OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of Perry James Irwin and Damien Lawrence Coates**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	State
FILE NO(s):	COR 721/04(2)
DELIVERED ON:	07 October 2005
DELIVERED AT:	Brisbane
HEARING DATE(s):	9 – 12 August 2005
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**Coroners inquest, shooting of police officer, suicide, QPS critical incident management, adequacy of communication devices for police, access and sale of ammunition, protective apparel etc ….**

REPRESENTATION:

Legal representatives

Counsel Assisting:	Mr Craig Chowdhury
Queensland Police Service Commissioner:	Mr Peter Baston
Family of Perry Irwin:	Mr Steve Zillman

The Coroners Act 1958 provides in s43(1) that after considering all of the evidence given before a coroner at an inquest the coroner shall give his or her findings in open court. What follows are my findings of the inquest into the deaths of Perry James Irwin and Damien Lawrence Coates.

Introduction

On Friday 22 August 2003, Damien Coates, a deeply troubled and angry 21 year old man took a rifle into a small area of bushland near where he lived in suburban Caboolture. He told people he met there that he was going to kill himself and any police officers who tried to intervene. This information was conveyed to police at the Caboolture Police Station. As they were preparing to go to the scene, they were told that Mr Coates was no longer in the bushland and that he no longer had the firearm with him. On receipt of this information, the plan they were preparing was abandoned and three cars were immediately dispatched to the location where Coates was then thought to be. A short time later, Senior Sergeant Perry Irwin went with two other officers to the bushland where Coates had initially been seen, hoping to find the firearm they assumed he had secreted in the bush. When the first group of officers were unable to locate Mr Coates they told their shift supervisor who had remained in the station. He told one of the officers with Senior Sergeant Irwin that Coates might be returning to the original location and recommended that those officers leave the bushland area immediately. They didn't follow this advice. Soon after, Senior Sergeant Irwin was shot dead. Mr Coates then also fatally shot himself.

These findings seek to explain how that occurred. With a view to assisting with the development of practices and procedures that might reduce the likelihood of similar future tragedies, they also examine the appropriateness and adequacy of:-

- the response of the Department of Corrective Services to an intensive correctional order imposed on Mr Coates by the District Court on 12 April 2002;
- the command and control of this critical incident;
- the police communications systems and equipment deployed on the day of the deaths;
- the protective apparel worn by Senior Sergeant Irwin; and
- the regulations governing access to ammunition.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Although the inquest was held in 2005, as the deaths being investigated occurred before 1 December 2003, the date on which the *Coroners Act 2003*

was proclaimed, they are both a "*pre-commencement death*" within the terms of s100 of that Act and so the provisions of the *Coroners Act 1958* (the Act) are preserved in relation to them.

Because the deaths were violent and unnatural, the police who became aware of them were obliged by s12(1) of the Act to report them to a coroner. Section 7(1)(a)(i) confers jurisdiction on a coroner to investigate such deaths and s7B authorises the holding of an inquest into them. Section 26 authorises the holding of concurrent inquests into more than one death if "*the deaths appear to be have been caused by the same incident.*" There is no assistance given in the Act as to the meaning to be given to the term "*incident*" in this section. I formed the view that as the deaths were so closely related in time and place and as the issues raised by each death were largely coterminous it was appropriate to hear the inquests concurrently.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death.

The Act, in s24, provides that where an inquest is held, it shall be for the purpose of establishing as far as practicable:-

- the fact that a person has died;
- the identity of the deceased;
- when, where and how the death occurred; and
- whether anyone should be charged with a criminal offence alleging he/she caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proven.

