bletchley reviewed complaints involving use of force allegations on the Gold Coast and other parts of the State.

10. The QPS is implementing relevant recommendations arising from the Violent Confrontations Review (VCR) and Taskforce Bletchley reports addressing policy development, training, inter-agency collaboration, information sharing, and enhanced governance surrounding the response to use of force incidents. While I have endeavoured to frame my recommendations in the context of those developments, there are inevitable overlaps.

11. The submissions on behalf of the Commissioner noted that many of the recommendations identified in the submissions of Counsel Assisting were an enhancement of the recommendations contained in the reports referred to above.

12. Of particular significance is the decision by the QPS, following the Taskforce Bletchley report, to revise the use of force model to centrally position communication, "acknowledging its importance as a precursor or in conjunction with other use of force options". The importance of skilful communication, particularly with persons who are suffering a mental illness, cannot be emphasised enough.

13. At the same time the QPS has also introduced relevant policies in response to the threat of active armed offender attacks which have emerged as a common tactic adopted by terrorists and other criminals around the world. The appropriate response in those circumstances would generally entail the rapid defeat or mitigation of the threat posed by the active armed offender. It is important to note that the consideration of police responses to those and other terrorist situations, such as the Lindt Café siege, was outside the scope of this inquest.

14. Police are routinely expected to enter dangerous situations in which their own safety may be jeopardised, where the response of ordinary citizens would be to escape the potential threat. In four of the deaths I investigated in this inquest, police officers were confronted by a hostile male armed with

[2] Exhibit R2.

a knife or other weapon within seconds of arriving at the scene. The other death followed a prolonged stand-off situation where officers were suddenly confronted with a replica weapon being pointed at them.

15. Each of the men had a history of known or suspected mental illness, highlighting the need for the QPS to treat mental health as 'core business'. This was reinforced in the evidence of experts at this inquest, Professors Alpert and Thomas, and in the Report of the Sentinel Events Review Committee in 2016: *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services.*[3] That report identified opportunities for improvements in information sharing and collaboration between health services and the QPS, and an increase in the level of specialist forensic mental health support to the QPS.

16. This very significant overrepresentation of mentally ill persons in fatalities associated with police use of force is consistent with both national data, and research from Victoria. That research indicates that 42% of those shot nationally[4] between 1989 and 2011 and over 50% of decedents in Victoria[5] between 1980 and 2008 were identified as having a mental illness. In my view it is, therefore, critical that the Mental Health Intervention Project between the QPS and Queensland Health is not only revitalised in accordance with the VCR Report's recommendations, but that it is embedded in a sustainable way in those agencies.

17. The evidence at the inquest does not indicate that the QPS' policies in relation to the use of force are fundamentally flawed, or that shootings are on the increase. Over the past 17 years in Queensland there have been fewer than two police shootings each year involving a civilian fatality.

18. The four shootings in the last quarter of 2014 were an aberration. They also occurred in the context of an estimated 6,000,000 interactions between police and the community during that year.[6] The VCR Report indicated that this included almost 70,000 domestic violence occurrences, 8,153 police emergency examination orders under the *Mental Health Act,* 15,815 drug arrests, and 5408 alcohol related assaults.

19. Section 46 of the *Coroners Act 2003,* relevantly provides that a coroner may comment[7] 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.

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[3] Exhibit R42

[4] *Police shootings of people with a mental illness*, Research in Practice No. 34, AIC Canberra, 2013

[5] Kesic D, Thomas S and Ogloff J. *Analysis of fatal police shootings – time, space, and suicide by police*. Crim Justice Behav 2012; 39: 1107-1125, cited in Scott, R and Meehan, T. *Inter-agency collaboration between mental health services and police in Queensland,* Australasian Psychiatry, 2017; 25 (4), 399-402

[6] Exhibit R2, page 19

[7] Schedule 2 defines 'comment' to include a recommendation

20. In this inquest specific evidence was heard about s 46 matters over a two week period in October 2016. This is referred to in this report as the 'recommendations phase'. This phase was an opportunity to step back from the "final frame" in which weapons are discharged to consider opportunities for changes in police and health responses that may lead to the prevention of similar deaths, and the tragic impacts they have on the families of the deceased, officers involved and the wider community.

21. The intent of this document is to detail the recommendations I consider to be appropriate, as a result of hearing that evidence and considering submissions from those granted leave to appear at the inquest, which were provided up until March 2017. Those submissions, particularly those of my Counsel Assisting, Mr Keim SC and Miss Cooper, have been of considerable assistance in the formulation of my recommendations.

22. The QPS has already made significant progress in the wake of these shootings in a range of areas, including refocussing the use of force model and, the roll out of body worn cameras and Q-Lite devices. I consider that the 19 recommendations I have made, if accepted, would complement those efforts.

23. I offer my condolences to the families of the men who died in each of the shootings. I also acknowledge the traumatic impact these events have had on all the police officers involved, their families, and colleagues.

Issues examined

Issues common to all deaths

24. The issues which were common, or relevant to all deaths, were settled as follows:

    (1) The appropriateness of the current QPS use of force model and the options of force available to police officers;

    (2) The adequacy and appropriateness of Queensland Police Service:

        (i) policies in relation to the use of firearms; and

        (ii) training provided to operational police officers in the use of firearms.

    (3) The adequacy of the approach taken by the Ethical Standards Command Internal Investigations Group in conducting the investigation into the deaths, particularly, whether an improved methodology might be adopted which places appropriate weight on and protects the welfare of first response police officers, post-incident, and also preserves the integrity of the evidence of those officers and other evidence at the scene including whether the

timing of and means of conducting interviews of first response officers by ESC officers should be varied or subject to greater flexibility;

(4) The adequacy and appropriateness of the current training of police officers with respect to the imposition of handcuffs after the use of lethal force;

(5) The adequacy of the current processes for dissemination of information, and updates of information, for attending crews to an incident including possible implementation of the Q-Lite program;

(6) The adequacy and appropriateness of QPS policies, procedures and training in relation to police dealing with mental health incidents, including the adequacy of the availability to QPS members, responding to an incident, of information/records from Queensland Health, and other medical practitioners, regarding the mental health history of persons;

(7) The current position regarding ownership of body worn cameras used by QPS officers and the storage of data including the progress of the roll out pursuant to the Commissioner's direction; and

(8) Lessons learned from these five inquests as to the benefits of body worn cameras being used by the police officers in terms of:

(i) preserving evidence;

(ii) providing a reliable record of what occurred;

(iii) avoiding unnecessary controversy about what happened;

(iv) vindicating police officers who have acted in accord with their training and policy.

Issues not common to all deaths

25. Issues which were not common to all deaths, but rather specific to a particular death, were settled as follows:

(9) The need for and, if necessary, the appropriate form of regulation of replica firearms in QLD. *(Kumeroa)*

(10) The effectiveness of the negotiation processes as observed in the incident involving Mr Kumeroa, including the options available for use when trying to negotiate a surrender plan and ways in which the process might be assisted in future. *(Kumeroa)*

(11) The positioning of the inner cordon police officers in the incident involving Mr Kumeroa leading to the necessity to use lethal force

soon after Mr Kumeroa departed his car and whether any practical alternatives were available or might be available in a future incident. *(Kumeroa)*

(12) The adequacy and appropriateness of QPS policies, procedures and training for Police Communications personnel, especially, in dealing with nuisance callers who are not an appropriate use of 000 service time but may be people facing emotional or other difficulties and may require QPS assistance. *(Zimmer)*

(13) Methods available to first response police officers who are deployed to deal with nuisance callers including means of establishing and maintaining communications without necessarily requiring officers to enter dwelling houses to prevent calls from continuing. *(Zimmer)*

(14) The appropriateness of the mental health assessment of Troy Foster conducted at the Gold Coast University Hospital on 24 November 2014. *(Foster)*

(15) The adequacy of the current processes by which police escort a person detained under ss. 33 – 36 of the Mental Health Act 2000 to a place of safety; by which police are required to provide information to hospital staff about the person for the purposes of the assessment; and by which hospital staff and police continue to communicate, if necessary, with regard to the person. *(Foster)*

26. I will proceed to deal with each issue in turn. Where appropriate, I have grouped related issues together.

The evidence

Issues 1 & 2

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

2. The adequacy and appropriateness of Queensland Police Service:

(i) policies in relation to the use of firearms; and
(ii) training provided to operational police officers in the use of firearms.

27. These issues were considered as part of the recommendations phase as lethal force was used by the attending police before each death. The focus of the evidence during the recommendations phase was not on criticizing the current use of force model but on considering how the model might be improved.

28. Evidence was heard on these issues from Senior Sergeant Damien Hayden, Officer in Charge of the QPS Operational Skills and Tactics Training Unit (OSTTU). Evidence was also heard from Professor Geoffrey Alpert, Professor of Criminology and Criminal Justice at the University of South Carolina. As noted above, this evidence was heard in the context of the s 45 findings that the use of lethal force by the officers concerned in each case was appropriate.

29. As part of each investigation conducted by the Ethical Standards Command (ESC), Senior Sergeant Hayden conducted a review of the evidence and provided an opinion as to the appropriateness, or otherwise, of the use of lethal force. Written statements of Senior Sergeant Hayden were received in each inquest setting out his opinions concerning the circumstances of each case. These statements were received as evidence during the s 45 phase and during the recommendations phase.[8] Each statement provides a detailed account of the following matters:

    - A conclusion as to the appropriateness of the actions and use of force options adopted by each of the officers in each case;
    - The function of the OSTTU;
    - A discussion of current police policy surrounding threat assessments and the tactical decision making process;
    - A review of the use of force applied to the situation by the attending police officers and an assessment of the appropriateness of that force when reviewed against the QPS Operational Procedures Manual;
    - A discussion of QPS issued service firearms and ammunition, including technical detail and capabilities and of the training provided to QPS officers for use;
    - A discussion of the training provided to recruits and sworn police with respect to lethal force;
    - An explanation as to the number of shots fired, with reference to there being a 'string of shots';
    - An explanation as to why the QPS does not have a 'shoot to wound' policy;
    - A discussion of the possibility of deploying alternative 'less than lethal' use of force options (i.e. Taser, or capsicum spray); and
    - A discussion of the post-shooting response.

30. A number of suggestions for improvements to police training arose from the evidence received during the factual phase of the inquest. These suggestions, as summarised below, formed the basis for much of the questioning of Senior Sergeant Hayden and Professor Alpert during the recommendations phase:

[8] Exhibits R3 – R8.

- Incident Command Training to be mandatory for all junior police, i.e., constables and senior constables;
- Leadership and tactical first response incident training for officers at constable and senior constable level;
- Improved communication training for all frontline police, in particular, training in radio techniques in terms of the relay of cognitive information and how that information is recognised as urgent and prioritised appropriately;
- Use of force training on a more frequent basis, including that this training should include night shooting scenarios;
- The roll out of weapon mounted light sources for all operational police; and
- Gunshot wound training and the use of quick clot bandages for frontline police officers.

31. Senior Sergeant Hayden gave very helpful evidence. He started at the OSTTU in 2004, having previously performed duties involving the delivery of training and assessment, and requalification of firearms training, and practical policing skills such as arrest techniques and tactics, since the mid-1990s.[9] In his current role, he is responsible for the research, design, development, implementation and evaluation of in-service training in relation to operational skills in the use of all forms of force, for the entire QPS.[10]

Current training

32. Senior Sergeant Hayden was asked about current methods of training which are aimed towards incident command for junior officers. The suggestions for 'incident command training' and 'leadership and tactical first response training' were both put to the Senior Sergeant during his evidence.[11] He explained that the QPS has experienced a marked flattening in the rank structure. As a consequence, it is common for officers of the same rank to be working a shift together. This can create some issues when it comes to those officers making decisions and being required to take command of a situation as one officer is not necessarily more senior than the other.[12]

33. Senior Sergeant Hayden made a recommendation during his evidence for dedicated frontline leadership training with the aim of empowering officers to be able to give commands to another officer of similar rank.[13] His evidence was that a frontline leadership component which actively promotes leadership values and decision making would assist in responding to incidents that may be of a critical nature. In most of these circumstances it

[9] Recommendations phase transcript of proceedings, day 3, page 4 from line 10.
[10] Recommendations phase transcript of proceedings, day 3, page 4 from line 17.
[11] Recommendations phase transcript of proceedings, day 3, page 31 from line 5.
[12] Recommendations phase transcript of proceedings, day 3, page 31 from line 25.
[13] Recommendations phase transcript of proceedings, day 3, page 31 from line 33.

is constables and senior constables who are the frontline officers who end up responding.[14]

34. Senior Sergeant Hayden's recommendation has a similar thrust to recommendation 24 from the Taskforce Bletchley Review, which states:

> *"That the Executive Officer, Training and Development – Police reviews leadership and frontline supervisor training within current programs to actively promote frontline leadership.*"[15]

35. Assistant Commissioner Clement O'Regan was also called to give evidence at the inquest on a variety of matters. He gave evidence regarding this recommendation and was asked whether recommendation 24 was targeted at a certain rank of police officer.[16] Assistant Commissioner O'Regan confirmed that the recommendation was holistic and sought to address the general capacity of officers at NCO (Non-Commissioned Officer) level to lead and manage people.[17]

36. Senior Sergeant Hayden gave evidence regarding some current gaps in the training regime for operational police in relation to events subsequent to a critical incident. He gave evidence that, in his experience, there is a lot of ignorance in this regard and a lot of frontline police officers are "*unaware of the tail end investigations if they're involved in a significant event or a significant incident*."[18] When asked whether the experiences of officers involved in critical incidents are used in some way in order to inform current training through the Academy, the Senior Sergeant's evidence was that the QPS had put in place a series of "lessons learned" from previous shootings, and incorporated some of those aspects into scenario based training.

37. The inquest heard evidence regarding the extent to which the current training addresses the aftermath of the application of lethal use of force. Senior Sergeant Hayden gave evidence that the focus is mainly on the post-event requirements that will occur, namely, taking possession of the officer's firearm, urine testing, blood/alcohol testing and gunshot residue testing.[19]

38. With regard to the suggestion put forward during the s 45 phase that operational police would benefit from scenario training in a night-time setting, Senior Sergeant Hayden's evidence was that, if there were a series of dedicated training venues around the State, more low-light training scenarios could be facilitated.[20] He explained that, because of the size of the State, training facilities are not standardised. Live fire shoots in low-light settings are very difficult to arrange in Queensland because the QPS does

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[14] Recommendations phase transcript of proceedings, day 3, page 31 from line 33.
[15] Exhibit R36.13, page 14.
[16] Recommendations phase transcript of proceedings, day 7, page 48 from line 36.
[17] Recommendations phase transcript of proceedings, day 7, page 48 from line 47.
[18] Recommendations phase transcript of proceedings, day 3, page 36 from line 40.
[19] Recommendations phase transcript of proceedings, day 3, page 37 from line 25.
[20] Recommendations phase transcript of proceedings, day 3, page 30 from line 5.

not own any firing ranges. It has access to some public ranges but their use is limited by certain range and safety templates. Senior Sergeant Hayden explained that, because the QPS shooting system is so dynamic and, thereby, remarkably different to traditional marksmanship, conducting QPS training at a public pistol club can cause a great deal of anxiety among members of the public.[21]

39. Most of the QPS skills training was conducted during 2015 in low-light scenarios by utilising closed off rooms with no lights turned on. Senior Sergeant Hayden described this method as a "*surprisingly effective*" means of training.[22] In terms of how a suitable low-light setting might be provided for training purposes in the future, Senior Sergeant Hayden's evidence was that

> *"… it probably wouldn't be something that we do all the time, but it would be something just to – realistically, to try and have a workplace simulation that reflects the actualities of the circumstances that the officers operate under. We would try and – you know, something as simple as doing a shoot on a range at night time, in low-light, with, you know, diminished, you know, the ability to see a target, would only benefit the officers with increasing their skill set."*[23]

40. Senior Sergeant Hayden also gave evidence regarding improved communication training for all frontline officers, particularly, concerning radio techniques to ensure effective transfer of cognitive information and to assist frontline officers to recognise critical information.[24] When asked about available methods with which to teach officers to absorb information, the Senior Sergeant's evidence was that information exchange is essential to formulate an appropriate response.[25]

41. Numerous suggestions were also made during the s 45 phase for more frequent use of force training to occur every six months, as opposed to the current system which mandates use of force training once every calendar year. Senior Sergeant Hayden explained that the current system relating to use of force training is that officers are required to complete a single live fire shoot every year, which is then followed by dynamic interactive scenario-based training.[26] The training regarding technical skills, tactics and techniques is rolled out during the live fire drills. The officer is assessed not only on technical proficiency but also their capacity to make appropriate decisions that are lawful; comply with QPS policy; and are tactically sound.[27]

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[21] Recommendations phase transcript of proceedings, day 3, page 30 from line 14.
[22] Recommendations phase transcript of proceedings, day 3, page 30 from line 11.
[23] Recommendations phase transcript of proceedings, day 3, page 30 from line 30.
[24] Recommendations phase transcript of proceedings, day 3, page 32 from line 25.
[25] Recommendations phase transcript of proceedings, day 3, page 32 from line 38.
[26] Recommendations phase transcript of proceedings, day 3, page 38 from line 5.
[27] Recommendations phase transcript of proceedings, day 3, page 38 from line 11.

42. Senior Sergeant Hayden was generally supportive of the idea of increasing the frequency of use of force training. However, in terms of the practicalities surrounding the idea, he outlined concerns about the significant operational and financial outlay to facilitate extra training.[28]

43. With respect to an increase in use of force training, Assistant Commissioner O'Regan was generally unsupportive of such a suggestion. His evidence in this respect was as follows:

> *"So already there is three days of block training a year. This year it's been increased to four days. So that's one day of operational skills and firearms. I'm Taser qualified. So there's a day of Taser - - -*
>
> *Yes?--- - - - training and then there's what they call Block 2 and this year it's active armed offending training – offender training and that is a two day process which is interactive scenarios using simulation. So ideally you could say that we can always do more training, but what's the balance of that and its effectiveness and its need.*
>
> *Yes?---We think at the moment we've got that balance right."*[29]

44. Submissions from Counsel Assisting also referred to the argument put forward by a number of witnesses that that the current flexibility in terms of when during a calendar year an officer undertakes use of force training can lead to a gap of nearly two years between training. However, it was submitted that this argument should not be given excessive weight. First, the flexibility allowed may be important to some police officers whose duties in a particular year may make it difficult to take time off. Second, it would be unusual for almost two years to pass between receiving training on more than one occasion, because there will be not much more than one 12 month period before the expiry of the next calendar year. As a consequence, gaps approaching two years would only occur occasionally.

<u>Weapon mounted light sources</u>

45. With respect to his recommendation relating to weapon-mounted light sources[30], Senior Sergeant Hayden's evidence was that this recommendation arose out of the Zimmer shooting and the circumstance that officers did not turn on any lights inside the dwelling.

46. Senior Sergeant Hayden accepted that there can be some difficulty in officers using a weapon and holding a torch at the same time.[31] He explained during his evidence that, currently, all frontline non-specialist police are equipped with a firearm by itself. There exists technology in the form of a torch which clips onto the firearm which allows an officer to use

[28] Recommendations phase transcript of proceedings, day 3, page 38 from line 23.
[29] Recommendations phase transcript of proceedings, day 7, page 55 from line 3.
[30] Exhibit R6, paragraphs 154 & specifically 164.
[31] Recommendations phase transcript of proceedings, day 3, page 23 from line 6.

the firearm with more accuracy in a low-light situation.[32] A demonstration of this technology was provided at the inquest.[33]

47. Senior Sergeant Hayden clarified during his evidence that three of the deaths involved circumstances of low-light or no light, thus exposing the police officers to a heightened risk.[34] While officers are taught how to hold a firearm and a torch at the same time, this is not an ideal situation in which to place an officer.

48. Senior Sergeant Hayden's evidence was that there is an identified product available and that it would be a significant investment for the QPS to make. In terms of training on how to use the technology, Senior Sergeant Hayden explained that such training would be relatively simple and quick and could be carried out at individual police stations utilising a rubber gun.[35]

49. I note that section 14.15 of the OPM now refers to the approval of the use of a weapon mounted light source for the Service issued concealable firearm for use by suitably trained officers and deals with the use, carriage, storage and maintenance of the light source.

50. Counsel Assisting submitted that I should recommend that the QPS invest in a weapon mounted light system for all operational police. However, having regard to the updated OPM, I do not consider that such a recommendation is necessary.

Improved first aid training

51. I heard evidence relating to 'quick-clot' or haemostatic bandages and the benefit of making such equipment available for the use of frontline police. This suggestion emerged due to the circumstances of each shooting, where police officers were required to immediately conduct first aid on a person who had sustained bullet wounds. Senior Sergeant Hayden explained that the current first aid training required to be undertaken by QPS officers is akin to what is offered to the general community. It covers everything from sunburn, spider bites, bandaging, splinting and CPR.[36] Upon reviewing the circumstances of each of the deaths which are the subject of the inquest, he had formed the view that the QPS needs to provide gunshot or trauma specific first aid training to frontline police.

52. Senior Sergeant Hayden explained the quick-clot bandage as a dressing with a haemostatic ability, which essentially "welds" the wound shut and stops the bleeding.[37] It does this through a pad inside the dressing, which

[32] Recommendations phase transcript of proceedings, day 3, page 28 from line 7.
[33] Recommendations phase transcript of proceedings, day 3, page 28 from line 31.
[34] Recommendations phase transcript of proceedings, day 3, page 28 from line 11.
[35] Recommendations phase transcript of proceedings, day 3, page 29 from line 10.
[36] Recommendations phase transcript of proceedings, day 3, page 13 from line 4.
[37] Recommendations phase transcript of proceedings, day 3, page 13 from line 18.

is filled with a chemical that reacts with emerging body fluids to effectively seal the wound.[38]

53. Senior Sergeant Hayden explained that, if haemorrhage control is not instituted straight away, the outcome is usually fatal, regardless of how much CPR is performed.

54. When asked about the ability for officers to easily carry the trauma kit on their person during a shift, Senior Sergeant Hayden gave evidence that what would be required is an individual first aid kit. He explained that it is a small pouch, slightly larger than a mobile phone in size and dimension, which could be easily secured on the load bearing vest, or a belt.

55. Senior Sergeant Hayden demonstrated how the bandages and modern form of tourniquet operate at the inquest.[39] He explained that the extra first aid training would act as an "*incident stopgap temporary status*", meaning, steps that can be taken by police in the lag time between when the incident finishes and the Queensland Ambulance Service (QAS) arrive.[40] When asked whether there would be any difficulty in training more officers in these methods, Senior Sergeant Hayden's evidence was that the QPS already has a line of liaison open with the QAS, by way of paramedics who are tied to SERT. He explained that workshops could be facilitated within a period of approximately four hours.[41] Senior Sergeant Hayden's evidence was that he believed that the expense of specialised first aid training would be relatively minor.[42]

56. Dr Adam Griffin, Director of the Clinical Forensic Medicine Unit, also gave evidence to the inquest on this topic from a medical perspective. He supported some sort of gunshot wound training for police officers. He explained the difference in the type of first aid which is required after a person has been shot, as follows:

> "*The primary concern in such care is the priority that needs to sort of be seen as a different change from your standard first aid response, where we're all trained in first aid to respond to the specific dangers in response and then switch to airway and breathing, but when somebody's clearly bleeding and bleeding a great deal, then any [indistinct] of support that you're providing to other aspects of their systems needs to be reprioritised. That re-priority means, effectively, trying to stop or control the bleeding before moving to other elements of resuscitation. And this wasn't the statement within the first aid management at the time of any of these shootings.*[43]

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[38] Recommendations phase transcript of proceedings, day 3, page 13 from line 23.
[39] Recommendations phase transcript of proceedings, day 3, page 13 from line 40.
[40] Recommendations phase transcript of proceedings, day 3, page 14 from line 15.
[41] Recommendations phase transcript of proceedings, day 3, page 14 from line 23.
[42] Recommendations phase transcript of proceedings, day 3, page 16 from line 44.
[43] Recommendations phase transcript of proceedings, day 5, page 38 from line 24.