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

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations[2], referred to as "*riders*" but prohibits findings or riders being

[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s43(5)

framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence.[3]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s34 of the Act provides that "*the coroner may admit any evidence the coroner thinks fit"* provided the coroner considers it necessary to establish any of the matters within the scope of the inquest.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[7]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I turn now to a description of the investigation. As soon as police command became aware of the shooting of Senior Sergeant Irwin, the State Homicide Investigation Group was detailed to investigate the incident. Officers from that unit were on site within an hour of the shooting and the scene was secured until all necessary examinations of it had been undertaken. Both of the officers who had been with Senior Sergeant Irwin were video taped doing a walk through re-enactment. Scientific and ballistics officers scoured the scene and recovered a number of spent cartridges and projectiles. A map of the scene was prepared and numerous photographs taken. Call charge records for relevant telephones were obtained. All people with any relevant information were interviewed. An

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[3] s43(6)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[8] (1990) 65 ALJR 167 at 168

autopsy was performed on the bodies of both men by a forensic pathologist from the John Tonge Centre

I am of the view that the investigation was thorough and sufficient. I commend the lead investigator, Detective Sergeant Herpich, for his work.

The inquest

Directions hearings

A directions hearing was convened on 10 May 2005. Mr Ralph Devlin was appointed counsel assisting but before the inquest commenced he was forced by his involvement in another matter to withdraw. He was replaced by Mr Craig Chowdhury. Leave to appear was granted to counsel representing Mr Irwin's family and the Commissioner of the Queensland Police Service. Members of Mr Coates' family attended but they chose not to be legally represented or to themselves appear to question witnesses. The legal officer attached to the OSC kept them informed of developments and counsel assisting met with them regularly before and during the inquest. At the directions hearings, those granted leave to appear were authorized to access the investigation report

The view

On 8 August 2005 the Court and those with leave to appear undertook a view of the scene of the shootings and other relevant places.

The hearing

The hearing commenced on 9 August and continued for 4 days. Twenty one witnesses gave evidence and 201 exhibits were tendered. After the hearing, submissions in relation to preventative recommendations were received from the solicitors for Senior Sergeant Irwin's family.

The evidence

I turn now to the evidence. Of course I can not even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

The timing of some of the events is crucial to an accurate understanding of what transpired. Unfortunately, in respect of most of the events, it is not possible to be precise about the times at which they occurred. Evidence of the times is available from numerous sources of varying reliability, including people's memories, wall clocks, wrist watches, personal computers and mobile phone records. I have not been able to reconcile the conflict that seems to exist in relation to the sequence of some aspects of the incident. What follows is my best estimate of when the events mentioned occurred.

Background

In the months before his death Damien Coates was seriously disturbed and emotionally unstable. He was prone to unprovoked, unexplained, violent attacks on his father and brother. On a number of occasions he senselessly damaged property of his and his father. He was certainly abusing alcohol and marihuana and may have also been using other illicit drugs. He frequently stole significant sums of money from his father who could ill-afford to lose it. Damien Coates' father made a number of attempts to reason with his son and to get him professional help. These efforts did not lead to any improvements in his behaviour.

On a number of occasions Damien Coates spoke of suicide and sometimes said he would kill other people before he killed himself. However, I am aware of no evidence of any suicide attempts.

In June 2003, the real estate agents managing the property his father rented and shared with Damien gave them notice to quit. By this stage his father had lost patience with Damien's violence and dishonesty. He told his son that he would not continue to provide accommodation for him and urged him to make arrangements for himself. It was apparent to Mr Coates senior that his son did not act on this advice and from comments made to associates it seems likely that it was around this time that the plan that led to these deaths was hatched.

Eye witness accounts

On the day that the father and son were due to give up the house they had been sharing, Mr Coates senior was making final arrangements to move all of his property and invited his son to put any possessions he did not want into an industrial bin that had been brought to the premises. He became alarmed when his son disposed of all of his possessions into the bin. Damien Coates then left the house at about 8.45am and his father never saw him alive again. Damien was not carrying anything when his father last saw him.

On the north eastern side of Caboolture, a kilometre or so from the town centre, a strip of bushland running along both sides of Lagoon Creek bisects a suburban residential area. The creek is aptly named as it contains a number of sizable lagoons, one at least created by a concrete weir. People who live in the area use the bushland for recreation and the weir as a pedestrian shortcut between the houses and shops on either side of the creek.