57. Dr Griffin's evidence was that the Australian Resuscitation Council published guidelines in January 2016, for the first time, to suggest that bleeding management and control could be incorporated as a primary response rather than waiting for airway and breathing and other elements to be instigated.[44] A copy of the guideline, *Principles for the Control of Bleeding*, was tendered at the inquest.[45]

58. Dr Griffin also gave evidence that Israeli bandages and tourniquets are inexpensive items. He explained that there would need to be training in their use, but this would not be complicated nor time consuming. Dr Griffin said that the QPS should adopt the Australian Resuscitation Guideline with respect to the management of external bleeding.[46] While Assistant Commissioner O'Regan informed the inquest that the concept is currently "*under active consideration*" but requires further consideration by the QPS, [47] I have been subsequently advised that revised training is being implemented as part of annual Operational Skills and Tactics (OST) training.

Reporting use of force

59. The reporting of the various uses of force applied by police each day was raised during the inquest by Professor Alpert, with reference to Chapter 14 of the OPM, as follows:

> "*The Section on Use of Force Reporting may want to be more inclusive than exclusive. In other words, it may be appropriate to report all uses of force into one searchable database. Again, this recommendation is included in the review of Violent Encounters, but merits comments here as well. In the United States, the most common reporting criteria for a use of force event is any level of force beyond a come-along hold, an injury, or a subject complaint about an injury. The benefits of having one searchable database will assist trainers and policy makers to understand the nature and extent of force used, by whom, under what conditions and the actions of the subject on whom the force was used. Without the benefit of such a system, the data on police use of force is fragmented and difficult to examine. A drop-down form with a narrative could be created that could be used for all uses of force and significant event messages. In any case, the narrative of the incident must include a description rather than conclusions and should avoid boilerplate and policy language.*"[48]

60. Professor Alpert's evidence was that any use of force over and above what he described as a "*come-along hold*" should be recorded in some way.[49] He explained further why the recording of these types of force is important, as follows:

[44] Recommendations phase transcript of proceedings, day 5, page 38 from line 42.
[45] Exhibit R16.1.
[46] Recommendations phase transcript of proceedings, day 5, page 39 from line 30.
[47] Recommendations phase transcript of proceedings, day 7, page 44 from line 31.
[48] Exhibit R32, pages 58-59.
[49] Recommendations phase transcript of proceedings, day 4, page 28 from line 39.

"…yeah, if you have a – a dropdown box which explains the level of force and/or type of force that was used and then a narrative to explain the sequence of events that took place, which you do in the sig event reports, then you can have that as a searchable database, so you'll know how much – how often force was used – is it used more in the midnight shift, is it used more in one district or another and – and you can start finding out, using evidence to – to create deployment issues, for training, for all sorts of different concerns, including looking at complaints and looking at public service."

61. Senior Sergeant Hayden was asked about the practicalities of reporting all uses of force during his evidence.[50] He explained that recording the use of force options at the higher end of the scale currently occurs through QPRIME. He indicated that recording the lower level uses of force could be difficult and explained that there might be issues operationally if a police officer had to list and record every interaction or every use of force option.[51]

62. Assistant Commissioner O'Regan gave evidence about the cost implications of such a recording system including the drop-down menu described by Professor Alpert. Assistant Commissioner O'Regan explained that QPRIME would be the system utilised for such recording, and to build a drop-down menu that would be simple and easy for officers to use would "*probably cost a couple of hundred thousand dollars…to implement*."[52]

Operational Procedures Manual Chapter 14

63. Professor Alpert also gave evidence with respect to the fallacy of the 'shoot to wound' theory, describing it as a "*Hollywood invention*".[53] I endorse those comments and accept that due to the nature and immediacy of an imminent lethal threat, it is essential that the police response is to incapacitate the threat. To achieve this police officers will shoot at the "armpit hold" – the centre of an imaginary transverse cross-sectional line between the two armpits of the human body (roughly centred on the heart/aorta and lungs).

64. As noted by the former State Coroner in the March 2008 findings into Police Shootings, "*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*".

65. In his evidence, Professor Alpert explained how the use of lethal force should be viewed by frontline police:

[50] Recommendations phase transcript of proceedings, day 3, page 40 from line 37.
[51] Recommendations phase transcript of proceedings, day 3, page 40 from line 41.
[52] Recommendations phase transcript of proceedings, day 7, page 36 from line 15.
[53] Recommendations phase transcript of proceedings, day 4, page 22 from line 3.

"*Well, we're – we're starting – maybe because of our US Supreme Court decisions, but we're starting to look at the use of deadly force as not a force option, but as just a whole different category.*

Yeah?---So they're levels of force in your options model, but deadly force is a different one, because it shouldn't be considered unless the – someone is threatening the life of an officer or someone else. So, I think, when you are authorised to use deadly force under your – your laws and your – and your policy, that's what you're doing. You're using deadly force.

And it should absolutely be the last resort?---Yes, sir."[54]

66. With respect to Chapter 14 of the OPM, Professor Alpert stated in his report that the policy for use of a firearm should "*include a mission statement reflecting the sanctity of life and that use of a firearm is a last resort. Training must specify the ways an officer understands "immediate peril" and how she or he can explain it*."[55] Assistant Commissioner O'Regan confirmed during his evidence that such a mission statement has been included in changes to Chapter 14.[56]

67. A copy of the updated Chapter 14 was tendered at the inquest.[57] The Assistant Commissioner also gave evidence as to other changes that had been incorporated into the document, particularly, in respect of communication skills. The Assistant Commissioner's evidence regarding the new document was that it was essentially the consolidation of the recommendation of putting all the use of force philosophy in one location:

> *…"it's the first major revision of our use of force model. So if you look at the use of force model on page 2, that is a significant revision of our existing use of force model in that it centres communication and communication skills as the basis of police interaction with the community and with people, followed with a continual assessment model. So continually thinking about a situation, but using communication as a basis for any interaction with the community. So that's, I guess, embodying the philosophy and thinking change from VCR and Bletchley.*"[58]

68. The Assistant Commissioner's evidence was that the revised Chapter 14 would be in place for the July 2017 training calendar.[59]

69. The evidence during the recommendations phase of this inquest referred to a variety of changes being implemented regarding police use of force policy and training. These reforms arise from the VCR and the Taskforce Bletchley Reports. Both reports were tendered at the inquest.[60] I fully endorse the implementation of the relevant recommendations from those reports.

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[54] Recommendations phase transcript of proceedings, day 4, page 22 from line 31.
[55] Exhibit R32 page 59.
[56] Recommendations phase transcript of proceedings, day 7, page 43 from line 3.
[57] Exhibit R36.21.
[58] Recommendations phase transcript of proceedings, day 7, page 40 from line 25.
[59] Recommendations phase transcript of proceedings, day 7, page 43 from line 26.
[60] Exhibit R2; Exhibit R36.13.

70. I heard evidence about the stages of implementation of those recommendations of most relevance to the issues discussed in this section of the inquest recommendations. Issue 6 referred to below discusses further matters relating to use of force training and how it intersects with mental health training.

71. The submissions received from the QPS noted that coronial recommendations made in relation to these issues would be considered as part of the implementation of the VCR Report.

72. The QPUE submitted that the evidence heard during the inquest as a whole demands improvement in the areas of training in relation to first response tactics, leadership and incident command. The QPUE also submitted that that the evidence of involved officers, experts and OST instructors supported a specific recommendation that officers should be undertaking firearms training at least every six months.

73. I accept that the QPS is required to balance constraints in time and financial resources with the need for frontline officers to maintain skills that are likely to perish without comprehensive and regular training. Use of force training needs to prepare officers sufficiently to enable them to consider, and then apply, lethal and other force in a dynamic and stressful confrontation. Access to a firing range alone will not meet this objective. In my view, the evidence at the inquest supports a further review in relation to how firearms skills can be maintained in the context of regular OST training across the QPS.

74. The submission on behalf of Mrs Zimmer and the Foster family supported the recommendations of Counsel Assisting in relation to improved first aid training, incident command training for all officers, better communication of information to frontline officers, light sources mounted on the weapons and the QPS review of the mandatory reporting of the use of force.

75. The submission on behalf of Mrs Zimmer and the Foster family also expressed concern about the use of the Taser on Laval Zimmer on the afternoon preceding his death following an incident at a local service station. He was subsequently arrested and later released from the watch house in the lead up to his death. The s 45 stage of this inquest did not examine the application of force at the service station. However, it was submitted on behalf of Mrs Zimmer and the Foster family that the OPM should be revised to clarify the circumstances in which Tasers may be used against suspects in order to establish control and take them into custody; and in what circumstances the Taser may be used as a threat to obtain compliance.

76. As the deployment of Tasers was not an issue within the scope of the inquest I have not made any recommendations in relation to that issue. However, I note that the thrust of the VCR Report was on training to reduce the use of higher level options which should address this concern. The VCR Report expressed the following concern:

"…there is a lack of emphasis placed on using and recording of UOF options at the lower end of the force spectrum. It is also evident in OST training, where greater emphasis is placed on higher level UOF options (baton, Taser, firearm), with little or no ongoing training in non-aggressive tactical communication, planning or de-escalation strategies".

Recommendations

77. While I acknowledge the significant work that is ongoing in respect of the recommendations already made by the reviews referred to above, I make the following further specific recommendations, largely consistent with those suggested by Counsel Assisting.

1. *I recommend that the QPS implement a model of incident command training for all operational police below the rank of Sergeant.*

2. *I recommend that the QPS review Operational Skills and Tactics Training to incorporate training on appropriate radio communication and active listening techniques to ensure the effective transfer of information, and to assist frontline officers to recognise critical information.*

3. *I recommend that the QPS revise its policy regarding first aid training for operational police so that it is consistent with the current guideline issued by the Australian Resuscitation Council.*

4. *I recommend that the QPS continue to review its method for reporting the use of force applied by operational police with a view to implementing a system that would provide the QPS with accurate data that can be used to better inform use of force policy, reporting and training.*

5. *I recommend that the QPS conduct a review with respect to how often, and in what manner, firearms skills should be refreshed in order to maintain effective performance under stress, and that as part of that review the QPS consider whether OST firearms training should occur more often than once every calendar year.*

6. *I recommend that the QPS continue to explore ways in which use of force training in low light conditions can be effectively delivered, including through the use of purpose built and dedicated facilities to assist in the delivery and frequency of this training.*

7. *I recommend that OST training continue to incorporate "lessons learned" from previous shootings into scenario based training, including anticipating the presence of weapons on arrival at the*

scene, tactical withdrawal, and managing bystanders during an incident.

Issue 3

3. ***The adequacy of the approach taken by the Ethical Standards Command Internal Investigations Group in conducting the investigation into the deaths, particularly, whether an improved methodology might be adopted which places appropriate weight on and protects the welfare of first response police officers, post-incident, and also preserves the integrity of the evidence of those officers and other evidence at the scene including whether the timing of and means of conducting interviews of first response officers by ESC officers should be varied or subject to greater flexibility***

78. I have already made a finding in each of the deaths investigated by me, confirming the appropriate separation of the officers post-incident and the adequate preservation of the evidence. This issue was deliberately framed to address future investigations. The focus of the evidence during the recommendations phase was on achieving a better methodology for investigations, rather than seeking to criticise the actions of the investigators in these deaths.

79. During the factual phase of the inquest, the following relevant matters were identified for consideration as part of this issue:

- Whether ESC interviews should be conducted as walk through interviews wherever possible;
- The appropriate period between when an incident occurs to when interviews with ESC take place, and the general welfare of the officers involved during that period;
- Whether a post shooting 'buddy' system could be adopted throughout the QPS like that employed by SERT to assist officers who have been engaged in critical incidents; and
- Whether counselling with a psychologist (independent of the QPS) should be mandatory for all police officers involved in a shooting or critical incidents involving a fatality or serious injury.

ESC Interviews

80. Detective Inspector David Hickey was the most senior ESC investigator called to give evidence during of the s 45 phase of the inquest. At the time of giving his evidence, he had been a senior investigating officer in relation to fatal police shootings since 1999. He was the investigating officer with respect to the death of Anthony Young.[61]

81. Detective Inspector Hickey referred to a set of standard operating procedures in place within the ESC which were later produced and tendered

[61] Young, Young and Dekens transcript of proceedings, day 1, page 5 from line 46.

at the hearings in relation to each death. The document entitled, 'Ethical Standards Command, Internal Investigations Group Standing Orders/Standard Operating Procedures', was also tendered during the recommendations phase.[62] It was apparent, from the evidence of a number of the ESC investigators, that they were unaware that these guidelines existed. The passage in relation to the conduct of interviews is extracted from that document as follows:

> **"4.9 MEMBER INTERVIEWS**
>
> 4.9.1 **Initial** *interviews should be undertaken with all officers as soon as practicable after the arrival of IIB investigators. These should be aimed at obtaining the initial versions of events with any immediate ambiguities addressed. Desirably the number of interviews with any officer should be kept to a minimum so it will be a matter for investigators to determine the appropriate time in the investigation that members should be approached for interviews.* ***Consider where practical, the conducting the initial interview with subject officers in the form of video re-enactments at the incident scene. This would enable ease of orientation by investigators of the scene and of the events under investigation. Likewise this may reduce the time required for the preservation and containment of the actual scene.*** *(In the event of fatal shootings the State Coroner may wish to attend and be present for this event.)*"[63]

82. It was apparent, from the evidence of the police officers involved in each of the shootings, that an interview at the scene in the form of a walk through was preferred by those officers to the more traditional approach to interviewing in an office at a police station. This was explained by Senior Constable Adam Tickner with respect to the Logan shooting, as follows:

> *"Okay. Then the next day you attended for the walk-through?---Correct.*
>
> *Okay. Can you explain to his Honour what that experience was like compared to the interview the night before?---It's still an experience that you don't want to go through. But at the same time I found the walk-through was beneficial in the fact that I could recall a lot more because we were at the scene. The car was parked. I could describe where the other cars were. I could describe where Mr Logan was. I could describe where I went from there. So it was a lot more beneficial in that regard, the walk-through, than the initial interview.*
>
> *And if we can compare them both, and if I could remind you of the process that was adopted in the interview about the diagram that you were asked to draw?---In the – in the record of interview, after the incident, that night, I was trying to explain to the officers some locations and so forth. So I – I had to get paper out and draw, you know, this is*

[62] Exhibit R1.
[63] Exhibit R1, page 50.

our car here and we went in in an around about way trying to describe to them distances and everything else, which I thought was quite ridiculous because I couldn't recall – and I'm not good at distances anyway. So I was trying to draw them on a map and I don't think it worked overly well."[64]

83. Detective Inspector Hickey's evidence was that he encourages his colleagues to adopt the approach of a walk-through interview wherever possible. He explained that the walk through affords the officer and the investigator the best opportunity to obtain the most accurate version of what transpired.[65] However, a walk-through interview may not always be an option for the first interview of officers. Detective Inspector Hickey explained that sometimes the scene will still be undergoing forensic analysis and that can mean access to it for the purposes of an interview can be delayed.[66]

84. In terms of the current policy surrounding the conduct of member interviews, Detective Inspector Hickey accepted in his evidence that the best way to conduct them is by a walk through at the scene. In terms of prescribing that practice in policy, he explained that this is difficult, given the variables that can occur with the scene. His explanation as provided in his evidence, is extracted as follows:

> "*Okay. And the practice of doing the interview in the interview room, then getting officers back to do a – then walkthrough – so you go through that whole process that you've described and then do a walkthrough in the days after that. Do you have any comment about that practice?---I have done that myself on occasion, but I found it quite laborious, quite repetitive, and – and – so to some degree, I – I would say that I, personally, have more evolved to going straight to a walkthrough where possible, but there are instances where my colleagues have done the interviewing first. Then they say can we try and line up the scene for 4 o'clock tomorrow to do a video re-enactment? As you would appreciate, sometimes these scenes – and I know we shouldn't be governed by restrictions, but sometimes these scenes are in the middle of a road, you know. I just can't close a road down for three days or something, so it – it requires – and – then at other times, it might be just lighting prohibited, that we're now in the dark and we can't really – you know, it happened at dusk. Well, it's not going to be a very good re-enactment when the lighting conditions are totally different. I might say, well, all right. Let's come back tomorrow, you know. I'd like to get a version from you now.*"[67]

85. I acknowledge the quantity and persuasive nature of evidence heard at this inquest about the advantages of walk through interviews as a means of gathering officer recollections over the more traditional type of interview in a closed room away from where the events took place.

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[64] Logan transcript of proceedings, day 2, page 27 from line 25.
[65] Young, Young and Dekens transcript of proceedings, day 1, page 49 from line 22.
[66] Young, Young and Dekens transcript of proceedings, day 1, page 49 from line 29.
[67] Young, Young and Dekens transcript of proceedings, day 1, page 51 from line 1.

General welfare of officers after a critical incident

86. The evidence provided by the police officers involved in shootings during the s 45 phase of the inquest varied in relation to this issue. When asked about his experience in relation to waiting for his ESC interview, Senior Constable Nickolas Coleman in the Foster hearing gave the following evidence:

> *"How did you cope with that period waiting?---Just played on my phone, I guess. I – I can't really recall. We had – the other two – had a few conversations with them, and messaging my wife. There wasn't really a – a lot to do. We sat there for a long period of time – had something to eat. Just, kind of, waiting and trying to deal with your own emotions and stress as best as you could.*
>
> *…*
>
> *Yeah. Okay. And particularly for the benefit of any recommendations that his Honour would make in that regard, how did you cope, and is there anything you can think of that would have helped you to cope – there's really two aspects of it, I suppose. The fact that you have been in a very traumatic situation, but then, secondly, that you've got nothing to do. You have to wait - - -?---Yeah.*
>
> *- - - until you're interview is conducted. Is there any other ways in which that could have been improved?---I'm not sure how they could improve the process, but it was a 14-hour day. I was interviewed at 3 in the morning after probably the worst experience of my life. So it was – it felt like I was being interrogated like a criminal.*
>
> *Yes?---Cross-examined for an hour and a-half. I had nothing left. It was – eyes felt like they were just falling out of my head. I was shaking – withdrawn and isolated from my partner for the whole period. I was worried about her. So the experience of how were treated – it's horrible. It's worse than how our worst criminals are treated.*
>
> *Yeah?---And the – the process is disgusting, as far as I'm concerned. I don't know how they would improve upon it, but at least shortening the length of time that we have to wait would be one course."*[68]

87. The evidence of Senior Constable Coleman was distinctly different to evidence provided by Constable Jamieson Wood during the hearing in relation to Mr Logan's death, which was as follows:

> *"And also a matter of concern is the welfare of the officers, because there are delays in obtaining your interviews. From your experience, do you have any suggestions that you would like to make with regard to that?---I found the walkthrough the next day to be probably more beneficial than the interview that night.*

[68] Foster transcript of proceedings, day 3, page 7 from line 5.

Yes?---Being put back in the scene.

Yes?---But as in regards to the timing of the interview, it didn't really have any effect on me.

Okay. What about that period while you're waiting – that nine hour period? Would you have liked to have spent more time with a human services officer? Would you – is there anything else that people could have done to make it easier for you?---No. I would have liked to have done the interview sooner."[69]

88. The concept that officers be given an opportunity for an initial 'information dump' at the scene was brought up at various stages throughout the inquest hearings. While there were differing views about when the main interview might have occurred, all were consistent that officers wanted to give a version of events very soon after the incident. It was explained by Senior Constable Tickner in the Logan inquest, as follows:

> *"Okay. And this is just a suggestion, I just would like you to comment on it: if – and there are welfare officers and sometimes they are able to be called in, but if somebody was able to talk to you just about how you felt without going into the facts of what had happened or anything like that, would that have been of assistance to you?---Oh, of course. I think it would have been. Yes.*
>
> *Yeah?---It's very hard not to talk – to talk to someone without talking about - - -*
>
> *Yes. Yes?--- - - - what's happened though.*
>
> *Yes?---That's the – and we were given directions not to talk to anyone about it.*
>
> *Yeah?---And that was the hardest thing of the lot.*
>
> *Yeah?---I mean, the first thing you wanted to do was talk about it."*[70]

89. Professor Alpert was asked during his evidence to comment on the concept of an 'information dump' and how that might work in practical terms. The concept was put to him as a proposition that, as soon as possible after a critical incident and after the officer has had a chance to speak with a union or legal representative, the officer is required to provide a short, uninterrupted version of the events which is recorded. After this version is received, the officer can go home and given a suitable direction to the effect that they are not to discuss the events. A time for the full interview is then set, considering the needs of the officer and the investigator.[71] Professor Alpert's comments with respect to this were to the effect that the preferable process will differ from case to case. His evidence was as follows:

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[69] Logan transcript of proceedings, day 2, page 38 from line 45.
[70] Logan transcript of proceedings, day 2, page 20 from line 19.
[71] Recommendations phase transcript of proceedings, day 4, page 37 from line 27.

"Well, I think, based on what we know and what we don't know, there may be situations, if – if an event occurs at the end of the shift, well, that may be totally appropriate because fatigue is critical.

Yes?---But, if it happens in – in the beginning of – of a shift, it may be appropriate to get more from the officer early on, and I think it depends on – on the situation. I think it depends on – on the – I guess my point is, unless there's a reason not to talk to the officer, and I can – one of the reasons we did that little study, as the head of the union from Miami was – was – told me that they – they – internal affairs tried to interview an officer whose partner had been shot. I mean it just doesn't make sense. That – that – this is – you know, it's just horrible to think of something like that. So, unless there's a reason not to interview the officer and get a lot of information, it's probably a good thing to do at this point. If there is a reason, such as, you know, a concern, obvious stress, obvious fatigue, injury, then – then, yes. Then you put it off until – until that's corrected."[72]

90. Professor Alpert's evidence was that the geographical size of Queensland means that delays in investigators arriving at incident scenes are inevitable, particularly, in remote centres. [73] This is another relevant factor that must be considered when developing any policies in this respect.

91. The use of body worn cameras in each of the shootings also raised the question as to the most appropriate time the footage is to be viewed by the involved officer. Professor Alpert was asked to comment on a proposition relating to a process with a number of elements to it, which could be followed by investigators after a critical incident occurs. The proposition was put in the following way:

"*Yes. Okay. And, again, this is sort of addressing that issue of we don't know what is best for memory but we have some indications, but the suggestion is we have that first initial on-camera short interview, that when – and this is really dealing with this question of walk-through or not and what's best – that, when the main interview comes to be held, the suggestion I want you to comment on is, and I'll give you the three elements of it: investigator conducts the full interview as they see fit on the basis of some investigators may feel best in a desk interview, others may feel best in a walk-through; that there be a follow-up walk-through if not the means of the first long interview. There seems to be a lot of evidence saying walk-throughs do help.*

The third element is that, after that first phase of the long interview is dealt with, that there be an opportunity to see all available videos. And then, fourthly, that the officer have an opportunity to provide a further statement or a further aspect of the statement in light of seeing the available video. Now, are there any problems with that? Are there any

[72] Recommendations phase transcript of proceedings, day 4, page 37 from line 43.
[73] Recommendations phase transcript of proceedings, day 4, page 38 from line 23.

issues with regard to that? Is that one way of tackling it? Is it a bad way of tackling it?"[74]

92. Professor Alpert gave evidence in response to the proposition that one of the most important factors was that an officer be given an opportunity for an initial recount of what occurred, unaided by video footage. Following this, the officer should be given further opportunities to provide addendum accounts, whether that be due to watching footage, or due to the natural process of memory returning over time.[75] It is likely that an account given after viewing camera footage will improve the officer's recall of what is depicted on the camera. At the same time, it may interfere with memory of what is not captured and of the officer's individual interpretation of the events.

93. Evidence was provided to the inquest by Senior Sergeant Hayden, Professor Alpert and Assistant Commissioner O'Regan regarding a current study being undertaken on the issue of police officer memory recall.[76] The issue was raised in terms of when an officer's memory is its best for a formal interview. It was confirmed by Professor Alpert that there was currently a lack of empirical studies with which to guide current practice.[77]

94. Evidence was heard that the current study was being conducted by the QPS, in conjunction with Griffith University, in which Professor Alpert was also involved. His evidence was that the study was aimed at collecting data with which to establish when the best time is to interview an officer after an incident. Senior Sergeant Hayden also gave detailed evidence as to how the study was being conducted and what questions were being explored.[78] The study was looking specifically at cognitive function and memory and was expected to provide the ability to collate how the two are related, if at all.[79] Preliminary results of the study were expected to be available towards the end of 2016.[80]

95. The results of this study are likely to be of assistance in informing police policy and practice in terms of when to interview an officer after involvement in a critical incident. Earlier studies (including by Professor Alpert) have suggested that officers are most accurate when recalling an event immediately, as opposed to when there is a delay before reporting, and that early testing of recall provides more accurate longer term memories. This diminishes support for the claim that giving officers time to de-stress will lead to a more accurate account than an immediate interview.[81]

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[74] Recommendations phase transcript of proceedings, day 4, page 39 from line 43.
[75] Recommendations phase transcript of proceedings, day 4, page 40 from line 6.
[76] Exhibit R47.
[77] Recommendations phase transcript of proceedings, day 4, page 36 from line 31; page 76 from line 17.
[78] Recommendations phase transcript of proceedings, day 3, page 48 from line 43.
[79] Recommendations phase transcript of proceedings, day 3, page 50 from line 42.
[80] Recommendations phase transcript of proceedings, day 4, page 35 from line 4.
[81] Grady, R et al, *What should happen after an officer involved shooting? Memory Concerns in Police Reporting Procedures*, Journal of Applied Research in Memory and Cognition 5 (2016) 246-251

96. Professor Alpert also gave evidence about a longitudinal life course study being conducted with Griffith University which was in its third year of data collection.[82] Professor Alpert explained that it was a life course study of police officers which started when a group of approximately 500 police officers were first starting at the academy. The questions asked at that stage related to their attitudes, beliefs, background and why they became police officers. The officers were interviewed again after they had finished at the academy and asked many of the same questions but also asked about training they had completed.[83] The results of this study will also be important in informing police policy and practice.

97. The inquest heard a large quantity of evidence relating to the waiting period between when a critical incident involving a shooting finishes and the officers are separated to when the officer is interviewed by the ESC. The evidence suggested that, during that period after each of the shootings, other than in the case of Mr Kumeroa, there was little or no process in place to provide support to the officers other than providing for attendance by representatives from the union and, through the union, attendance of legal representatives. The situation was described by A/Sergeant Bradley Grieve during the Zimmer s 45 hearing, as follows:

> *"Okay. Now, during that period when you were separated by space and standing on the opposite side of the road, did you have any support, any emotional support or anything at that stage?---No,*
> *Okay. And how were you transported to the police station?---I drove the car that I'd driven there back to the station.*
>
> *Yes. By yourself?---Yes.*
>
> *Okay. And who took responsibility for the group of you or at least you specifically when you arrived back at the station? What happened then?---I don't remember exactly. I remember – I think Mr Leavers was there and I think he was probably responsible for most of that when we got back to the station.*
>
> *Okay. And so at least you had available to you the support of the union representative - - -?---Yes.*
>
> *- - - when you were back at the station?---Yes*."[84]

98. During the Kumeroa inquest hearing it became evident that SERT had a system in place following a critical incident, akin to a 'buddy system'. Each SERT officer who was involved in the shooting of Mr Kumeroa, subsequently, had another, uninvolved SERT officer at the scene with them during the period when they were awaiting their interview with ESC. The

[82] Recommendations phase transcript of proceedings, day 4, page 29 from line 29.
[83] Recommendations phase transcript of proceedings, day 4, page 30 from line 6.
[84] Zimmer transcript of proceedings, day 3, page 36 from line 17.

additional SERT officer acted as their buddy and provided them with support without talking about what had happened in the incident. Inspector Bradley Wright explained in his evidence that the objective of the process was to provide the officer with "*the moral support of being there, encourage the officer to go to a quiet place, start writing out their notes and recording what occurred*."[85] A copy of the document which provides for the process to be followed, a policy document specific to SERT, was tendered at the recommendations phase.[86]

99. The effectiveness of the SERT buddy system was explained in detail by SERT officer 113 during his evidence to the s 45 phase, as follows:

> *"Obviously in a – in a critical incident like this, for the – to avoid contamination of evidence, for a better word, we're not supposed to talk about the situation, and – and everyone accepts that. So my support person, I was taken probably 15 metres away to an adjacent car port where I sat down in the shade. He's given me – given me a heap of– heap of drink. I think I drank about six water bottles in a row as I'd been sitting in a hot position for a good three and a half hours, so I was dehydrated and thirsty, so – yeah, so he gave me a heap of water. I didn't – I wasn't in possession of my notebook at the time so he provided me with his notebook to – so I could start writing some initial notes down. Yeah, and just basically just – just a support – support person, just – just to know that somebody's there. We – yeah, we work in a – in tightknit groups in our unit and it's just – there is nothing special that he needed to do apart from just be there, and anything that I needed or wanted he would just get for me.*"[87]

100. Professor Alpert's evidence was that peer support after these types of critical events is a very important consideration.[88] In terms of the practicality of the QPS rolling out a buddy process, like that of SERT on a State-wide basis, Assistant Commissioner O'Regan's evidence was that the process works well for SERT because of its unique structure and rostering of officers into designated teams. This structure is not replicated across the State for general duties police officers.[89] For these reasons, I have not recommended that a standardised policy, akin to that in place for SERT, be rolled out for all general duties police across the State.

101. The question of mandatory psychological counselling for all police officers involved in critical events such as these shootings also arose during the inquest. I note that, since the evidence at the inquest concluded, the Queensland Industrial Relations Commission has certified an agreement between the QPS and the QPUE, specifically clause 55, relating to critical incident leave for police officers, as follows:

> **"*55 Critical Incident Leave – Police Officers***

[85] Kumeroa transcript of proceedings, day 3, page 20 line 4.
[86] Exhibit R29.
[87] Kumeroa transcript of proceedings, day 3, page 80 from line 43.
[88] Recommendations phase transcript of proceedings, day 4, page 40 from line 19.
[89] Recommendations phase transcript of proceedings, day 7, page 23 from line 6.

(1) As from date of certification of this Agreement, a police officer will be entitled to a maximum of 3 days paid "Critical Incident Leave" when the officer has been involved in a critical incident.

(2) A "critical incident" will be defined in accordance with section 5A.2 (as amended) of the Police Service Administration Act 1990.

(3) Critical Incident Leave will be in addition to any other paid leave the officer is entitled to and will be granted by the Commissioner subject to operational requirements."

102. The clause is silent as to whether this critical incident leave will be mandatory. Differing views were expressed by police who gave evidence on whether police officers should be mandated to take this leave following a critical incident involving a shooting. It was apparent that some officers wished to return to work straight away, while others appreciated, and indeed required, some time off. It was also apparent that when an officer returned to work tended to be something worked out, on a case by case basis, between the officer and their direct supervisor.

103. The situation was similar when it came to the idea of mandatory psychological counselling. The issues relating to counselling were discussed by Senior Constable Lyle Slingsby, during the Foster inquest hearing, as follows:

"Would you be supportive of mandatory counselling?---Yeah. I think some sort of counselling, whether it be to help the officer or as in QPS cover the services, agendas or [indistinct] and such.

Would you accept that in regards to HSO's, there is some trust issues between police and HSO's because they're employed by the Commissioner - - -?---Very - - -

- - - and there's no confidentiality?---Very much so.

So if there was to be mandatory counselling it would need to be with an independent counsellor?---Yes, I believe so."[90]

104. Evidence was also heard from psychologist, Dr Bill Lewinski, the Director of the Force Science Institute. A report under his hand was tendered at the inquest.[91] When questioned about the idea of mandatory counselling for police officers following critical incidents, he gave evidence of a model in the United States where the officers concerned are required to attend one session with a psychologist but where, thereafter, any further sessions are voluntary. His evidence is extracted as follows:

"And, I guess, on the topic, sir, should that counselling be voluntary at the police officer subject to the critical incident, or should it be

[90] Foster transcript of proceedings, day 4, page 32 from line 33.
[91] Exhibit R46.

mandatory to the police officer?---The only thing that – we recommend it – I – I [indistinct] after, kind of, being on the periphery of the profession for over a quarter century is – is that the first meeting is mandatory, and it's mandatory primarily because in the profession, almost nobody will go voluntarily. At least that's what has been – has been discovered. And so it's – it's mandatory. But then after that, it's voluntary, unless the department finds that the officer, for some reason, is not able to function, and – and then the department may order a fitness for duty evaluation, and that may include mandated therapy – that the therapist needs to release the officer for a return to duty before the officer is able to get back onto duty and work on the streets."[92]

105. Evidence was also heard from Assistant Commissioner O'Regan concerning the current support network provided by the QPS to its officers and the role of the Human Support Officers (HSO).[93] The evidence confirmed that, following a critical incident involving a fatal shooting, an officer is contacted by a HSO, either by an email and/or a phone call. Whether the officer accepts the offer of assistance from the HSO is left to the individual officer. The assistance includes the option of sessions with a psychologist. Evidence was also heard about the availability of a police chaplain. Not all officers involved in the shootings accepted these services. Some officers preferred the support provided by loved ones and close work colleagues.

106. In his evidence regarding the usual position in respect of mandatory counselling for police in the United States,[94] Professor Alpert explained that officers in the United States do not return to work after a critical incident until they have been cleared by a mental health clinician:

> "*I don't know any police department, for an officer who's been involved in a shooting, who isn't required to get psychological assistance. It's not a question. It's not should I. It's – it's when. And – and they're – they're different models of payment so the department doesn't know if it goes on, but – but it's not – you don't return to work because you want to, because everyone – a lot of people will. You return to work when you are given a pass by that mental health person.*
>
> *Yes?---So – so that's not – that's really not an issue in the States any more. It's mandatory. Some departments limit it to six visits. Now some are moving to 12. I mean it's – it's helping the officer as much as they can because it's a mental health concern.*"[95]

107. Assistant Commissioner O'Regan also gave evidence about a current working group which is in place to specifically look at officer welfare.[96] He

[92] Recommendations phase transcript of proceedings, day 2, page 90 from line 15.
[93] Recommendations phase transcript of proceedings, day 7, page 24 from line 7.
[94] Recommendations phase transcript of proceedings, day 4, page 40 from line 32.
[95] Recommendations phase transcript of proceedings, day 4, page 40 from line 40.
[96] Recommendations phase transcript of proceedings, day 7, page 25 from line 40.

explained that the aim of the working group is to "*destigmatise the whole idea of mental illness and the need for assistance across the service*."[97]

108. The evidence at the inquest supports the need to retain a flexible approach to the way in which ESC critical incident investigations are conducted. It is clear that a 'one size fits all' investigative approach is inappropriate, as each case is different, not only in its factual circumstances, but also with respect to geographical location and the circumstances and/or needs of the individual officers involved.

109. Counsel Assisting submitted that I should recommend a range of relevant matters for inclusion in the ESC standing orders to be considered by investigators, and that the ESC should raise awareness with respect to the standing orders, given the evidence from ESC officers that they were not aware that formal guidelines existed.

110. Counsel Assisting also submitted that investigating ESC officers should supported by a separate senior officer. They noted that due to the serious nature of the role, there is a strong potential for the involved officers not to be the central focus of the ESC officer with primary responsibility for the investigation. The suggested position would not be a welfare position, but would take responsibility for ensuring that all matters concerning the affected officers in the investigation are considered and addressed.

111. The QPS submission indicated that it would consider these recommendations as part of the implementation of the VCR recommendations.

112. The QPUE submission indicated broad support for the recommendations suggested by Counsel Assisting, noting that the review of standing orders should be conducted in partnership with the Union. The QPUE also expressed support for mandatory counselling by a psychiatrist rather than a psychologist on the basis that it remain external to the QPS.

113. Submissions on behalf of Mrs Zimmer and the Foster Family argued that counselling should also be offered "by way of an assertive outreach to non-QPS personnel" where those persons were present and/or were witness to a fatal police shooting; or are recorded as the next-of-kin or are persons who identify as a close relative or friend of a person the subject of a fatal police shooting.

114. I agree that the families of those who are shot by police need to be appropriately supported. In several of the deaths considered in this inquest family members had called for police assistance in the lead up to the death, and were present when the shooting took place.

[97] Recommendations phase transcript of proceedings, day 7, page 25 from line 43.

Recommendations

8. *I recommend that the QPS conduct a review of the standing orders governing the conduct of ESC investigations of critical incidents involving a fatality. The review should include the following matters for the consideration of investigators*:

    a. *Where it is desirable to defer an interview with the ESC investigator (including for the welfare of involved officers), or impractical for that interview to occur close to the time of the incident, an initial account of events should be taken in a short interview recorded by a suitably independent, but readily available, investigator. The officer conducting this initial interview should be someone whose involvement is approved by the person directing the ESC investigation, but need not be that officer or an ESC officer;*
    b. *A restatement of the advantages of walk-through interviews as the primary means of obtaining the account of involved police officers, while leaving the means of the primary interview to the discretion of the investigator;*
    c. *Provision for officers to be given the opportunity to view relevant video or other recordings, including body worn camera footage, of an incident at a time considered appropriate by the investigator but not before the primary interview; and an opportunity for officers to provide addendum statements or take part in addendum interviews where either officers or investigators consider that desirable;*
    d. *All forensic testing of involved officers should be conducted within two hours of the incident occurring; and*
    e. *A separate senior ESC officer should be given oversight of actions concerning involved officers, including officer separation; initial interviews; forensic testing; issuing instructions; sending officers home if appropriate; transporting and accommodating officers; providing a change of clothes etc.*

9. *I recommend that the QPS consider adopting service-wide an approach analogous to the system employed by SERT for post incident support of officers, subject to appropriate adaptations having regard to local circumstances and officers being trained as to the limits of their role.*

10. *I recommend that officers involved in a critical incident involving a fatality be mandated to attend at least one session with a psychologist or psychiatrist independent of the QPS and that this issue be the subject of a separate review by the QPS. The review should consider:*

    - *the most effective ways of supporting police officers after a critical incident involving a fatality in the medium to long term;*

- *the training of officers in supervisory positions to ensure that they can appropriately monitor officers under their supervision who have been involved in critical incidents involving a fatality; including an awareness of warning signs that an officer is experiencing difficulties; and of steps that can be taken to ensure that such officers receive timely support;*
- *how appropriate support mechanisms can be established and how the adequacy of existing mechanisms is monitored.*

11. I recommend that the Queensland Government develop appropriate referral pathways, through an agency such as Victim Assist Queensland, to enable the families of those shot by police and witnesses to such events to be provided with counselling and support.

115. I acknowledge that police officers may suffer trauma in ways other than shooting incidents, for example, a serious assault on an officer by an offender. Accordingly, the reviews referred to above may have application beyond the types of incidents which have been the subject of this inquest.

Issue 4

4. The adequacy and appropriateness of the current training of police officers with respect to the imposition of handcuffs after the use of lethal force

116. This issue, while stated broadly, arose from the circumstances of the death of Laval Zimmer. Evidence was given on the issue during the recommendations phase by Senior Sergeant Hayden and Professor Alpert.

117. The context for the examination of this issue appears in relevant portions of my s 45 findings into Mr Zimmer's death:

> *106. Officers Lubbock and Grieve both discharged their firearms. Three shots were fired – two from Grieve and one from Lubbock. Two of those shots hit Mr Zimmer in the upper torso – one to the right and one to the left. At that time, however, neither officer was aware where Mr Zimmer had been struck.*
>
> *107. Mr Zimmer fell to the ground. He continued to have the knife in his hand and was making some attempt to crawl forward. Constable Davey was covering Mr Zimmer with his firearm, as was Constable Lubbock. Mr Zimmer ended up releasing his grip on the knife and Sergeant Grieve kicked it out of the way. From the subsequent scenes of crime photos, I am satisfied that the knife ended up in the bathroom.*
>
> *108. Constable Davey proceeded to handcuff Mr Zimmer, and was assisted by Constable Ryan. Mr Zimmer strongly resisted this process and the video shows that it was achieved only with difficulty. In their evidence, all officers accepted that Mr Zimmer's level of resistance to*

handcuffing could have been consistent with his reaction to having been shot.

109. The officers gave consistent evidence that handcuffing is the default course of action in all the use of force training, including in the aftermath of a person of interest having been the subject of lethal force.

110. Counsel Assisting has submitted that the recommendations phase of this inquest should consider whether the training with regard to the imposition of handcuffs after the use of lethal force should be modified in some way. I note that in each of the other inquests conducted in this series, police officers involved reached the conclusion that full handcuffing was not required.

111. The footage depicting the handcuffing was confronting. It appears to have delayed the administration of first aid and exposed officers to blood contamination. However, I accept that the officers acted in accord with their training in the application of handcuffs. I consider that whether a better or different course was available should be examined at the recommendations phase of this inquest.[98]

118. Senior Sergeant Hayden gave evidence about the current training provided to police officers with respect to the application of handcuffs.[99] He explained that OSTTU promotes, as good practice that police move forward to establish control of a situation where a person has been the subject of lethal force, or a lethal force deployment. Police are trained to obtain this control by the application of handcuffs on the person. Police are trained so that they understand the application handcuffs to be a temporary form of restraint, which can be removed after control of the situation has been achieved.[100]

119. During his evidence, Senior Sergeant Hayden explained that the hands are the primary means by which assaults can occur. By restraining a person's arms behind their back, they are unable, for example, to fire a weapon, stab someone, or, otherwise, use their hands to assault someone.[101]

120. Senior Sergeant Hayden gave evidence of his concerns about the dangerous situations that could arise if police, as a matter of course, were to stand back in a situation where lethal force had been deployed. During his evidence, he applied his concerns to the circumstances of Mr Zimmer's death and explained those concerns as follows:

> *"I have concerns if we stand back; that we have an obligation to provide the necessaries of life; a person is injured as a result of a police operation, that we need to make all and every effort to render*

[98] Findings of inquest into the death of Laval Donovan Zimmer, page 15, paragraphs 106-112.
[99] Recommendations phase transcript of proceedings, day 3, page 23 from line 35.
[100] Recommendations phase transcript of proceedings, day 3, page 24 from line 21.
[101] Recommendations phase transcript of proceedings, day 3, page 25 from line 12.

assistance to that member of the community. By moving forward and handcuffing Mr Zimmer and taking him into custody – and it was a very, very confronting dynamic and a very, very emotionally charged situation, but it allowed the police to transition into a role where they were taking him into custody and they could make efforts to move on to his care."[102]

121. Senior Sergeant Hayden also provided some further context for the practice that police officers are trained to apply handcuffs after the use of lethal force, by way of explaining various risks that will be unknown to the police officers involved in the action. He gave examples that a person may have a concealed weapon/s on their body, and despite their injuries, could use such weapons if they have the use of their hands.

122. While the application of handcuffs is promoted as best practice, Senior Sergeant Hayden also referred to the shootings where handcuffs were not applied, and the circumstance that those police officers made their own assessment that the person no longer constituted a threat.[103] I agree that this is an assessment that only those police officers can make, having regard to the circumstances presenting to them at the time.

123. Professor Alpert also gave evidence on this issue during the recommendations phase.[104] He was asked whether there should be a clear rule on whether police officers should apply handcuffs, or not, after lethal force has been used. Professor Alpert's evidence was to the effect that, in the United States, police officers would always apply handcuffs, for their own safety, to persons who had been shot.[105] Professor Alpert also touched on the danger of the unknown threat as described by Senior Sergeant Hayden.

124. While the video footage depicting Mr Zimmer's handcuffing was confronting, the evidence of Senior Sergeant Hayden was compelling in explaining the basis for why the training provided to police officers is to apply handcuffs even after lethal force has been applied. This evidence was supported by Professor Alpert, drawing on his knowledge from United States jurisdictions.

125. Counsel Assisting submitted that I consider not making any recommendations for change of police policies, training or practice with regard to this issue. After considering the responses received from those represented at the inquest regarding that submission, I consider it unnecessary to make any recommendations about the current training of police officers with respect to the imposition of handcuffs after the use of lethal force.

[102] Recommendations phase transcript of proceedings, day 3, page 24 from line 47.
[103] Recommendations phase transcript of proceedings, day 3, page 25 from line 16.
[104] Recommendations phase transcript of proceedings, day 4, page 15 from line 24.
[105] Recommendations phase transcript of proceedings, day 4, page 16 from line 24.

Issue 5

The adequacy of the current processes for dissemination of information, and updates of information, for attending crews to an incident including possible implementation of the Q-Lite program.

126. This issue arose to varying extents in each of the shootings examined at this inquest. Evidence was given on the issue during the recommendations phase by A/Superintendent David Nevin, in addition to a written statement tendered by Superintendent Glenn Horton.[106]

127. To set the context for this issue being examined during this phase, Counsel Assisting referred to relevant portions of my s 45 findings into Mr Foster's death, as a pertinent example of the way in which the issue arises in practice, as follows:

> *70. "At 6:55pm, Ms Ryan dialled 000 from her mobile phone and left the phone open but hidden on the couch. The 000 call was essentially an 'open line' call. Ms Ryan gave evidence that she did not want her son to know she had called 000.*
>
> *71. On the tape recording of the 000 call[107], Ms Ryan is heard to repeat her address a number of times and she mentions that Mr Foster has a knife, has smashed the house up and assaulted her. Mr Foster can be heard repeatedly asking for the car keys, and Ms Ryan can be heard refusing them.*
>
> *72. Sergeant Patricia Hosking, an experienced call taker and Communications Coordinator (COMCO), took the call at the Brisbane Police Communications Centre. She was working as a call taker that evening. Sergeant Hosking checked the address and saw the domestic violence history from 15 November 2014 (DFVPO issued) and was able to infer the identities of both the caller and the male at the address.*
>
> *73. The COMCO covering the Gold Coast area on 24 November 2014, Sergeant Jane Beare, gave evidence at the inquest. Her evidence surrounded the information that was relayed to her by Sergeant Hosking, as well as the direct phone calls being made by Sergeant Hosking to Gold Coast Police Communications to ensure the information was being received.*
>
> *74. At 6:58pm, the job was tasked as a Code 2 priority to a general duties crew, Constables Trent King and Claire Bibby. Both officers gave evidence at the inquest. They were at the Southport station when the call came over the radio. The radio operator on shift was Senior Constable Craig Rudd.*
>
> *75. Senior Constable Nickolas Coleman and his partner, Constable Sarah Davey, were also at the station at the time the call came through. They offered to provide back up to the other officers. Both cars proceeded to*

[106] Exhibit R30.
[107] *Exhibit E28.5*

the address. Sergeant Hosking continued to update the job card with details she was receiving from Rhonda Ryan's 000 call.

76. *The audio of the initial job call was replayed to Officers King, Bibby and Coleman during their evidence.*[108] *It is apparent that the full extent of the information available from that call was not absorbed or heard by those officers.*

77. *The evidence from Sergeant Beare was telling in this regard. She reported that she constantly receives calls from general duties crews asking for significant information, such as the job address, after it had been relayed over the radio many times. I agree with Counsel Assisting that this raises an issue as to how best to disseminate significant information to general duties crews.*

78. *Constable Davey was wearing a body worn camera, which captures the approach to the residence, the meeting at the nearby child care centre, and the immediate aftermath of the shooting. While this was helpful in many respects the experience from earlier inquests suggests that the same technology worn by the officers who discharged their guns would have been of much greater assistance in resolving conflicts of evidence. The parts of Ms Davey's video up until shortly after shots were discharged were played during the hearing.*

79. *Sergeant Beare was continuing to monitor updates coming from Sergeant Hosking and the 000 call. She was concerned about the escalating violence and the fact that Mr Foster was wanted for the armed hold up at the Matilda service station from the previous night. Sergeant Beare knew that dog squad officers were on a training night in the vicinity, as she had already used Senior Constable Nicholas Donald for a job earlier that day.*

80. *Sergeant Beare phoned the District Duty Officer, Senior Sergeant Chris Hurley. He agreed that the uniformed crews already tasked were relatively junior and the dog squad officers should support them. Coincidentally, three members of the Gold Coast dog squad were on a meal break at Ashmore when Senior Constable Lyle Slingsby received a call on his mobile phone from the COMCO. Senior Constable Slingsby was in company with Senior Constables Benjamin Staples and Nicholas Donald.*

81. *I heard from each of the dog squad officers at the inquest. Their recollection of the initial job details was also very limited. They each did not recall being told that Mr Foster was armed with a knife, the nature of the relationship between Mr Foster and his mother, or details of the persons involved in the disturbance they were to attend. There was also an impression that general duties crews were attending the job location rather than standing by, waiting for the arrival of the dog squad.*"[109]

[108] Exhibit E40.

[109] Findings of inquest into the death of Troy Martin Foster, pages 10-12, paragraphs 68-81.

128. The recommendations phase examined ways in which job information could be better disseminated to general duties crews. One such method was for the officers to have access to the information over the radio and also in written form. In this respect, the implementation of the 'Q-Lite program' had been raised on numerous occasions during the s 45 phase of the inquest.

129. The Q-Lite program gives general duties officers the capacity to check job information heard over the radio for themselves on a QPS-issued I-Pad, or similar tablet device, with full access to QPRIME. A/Superintendent Nevin gave evidence during the recommendations phase about the Q-Lite program.[110]

130. A/Superintendent Nevin explained that the Q-Lite device is basically an I-Pad that officers, whether they are supervisors or frontline, have access to. On the device, the officers have access to QPRIME which is a QPS database which stores records; checks on persons, vehicles and places; and displays safety flags which identify particularly important information (e.g. if a person is known to be violent, or possess weapons).[111]

131. The capacity for frontline staff to have access to the device means those officers will have access to QPRIME in real-time and can check any information as required. In practical terms, this would mean that the officers in the Foster shooting would have had the ability to start researching Mr Foster's background, en route to the job.[112]

132. A/Superintendent Nevin was asked about potential problems with using the devices, such as in places that might not have ample internet coverage. His evidence was that, in areas in the west of the State, the devices usually work off satellite. He was unable to provide any further information about that aspect or capability of the device.[113]

133. The A/Superintendent also gave evidence of a project currently underway with the objective to add information available via QCAD (the Computer Aided Dispatch System) to the Q-Lite devices so that officers, remote from their station computers, will also be able to receive job details directly via the Q-Lite tablet. The officers will be able to see the job details on the screen in front of them, just as the COMCO would, and have access to other information over and above what is available on QPRIME.[114]

134. A/Superintendent Nevin's evidence was that there were currently just over 5000 Q-Lite devices distributed to police across the State.[115] The Project sits under the Mobility Services Project Team, and the A/Superintendent

[110] Recommendations phase transcript of proceedings, day 1, page 34 from line 1.
[111] Recommendations phase transcript of proceedings, day 1, page 34 from line 9.
[112] Recommendations phase transcript of proceedings, day 1, page 35 from line 1.
[113] Recommendations phase transcript of proceedings, day 1, page 34 from line 31.
[114] Recommendations phase transcript of proceedings, day 1, page 35 from line 21.
[115] Recommendations phase transcript of proceedings, day 1, page 36 from line 40.

was aware that this Team constantly reviews the Project and are responsible for making submissions in that regard.[116]

135. The A/Superintendent's evidence was that a proportion of devices were allocated to various regions and districts based on the number of frontline operational police. The further distribution is managed by the individual police districts and regions.[117]

136. In terms of the benefits of the Q-Lite devices to frontline police, the A/Superintendent was asked to give evidence about how the devices would work in conjunction with the usual method of disseminating information via the radio. The A/Superintendent explained during his evidence the two media would work together, as follows:

> *"I think to answer that it – I think they go hand in hand with the urgent jobs. The ability to have that verbal recognition and being able to tell the crew and the training standard we like to look at is when our communications radio dispatch people - - -*
>
> *Yes?--- - - - are giving jobs to our crews that are urgent (a) they get them to acknowledge verbally and if there's anything in particular they want to highlight they will generally ask them please acknowledge you heard that warning or please acknowledge that you understand what's going on but it's also – I think it's complemented – the aim of the Q-TASK or the LCAD, it actually should complement and work hand in hand, the verbal instructions to go the priority 1 and priority 2.*
>
> *Yes?---So as they're going, usually you will have two in a crew and you'll have the person driving who can receive that verbal recognition from the radio.*
>
> *Yes?---The person next to him should have the Q-Lite where they can actually look through the information, regurgitate it if need be and discuss it."*[118]

137. Senior Sergeant Hayden also gave evidence regarding improved communication training for all frontline officers, particularly with respect to radio techniques in terms of the relay of cognitive information and how that information is recognised as urgent.[119]

138. Counsel Assisting submitted that the circumstances of the Foster inquest were an apt example of a largely ineffective dissemination of significant information to frontline police. In that matter information was conveyed across multiple channels, including mobile telephones. This resulted in critical information not being available to all officers involved in the incident. While the introduction of the encrypted digital radio network in the QPS will

[116] Recommendations phase transcript of proceedings, day 1, page 37 from line 1.
[117] Recommendations phase transcript of proceedings, day 1, page 37 from line 24.
[118] Recommendations phase transcript of proceedings, day 1, page 41 from line 9.
[119] Recommendations phase transcript of proceedings, day 3, page 32 from line 25.

go some way to addressing this issue, the Q-Lite program is also an integral part of effectively disseminating significant information to frontline police.

139. The evidence heard of A/Superintendent Nevin, in terms of how the Q-Lite devices should work in conjunction with the radio dispatch, has clearly pointed to the benefits of frontline officers having access to these devices. It is clear from A/Superintendent Nevin's evidence that just over 5000 devices are currently in the field. However, these are not necessarily all distributed to frontline police, of which there are upwards of 7000.[120]

140. The issue of access to Q-Lite devices by front line police officers was subsequently canvassed in the *Inquest into the death of Robert Noel Turpin*. In that matter I made the following recommendation on 4 May 2017:

> *Recommendation 1*
>
> *The Queensland Police Service continue to prioritise the distribution of Q-Lite devices to front line officers, and that the Queensland Government provide the Queensland Police Service with the necessary resources to enable the rollout of these devices.*

141. On 9 August 2017 the Minister for Police, Fire and Emergency Services and Minister for Corrective Services provided the following response to that recommendation:

> *Over the past three financial years, the Queensland Police Service has invested $55.4 million into providing mobile data to our officers. Currently, 5,400 Q-Lite devices allocated to officers performing frontline operational duties provide an increasing range of capability through a suite of mobile applications.*
>
> *In addition to capacity to undertake person, vehicle and location searches, report missing persons and issue traffic infringements, recent innovations include ability to deal with good order offences, mental health incidents, and non-reportable sudden deaths. The QTasks application currently being rolled out will also streamline resource allocation through officers being able to access and select non-urgent tasks through the computer aided despatch system.*
>
> *The QPS remains committed to further enhancing our mobile capability and this initiative will remain at the forefront of QPS' funding priorities into the foreseeable future. The allocation of Q-Lite devices is currently being reviewed to ensure the most effective and equitable distribution to frontline officers across the state.*

[120] Recommendations phase transcript of proceedings, day 1, page 79 from line 4.

142. Having regard to the Minister for Police's recent response in relation to additional resourcing for Q-Lite devices, I make no further recommendation about this issue.

143. Recommendation 2 above addresses the issue of improving communication skills to enhance dissemination of information, and updates of information to attending QPS crews.

Issue 6

6. The adequacy and appropriateness of QPS policies, procedures and training in relation to police dealing with mental health incidents, including the adequacy of the availability to QPS members, responding to an incident, of information/records from Queensland Health, and other medical practitioners, regarding the mental health history of persons

144. The context for the examination of this issue as part of the recommendations phase is found in relevant portions of my s 45 findings into Mr Zimmer's death. The first example relates to the availability of the mental health history of Mr Zimmer:

> *32. "The first event occurred on 27 July 2011. Mr Zimmer was taken to the Redcliffe Hospital Emergency Department for the purposes of an Emergency Examination Order (EEO). The medical records relating to this event were tendered to me at the inquest. Those records indicate that Mr Zimmer was known to the mental health team, and had been brought in by police after arguments had taken place with other residents in his unit complex.*
>
> *33. I heard an abundance of evidence during this inquest that, for reasons unknown, this event was not flagged on the police database known as QPrime so as to warn police, for any future events, that there was a mental health history of some sort relating to Mr Zimmer."*[121]

145. The second example sets out the circumstances relating to how attending police responded to information, received just prior to the shooting, that suggested Mr Zimmer might have been suffering from a mental illness:

> *87. While Sergeant Grieve was in the bathroom, Constables Davey and Lubbock were speaking to Adam Sant, another occupant of the house who had been sleeping but was woken by the police as they cleared the house. Mr Sant's bedroom was the second on the right off the same corridor, between Mr Duce and Mr Zimmer's rooms.*
>
> *88. While this was all happening, Constable Ryan had remained at the entrance to Mr Duce's room, adjacent to the lounge area, and had a further conversation with him. Constable Ryan's recorder depicts Mr Duce saying (with respect to Mr Zimmer) 'he's mental health'. However, Constable Ryan did not explore this information further.*

[121] Findings of inquest into the death of Laval Donovan Zimmer, page 6 paragraphs 32-33.

89. *Constable Ryan's evidence was that while she recalled hearing the information from Mr Duce; it made no difference to how the job was going to be handled. On her estimate, 90% of persons dealt with by police at Redcliffe have some sort of mental health history. The fact that Mr Zimmer had a background of mental illness was nothing out of the ordinary. When asked whether knowledge of the information should have changed the approach to the job, Constable Ryan was adamant that it would not.*

90. *I accept Constable Ryan's evidence in this respect, in relation to this incident. Once tasked to attend upon Mr Zimmer to stop the nuisance calls, the officers were under an obligation to make contact with Mr Zimmer and cause him to desist. His mental health status did not relieve them of that primary obligation. In the absence of a specific understanding of Mr Zimmer's mental health history, the officers would have to respond to Mr Zimmer in accordance with his presentation at the time.*

91. *However, I consider that if his mental health status had been recorded on QPrime it might have enabled a planned approach to the job to be considered in partnership with his mental health clinicians, which was responsive to Mr Zimmer's particular needs and situation. However, this would either have required direct access to his mental health history on the night of his death, or for the QPS to delay its intervention until appropriate plans could be developed.*

92. *I also accept from the evidence of the officers that there was no predetermined intention that Mr Zimmer was to be arrested that night and charged with any offence, including that of misusing a telecommunications device.*

93. *It is also consistent with Constable Ryan's evidence that any effective response to Mr Zimmer's mental health status was precluded by the speed in which he reacted to police when they went to the door of his room.*

94. *Had Mr Zimmer presented differently, it is possible that Constable Ryan, and the other police officers, would have used an appreciation that he suffered from a mental illness in shaping their interaction and communication with Mr Zimmer. I consider that Constable Ryan's evidence should be understood in this way.*"[122]

146. Consideration of this issue during the inquest extended to examining ways in which assistance is provided by mental health clinicians to frontline police when dealing with individuals who do, or might, have a mental illness. The recommendations phase examined the ways that the QPS interacts with Queensland Health ('QH') not only in respect of sharing information but also in respect of interagency cooperation generally when dealing with vulnerable individuals.

[122] Findings of inquest into the death of Laval Donovan Zimmer, pages 12-13 paragraphs 87-94.

147. Given that these matters arose more particularly during the Zimmer and Foster inquest hearings, evidence was provided during the recommendations phase by the relevant QPS and QH witnesses from the Gold Coast Hospital and Health Service (GCHHS), and the Metro North Hospital and Health Service (MNHHS). The adequacy of the current wording of section 6.6.20 of the QPS Operational Procedures Manual, relating to mental health incidents, was also examined.[123]

148. The importance of early collaboration between health professionals and the police, and the increasing need to be equipped to deal with persons in crisis, were aptly set out by Professor Alpert with reference to the Kumeroa shooting, during his evidence, as follows:

> *"Well, I think it's prior to there's a "serious problem". I think it's if we have any information that the subject has – is in crisis or has … any type of concerns that way, to bring in someone who knows more about the mental processing of people than – than someone who doesn't. And – and it's – I mean, again, I can relate more to our issues in the States where it's become – we don' t know the numbers, but it's a – it's a very large percentage of all interactions with the police are now with people who are in crisis. So there's been a huge push to increase training to try to figure out how best to deal with people in crisis. There are multiple models, as you talked about. But certainly when you are aware – you as a police officer or agency, when you're aware that the subject is in crisis it's always better to get someone who has more training in dealing with people in crisis."*[124]

The Mental Health Intervention Project

149. A great deal of evidence was heard about the 'Mental Health Intervention Project' ('MHIP'). The MHIP is a state-wide tri-agency partnership between Queensland Police Service (QPS), Queensland Health (QH) and the Queensland Ambulance Service (QAS). The project aimed to provide a more coordinated, interagency response to mental health crisis situations to prevent and/or safely resolve mental health crisis situations and reduce the risk of injury to members of the community and agency staff.

150. The MHIP provides, within the QPS, for various 'Mental Health Intervention Coordinator' ('MHIC') roles with responsibility to liaise with their relevant counterparts within QH and the QAS about individuals who have been identified as either having come into contact with police or are likely to come into contact with police. I heard evidence from A/Senior Sergeant Peter Thompson, the MHIC for the Moreton region, and Senior Sergeant Kenneth Becker, the MHIC for the Gold Coast region.

151. A/Senior Sergeant Thompson is an experienced police officer with 23 years' service. He gave evidence that he had been in the MHIC role since 2013, and carries out those duties in addition to his substantive role, which was

[123] Exhibit R25.
[124] Recommendations phase transcript of proceedings, day 4, page 12 from line 36.

the Shift Supervisor at Caboolture Station. He confirmed that the OPM 6.6.20 correctly outlined the scope and responsibilities of the MHIC role. A/Senior Sergeant Thompson confirmed in his evidence that the MHIC role requires more of his operational time and that he receives no allowance or support for undertaking the role.[125] He suggested that the MHIC role, in his experience, is a full-time role.[126] It was confirmed during the A/Senior Sergeant's evidence that, even though OPM 6.6.20 provides for a regional MHIC role, there was nobody in that position.[127]

152. A/Senior Sergeant Thompson gave evidence of a strong relationship between himself and the MHIC at the MNHHS.[128] He said that they speak many times a day about different consumers and they share information routinely. He also attends operational liaison committee meetings, approximately every two months, which comprise emergency department, mental health and security staff at the hospitals. Issues discussed at these meetings include ways to build capacity and capability, as well as identifying risk and ways to overcome that risk in the future.[129]

153. Ms Helen Cartwright is the QH MHIC for the MNHHS, operating out of the Royal Brisbane and Women's Hospital. Ms Cartwright also gave evidence at the inquest, during which she confirmed she has a 28-year background in nursing, and has been in the MHIC role for the past 6 years.[130] She confirmed A/Senior Sergeant Thompson's evidence surrounding the extent of the current collaboration between QPS and QH and compared it to when she first came into the role, saying it was quite apparent that "*we weren't talking to each other*" and "*it was almost a little bit tense*."[131]

154. Ms Cartwright confirmed that QH has fully funded its MHIC positions, something which was not matched across the QAS and QPS.[132] She confirmed that she has colleagues in MHIC roles stationed at The Prince Charles Hospital and Redcliffe/Caboolture Hospitals.[133]

155. A/Senior Sergeant Thompson also explained that he had been part of an initiative called the 'co-responder model' since approximately January 2015. He explained that different models are being trialled around the world, which involve the bringing together of first responders, i.e. police, ambulance, fire and health workers.[134]

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[125] Recommendations phase transcript of proceedings, day 5, page 51 from line 17.
[126] Recommendations phase transcript of proceedings, day 5, page 52 from line 18.
[127] Recommendations phase transcript of proceedings, day 5, page 62 from line 13.
[128] Recommendations phase transcript of proceedings, day 5, page 52 from line 36.
[129] Recommendations phase transcript of proceedings, day 5, page 52 from line 38.
[130] Recommendations phase transcript of proceedings, day 6, page 2 from line 24.
[131] Recommendations phase transcript of proceedings, day 6, page 4 from line 16.
[132] Recommendations phase transcript of proceedings, day 6, page 4 from line 37.
[133] Recommendations phase transcript of proceedings, day 6, page 6 from line 7.
[134] Recommendations phase transcript of proceedings, day 5, page 52 from line 47.

156. A/Senior Sergeant Thompson's evidence was that the model being trialled in the Moreton area involves police and health. No additional budget was provided. The model involves a clinician provided by QH on a .5 FTE basis, along with a suitably competent MHIC or police officer provided by the QPS on a .5 FTE basis. The two roles work in partnership as a team and operate out of Caboolture Police Station. The team monitors and responds to calls for service.[135] At the commencement of a co-responder shift, an email is generated to the police communications centre and ambulance communications centre to advise that the relevant COMCO and QAS equivalent that the team is available.[136]

157. The current model operates on a part-time basis, such that the team operates on day shifts over Tuesday/Wednesday one week, and then Tuesday/Wednesday/Thursday the next week.[137] In terms of any plans on foot to make the co-responder model full-time, A/Senior Sergeant Thompson's evidence was that he was aware further budget submissions had been made to the Minister by MNHHS for a further three clinicians to be funded. An additional submission was made for a mental health clinician and an emergency department nurse to be placed in the watch house.[138] A/Senior Sergeant Thompson explained that, when the initiative started in the Moreton area, a model was followed that had been running in Cairns for some time.

158. In terms of the effectiveness of the model, A/Senior Sergeant Thompson explained that, to his knowledge, QH was conducting an evaluation. However, he was also able to relay his own figures in which he estimated that, in the past 18 months, there had been some 150 potential EEO situations but less than 10 EEOs had been made. He explained that this was a direct result of the ability of the co-responder model to suggest and implement other pathways for consumers.[139] When asked to explain the 'other pathways' that might be available, A/Senior Sergeant Thompson's evidence was as follows:

> *"When you said there were "other pathways" available, what were they?---So the – the – I guess the process is one of least restriction. The most least restrictive method of providing support to people with mental illness, or suspected mental illness, so that may be referral to a either informal or formal for follow-up later on within the community. It – it may be that the clinician engages with the consumer at the time. If it's a co-responder and the clinician is on the clinician will interact with the consumer and then make some other arrangements for follow-up services within the community. EEOs are obviously a last resort but sometimes they are the only resort. But, as I said, with the statistics before that we've found if – if the co-responder model is on and*

[135] Recommendations phase transcript of proceedings, day 5, page 53 from line 14.
[136] Recommendations phase transcript of proceedings, day 5, page 59 from line 46.
[137] Recommendations phase transcript of proceedings, day 5, page 53 from line 22.
[138] Recommendations phase transcript of proceedings, day 5, page 53 from line 36.
[139] Recommendations phase transcript of proceedings, day 5, page 54 from line 9.

available and engaged in those calls for services the – the police officers on the frontline are not completing EEOs and the consumers are getting the support and treatment that they need."[140]

159. A/Senior Sergeant Thompson was also asked whether the model was helping to avoid repeat calls for service. His evidence was that it is, and he explained as follows:

> *"Okay. Officer, are you able to say whether the – particularly the co-responder model, as you've outlined, are you able to say whether the use of that model has tended to avoid this repeat calls for service-type syndrome that we see?---Yes, it does. The – from listening to Mental Health provide information to us during operational liaison committee meetings - - -*
>
> *Yes?--- - - - the – the frequency of emergency examination orders, and I suppose the long term diagnosis may not correlate or be congruent together. It's – it's definitely – having the expert knowledge of the co-responder team in the operational frontline definitely provides that education and that clinical expertise that police officers – we've got training in tactical, communication and OST and some mental health training - - -*
>
> *Yes?--- - - - that we receive but having a professional clinician definitely does make a difference - - -*
>
> *Yes. And an expert clinician who is right there and available to give that on-the-spot advice?---That's correct. That's correct."*[141]

160. A/Senior Sergeant Thompson also gave evidence to the effect that, on occasion, the result of sharing information about an individual might result in a co-visit being organised. This meant that the QH MHIC and the QPS MHIC both meet with the consumer at the same time and discuss any ongoing needs.[142] This meeting may result in a Crisis Intervention Plan ('CIP') being completed, with input from both MHICs.

161. The CIPs were brought about from a review conducted by MNHSS in 2015 during which improvements were considered to the way frontline staff were being provided with information. A/Senior Sergeant Thompson explained that police needed to know matters like triggers and cues, approaches and strategies to use, as well as those to avoid. This brought about the creation of the CIP.[143] With the commencement of the *Mental Health Act 2016*, the CIP will change to a Police and Ambulance Intervention Plan ('PAIP').[144]

[140] Recommendations phase transcript of proceedings, day 5, page 54 from line 33.
[141] Recommendations phase transcript of proceedings, day 5, page 55 from line 14.
[142] Recommendations phase transcript of proceedings, day 5, page 56 from line 6.
[143] Recommendations phase transcript of proceedings, day 5, page 56 from line 17.
[144] Recommendations phase transcript of proceedings, day 5, page 56 from line 27.

162. As was aptly explained by Ms Cartwright during her evidence, the tool (or the plan) itself is not what is important. It is the process behind the tool which is important:

> *"Because when – when you – you know, you don't do to people. You do with people. If you want good outcomes, you're inclusive, and the systems that you have in place support that inclusiveness. So we start by bringing the consumer – like [indistinct] we just ask the consumer to come to a forum, and we bring everybody around the table, and we all bring the pieces of the puzzle together, and we have a conversation about what does that consumer want from us when they're having some sort of a disequilibrium? What can we do?*
>
> *Yes?---And that's where those tools came out of. Those tools took six years to develop. There was a lot of consultation between consumers, carers, police, ambulance, clinicians and senior management at the Royal. So we established them at the Royal and then we got some funding to then roll it out across Metro North. So they're very robust."*[145]

163. A/Senior Sergeant Thompson explained the PAIP has been a process of evolution since its inception. It is generally a two page document which is drafted between the mental health coordinator and the clinician, the police, and the QAS. The document is shared among the three agencies and uploaded to each respective database. For the purpose of the QPS, the document is uploaded onto QPRIME and, as a result, is immediately accessible to frontline police.[146] Ms Cartwright expanded on this during her evidence, stating that the stakeholder meeting generally results in an Acute Management Plan ('AMP') for the use of clinicians being developed[147] which will often trigger the development of a PAIP.

164. A/Senior Sergeant Thompson also explained that one of the main features of the PAIP is to condense relevant information for the police and QAS staff when attending a critical incident.[148] A copy of a blank template PAIP was tendered.[149] Individual PAIPs are reviewed, and then re-released, by the QH MHIC on a 6 monthly basis.[150]

165. I heard evidence that, in 2015-16, the AMP and PAIP templates have been rolled out into the State-wide QH mental health database, known as the Consumer Integrated Mental Health Application (CIMHA). This means that the tools are available to all mental health practitioners across the State.[151] Ms Cartwright also gave evidence regarding an e-Learning package, she has recently completed, which is aimed at educating clinicians on how to write an AMP and PAIP.[152]

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[145] Recommendations phase transcript of proceedings, day 6, page 5 from line 26.
[146] Recommendations phase transcript of proceedings, day 5, page 56 from line 31.
[147] Exhibit R13.4.
[148] Recommendations phase transcript of proceedings, day 5, page 67 from line 26.
[149] Exhibit R13.3.
[150] Recommendations phase transcript of proceedings, day 6, page 21 from line 17.
[151] Recommendations phase transcript of proceedings, day 6, page 10 from line 24.
[152] Recommendations phase transcript of proceedings, day 6, page 10 from line 32.

166. Ms Cartwright was asked whether she had received any feedback from consumers with respect to concerns that their information held by QH might be made available to the QPS. Her evidence in that respect was that, six years ago, when she first came into the role, this would have been a consideration. However, Ms Cartwright noted that the involvement of the consumer in the creation of their own management plan has meant that there is less concern that the QPS could access clinical information relating to them from QH.[153]

167. When asked during his evidence whether he could provide any assistance to the inquest in terms of potential recommendations, A/Senior Sergeant Thompson indicated that he supported the expansion of a co-responder initiative as well making the police MHIC a full-time position.

168. It was apparent from the evidence heard from the QH MHICs, as well as the QPS MHICs, that they are committed to their respective roles and they have a wealth of experience. However, the progress of the MHIP relies primarily on the goodwill of those who operate within it.

169. Ms Cartwright gave evidence of some challenges with the various service models moving forward. She explained that healthcare services are driven by outcomes. Accordingly, there must be 'runs on the board' and those, in turn, support applications for funding. She explained that, for QPS, the 'runs on the board' will be, for example, how many jobs they attend and what the outcomes of those jobs are.[154]

170. Ms Cartwright gave evidence as to how the preventative outcomes could be measured, explaining that it would need to be a tri-agency approach and would require more funding. Her evidence in this regard was that there needs to be a robust across-agency project to measure the outcomes of the MHIP.

171. While there exists the Memorandum of Understanding relating to Mental Health Collaboration between QH and the QPS,[155] it is apparent from the evidence that each police district, and each corresponding hospital and health service, operate differently and separately. In relation to the decentralisation of the QH model by establishing the localised Hospital and Health Service Boards, it has already been identified that, while the service model is intended to promote responsive health care at the local level, it may not be a suitable way of organising State-wide services that "*require common standards and centralised expertise*".[156]

[153] Recommendations phase transcript of proceedings, day 6, page 9 from line 13.
[154] Recommendations phase transcript of proceedings, day 6, page 13 from line 16.
[155] Exhibit R33.1; Note this was a draft document and was awaiting ratification at the time of the inquest.
[156] Exhibit R42, *When mental health care meets risk: A Queensland sentinel events review into homicide and mental health services 2016*, page 53.

172. In this regard the QH MHIC from MNHHS, Ms Helen Cartwright, gave evidence of the need for some State-wide governance, as follows:

> *"I mean, for example, the memorandum of understanding that you've spoken about is a Queensland Health document. That's right, isn't it, that Queensland Health is broken up into a number of hospital and health service boards? So that document could be implemented in each district or board differently; is that right?---That's correct. I mean you put the nail – you know – put the – put the – put that very succinctly, and what it needs is some – there's no statewide governance. When I first came into the role, there was statewide governance.*[157]

173. Ms Cartwright also explained that there used to be annual meetings between the different districts to identify local strategies. Her evidence was that part of the disconnect currently experienced stemmed from the fact that these meetings do not currently occur between the various hospital and health services, and as such each service does things in its own way.[158]

174. This difference in approach was demonstrated in the evidence heard at the inquest, particularly, in terms of differences between police districts in the management of the MHIP. In that regard, evidence was heard from the QPS MHIC for the Gold Coast region, Senior Sergeant Kenneth Becker. Like A/Senior Sergeant Thompson, Senior Sergeant Becker is a very experienced police officer with 38 years' service. He has been in the MHIC role for 10 years. He also carried out the MHIC role in addition to his substantive role as the Officer-in-Charge of the Southport watch house.[159]

175. The evidence from Senior Sergeant Becker confirmed a similar approach to that taken by the Moreton district with respect to CIPs and PAIPs. However, he confirmed that the Gold Coast does not have a co-responder model in place.[160] Going back to A/Senior Sergeant Thompson's evidence, he had explained that QH has a number of Acute Care Teams, which are mental health teams available on a 24 hour a day, 7 day a week basis. He had explained that those teams are available, in addition to the QH MHIC, for the QPS to access necessary clinical advice.[161] Senior Sergeant Becker spoke of a strong collaboration between the Gold Coast QPS district and the respective Acute Care Teams on the Gold Coast. The use of those teams has replaced any need for a co-responder model.

176. Ms Karlyn Chettleburgh, General Manager of Mental Health and Specialist Services for the GCHHS, also gave evidence at the inquest. Ms Chettleburgh is a very experienced psychiatric nurse with some 35 years' experience. She explained that the QH MHIC role for the Gold Coast is

[157] Recommendations phase transcript of proceedings, day 6, page 14 from line 2.
[158] Recommendations phase transcript of proceedings, day 6, page 15 from line 46.
[159] Recommendations phase transcript of proceedings, day 5, page 69 from line 28.
[160] Recommendations phase transcript of proceedings, day 5, page 74 from line 10.
[161] Recommendations phase transcript of proceedings, day 5, page 60 from line 28.

embedded within the Acute Care Team.[162] It is a funded full-time role, currently occupied by an individual four days a week.[163]

177. Ms Chettleburgh confirmed that the Acute Care Team is available 24 hours a day, seven days a week, and is accessible to the QPS after hours by a specific '1300' phone number.[164] She confirmed during her evidence the range of scenarios for which the Acute Care Team might be utilised.[165] This evidence was consistent with the approach explained by Senior Sergeant Becker in his evidence. He explained the basis for this approach, from the Gold Coast perspective, as follows:

> *"We don't have a co-responder model. There's – I haven't decided which way – whether a co-responder model is appropriate.*
>
> *Okay?---Initially when I was on the inter-departmental steering committee we looked at part of – with Queensland Health there's a – a model in Memphis in the United States they call the Crisis Intervention Team model where they have their select police attend a week's training and they call them CIT teams, and they would respond to all the mental health related jobs in Memphis. They had a similar population of 600,000 to the Gold Coast. The challenge that we have on the Gold Coast, you've got a long strip of policing and population from Coolangatta up towards Beenleigh on the coastline. So if you had specific crews trained in this process you could have a CIT team at Coolangatta and you would have to send them up to Coomera or Springbrook or somewhere like that.*
>
> *Right?---So that was a state-wide issue – and this came out of the inter-departmental steering committee – that the best method was to train all our police in de-escalating strategies and that's when the Mental Health Intervention Project came online. In 2006 we would train all our police so that any police officer would have those skills to attend a job suspected of being mentally ill, to have those skills to de-escalate, use less than lethal force, use of force options, isolate, contain, use negotiators as required and use the information from the Acute Care Team that were working 24/7 to get information to help and assist in de-escalating situations*."[166]

178. Assistant Commissioner O'Regan also gave evidence regarding the implementation of the co-responder model on a State-wide basis. He explained that, in 2013/2014, he was tasked with considering whether the Cairns model of the co-responder system should be implemented State-wide. He ultimately determined that the model should not be implemented across the State, and his findings in that respect, were tendered at the

[162] Recommendations phase transcript of proceedings, day 8, page 3 from line 1.
[163] Recommendations phase transcript of proceedings, day 8, page 5 from line 6.
[164] Recommendations phase transcript of proceedings, day 8, page 6 from line 5.
[165] Recommendations phase transcript of proceedings, day 8, page 6 from line 26.
[166] Recommendations phase transcript of proceedings, day 5, page 74 from line 11.

inquest.[167] The reasons for the decision were explained during his evidence, as follows:

> *In assessing that model, it was found that police were used in interventions that didn't require police skills. And in many respects, police were doing jobs that health professionals should've done, or ambulance providers should have done, but it was convenient for those practitioners for police to do that. Given that there are 19 distinct health districts around the state, each of those do their business very differently.*
>
> *Yes?---And you've actually got to negotiate with every health district to get an agreement on how business is to be done in that particular health district, not with the Health Department.*
>
> *Yes. Yes?---And in talking and dealing with every district, they all were satisfied with how they were doing business that was particular for their particular district."*[168]

179. A recent review of the Cairns Mental Health Co-Responder Project by Dr Michelle Fitts and Dr Jan Robertson of James Cook University found the model has proven to be successful within the specific context of a regional city with a high proportion of homeless people, including transient Indigenous peoples from remote communities. The review found that the project has resulted in at least the following[169]:

- *Improved experiences and outcomes for consumers including reduced trauma, less use of force and reduced stigmatisation*
- *De-escalation and prevention of crisis situations*
- *Improved inter-agency collaboration*
- *Improved safety for first responders and mental health practitioners*
- *Reduction in use of involuntary assessment procedures*
- *Saving of staff-hours by first responders and mental health practitioners*
- *Provision of further mental health training opportunities for first responders*
- *Improved awareness and utilisation of the project by Queensland Police Service, Queensland Ambulance Service and Queensland Health mental health service providers.*

180. However, the 2017 Cairns review also highlighted issues raised by witnesses at this inquest in relation to the sustainability and governance of the project, including its reliance on the good-will of individual police officers, rather than a firm resourcing commitment from the QPS. It also highlighted the absence of an evaluation framework.

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[167] Exhibit R36.22.
[168] Recommendations phase transcript of proceedings, day 7, page 49 from line 37.
[169] http://www.centacarecairns.org/fileadmin/user_upload/Co-responder_Review_Website_Version_2017.pdf.

181. Ms Chettleburgh also gave evidence in relation to some suggestions to improve the current MHIP system. One such suggestion went to training, with Ms Chettleburgh putting forward that the training for mental health practitioners and QPS officers should be combined. She explained that one of the important components of the localised protocols which sit underneath the overarching MOU,[170] is about building local relationships and trust, particularly for frontline staff. Therefore, those staff coming together and sharing knowledge and experiences through training is a very important component.[171]

182. Ms Chettleburgh also gave evidence on a topic touched upon by Ms Cartwright, namely, that of overarching governance of the MHIP in existence within QH. When asked who, within QH, has the responsibility for managing the MHIP, Ms Chettleburgh gave the following evidence:

> *"Who within Queensland Health would be the person with responsibility for managing that?---That – that now – that responsibility for the governance of health services and mental health services had been devolved to the hospitals and health services, that it would be the responsibility of each individual HHS.*
>
> *Right. And who, within Queensland Health, monitors how the local districts are complying with those responsibilities?---I'm aware that – that there is an annual forum that's undertaken and coordinated by the mental health, alcohol and other drugs branch, in which all of the mental health intervention coordinators from across the state meet and it would be through that process. But also the mental health intervention coordinators work very closely with the legislative areas of the mental health branch and it would be through their contacts there that they would escalate issues.*"[172]

183. In addition to the MHIP, evidence was also heard about an ongoing initiative whereby a mental health clinician has been embedded within the Brisbane Police Communications Centre.[173] Having that clinician available and near police, means that the exchange of information can happen much more quickly. The clinician has access to the QH mental health database, CIMHA, and thus can readily access information on that database where required. In addition, the clinician is also available via phone to speak with frontline officers and offer advice on how best to deal with an evolving situation.

184. It was apparent from the evidence heard that the rostering in relation to that clinician was a work in progress. A/Superintendent Nevin stated that the goal is to have clinician coverage on a 24 hour a day, 7 day a week basis. The clinicians were rostered on during peak times, being Thursday –

[170] Exhibits R33.3-R33.4.
[171] Recommendations phase transcript of proceedings, day 8, page 10 from line 38.
[172] Recommendations phase transcript of proceedings, day 8, page 15 from line 30.
[173] Recommendations phase transcript of proceedings, day 1, page 54 from line 30.

Sunday nights. A/Superintendent Nevin gave evidence that six clinicians would be required to achieve the 24/7 coverage.[174]

185. Ms Cartwright explained that, from the QH perspective, funding for this initiative is obtained from the State-wide Forensic Mental Health Service. Her evidence was that the rostering of the clinicians had recently increased to five days a week.[175]

186. I also heard evidence from Inspector Regan Carr, the current Manager of the Domestic and Family Violence and Vulnerable Persons Unit within the QPS.[176] Inspector Carr's evidence was that the rostering of the clinicians had recently increased to six shifts a week, from Monday through to Saturday.[177] Inspector Carr explained that there were plans to increase that rostering further.

Mental Health Training

187. A significant portion of the evidence heard during the recommendations phase of this inquest focused on training. This evidence included an analysis of the current methods of training of police officers in relation to mental health and an analysis of any improvements that could be made in this respect.

188. As a starting point, A/Senior Sergeant Thompson confirmed during his evidence that part of the QPS MHIC role is to conduct relevant training with frontline police officers. He explained that a training day is usually held twice a year in the Moreton district. It is coordinated by the local training office and is facilitated by police negotiators, as well as the MHIC. The QH MHIC is also invited to attend the training day.[178]

189. The training involves the officers' undertaking an education session which generally consists of presentations and training on various policy and any emerging issues. It also involves scenario based training and real-life simulation, after which critique and advice is given to individual officers regarding how they dealt with the situation.[179] It was confirmed that the transition to PAIPs, for example, would be discussed during one of these training days. Operational advice and changes are also distributed to police officers via email.[180]

190. Ms Cartwright explained that she used to run in-service training every month in coordination with her QPS MHIC for teams of police officers. The in-

[174] Recommendations phase transcript of proceedings, day 1, page 54 from line 34.
[175] Recommendations phase transcript of proceedings, day 6, page 11 from line 12.
[176] Recommendations phase transcript of proceedings, day 6, page 23 from line 13.
[177] Recommendations phase transcript of proceedings, day 6, page 32 from line 42.
[178] Recommendations phase transcript of proceedings, day 5, page 57 from line 4.
[179] Recommendations phase transcript of proceedings, day 5, page 57 from line 13.
[180] Recommendations phase transcript of proceedings, day 5, page 57 from line 20.

service involved a half-day session on the topic of mental health. On-the-job training also took place, such that if the QPS MHIC and the QH MHIC were attending a job, another crew would attend with them so they could be shown directly how to approach it.[181]

191. Inspector Carr outlined in her written statement the extent of the training which is provided to police officers in relation to mental health, from the point where they are recruits, to when they become sworn officers.[182] Inspector Carr confirmed that all the mental health components of training materials are overviewed by the State MHIC.[183]

192. The recruit training is largely scenario based to better articulate the various legislative requirements. When an officer is sworn, and becomes a first-year constable, they undergo that first year under the supervision of a more senior member of the QPS. There is also an online learning product which, at the time of Inspector Carr's evidence, was under review. That product focused on the application of the *Mental Health Act 2000* and how it intersected with the daily operations of the QPS.[184]

193. Inspector Carr explained that the online learning product was under review to make it a prerequisite for a compulsory new training package. The intent is to make that training package compulsory for all QPS members up to and including the rank of Inspector.[185] The new training package was described as a two day vulnerable persons training package.[186]

194. Having regard to the size of Queensland and the logistical limitations in having all members travel to Brisbane for the training, Inspector Carr explained that various 'super trainers' will be trained in Brisbane, and then deliver regional training. The training was expected to be rolled out from March 2017.[187] Inspector Carr's evidence was that it was anticipated that mental health clinicians, Police Communications staff, PoliceLink staff and call takers would all be invited to the training.[188]

195. I heard from Professor Stuart Thomas, Professor of Forensic Mental Health at RMIT University in Melbourne.[189] Professor Thomas reviewed all the current training materials provided by the QPS to its members in relation to mental health. His opinion was that that the current level of training provided to the QPS officers was inconsistent with what he would consider best practice.[190] He explained that mental health must be considered as 'core

[181] Recommendations phase transcript of proceedings, day 6, page 17 from line 6.
[182] Exhibit R39, paragraph 11.
[183] Recommendations phase transcript of proceedings, day 6, page 25 from line 29.
[184] Recommendations phase transcript of proceedings, day 6, page 26 from line 16.
[185] Recommendations phase transcript of proceedings, day 6, page 26 from line 26.
[186] Exhibit R39, paragraph 11; Recommendations phase transcript of proceedings, day 6, page 27 from line 5.
[187] Recommendations phase transcript of proceedings, day 6, page 28 from line 26.
[188] Recommendations phase transcript of proceedings, day 6, page 28 from line 43.
[189] Exhibit R40; Recommendations phase transcript of proceedings, day 6, page 56 from line 21.
[190] Recommendations phase transcript of proceedings, day 6, page 60 from line 40.

business' for police, not an exception to usual practice. His evidence in this respect was as follows:

> *"…– you know, mental health is – you know, has got to be considered core business for police. It's not the exception … the whole thing's got to be reframed in terms of this is our daily business, that we're going to encounter people, for a whole range of reasons, who have mental health related issues."*[191]

196. When asked about the two day vulnerable persons training package, Professor Thomas's evidence was that there must be an opportunity for the trainees to test the skills learnt throughout the training. He preferred the four day training model adapted in New South Wales. His evidence in this respect was as follows:

> *"But then if you look at [indistinct] at least have access really to two days of mental health training, and we know that internationally, like, their CIT model, which has evolved very rapidly in the US [indistinct] operational police, and it involves a whole range of different activities, but it's – there's both knowledge acquisition, there's attitudinal change and then there's the experiential learning, and what we know is that the way that police learn, that sort of on-the-job mentorship model of learning is very much enforced through the opportunities to do the experiential learning. It's not about acquisition [indistinct]*
>
> *Yes?---It's about the acquisition and then trial and error of skills and attempting some processes they can [indistinct] cognitive templates so they've got a range of different responses which have worked in the past that they can then draw upon when faced with something similar.*
>
> *Yes?---And so the challenge you've got with them having a day or having two days is they don't have the opportunity to embed and test those skills.*
>
> *Yes. So there needs to be almost a practical component or a practical opportunity to test the skills that were learnt during the theoretical phase; is that what you're saying?---Yeah, that's certainly [indistinct] kind of required reading - - -*
>
> *Yes?--- - - - and then use some additional specialised training space to really test that out, because, you know, there's a lot of subjectivity around the way that this can be put into practice and a lot of different situations and scenarios that can be taken into account, and I think that that applied learning that happens in a group of officers, who are constables through to inspectors, who've got a whole range of different experiences - - -*
>
> *Yes?--- - - - years on the job experience, you know, it's really valuable to that, and so that's something that really can't be cut short."*[192]

[191] Recommendations phase transcript of proceedings, day 6, page 61 from line 6.
[192] Recommendations phase transcript of proceedings, day 6, page 61 from line 34.

197. I also heard from Senior Sergeant Hayden with respect to ways in which the annual OST training currently incorporates mental health training.[193] Recommendation 2 from the VCR was put to Senior Sergeant Hayden during his evidence with respect to the idea of embedding mental health training within the annual OST training.[194]

198. Senior Sergeant Hayden was generally supportive of further training in the area of mental health. His evidence was that any training or support to help officers respond to or manage the types of situations that arose in each of the deaths would be welcomed.[195] As for how that training would be embedded within the OST training, Senior Sergeant Hayden said that this would require further internal consideration. He explained that any extra training, or training initiatives, have an organisational and operational impact in addition to issues of funding.[196]

199. Professor Thomas's evidence was that while he understood the benefit of embedding mental health training within the annual OST training, there was a concern that it would be treated as an afterthought. In this respect, Professor Thomas gave evidence that, if the OST training were overhauled to embed mental health training across all aspects of it, rather than having it as an additional aspect, this would be the most effective means of utilising the annual OST training.[197]

200. Professor Thomas's evidence was that there must be a core element of mental health training available to police, in addition to refresher training, so that skills are not lost over time.[198]

201. Professor Thomas gave valuable evidence concerning how the various training and information initiatives canvassed during the hearing could realistically assist frontline police, an in particular strategies to give officers more time to develop an appropriate response in a crisis. Counsel Assisting submitted that his evidence in this respect was important to place these deaths in an appropriate context. In his report prepared for this inquest[199] Professor Thomas noted:

> *A factor common to many fatal police shootings is that the whole incident transpires in a very short period of time, sometimes in just a matter of seconds. As such, police officers are being required to assess, engage and react very quickly in what is commonly an extremely stressful and potentially ambiguous situation, often with family members and/or other bystanders in*

[193] Recommendations phase transcript of proceedings, day 3, page 41 from line 11.
[194] Recommendations phase transcript of proceedings, day 3, page 41 from line 25.
[195] Recommendations phase transcript of proceedings, day 3, page 41 from line 29.
[196] Recommendations phase transcript of proceedings, day 3, page 41 from line 34.
[197] Recommendations phase transcript of proceedings, day 6, page 64 from line 37.
[198] Recommendations phase transcript of proceedings, day 6, page 75 from line 37.
[199] Exhibit R40, page 9

close proximity. The incidents considered in the context of this review note the extremely rapid escalation of the incident from the point of arrival of the police at the address and the fatal shots being fired by police. This raises an important question about the effectiveness of training in these circumstances and brings into question what resources police draw upon when faced with such time-pressured, stressful and ambiguous situations. In some of my work I have commented on the importance of 'cognitive templates' (which shares a number of similarities with what the author Gary Klein terms 'Recognition Primed Decision Making' which is referred to in the QPS Violent Confrontations Review document). These templates are primarily based upon prior experiences (e.g., last time I was faced with a similar person/similar weapon/similar environment this is what I did and this is what worked/didn't work), which serve to form an accumulated practice-based wisdom associated with on-the-job experience.

OPM 6.6.20

202. The adequacy of the relevant OPM relating to mental health incidents, OPM 6.6.20,[200] was put forward as a sub-issue to be considered during the recommendations phase under the umbrella of this issue.

203. Arising out of the Kumeroa inquest was the suggestion made by Detective Senior Sergeant Richard Lacey that mental health assistance should be called for as a matter of course with respect to siege (and similar) events. Detective Senior Sergeant Lacey's evidence was that the current OPM 6.6.20 was difficult to apply in a practical sense and it should be changed so that there is no need for a police officer to subjectively assess whether the incident should be classed as a 'mental health incident' under the OPM. The Detective Senior Sergeant's evidence on the issue was as follows:

> *"Yes. Okay. Now, one of the issues that was raised with you in your second interview was the fact that no attempt was made to obtain information with regard to Mr Kumeroa's mental health history from Queensland Health, and there's a particular chapter of the OPM that deals with that. Again, was that a conscious decision? Can you just tell his Honour what matters you thought would have contributed to making that request, what things were relevant in you not specifically raising them?---I – I would – my personal opinion again - - -*
>
> *Yep?--- - - - and I'm conscious of my place in the organisation. I'd love to see that OPM change to say that in a situation like this, it's mandatory that we contact Queensland Health.*
>
> *Yes?---Certainly, it is a practice that we, as negotiators, have instigated.*

[200] Exhibit R25.

Yes?---And now, every time we're deployed to a job, if we have a name of our person of interest, our state coordinator will make that call - - -

Okay?--- - - - for us while we're on our way to a job, but in terms of the command element of the QPS having an obligation, maybe, to make that call, I – that OPM could maybe do with some rewording.

Yes. Do you find it difficult to apply or difficult to read?---The OPM? Probably, for me, it's a little bit two bob each way. I'd – I'd – coppers are pretty simple people. If you throw a must in there, or a shall, we understand what that means.

Yes?---If you throw a maybe in there, well, that's something to think of."[201]

204. Further to that issue, Detective Sergeant Pfeffer made a recommendation in her ESC report that a review be conducted of the definition of the term 'mental health incident' contained within that OPM.[202] I also heard evidence from Professor Thomas concerning some issues he had with the current wording of OPM 6.6.20.[203] Inspector Carr's evidence was that this Chapter of the OPMs was under review.[204] While Chapter 6.6.20 has been deleted, it now appears in substantially the same form as Chapter 6.6.13 of the OPM.

205. Acknowledging the range the recommendations already in the process of being implemented in relation to the MHIP, Counsel Assisting submitted that I consider making a recommendation for a further mainstream review process to occur with respect to the MHIP, and that the review be undertaken on a State-wide level with representatives from Queensland Health and the Queensland Police Service.

206. It was submitted that the review process should analyse how the MHIP is currently implemented in each HHS and/or police district, and explore ways that those approaches could be streamlined to achieve a level of consistency across the State. The review process should also look at ways the current methods could be evaluated so that the extent of the preventative work being done, and the outcomes being achieved, can be quantitatively measured.

207. It is important to emphasise that repeat calls for service are a source of frustration for first response police officers as well as a waste of resources for health, ambulance and police services. However, the evidence indicated that proactive responses to repeat callers are effective in addressing the problems and reducing the resources that need to be expended on these calls.

[201] Kumeroa transcript of proceedings, day 2, page 65 at line 4.
[202] Kumeroa brief of evidence, Exhibit A9, page 76.
[203] Recommendations phase transcript of proceedings, day 6, page 57 from line 16.
[204] Recommendations phase transcript of proceedings, day 6, page 37 from line 8.

208. Counsel Assisting also submitted that I consider making a further recommendation, in support of the VCR recommendation 2, that the QPS consider embedding mental health training within the annual OST training. It was submitted that the training should be dynamic, scenario-based training, and include communication skills and, importantly, de-escalation skills. It should also include the consideration of ways in which proactive programs can be put in place and utilised for individuals between calls for service being received to reduce the number of repeat calls. The training should include a means by which officers can learn from how they dealt with the scenarios.

209. I agree with submission of Counsel Assisting that dealing with mental health issues should not be restricted to narrow definitions of mental illness. The evidence has clearly pointed to the issues being much wider. The impact of drugs, alcohol, mental impairment and intellectual disability can co-exist with a diagnosed mental illness. All produce chronic problems for sufferers, those around them, and first responders. The reactive and pro-active responses need to equip police and other services to provide the best short and medium term responses to each one of these problems without the need to satisfy technical definitions.

210. Submissions on behalf of the Commissioner indicated that any review of the MHIP can incorporate the actions arising out of recommendation 2 of the VCR and the establishment of the QPS mental health strategy. The submissions noted that the incorporation of tactical communication training into OST training would happen when the training calendar permitted. The submission also suggested that the matters submitted by Counsel Assisting could be incorporated into a review of the MHIP by the QPS in conjunction with Queensland Health.

Recommendations

211. I acknowledge the variety of other recommendations in relation to these issues, and the evidence heard during the inquest of the ongoing work in implementing those recommendations.[205] However, I consider that the following recommendations will address more specific matters that have arisen during this inquest.

12. I recommend that the Queensland Government conduct a comprehensive review of the MHIP to ensure the revitalisation of the MHIP as recommended by VCR recommendation 2, and its sustainability. The review of the MHIP should consider:

- *the establishment of full time dedicated MHIC in each police district;*
- *the establishment of full-time dedicated MHIC roles in each police region;*

[205] Exhibit R2; Exhibit R42; Exhibit R36.13.

- *the extension of the hours of operation for the mental health clinicians embedded within the Brisbane Police Communications Centre to 24 hours a day, 7 days a week;*
- *a model for dedicated training to take place for police officers and mental health clinicians involved in the MHIP;*
- *the governance framework in place with respect to the MHIP with a view to ensuring a level of consistency across the State, and the exchange of information between QPS districts and hospital and health services;*
- *a review of each police district to ascertain whether a co-responder model is in place and possible expansion of the model to all districts;*
- *how to embed mental health training within annual OST training. The training should be dynamic, scenario-based, and include communication and de-escalation skills and be delivered with the assistance of mental health professionals and those who have 'lived experience' of mental health or cognitive disabilities;*
- *The inclusion of appropriate flags in Q-Prime to alert QPS officers to relevant mental health history.*

13. *I recommend that the QPS amend Chapter 6 of the OPM so that that there is no need for a police officer to subjectively assess whether the situation is a 'mental health incident' as defined currently within the OPM. The OPM should be drafted in such a way that frontline police are encouraged to call for mental health assistance in respect of incidents.*

14. *I recommend that the QPS retain mental health training as a core component of the Recruit and First year Constable Training Programmes.*

Issues 7 & 8

7. The current position regarding ownership of body worn cameras used by QPS officers and the storage of data including the progress of the roll out pursuant to the Commissioner's direction; and

8. Lessons learned from these five inquests as to the benefits of body worn cameras being used by the police officers in terms of:

- ***(i) preserving evidence;***
- ***(ii) providing a reliable record of what occurred;***
- ***(iii) avoiding unnecessary controversy about what happened; vindicating police officers who have acted in accord with their training and policy.***

212. Each of the five shootings involved the activation of a body worn cameras. Recommendations were made by the ESC investigators, in several the shootings, to the effect that body worn cameras should be either

implemented service-wide, or ongoing reviews should occur in the area.[206] It was in this context that these matters were placed on the issues list for this inquest.

213. Shortly after the inquest was opened in September 2015, the Commissioner of Police issued Instruction 1/2015 relating to body worn cameras.[207] That Instruction confirmed a state-wide roll out of service-issued body worn cameras, commencing with the Gold Coast. There was a wealth of evidence, particularly, during the Foster s 45 inquest hearing, as to the benefits of these cameras and the progress of the rollout on the Gold Coast.

214. Two statements were tendered from A/Inspector Wayne Hutchings, who has overseen the QPS Body Worn Camera Project ('the Project') since May 2015.[208] He had previously been the Project Manager for the Taser rollout from 2009 to 2011. In his written statements, A/Inspector Hutchings provided information about funding issues relating to the Project, including further funding submissions that had been made. He also provided a summary of the objectives sought to be achieved by the Commissioner's Instruction. A/Inspector Hutchings also gave oral testimony during the recommendations phase.[209]

215. A/Inspector Hutchings explained to the inquest that the product chosen by the QPS for use is called the TASER® Axon Flex camera. It was described in the evidence as a three-part device including a controller (a battery and on/off switch), and a tethering cable which connects to the camera. The camera itself holds the storage system, and the camera is worn by officers in various mounting modes.[210] During his evidence, A/Inspector Hutchings demonstrated the variety of ways the TASER® issued body worn camera could be worn.

216. Docking stations were in the process of being installed at all police stations, to enable cameras to be docked appropriately. A/Inspector Hutchings' evidence was that, once the camera is docked, data on the camera is automatically uploaded to a secure evidence management system, called 'evidence.com'.[211] Every officer who has an account within 'evidence.com' can search for and view any file within the system. Every time an officer 'touches' a file within the system, that transaction appears on the audit trail. When the audit trail is viewed by an officer authorised to do so, it will show who has accessed the file. There are restrictions on access that can be put in place, namely, a category called 'confidential restricted'. This category of restriction can be applied to any file and restricts the file so that it may only

[206] Exhibit A5, Young/Young/Dekens brief of evidence, page 81, para 8.6; Exhibit A9, Kumeroa brief of evidence, page 74, para 7.9; Exhibit A6, Logan brief of evidence, page 62, para 8.9; Exhibit A11, Foster brief of evidence, from page 78, para 8.1.16.
[207] Exhibit R9.1.
[208] Exhibits R9 and R9.2.
[209] Recommendations phase transcript of proceedings, day 1, page 66 from line 44.
[210] Recommendations phase transcript of proceedings, day 1, page 69 from line 9.
[211] Recommendations phase transcript of proceedings, day 1, page 69 from line 22.

be viewed by Commissioned officers and members of the ESC.[212] A/Inspector Hutchings confirmed that data could not be deleted from the camera.[213]

217. The cameras are digitally assigned to individual officers. The cameras are docked in the same slot each shift and all data is uploaded into the individual's evidence account.[214] At the time of the s 45 hearings a large number of police officers were using privately owned body worn cameras. I heard evidence that separate licences have been obtained so that data from those devices can also be downloaded onto 'evidence.com.'

218. When asked about the ability of police to review camera footage immediately after an incident occurred, A/Inspector Hutchings explained that, while there was no playback option on the device itself, the device could be paired to a smart device. This would mean that an officer could pair the camera with their own smart phone, Q-Lite device, or tablet, and view the camera footage straight away.[215]

219. Alternatively, an officer could take the device back to the police station, dock it, and then have access to the footage. In this regard, A/Inspector Hutchings confirmed that the camera itself was of no evidential value and could be returned to an officer relatively easily and quickly after a relevant event. The system is designed to operate on the basis that any police investigating an incident should not have to seize a device once it has been docked. [216]

220. A/Inspector Hutchings gave evidence that the initial funding for the Project was $6.03 million to be provided over three financial years. This had to cover the process of seeking tenders, assessing the different tenders and the contractual work. The administrative requirements were funded from other sources.[217]

221. The contract provided for a total of 2700 devices to be in the field, supported by the digital evidence management system, for the next three years.[218] A/Inspector Hutchings confirmed that, if one worked off the principle that every frontline officer on every shift had a TASER® issued body worn camera, the figure of 2700 represents about one third of the current need. The number required, on that assumption, is upwards of 7000.[219] It is clear that additional funding will be required if this number is to be achieved.

[212] Recommendations phase transcript of proceedings, day 1, page 99 from line 43.
[213] Recommendations phase transcript of proceedings, day 1, page 69 from line 20.
[214] Recommendations phase transcript of proceedings, day 1, page 72 from line 19.
[215] Recommendations phase transcript of proceedings, day 1, page 91 from line 38.
[216] Recommendations phase transcript of proceedings, day 1, page 92 from line 10.
[217] Recommendations phase transcript of proceedings, day 1, page 76 from line 33.
[218] Recommendations phase transcript of proceedings, day 1, page 78 from line 21.
[219] Recommendations phase transcript of proceedings, day 1, page 79 from line 4.

222. In terms of gauging the level of success of the Project, A/Inspector Hutchings said that the QPS has partnered with the University of Queensland to evaluate the use of body worn cameras. The study will look at issues in relation to the number of complaints made against police, use of force reports, the number of complaints resolved successfully, any reduction in the numbers of complaints made, and any benefits to the prosecution process.[220]

223. A/Inspector Hutchings could say that there had been a high take-up of body worn cameras already by police officers. The inquest heard anecdotal evidence as to positive encounters experienced by police officers in the field due to the use of body worn cameras. There is also an intention to use footage obtained by the body worn cameras as a tool for police training. [221]

224. Counsel Assisting submitted that the evidence heard throughout the s 45 phases and recommendations phase of this inquest has been a testament to the usefulness of body worn cameras. The evidence heard throughout the s 45 phases has clearly pointed to the benefits of frontline officers using body worn cameras. Counsel Assisting submitted that these benefits obviously outweigh any negatives concerning the use of the cameras. It was clear, from A/Inspector Hutchings' evidence, that the funding for the Project related to the provision of 2700 body worn cameras to frontline police, which equates to approximately one third of the number that is actually required to fit every frontline police officer with a camera.

225. The Project is of much benefit to the QPS and is of overall benefit to the criminal justice system. The footage caught by body worn cameras will ultimately result in the increased early resolution of criminal charges brought by police and complaints against the police, resulting in fewer matters proceeding to court. From the evidence heard, it is likely that the research study being commissioned by the QPS with the University of Queensland will shed further light on these matters.

226. I also heard evidence surrounding the QPS Digital Electronic Recording of Interviews and Evidence Manual, a copy of which was tendered during the recommendations phase.[222] That Manual deals with the appropriate use of body worn cameras, in addition to how the devices are to be issued and stored.[223] The Manual extends to the appropriate use of in-vehicle cameras.[224] Counsel Assisting submitted that consideration should be given to expanding the current Manual with respect to these matters so as to clarify further issues pertaining to the responsibility for handling footage, and similar issues.

[220] Recommendations phase transcript of proceedings, day 1, page 82 from line 8.
[221] Recommendations phase transcript of proceedings, day 1, page 82 from line 32.
[222] Exhibit R26.
[223] Exhibit R26 from page 26.
[224] Exhibit R26 from page 28.

227. This inquest has demonstrated that many benefits flow from the deployment of body worn camera to frontline police and to subsequent investigations using the footage captured by these cameras.

228. I also note that as part of the 2016-17 Queensland Budget the Minister for Police announced the commencement of stage two of the state-wide roll out of body worn cameras, which will result in the total number of devices in use in the QPS increasing to 5100 in a total of 168 stations.

Recommendation

15. I recommend that the Queensland Government continue to allocate funds to the body worn camera roll out to enable all front line officers to be equipped with this technology.

Issue 9

9. The need for and, if necessary, the appropriate form of regulation of replica firearms in Queensland. (Kumeroa)

229. This issue was first raised by Detective Sergeant Sandra Pfeffer in her investigation report into the death of Mr Kumeroa. Detective Sergeant Pfeffer recommended the regulation of the sale and possession of replica firearms. During the s 45 phase, Detective Sergeant Pfeffer said "*That is my recommendation, that they should not be freely available just by walking into a store and purchasing weapons which are exact replicas of the real thing*."[225] Detective Sergeant Pfeffer outlined the current legislation relating to replica firearms in her report.

230. During the s 45 phase, it was established from Ms Lamaro's evidence that Mr Kumeroa had purchased the replica firearm he pointed at police from the Collectors Armoury at the Gold Coast War Museum shortly before his death. In Queensland, it is currently not an offence to purchase and own a replica weapon. A range of replica weapons can easily be purchased over the internet.

231. A statement was obtained from Inspector Craig Rolls, Manager of Weapons Licensing within the QPS, which outlines the current legislative provisions under the *Weapons Act 1990* and the *Weapons Regulation 1996*.[226] Inspector Rolls was called to give evidence during the recommendations phase regarding the issues associated with the prohibition of replicas, including:

- How to remove replicas already in the community;
- Whether restitution should be paid by the Government; and
- How a replica weapon should be defined (e.g. should it include a toy?)

[225] Kumeroa transcript of proceedings, day 1, page 31 at line 37.
[226] Exhibit R37.

232. Inspector Rolls drew the Court's attention, in his evidence, to the definition of "replica weapon" in the *Weapons Act 1990* which provides as follows:

> ***"6A What is a replica***
>
> *(1) A **replica of a weapon** is—*
> *(a) a reasonable facsimile or copy of a weapon, even if it is not capable of discharging a projectile or substance; or*
> *(b) a category A, B or C weapon that has been rendered permanently inoperable; or*
> *(c) a hand grenade that is inert.*
> *(2) A **replica**—*
> *(a) of a particular weapon—means a reasonable facsimile or copy of the weapon, even if it is not capable of discharging a projectile or substance; or*
> *(b) of a spear gun, longbow or crossbow—means a reasonable facsimile or copy of a spear gun, longbow or crossbow even if it is not capable of discharging a projectile; or*
> *(c) of a thing prescribed under a regulation—means anything prescribed under a regulation to be a replica of the thing."*

233. Inspector Rolls confirmed that the use of the phrase "*reasonable facsimile or copy of a weapon*" was to provide a means with which to distinguish a replica firearm, from what would obviously be a toy (i.e. a water pistol). Inspector Rolls' evidence in this regard was as follows:

> *"I might just take you back to section 6A. I know that in some cases there's a reference to the use of the phrase "not a toy", or "not obviously a toy", but section 6A uses the phrase "a reasonable facsimile or copy of a weapon" in a number of cases, and that's the way in which the law distinguishes between a water pistol on the one hand and something like the replica weapon carried by Mr Kumeroa: is that correct?---Yes. That's correct."*[227]

234. Inspector Rolls also drew attention to those provisions of the *Weapons Act* which currently prohibit the use of replica weapons. Those sections are:

> ***"57 Particular conduct involving a weapon in a public place prohibited***
>
> *(1) In this section—*
> ***public place** includes a vehicle that is in or on a public place.*
> ***weapon** includes—*
> *(a) an antique firearm, spear gun, longbow or sword; and*
> *(b) a replica of a weapon; and*
> *(c) a replica of a thing mentioned in paragraph (a); and*

[227] Recommendations phase transcript of proceedings, day 1, page 15 at line 3.

(d) a slingshot or shanghai.
(2) A person must not, without reasonable excuse, carry a weapon exposed to view in a public place.
Maximum penalty—40 penalty units or 6 months imprisonment.

58 Dangerous conduct with weapon prohibited generally

(1) In this section—
***weapon** includes—*
(a) an antique firearm, explosive tool, captive bolt humane killer, spear gun, longbow or sword; and
(b) a replica of a weapon; and
(c) a replica of a thing mentioned in paragraph (a); and
(d) an explosive; and
(e) a slingshot or shanghai; and
(f) a laser pointer.
(2) A person must not—
(a) without reasonable excuse; and
(b) by the physical possession or use of a weapon;
engage in conduct, alone or with another, likely to cause—
(c) death or injury to a person; or
(d) unlawful destruction or damage to property; or
(e) alarm to another person.
Maximum penalty—200 penalty units or 4 years imprisonment.

59 Possession or use of weapon under the influence of liquor or a drug prohibited

(1) In this section—
***weapon** includes—*
(a) an antique firearm, spear gun, longbow or sword; and
(b) a replica of a thing mentioned in paragraph (a); and
(c) a slingshot or shanghai; and
(d) an explosive.
(2) A person must not have physical possession of or use a weapon if the person is under the influence of liquor or a drug.
Maximum penalty—40 penalty units."

235. Inspector Rolls confirmed that attending police must always consider that a replica firearm is a real firearm.[228] Generally, the fact that a firearm is a replica is only ascertained after the event. During the event, attending police must perceive the threat as real and take appropriate action to address it.[229]

236. In terms of issues and concerns associated with regulating replica weapons, Inspector Rolls' evidence was that approximately 811,000 items currently require registering and regulation under the *Weapons Act*. In that light, while, on the one hand, full regulation of such weapons would be ideal, there

[228] Recommendations phase transcript of proceedings, day 1, page 15 from line 29.
[229] Recommendations phase transcript of proceedings, day 1, page 15 from line 32.

were issues to address, such as costs and infrastructure. As a starting point, Inspector Rolls said that a total ban on replica weapons would require consultation with the community, as there would be issues of compensation, and potential loss of business to consider.[230] The cost of the additional human resources associated with tracking the replica firearms as they are on-sold, would also need to be considered.[231]

237. Inspector Rolls' evidence was that one of the considerations would have to be whether a person would need to be licensed to possess such firearms, and thus obtain a licence through the QPS Weapons Licensing Branch. This process would require a person to go through the testing provisions relating to their suitability of being a 'fit and proper person'.[232]

238. Inspector Rolls' evidence was that this would be a helpful scenario as it would allow the QPS to regularly monitor the licensee through the QPS licensing system. Inspector Rolls explained that this monitoring process occurs by way of a daily download from the QPS QPRIME system which identifies if persons have committed offences such as *Weapons Act* offences. This then allows for the QPS Weapons Licensing Branch to take appropriate regulatory action against those persons.[233]

239. The possible complicating factors of such a scheme were also explained by Inspector Rolls. Those factors related to the ability to on-sell replica weapons. By way of an example, if a person bought a replica weapon through a tobacconist, or a market, the question would be whether the QPS would be required to license persons to on-sell the replica. If a requirement did exist, resulting in a refusal for a particular person to on-sell a replica, potential ramifications to be considered might include loss of business and claims of compensation to the Government.[234]

240. Inspector Rolls also gave evidence surrounding current issues relating to the manufacture of replica weapons. These issues included the ease with which weapons can now be manufactured at home by way of 3D printing and how this could potentially make any regulatory regime irrelevant. Inspector Rolls said:

> *"Yes. Okay. Now, ease of availability and manufacture, in terms of the implications for a regulatory regime, is part of that problem that a regulatory regime can just become irrelevant in the sense that, if everybody has an opportunity and is able to produce their own weapon, a lot of people may just not choose to obey the law?---That's right. Yes. They'd all be the – the instance of someone who wants to have a firearm that looks like a replica to use for armed robberies. There's options for them.*

[230] Recommendations phase transcript of proceedings, day 1, page 16 from line 7.
[231] Recommendations phase transcript of proceedings, day 1, page 19 from line 5.
[232] Recommendations phase transcript of proceedings, day 1, page 16 from line 32.
[233] Recommendations phase transcript of proceedings, day 1, page 16 from line 35.
[234] Recommendations phase transcript of proceedings, day 1, page 16 from line 44.

> *Yes?---Make it themselves, or even get a toy gun, paint it black. In poor light or – or whatever, the person at the service station could still perceive that's a – a replica firearm – or a real firearm, sorry.*
>
> *And other people who aren't intending to use it, you know, might just see the regulatory system as useful – useless bureaucracy stopping me from doing something that's quite harmless?---Yes."*[235]

241. Inspector Rolls did not have a preferred view on whether scheme for the regulation of replica weapons should be implemented in Queensland.[236] To his knowledge, South Australia and Western Australia do not have regulatory schemes in place. New South Wales and Victoria do have regulatory schemes. Inspector Rolls was not aware of the detail of those schemes. However, Inspector Rolls provided information about a 2008 motion of the Ministerial Council for Police and Emergency Management (MCPEM).[237]

242. At that MCPEM meeting, Ministers agreed in principle to pursue legislative or regulatory change to implement national minimum standards for imitation firearms. This motion was named 'Resolution 3.5'.[238] Inspector Rolls confirmed that since his being in Weapons Licensing from 2011, he was not aware of the issue being tabled, or further pursued at a national level through that forum.[239]

243. To the extent that Inspector Rolls was unaware of how the schemes in New South Wales and Victoria operated, Detective Sergeant Pfeffer provided some detail in her report on these matters.[240] She confirmed that New South Wales, Victoria, South Australia and Tasmania all include certain replica or imitation weapons within the definition of firearm. As a result, permits or licenses are required for the purchase and possession of those replica weapons in those States. Governments which have implemented laws relating to replica weapons have usually established amnesty periods to allow people to surrender any relevant replica weapons.

244. In South Australia, the *Firearms Regulation 2008* provides in Regulation 5(2)(a) that a regulated imitation firearm is:

> *"(a) an item that contains a mechanism that imitates the loading mechanism or firing mechanism of a firearm*"

245. Therefore, to fall within regulation 5(2)(a), an item must contain a mechanism, or mechanical parts, which imitate the loading or firing mechanism of a firearm. This allows, to an extent, for toy guns to be excluded from the definition.

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[235] Recommendations phase transcript of proceedings, day 1, page 18 from line 17.
[236] Recommendations phase transcript of proceedings, day 1, page 19 from line 33.
[237] Exhibit R37.1, page 1, email dated 13.10.2016; Recommendations phase transcript of proceedings, day 1, page 20 from line 22.
[238] Exhibit R37.1, page 1, email dated 13.10.2016.
[239] Recommendations phase transcript of proceedings, day 1, page 20 from line 22.
[240] Exhibit A9; Kumeroa brief of evidence; from page 56 para 5.24.

246. In New South Wales, the *Firearms Act 1996* per section 4D, provides for licensing of imitation firearms in the following way:

> *"**4D Special provisions relating to imitation firearms***
>
> *(1) This Act applies to an imitation firearm in the same way as it applies to a firearm, subject to the following:*
> *(a) the Commissioner may not issue a licence authorising the possession or use of an imitation firearm (except to a firearms dealer) but may issue a permit authorising the possession or use of an imitation firearm,*
> *(b) an imitation firearm is not required to be registered.*
> *(2) For the purposes of the application (as provided by this section) of this Act to imitation firearms:*
> *(a) an imitation firearm that is an imitation of a pistol is taken to be a pistol, and*
> *(b) an imitation firearm that is an imitation of a prohibited firearm is taken to be a prohibited firearm.*
> *(3) In this section, imitation firearm means an object that, regardless of its colour, weight or composition or the presence or absence of any moveable parts, substantially duplicates in appearance a firearm but that is not a firearm.*
> *(4) However, an imitation firearm does not include any such object that is produced and identified as a children's toy."*

247. New South Wales helpfully provides, by way of s 4D(4), that an object produced and identified as a children's toy is not the subject of the imitation firearm provisions and regulations.

248. Firearms and imitation firearms are regulated in Victoria under the *Firearms Act 1996* and *Control of Weapons Act 1990* respectively. Section 3 of the *Control of Weapons Act 1990* provides the definition of imitation firearms as follows:

> "***imitation firearm** means a device—*
>
> *(a) the appearance of which could reasonably be mistaken for that of an operable firearm; but*
> *(b) which is not designed or adapted to discharge shot or a bullet or other missile by the expansion of gases produced in the device by the ignition of strongly combustible materials or by compressed air or other gases, whether stored in the device in pressurised containers or produced in the device by mechanical means and is not capable of being made to do so*"

249. Section 5AB of the *Control of Weapons* Act *1990 (Vic)* provides for the offence of possessing an imitation firearm as follows:

> "***5AB Offence to possess, use or carry an imitation firearm***

(1) A non-prohibited person must not possess, use or carry an imitation firearm without an exemption under section 8B or an approval under section 8C.
Penalty: 240 penalty units or imprisonment for 2 years.
(2) A prohibited person must not possess, use or carry an imitation firearm.
Penalty: 1200 penalty units or imprisonment for 10 years."

250. While New South Wales, Victoria and South Australia all have a regulation scheme in place in relation to replica or imitation weapons, each State has a different approach with respect to the process to be used. As Queensland and Western Australia having no regulatory scheme in place, the national picture is one of a complete lack of consistency.

251. Detective Sergeant Pfeffer helpfully identified the proposed national approach to the regulation of replica firearms, stemming from the National Committee set up in the aftermath of Port Arthur. In June 2014, the Senate referred '*The ability of Australian law enforcement authorities to eliminate gun-related violence in the community'* to the Legal and Constitutional Affairs References Committee for inquiry and report by 26 March 2015. The terms of reference for that inquiry included "*the extent to which there exist anomalies in federal, state and territory laws regarding the ownership, sale, storage and transit across state boundaries of legal firearms, and how these laws relate to one another."*[241]

252. In addition to the Senate inquiry, a national Firearms and Weapons Policy Working Group (FWPWG) is also in existence. The aim of that group is to "*drive the development of national and consistent policy on firearms and weapons-related issues that are common to all jurisdictions."* Detective Sergeant Pfeffer, ultimately, concluded, in her evidence, that the combination of the inquiry and FWPWG may culminate in weapons legislation change in Queensland.[242]

253. The Senate Committee's Report, *Ability of Australian law enforcement authorities to eliminate gun-related violence in the community,* was tabled on 9 April 2015. The Committee Report contained recommendations from some Committee members relevant to the productions of operational 3D weapons but none about the regulation of replica firearms.

254. Senior Sergeant Hayden also included a summary of the current position in Queensland relating to the possession and use of replica firearms.[243] He also provided detail about a previous coronial inquest involving a replica firearm, namely, the Inquest into the death of Jason Protheroe, where no recommendations were made about the regulation of replica firearms.[244]

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[241] Exhibit A9; Kumeroa brief of evidence; from page 57 para 5.29.
[242] Exhibit A9; Kumeroa brief of evidence; from page 58 para 5.32.
[243] Exhibit R5, page 26, from para 100.
[244] Findings of inquest into the death of Jason Paul Protheroe; http://www.courts.qld.gov.au/courts/coroners-court/findings.

255. Senior Sergeant Hayden made a recommendation in his statement that the following proposal be given consideration:

> *(i) "That persons wishing to acquire a replica of any type of handgun other than an obvious non-weapon (such as a child's toy, cap gun, water pistol, "nerf" type toy, fantasy type weapon, etc.) obtain, complete and register the weapon with a Certificate of Registration similar to that is required of Antique Concealable Firearms or Handguns.*
> *(ii) The completion of a Certificate can be a requirement condition of any possession, purchase or on-selling. It will require the filling out of a single form with purchaser details and a basic identification check. (Driver's licence etc.) Sellers can send or fax details through to the QPS Weapons Licensing Branch. This simple process can be completed at the point-of-sale.*
> *(iii) Information will be collated and stored with the QPS Weapons Licensing Branch.*
> *(iv) This information may assist police in responding to incidents where these types of weapons may be a factor in deciding the tactical response.*
> *(v) Persons obtaining this Certificate are not required to obtain a Weapons Act licence or be subject to the ongoing high level of security applied to concealable handguns, but will be responsible for the storage and basic security precautions of the weapon. As an example, not allowing a child to play with the weapon as a toy or not carrying the weapon in public without a reasonable excuse.*
> *(vi) From time to time a "Firearms Amnesty" can be called by the Commissioner of Police giving an opportunity for persons possessing such weapons the ability to register any unrecorded replica without fear of sanction, or hand them in for disposal."*[245]

256. Inspector Rolls made it clear in his evidence the fact that even if police do have a notification that a person possesses a replica handgun, and that person presents to police with a handgun, police would still have to deal with that situation as one involving a real handgun. This is due to the possibility that the person might, in addition to the known replica weapon, also have access to a real weapon. So, the police response even with a regulatory scheme in place relating to replica weapons, would still be the same as it is now.[246]

257. Under cross-examination from Mr Gnech for the QPUE, Inspector Rolls accepted that the positive points relating to regulation of replica weapons focused on community safety. Inspector Rolls also accepted that the negative points focused around logistics, costs and resources.[247]

258. Appreciating the evidence that, ultimately, police will always have to deal with the threat of a firearm as a real one if they perceive the firearm to be real, Counsel Assisting submitted that there is merit in a State-wide

[245] Exhibit R5, page 26, para 101.
[246] Recommendations phase transcript of proceedings, day 1, page 22 from line 1.
[247] Recommendations phase transcript of proceedings, day 1, page 26 from line 5.

regulatory scheme being explored further by the Minister for Police, because of the current ease by which any person can purchase a replica firearm, without any details of that person being obtained, nor checks of that person's criminal history being made.

259. The monitoring of the purchase of replica firearms by the QPS may act as a deterrent for persons considering whether to purchase such a firearm. This may, in turn, reduce the number of presentations police experience involving persons with replica firearms. Counsel Assisting submitted that I consider recommending that this possibility should at least be explored further, by the QPS and the Minister for Police.

260. The QPS submission indicated that the QPS can consider this recommendation, which would impact on potential amendments to the *Weapons Act 1990*.

Recommendation

16. I recommend that the Queensland Government consider whether a scheme for the regulation of replica firearms with linkages to relevant QPS intelligence holdings should be established in Queensland, having regard to interstate legislation and the work of the national Firearms and Weapons Policy Working Group.

Issues 10 & 11

10. The effectiveness of the negotiation processes as observed in the incident involving Mr. Kumeroa, including the options available for use when trying to negotiate a surrender plan and ways in which the process might be assisted in future. (Kumeroa)

11. The positioning of the inner cordon police officers in the incident involving Mr. Kumeroa leading to the necessity to use lethal force soon after Mr. Kumeroa departed his car and whether any practical alternatives were available or might be available in a future incident. (Kumeroa)

261. These issues are specific to the death of Mr Kumeroa but were not specifically dealt with in my s 45 findings, and were ultimately not matters of controversy. The evidence relating to the negotiation tactics was largely received from Detective Senior Sergeant Richard Lacey during the s 45 phase.[248] Some evidence was given on these issues during the recommendations phase by Professor Alpert and Senior Sergeant Hayden.

262. Professor Alpert was unable to provide any comment on the use of tactics by negotiators. During his evidence, Professor Alpert agreed with the

[248] Kumeroa s 45 phase transcript of proceedings, day 2, page 51 from line 37.

proposition that it is important that every frontline police officer have some training in negotiation and 'tactical speaking'.[249]

263. Senior Sergeant Hayden's evidence about the positioning of the Bearcat and, the inner cordon was that, in a siege situation, the immediate priority of frontline police would be to put in place a foot escape plan and a vehicle escape plan.[250]

264. The foot escape plan needed to negate the risk posed by Mr Kumeroa if he were to exit the vehicle and enter a nearby dwelling. This plan involved the first response officers putting in place a basic cordon around Mr Kumeroa's vehicle, while holding him at gunpoint and calling upon him to surrender. These officers were eventually replaced by SERT officers.[251]

265. The vehicle escape plan needed to negate the risk posed if Mr Kumeroa were to attempt to escape using his vehicle. The ability to move the Bearcat within close proximity to Mr Kumeroa's car meant that this effectively blocked this means of escape. Given that the only method available to the QPS to bring a moving vehicle safely to rest involves use of Stinger tyre deflation spikes, the use of the Bearcat in this way was appropriate.[252]

266. Senior Sergeant Hayden's evidence was that having the negotiator at close range in the back of the Bearcat allowed for the negotiator to look through the side panels of the Bearcat and observe Mr Kumeroa. This was of benefit to the negotiator as it allowed them to observe the effect of the negotiation on the person they are trying to negotiate with.[253]

267. Considering Senior Sergeant Hayden's evidence, coupled with evidence heard from the negotiators during the s 45 phase, Counsel Assisting submitted that I can be satisfied that the negotiation processes utilised in Mr Kumeroa's case were appropriate in the circumstances. The positioning of the Bearcat and, indeed, the inner cordon was also appropriate in the circumstances. I accept those submissions.

268. Counsel Assisting referred to evidence heard from SERT operative 113 during the s 45 phase, to the effect that, because SERT officers were closer to Mr Kumeroa than the negotiators, they were able to engage in a more effective conversation with him.[254] In that regard, SERT operative 113 gave evidence, to the effect, that it might be helpful for some sort of negotiator presentations and/or communications training to be provided to SERT officers.

[249] Recommendations phase transcript of proceedings, day 4, page 14 from line 6.
[250] Recommendations phase transcript of proceedings, day 3, page 21 from line 24.
[251] Recommendations phase transcript of proceedings, day 3, page 21 from line 26.
[252] Recommendations phase transcript of proceedings, day 3, page 21 from line 39.
[253] Recommendations phase transcript of proceedings, day 3, page 22 from line 7.
[254] Kumeroa s 45 phase transcript of proceedings, day 3, page 79 from line 6.

269. Inspector Bradley Wright gave evidence as to the extent of the interaction between SERT and the negotiators, as follows:

> *"Do the SERT officers, do they receive communication training as part of their training, because at least a couple of them have said they've done very well in the situation?---They've got a lot of experience. We – they aren't trained negotiators, but the negotiators unit is part of SERT, and so there is constant interaction. They go to a lot of sieges. There's constant – or fairly regularly instruction given by the – by the negotiators, and as strategies change they will come and present on that. But generally speaking, it is just from experience, and – and they understand that the focus is on negotiation and they will – they know what they've said before and what's – what's been able to get re-engagement before."*[255]

270. An internal SERT memorandum was tendered during the s 45 phase[256] and, again, during the recommendations phase[257] which outlined several training issues to be addressed as a result of the Kumeroa case. One such matter outlined under this heading was as follows:

> *"Interoperability with Negotiators – Throughout this incident, SERT officers maintained a dialogue with the POI whenever he ceased communication with the QPS Negotiator or whenever he was observed to be escalating in his behaviour.* ***SERT Training Cell Sergeant to coordinate presentation from negotiators on basic negotiation skills."***[258]

271. Counsel Assisting supported the suggestion put forward by SERT operative 113 and effectively re-stated in the evidence as tendered.[259] Counsel Assisting submitted that I consider recommending that the QPS Negotiator Coordination Unit work with SERT to develop a means by which negotiator specific presentations and/or communications training can be provided to SERT officers.

Recommendation

17. *I recommend that the QPS continue to provide SERT officers with training in negotiation and de-escalation skills to ensure that they are equipped to deal with parties in siege situations and other high risk environments*.

Issues 12 & 13

12. The adequacy and appropriateness of QPS policies, procedures and training for Police Communications personnel, especially, in dealing with nuisance callers who are not an appropriate use of 000 service time but may be people

[255] Kumeroa s 45 phase transcript of proceedings, day 3, page 12 from line 20.
[256] Kumeroa brief of evidence; Exhibit C62.
[257] Exhibit R45.
[258] Exhibit R45 at page 2, para 11.
[259] Ibid.

facing emotional or other difficulties and may require QPS assistance. (Zimmer)

13. Methods available to first response police officers who are deployed to deal with nuisance callers including means of establishing and maintaining communications without necessarily requiring officers to enter dwelling houses to prevent calls from continuing. (Zimmer)

272. These issues were specific to the Zimmer shooting and were not dealt with in my s 45 findings. As a result, they were issues for the recommendations phase of the inquest. Evidence relating to the issues was heard from A/Superintendent Denis Fitzpatrick, Manager of the Brisbane Police Communications Centre, during the s 45 phase.[260]

273. Additional evidence was heard during the recommendations phase from the A/Superintendent of the Communications Group within the Community Contact Command, David Nevin.[261] In that role, A/Superintendent Nevin holds responsibility for the management of all police communication centres in Queensland. Some evidence was given on these issues during the recommendations phase by Professor Alpert and Senior Sergeant Hayden.

274. The relevant portion of my s 45 findings into Mr Zimmer's death is set out below:

> *46. Police records confirm that 21 calls from Mr Zimmer's mobile number were made to police via the 000 line after 11:30pm. I was provided with statements from each of the call takers involved in these calls as well as recordings and transcripts of the calls themselves. The responses to Mr Zimmer's repeated calls differed widely among the call takers, depending on their level of experience and personality. It is clear that their skills in dealing with Mr Zimmer varied considerably. Some responses were less than helpful and appeared to goad Mr Zimmer, escalating his level of agitation.*
>
> *47. The difficulty for call takers was that Mr. Zimmer was not seeking police assistance to deal with an emergency. Therefore, his calls were classified as nuisance calls. The QPS view was that these calls potentially blocked emergency lines, and could delay emergency assistance to another caller who was facing a genuine emergency. The response of call takers was to terminate the calls rather than investigate the reason Mr Zimmer had called in any depth.*
>
> *48. Senior Constable Carlene Groube eventually provided Mr Zimmer with advice to call the number for PoliceLink – 131 444.*
>
> *49. It was submitted on behalf of Mr Zimmer's family that a referral to PoliceLink should have occurred earlier in the course of the calls. I consider that if the call takers were more skilled in eliciting information from Mr Zimmer that may have been an option. The analysis of his calls suggests that he*

[260] Zimmer brief of evidence; Exhibit B30 and transcript of proceedings, day 4, page 54 from line 35.
[261] Exhibit R41; Recommendations phase transcript of proceedings, day 1, page 30 from line 1.

expressed various reasons for calling, ranging from seeking QPS attendance at the address of the person he had fought with at Margate to wanting to fight police and complain about his treatment when arrested.

50. *At the inquest I was assisted by evidence from Superintendent Denis Fitzpatrick, who commands the Brisbane call centre and has, at times, acted as the State Administrator for the communications section of the QPS.*

51. *Superintendent Fitzpatrick gave evidence concerning the training of the call takers and how they are to deal with nuisance calls. His evidence was that there is, and was at the time of Mr Zimmer's death, the technical capability for 000 calls to be transferred from a call taker on a 000 call to the PoliceLink service.*

52. *However, this is not an option which is used and indeed appears not to be widely known including, by Communications Coordinators (COMCO's) who are in charge of Regional Communications rooms for a particular shift.*

53. *Mr Zimmer's calls were eventually assessed as nuisance calls by the Acting Police COMCO for the Redcliffe and Caboolture Districts for that shift, Sergeant Krista Owens. I note that Sergeant Owens had not been provided with training in relation to PoliceLink.*

54. *Sergeant Owens was operating out of the communications room at Maroochydore. Only seven of Mr Zimmer's calls had actually reached Sergeant Owens' communication room, indicating that his other calls were diverted to other centres across Queensland because the Maroochydore room was fully occupied with other calls.*

55. *Sergeant Owens made the decision to task officers from the Redcliffe Police Station to attend Mr Zimmer's house with the objective of causing the calls to stop. I am satisfied from the evidence that she was authorised to take this action.* [262]

……

70. *In his evidence, Superintendent Fitzpatrick made it clear that Sergeant Owens' decision was in accord with her training and Communications practice at the time. Sergeant Owens said in her evidence that she was unaware that a call received as a 000 emergency call could be switched through directly to PoliceLink call takers, who have a completely different role.*

71. *I accept the submission of Counsel Assisting that placing police officers in a situation of unknown but likely significant risk in order to prevent nuisance calls should only happen after less risky and less dangerous options have been exhausted. That submission was made with full acknowledgement of the importance of the 000 service and the communications resources on which it depends.*

[262] Findings of inquest into the death of Laval Donovan Zimmer, pages 7-9, paragraphs 46-55.

72. Superintendent Fitzpatrick was frank in his evidence and accepted that various safer options might have been used. These included earlier referral to PoliceLink; detailing the local station shift supervisor to exercise discretion in dealing with the situation (including by calling the nuisance caller); and possible use of QPS trained negotiators. These options might have been available on the night or made available relatively easily in the future.

73. It was submitted on behalf of Mr Zimmer's family that the alternatives ought to have been considered by Sergeant Owens prior to tasking police to attend his residence, and that in that circumstance, her decision was inappropriate.

74. However, I am unable with the benefit of hindsight to be critical of Sergeant Owens for tasking the officers to attend. I appreciate the series of pressures facing a COMCO during a shift, and the large number of issues demanding attention when balancing resources and making decisions. I accept that her motive for requiring police to attend included wanting to have police check on Mr Zimmer's welfare. I also accept that the COMCO does not have access to the same level of detail in relation to calls as the call taker.

75. I also accept that once Sergeant Owens had tasked officers from Redcliffe to attend at Mr Zimmer's residence, they were equipped with enough information to suggest a risk assessment was required, and could exercise their independent judgement at the scene in relation to strategy prior to entering the residence.

76. I consider that the recommendations phase of this inquest should closely examine ways in which the QPS can deal with threats to the public interest arising from nuisance callers, particularly those experiencing mental illness, without placing the safety of police officers, and members of the public, at risk.[263]

275. In her investigation report, Detective Sergeant Pamela Leech explained the overall rationale of the police response to nuisance calls. She explained that nuisance calls, depending on their content, are considered as offences. She confirmed section 474.18 of the *Criminal Code Act 1995 (Cth)*, relating to the improper use of emergency call service, provides a person is guilty of an offence if they make a call to an emergency service number, other than for the purpose of reporting an emergency.[264] Further, section 474.17, relating to using a carriage service to menace, harass or cause offence, provides a person is guilty of an offence if they use a carriage service in a way that reasonable persons would regard as being, in all the circumstances, menacing, harassing or offensive.

276. The degree of concern with which the QPS attaches to nuisance calls is also set out in Detective Sergeant Leech's report, as follows:

[263] Findings of inquest into the death of Laval Donovan Zimmer, pages 10-11, paragraphs 70-76.
[264] Zimmer brief of evidence, Exhibit A10, pages 89-90, paragraphs 5.24-5.25.

> *"As stated in Acting Superintendent Fitzpatrick's statement, PCCs hold the responsibility to answer all 000 calls. The standard is to answer 100% on first presentation. This pressure also creates a mindset amongst operators. Calls are to be answered quickly and efficiently and no time to be wasted by someone who appears to be making nuisance calls. The call takers believe they instead could be assisting someone who has a real emergency."*[265]

277. With respect to the 21 calls made by Mr Zimmer, it is apparent that they were not all dealt with in a professional manner. In his report, Professor Alpert states:

> *"First, there should be some way for 000 and Policelink dispatchers to manage multiple, harassing calls. While outside the purview of this report, it seems that a better management of these calls could have defused some of Mr. Zimmer's anger when the police came to his house."*[266]

278. During her investigation, Detective Sergeant Leech examined the extent to which call takers are trained. She confirmed in her report that Police Communication Centres provide training for a person to become a call taker.[267] Call takers are trained from a handbook which outlines the importance of 000 calls. The handbook also outlines how to speak to a caller and general rules of etiquette. During the course required to become a call taker, participants are taught how to answer emergency 000 calls with reference to the Client Service Charter. The handbook also covers tactical communication and ways to deal with difficult calls. This section refers to being polite, respectful and professional always. A synopsis of the Call Taker Course was tendered during the inquest.[268]

279. During her evidence in the s 45 phase, Detective Sergeant Leech was asked whether, in the Call Taker Course, there was any particular focus on tactical communication:

> *"Just in paragraph 5.41, you talk about the call taker course outline and, from what you were saying, you indicate that there's no particular focus on tactical, tactical communication - - -?---No, there's not.*
>
> *- - - ability to deal, find out what people's real problems are, etc. I think it also deals with some of the issues that you and I've already discussed. One is that people expect to be referred to an agency that can help them. That seems to be reflected in Mr. Zimmer's – even though it was a nuisance call, he seemed to think that somebody could respond to his concerns?---Yeah, yeah. Yes."*[269]

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[265] Zimmer brief of evidence, Exhibit A10, page 89, paragraph 5.21.
[266] Exhibit R32, page 30.
[267] Zimmer brief of evidence, Exhibit A10, page 91, paragraph 5.40.
[268] Zimmer brief of evidence, Exhibit C17.
[269] Zimmer s 45 phase transcript of proceedings, day 1, page 93 from line 16.

280. The State-wide Call Taker Upskill Training, which is also covered in the tendered synopsis,[270] outlines phone call management and provides the suggested dialogue that should be followed when answering a 000 call. This training also lists the standard required of a call taker in a police communication centre, focusing on professionalism.[271]

281. Detective Sergeant Leech confirmed that, during her investigation, one call taker was identified as having had conversations with Mr Zimmer which were formally deemed to be less than professional. That call taker was dealt with through the QPS complaint management process.[272]

282. Detective Sergeant Leech recommended that consideration should be given to develop advanced training for call takers in topics such as conflict management and negotiation.[273] When asked to expand upon this in the s 45 phase, her evidence was that tactical communication is just for call takers but for all police.

283. A/Superintendent David Nevin was also able to give evidence about current training programs for call takers. His evidence was in addition to that contained within a written statement by Superintendent Glenn Horton.[274] In that statement, Superintendent Horton had confirmed a special training development project had been underway since early 2015, that is, commencing soon after Mr Zimmer's death. The purpose of that project was to review the whole of the communications group curriculum, consider and design new courses, and advise on training delivery across Queensland.[275]

284. A/Superintendent Nevin explained that the Training Development Team had re-written the training curricula for radio dispatch and call taking.[276] He explained that, to become a communications operator, one has to pass both aspects of the training. It involves an eight-week course, with four of those weeks dealing with a combination of learning the QCAD system and call taking. The remaining four weeks deal with radio dispatch.

285. During the eight-week course, regular examination days are scheduled, during which the participants are given varied real-life scenarios to deal with. A/Superintendent Nevin explained the participants are required to meet strict standards when being examined on these scenarios.[277]

286. Once a participant has completed the course, they are placed in a communications centre and mentored by more experienced operators.

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[270] Zimmer brief of evidence, Exhibit C17.
[271] Zimmer brief of evidence, Exhibit A10, page 92, paragraph 5.41.
[272] Zimmer brief of evidence, Exhibit A10, pages 91-92.
[273] Zimmer brief of evidence, Exhibit A10, page 117.
[274] Exhibit R30.
[275] Exhibit R30, paragraph 6.
[276] Recommendations phase transcript of proceedings, day 1, page 44 from line 40.
[277] Recommendations phase transcript of proceedings, day 1, page 45, lines 1-2.

The period with which the mentoring occurs is about two weeks. A/Superintendent Nevin's evidence was that if deficiencies are identified with the operator's standard of work, they can be sent back for a refresher course in the relevant aspect of training and then be required to undergo further mentoring. A/Superintendent Nevin's evidence was that an operator will not be allowed to work until they have met the required standard.[278] Further to this, the level of monitoring continues on a regular basis even once the operator has been signed off as competent so as to ensure the level of competency does not deteriorate over time.[279]

287. A/Superintendent Nevin confirmed that, prior to the review taking place, the communications centres across the State each had their own training packages and mechanisms for delivering that training. In fact, some centres did not have any training packages.[280] The review has allowed for the Training Development Team to standardise the training delivered to all call takers and radio dispatchers across the State.

288. A/Superintendent Nevin acknowledged in his evidence the varying quality of responses provided by the call takers when dealing with Mr Zimmer. When the A/Superintendent was asked whether the call takers in place, prior to the review commencing, would expect to be re-trained to be in line with the current standard, he said it was a case of dealing with the worst first, and then progressing forward.

289. A/Superintendent Nevin confirmed under cross examination that there is a component of mental health training in the current PoliceLink communications operators training. A similar component does not exist in the police communications training. However, it is in the process of being developed by the Training Development Team.[281] The A/Superintendent explained that due to the structure of PoliceLink being markedly different to that of the police communications centres, a different roll out was required for the respective training packages. The mental health component of the training, upon its completion, is to apply to both sworn police officers and civilian employees.[282]

290. A/Superintendent Nevin was asked during his evidence about the capacity for 000-call takers to transfer a call to the non-urgent police line, PoliceLink. The question, and the context surrounding it, were put to the A/Superintendent as follows:

> *"So my question is really this. If nuisance – if an obviously disturbed person was repeatedly calling triple zero now and thereby misusing those resources because they didn't have the type of emergency that triple zero is designed, would the benefits of transferring to Policelink or*

[278] Recommendations phase transcript of proceedings, day 1, page 45, from line 4.
[279] Recommendations phase transcript of proceedings, day 1, page 45, from line 37.
[280] Recommendations phase transcript of proceedings, day 1, page 45, from line 15.
[281] Recommendations phase transcript of proceedings, day 1, page 63 from line 31.
[282] Recommendations phase transcript of proceedings, day 1, page 63 from line 11.

telling the person to ring Policelink be recognised quickly and so that the supervisor would say, "Look, this guy's obviously got some problems but he's not for us. Can we – next time he calls, can we switch him through to Policelink or make sure he knows about it." I'm just wondering whether that state of knowledge – it seems to be an important aspect of the strategic plan, as it were, but has that state of knowledge got down to all the call takers and all the supervisors now?---The – the ability for us to transfer from our triple zero centres to Policelink actually was enabled in January this year."[283]

291. Counsel Assisting submitted that I can be satisfied that the capacity to transfer a 000 call to PoliceLink exists, and since Mr Zimmer's death, awareness of that has increased across police communications centres. Further to this, A/Superintendent Nevin was asked during his evidence about the proposal put forward by Senior Sergeant Hayden for a Nuisance Caller Diversion Protocol to be put in place.[284] The A/Superintendent agreed that a similar type of policy and/or practice has now been adopted and communicated to the call takers.[285]

292. In terms of where the information relating to the appropriate response to nuisance calls is placed, A/Superintendent Nevin was also asked whether that type of information should be incorporated into the QPS OPM. His evidence was that the information lends more to a communications centric issue, so that it is more appropriately placed in the standing instructions which are available to all call takers via the Share Point site.

293. It is apparent from listening to several of the 000 calls made by Mr Zimmer that there was inadequate training for call takers in dealing with members of the public calling 000 without an emergent issue. Call takers should receive training in communication skills and civilian call takers should not be excluded from this training.

294. More generalised communication skills might best be part of an integrated approach in dealing with people affected by mental health issues and other issues affecting their mental functioning. It is clear from the evidence heard throughout the inquest that substantial work is going on within the QPS, and more specifically by the Training Development Team, which is directly relevant to these issues.

295. Counsel Assisting submitted that the most effective way for police to deal with nuisance callers is to have them categorised as non-urgent calls and, subsequently, referred and/or transferred to Policelink at the earliest opportunity. Nuisance calls should be treated as core police business since they may indicate an important need affecting the caller, even though this might not be an emergent need at the time of the call.

[283] Recommendations phase transcript of proceedings, day 1, page 46 from line 21.
[284] Exhibit R6, paragraphs 166-168.
[285] Recommendations phase transcript of proceedings, day 1, page 48 from line 15.

296. I found the evidence from A/Superintendent Nevin, regarding the steps taken by the QPS to widely disseminate and encourage the ability to refer/transfer calls to PoliceLink, helpful in this respect.

297. Counsel Assisting urged that this ability, combined with improved communications training and standards of performance for call takers, both sworn and civil, as is being undertaken by the Training Development Team, should provide me with a degree of satisfaction that further calls like Mr Zimmer's, will be treated in a more appropriate and understanding way.

298. Counsel Assisting submitted that I should consider recommending that the QPS continue to examine the way in which it deals with threats to the public interest arising from nuisance calls, with a view to continually improve the communication training made available to call takers, both sworn and civil, with respect to dealing with callers who may have a mental illness. Such examination should address both training and technology solutions.

299. Submissions on behalf of Mrs Zimmer and the Foster family sought to critique the response of the officers who attended at Mr Zimmer's home on the night of his death. I have already made comment in my s 45 findings about the methods available to first response police by which they can deal with nuisance callers, including establishing and maintaining communications with nuisance callers.[286] In those findings, I found that there were clearly other options that might have been used to respond to Mr Zimmer, including earlier referral to PoliceLink; detailing the local station shift supervisor to exercise discretion in dealing with the situation (including by calling the nuisance caller); and possible use of QPS trained negotiators.

300. Submissions on behalf of Mrs Zimmer and the Foster family sought the following specific recommendations for inclusion in training and standard operating procedures arising from the circumstances of his death. I have referred to these matters in recommendation 7 above:

- *Police officers attending a call for service where threats of violence have been made towards police officers should anticipate that the suspect may be armed and plan accordingly.*
- *Police officers should consider the advantages and disadvantages of inviting a suspect to come outside a building and plan accordingly.*
- *Police officers who expect violent resistance from a suspect should not put members of the public between themselves and the suspect.*

[286] Findings of inquest into the death of Laval Donovan Zimmer, pages 10-11, paragraph 72.

301. Submissions on behalf of Mrs Zimmer and the Foster family also submitted that the OPM should require a warning to be given prior to the use of lethal force. Chapter 14 of the OPM now provides that officers should read and follow the principles contained in the '*Australia New Zealand Guidelines for deployment of police to high risk situations'* with respect to the use of lethal force. Guideline 35 provides as follows:

> *Where the use of firearms by police officers is warranted, police should if possible without adding undue risk to themselves or to others under threat:*
> *(i) identify themselves as police;*
> *(ii) give a clear verbal warning of their intent to use firearms;*
> *(iii) not fire warning shots; and*
> *(iv) ensure there is sufficient time for the warning to be acted on before using firearms, unless it would:*
> > *(a) unduly place the officer at risk;*
> > *(b) create a risk of death or serious harm to other persons; or*
> > *(c) be clearly inappropriate in the circumstances.*

Recommendations

18. I recommend that the QPS continue to examine the way in which it deals with threats to the public interest arising from nuisance calls, with a view to continuous improvement in the communication training made available to all call takers with respect to dealing with callers who may have a mental illness and/or cognitive impairment. Such examination should address both training and technology solutions.

19. I recommend that the QPS incorporate options for dealing with nuisance callers in relevant standing instructions and mandatory training for call takers including:

- *early diversion to PoliceLink or another support agency, including the caller's primary clinician;*
- *interrogation of Q-Prime to ascertain relevant mental health history;*
- *giving local station shift supervisors discretion in dealing with the situation (including by calling the nuisance caller); and*
- *engagement of mental health clinicians embedded in QPS communications centres;*
- *engagement of QPS trained negotiators.*

Issue 14

14. The appropriateness of the mental health assessment of Troy Foster conducted at the Gold Coast University Hospital on 24 November 2014. (Foster)

302. The circumstances surrounding Mr Foster's attendance at the Gold Coast University Hospital ('GCUH') in the early hours of 24 November 2014, as taken from my s 45 findings, as follows:[287]

> *49. "Senior Psychologist, Carla Ferrari, gave evidence at the s 45 phase of the inquest that on the morning of 24 November 2014, she was called in to assist at the hospital shortly after she had arrived at the outpatient clinic at Ashmore. She was asked to assist as an unusually high number of patients required mental health assessments. Ms Ferrari is a registered psychologist with eight years' experience.*
>
> *50. After Ms Ferrari attended at the hospital she spoke with the MHLN on shift and was provided with a handover of the current list of patients waiting to be seen. She reviewed Mr Foster's EEO and Medical Evaluation Form and noted that the timeframe for involuntary assessment had lapsed. However, Mr Foster had been compliant with hospital staff and was engaging during her interaction with him.*
>
> *51. Mr Foster was still asleep, and had to be woken by Ms Ferrari so that she could commence her mental health assessment. The assessment went for about 90 minutes. A copy of that assessment was tendered at the inquest.[288]*
>
> *52. Ms Ferrari recalled in her evidence that she considered Mr Foster to be 'scattered' and it was her opinion that he was displaying indicia consistent with drug use. Mr Foster admitted drug use during the assessment, stating that he used 1.5 points of 'Ice' every day, in addition to cannabis. He told Ms Ferrari that he had crashed the car on purpose to try and kill himself.*
>
> *53. Ms Ferrari asked Mr Foster if he was depressed. He answered that he did not suffer depression but was angry all the time. When asked what he was angry about, Mr Foster said it was mainly due to 'conflict with his family over his drug use and having to go to court and being in and out of jail'. Ms Ferrari gave evidence that she asked Mr Foster directly if he wanted to kill himself. Ms Ferrari confirmed that Mr Foster displayed no plan, intent, or ideation to suicide at the time of her assessment.*
>
> *54. Ms Ferrari's opinion was that Mr Foster's issues were not related to mental health but, rather, his lifestyle and personality vulnerabilities stemming from drug use and anti-social behaviour. She concluded that, while there was history of drug-induced psychosis, there was no evidence of a mental illness, insofar as there was no evidence of an*

[287] Findings of inquest into the death of Troy Martin Foster.
[288] Foster brief of evidence, Exhibit C5.

'Axis I disorder', mood disturbance, pervasive psychotic illness or acute psychotic symptoms. Ms Ferrari was of the opinion that drug rehabilitation was the most appropriate course of action for Mr Foster and that he was not at acute risk.

55. At the end of the assessment, Ms Ferrari informed Mr Foster that he would need to wait to be medically cleared due to the car crash in which he had been involved. Ms Ferrari recalled that she had also mentioned to Mr Foster that the police wanted to speak with him before he left the hospital.

56. After assessing Mr Foster, Ms Ferrari also called Ms Ryan to obtain 'collateral' information about Mr Foster to assist in her assessment. Ms Ferrari said that this was her usual practice and helped to either confirm or deny the information provided during the assessment. This phone conversation lasted about fifteen minutes.

57. Not long after speaking with Ms Ryan, Ms Ferrari received a phone call from the MHLN asking if she had Mr Foster with her. This was after she had consulted with Dr Rawley about Mr Foster's presentation. It was at this point it was discovered that Mr Foster might have absconded. Ms Ferrari said that at around this time, she called police to advise that he would be discharged and to find out what Mr Foster was wanted for. She also passed this on to the MHLN. However, she did not recall which police officer, or which police station she spoke to.

58. CCTV footage from the GCUH confirmed that Mr Foster left the hospital at 10:29am."[289]

303. Expert opinion was obtained regarding the appropriateness of Ms Ferrari's assessment. Dr Jill Reddan, Consultant Forensic Psychiatrist, provided a report which was tendered during the s 45 phase of the inquest. I made the following comments in the s 45 findings regarding that opinion:

165. "While Dr Reddan has not been called during this phase of the inquest, her report has been tendered. At this stage, it is sufficient to note her conclusions surrounding the EEO process, and that the assessment conducted by Ms Ferrari was adequate and appropriate in the circumstances.

166. Dr Reddan also commented in her report about the current process for an EEO prescribed by s 33 of the MHA as being adequate and appropriate. I also heard evidence from Ms Ferrari surrounding potential changes to the MHA in this regard, and from Constables Melville and Hay with respect to possible improvements to the EEO form.

167. I am of the view that these are matters which are more appropriately addressed at the recommendations phase, after Dr Reddan and other experts have given oral evidence. Consequently, I make no

[289] Findings of inquest into the death of Troy Martin Foster, pages 8-9, paragraphs 49-58.

finding at this time as to the adequacy or appropriateness of the mental health assessment conducted at the GCUH on the day of Mr Foster's death."[290]

304. Dr Reddan's report was tendered again at the recommendations phase.[291] I received no additional expert evidence about this issue. In her evidence, Dr Reddan confirmed that Ms Ferrari's assessment of Mr Foster was adequate and appropriate. Dr Reddan commented on the time taken for the assessment in the emergency department:

> *"The assessment by Ms Ferrari was 90 minutes long. That's very long for an ED assessment.*
>
> *Yes. How long would you say a usual assessment would be in these circumstances?---Oh, look, it will vary, but – it would usually be – you know, less than an hour. Sometimes half an hour. It depends on what else is going on in the ED. Most EDs are very busy, very noisy places. But 90 minutes was long. But that enabled her to observe his mental state. She telephoned his mother and she spoke with the police, and then she, as per the usual practice, she then called the psychiatrist on a call – Dr Ravi Rawley – and again, that was quite an orthodox, usual thing to do. So she would have then had to have discussed the case with him. My understanding is he was in the ED for about 10 hours or more, and she developed an appropriate follow-up plan. Most cases like Mr Fosters wouldn't be admitted to hospital. I don't think Mr Foster was going to change with psychiatric treatment.*
>
> *Yes?---It's not – it's uncommon these days, but, you know, we once used to say people were untreatable, but I don't think Mr Foster was going to be treatable.*
>
> *Yes?---He would have required a major change in his environment and in his attitudes and in his beliefs and in his determinations about what he should do himself. So I thought that the assessment was – would have been targeted on whether there was a major mental illness that was treatable, present or not."*[292]
>
> …
>
> *"I think the assessment was reasonable, given the information she had. She couldn't look into a crystal ball, and it was reasonably comprehensive, given that it's an Emergency Department."*[293]

305. In all of the circumstances, Counsel Assisting submitted that the opinion expressed by Dr Reddan to the court in these respects was reliable and credible evidence. No evidence was produced with which to contradict, or test that evidence. I find that that the mental health assessment of Troy

[290] Findings of inquest into the death of Troy Martin Foster, pages 22-23, paragraphs 165-167.
[291] Exhibit R20.
[292] Recommendations phase transcript of proceedings, day 5, page 16 from line 9.
[293] Recommendations phase transcript of proceedings, day 5, page 17 from line 20.

Foster at the Gold Coast University Hospital on 24 November 2014 was thorough and appropriate.

Issue 15

15. The adequacy of the current processes by which police escort a person detained under ss. 33 – 36 of the Mental Health Act 2000 to a place of safety; by which police are required to provide information to hospital staff about the person for the purposes of the assessment; and by which hospital staff and police continue to communicate, if necessary, with regard to the person. (Foster)

306. The adequacy of the process under the *Mental Health Act 2000* ('MHA') pertaining to Emergency Examination Orders ('EEO') remained as an issue to be examined at the recommendations phase. In her written report relating to Mr Foster, Dr Reddan provided opinion on the EEO process at the time of Mr Foster's death, namely that the provisions were adequate.[294]

307. During the course of the s 45 phase, it became apparent that significant changes to the MHA were being implemented. Ms Ferrari's evidence was to the effect that, under the new Act, clinicians would have the ability to extend the six hour mandatory timeframe for assessment, if required, to not more than twelve hours.[295]

308. Further to that, clinicians would also have the option of conducting an examination by audio-visual link if that were considered clinically appropriate. In that regard the *Mental Health Act 2016 inserted the* following amendments into the *Public Health Act 2005*:

> "***Part 2 Taking persons to treatment or care place***
>
> ***157B Ambulance officer or police officer may detain and transport person***
> *(1) This section applies if an ambulance officer or police officer believes—*
> *(a) a person's behaviour, including, for example, the way in which the person is communicating, indicates the person is at immediate risk of serious harm; and*
>
> *Example—*
> *a person is threatening to commit suicide*
>
> *(b) the risk appears to be the result of a major disturbance in the person's mental capacity, whether caused by illness, disability, injury, intoxication or another reason; and*
> *(c) the person appears to require urgent examination, or treatment and care, for the disturbance.*

[294] Exhibit R20, page 11.
[295] Foster transcript of proceedings, day 2, page 68 from line 24.

(2) For the Police Powers and Responsibilities Act 2000, section 609(1)(a)(i), the police officer may consider advice received from a health practitioner about the person in forming a view as to whether there is an imminent risk of injury to a person.
(3) The ambulance officer or police officer may detain the person and transport the person to a treatment or care place.
(4) If the treatment or care place is a public sector health service facility that is not an inpatient hospital, the person may only be transported to the facility with the approval of the person in charge of the facility.
(5) If the person is detained and transported to a treatment or care place, other than a public sector health service facility or authorised mental health service, the person can not be detained at the place unless an Act otherwise requires.

Note—
See section 157E for detention in a treatment or care place that is a public sector health service facility or authorised mental health service.

(6) In this section—
***inpatient hospital** means a hospital where a person may be discharged on a day other than the day on which the person was admitted to the hospital.*

157E Detention in treatment or care place
*(1) A person subject to an emergency examination authority may be detained in a treatment or care place that is a public sector health service facility or an authorised mental health service for a period (the **examination period**) of not more than 6 hours starting when the authority is made.*
(2) A doctor or health practitioner must explain the effect of the authority to the person.
(3) The doctor or health practitioner must take reasonable steps to ensure the person understands the information given under subsection (2), including by telling the person or explaining the information to the person—
(a) in an appropriate way having regard to the person's age, culture, mental impairment or illness, communication ability and any disability; and
(b) in a way, including, for example, in a language, the person is most likely to understand.
(4) Also, a doctor or health practitioner may extend or further extend the examination period to not more than 12 hours after it starts if the doctor or health practitioner believes the extension is necessary to carry out or finish an examination of the person under section 157F.

157F Examination
(1) A doctor or health practitioner may examine a person subject to an emergency examination authority to decide the person's treatment and care needs.
(2) Also, a doctor or authorised mental health practitioner may examine the person to decide whether to make a recommendation for assessment for the person under the Mental Health Act 2015.

(3) An examination may be carried out using an audiovisual link if the doctor or health practitioner examining the person believes it is clinically appropriate.
(4) In this section—
***audiovisual link** means facilities that enable reasonably contemporaneous and continuous audio and visual communication between persons at different places."*

309. Two statements were tendered during the recommendations phase from Associate Professor John Allan, Chief Psychiatrist and Executive Director of the Mental Health and Other Drug Branch.[296] His statements were received without his giving oral evidence to the inquest. He confirmed that the *Mental Health Act 2016* was to commence on 5 March 2017.[297] By way of summary, his statements confirm:

- The new Act was brought about in response to stakeholder concerns that the MHA was outdated, overly complex, inconsistent and difficult to understand and administer;
- The problems with the EEO provisions in the MHA were that persons are 'presumed' to have a mental illness in order to meet legislative criteria when; in many cases persons are actually suffering from adverse effects of alcohol or drugs, or a physical injury, rather than an underlying illness. This has resulted in persons not receiving appropriate medical intervention;
- Under the changes, Emergency Examination Orders under the MHA will be replaced by Emergency Examination Authorities under the *Public Health Act 2005*;
- The new provisions will apply when an ambulance or police officer believes a person is at immediate risk of serious harm, such as threatening to commit suicide, and the risk appears to be the result of a major disturbance in the person's mental capacity. This could apply due to an illness, disability, an injury, intoxication or any other reason. The officer is not required to decide into which of those categories the person's behaviour might fall;
- There is no presumption required under the new process that the person being transported has an underlying mental illness;
- There is flexibility to ensure that a person is examined at the most appropriate place, whether that be an emergency department, an authorised mental health service, or a person's home; and
- A person can be detained for six hours for an examination, and if required, the examination period can be extended another six hours to a total of twelve hours – this discretion was included so as to ensure a doctor has sufficient time to

[296] Exhibits R35 – R35.4.
[297] Exhibit R35.4, paragraph 6.

examine a person to properly decide the person's treatment and care needs.

310. During the Foster inquest, I heard evidence from the police officers involved in the EEO, Constables Bradley Melville and Leanne Hay. The evidence particularly that from Constable Melville, was to the effect that the form could be improved by way of including various standard prompting questions, as well as ample space for free text.

311. Associate Professor Allan provided a draft copy of the new form which will be required to be completed, namely the Emergency Examination Authority Form ('EEA form').[298] He explained that the draft EEA form:

> - *"Reflects improved legislative criteria for the making of an EEA;*
> - *Contains ample space for documenting all relevant information; and*
> - *Requires that a police officer or ambulance officer must contact the public sector health service facility or authorised mental health service in advance to advise the facility or service of significant risks in managing the person, for example:*
>
> *i. If the person is, or has been, violent or aggressive towards others;*
> *ii. The person has attempted, or has threatened, to commit suicide.*"[299]

312. Associate Professor Allan confirmed that the EEA form was developed by officers in the Mental Health Act Implementation Team under the guidance and assistance of an EEA working group. The EEA working group comprised of a representative from each of the QPS and QAS, in addition to representatives by other key stakeholders. The evidence confirms that Senior Sergeant Mark Mitchell, the QPS State MHIC, was part of the EEA working group.[300]

313. One of the key changes the QPS advocated for in considering the changes to the MHA, was that police officers not be asked to consider whether an individual was suffering from a mental illness at the time of the incident.[301] Inspector Carr gave evidence on this point, and said that this request has been satisfied by the changes under the new regime, whereby police officers are only asked to consider whether a person is suffering from an impairment of mental capacity.[302] In her evidence to the inquest, Inspector Carr was positive about the changes being made.[303]

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[298] Exhibit R35.4, attachment 2.
[299] Exhibit R35.4, paragraph 12.
[300] Exhibit R35.4, attachment 1.
[301] Exhibit R39, paragraph 15.
[302] Ibid.
[303] Recommendations phase transcript of proceedings, day 6, page 35 from line 32.

314. Dr Reddan's evidence on this issue was set out in her report[304], and during oral evidence. Dr Reddan expressed the view that the EEO process was adequate, and with respect to Mr Foster, that there was "*no change which could be instituted which would have changed the outcome in this case*."[305] She was supportive of the changes being made, and her evidence in this respect was as follows:

> *"…but I was aware that one of the – and I know there might be some issues – questions about this later on, but I was aware that under the new Mental Health Act police – the EEOs are being moved out of the Mental Health Act into the Public Health Act.*
>
> *Yes?---Which I think is actually a very good initiative.*
>
> *Yes?---Because – for a number of reasons. And I think that police shouldn't be expected to have some in-depth knowledge of mental illness and all its varieties. And I think it's important too that we just be a little bit careful of unintended consequences. A diagnosis may not tell you how to manage someone.*
>
> *Yes?---Because people with mental illnesses are not homogenous. They're as variable as the rest of us.*
>
> *So it's not like he's got schizophrenia, so we treat him this way?---That's right. And I always think that it's better to appeal to the rational side of people, and even many people with mental illnesses do have a rational side, and can be rational, rather than to assume they're always irrational. I think that can be a mistake. And everybody, where possible, should be managed with clear directions, short sentences, no bargaining, no, you know, complex communications. One-stage things. And that should be for everyone, whether you're mentally ill or not."*[306]

315. Associate Professor Allan's statements are comprehensive, and also include various fact sheets about the new regime. Counsel Assisting referred to the circumstances of Mr Foster's EEO, in that there was no obvious issue relating to the process or procedure followed by Constables Melville and Hay concerning the EEO. Both officers engaged effectively with Mr Foster, and were able to detain him for the purposes of the EEO without incident, and successfully transfer him to the GCUH.

316. Considering the evidence on this issue, including the written evidence of Associate Professor Allan, the oral and written evidence of Dr Reddan and Inspector Carr, Counsel Assisting submitted that there are no further recommendations that I could reasonably make in the circumstances. In that respect, I accept that the matters raised in evidence have been addressed by the legislative and administrative changes which have been implemented.

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[304] Exhibit R20, page 11.
[305] Ibid.
[306] Recommendations phase transcript of proceedings, day 5, page 13 from line 28.

317. I close the inquest into these deaths.

Terry Ryan
State Coroner
Brisbane
20 October 2017