Alan Teague was in the habit of taking his dog to the area for exercise most mornings. On 22 August 2003 he did that between 8.30 and 9.00am. He accessed the area by walking to the northern end of Wallace Street and turning west down a gazetted but unmade road called Buckle Street. After a short distance, this led to a bush track approximately 100 metres long that ended on the bank of a lagoon.

While he was sitting in the bush near the water reading, he noticed Damien Coates, who he had not previously met, acting suspiciously near the ruins of an

old pumping station adjacent to where Mr Teague was sitting. He saw that Mr Coates was carrying what looked like an iron bar that he hid near the pumping station before coming closer to where Mr Teague was sitting. After a few minutes of uneasy silence, they spoke. Coates soon told Teague that what he had hidden was a rifle that he intended to use to commit suicide. Mr Coates told Mr Teague that he had considered killing other people before killing himself but that he had now decided to kill just himself.

It seems they talked for approximately 30 minutes before two youths, now known to be James Stehbens and Keith Godfrey, came along the same track from Buckle Street pushing their bicycles. They were heading in the general direction of where Mr Coates had hidden the gun. He got up and made to intercept them. One of them knew him and as they came together they spoke. Mr Coates and the two youths continued towards the location of the hidden gun. This alarmed Mr Teague and he went over to the group but then simply said goodbye to Coates and left. He says that at no time did he actually see the rifle Mr Coates claimed to have.

He was obviously worried by what he had seen and heard and so Mr Teague walked the six or seven blocks to his house, and after making a couple of telephone calls got in his car and drove to the Caboolture Police Station to report his concerns.

Coincidentally, Damien Coates' father had already been to the police station to talk about his son. After attending at the real estate agents office to finalise his quitting of the house, Mr Coates senior had gone there to express his concern that his son might be intending to self harm. He gave Sergeant Daly, the duty shift sergeant, his son's particulars. He told Sergeant Daly that his son suffered from a psychological disorder and that he had on occasions threatened to run amok and kill people before taking his own life. Sergeant Daly knew Damien Coates from previous contact and retrieved from the QPS computer system a police photograph of Damien to enable his father to confirm his son's identity.

Mr Teague arrived at the station before Sergeant Daly had taken any action in response to the information given to him by Mr Coates senior. When Mr Teague told Sergeant Daly about his meeting at the lagoon, Sergeant Daly showed him the picture of Damien Coates that was still on the computer screen. Mr Teague confirmed the picture was of the man he had seen at the lagoon and told the officer that Mr Coates had a rifle with which he was threatening to kill himself and others. No description of what Mr Coates was wearing was sought or given.

At about 10.38, soon after Mr Teague left the station, Sergeant Daly telephoned the Redcliffe Police Communications Centre and requested that all Caboolture police cars be instructed to return to the station. This was the only means he had to make contact with the officers within his division other than calling the officers on their personal mobile phones.

It seems this instruction was conveyed to the two cars in question at about 10.42 and both then responded promptly arriving back at the station at about 10.49.

Sergeant Daly briefed the officer in charge of the Caboolture Division, Inspector Janke, the officer in charge of the Caboolture Station, Senior Sergeant Irwin and the officers of the Caboolture Criminal Investigation Branch. Discussion focussed on how they should try to contain Mr Coates in the lagoon area. All general duties officers who were in the station were also informed of the emergent situation. A request was made for the Redcliffe District dog squad officer to be detailed to attend.

While these conversations were occurring, maps were being consulted and officers were kitting up with protective vests. No handheld radios were available to the officers in the station as the four on issue were held by the officers who had been on the road earlier in the day.

After he left the police station, Mr Teague drove back to Wallace St and parked his car a couple of blocks south of where the track to the lagoon joined that street. He said he did so to watch for Mr Coates emerging with the intention of passing that information on to police if it happened before they arrived at the scene. He is uncertain of how long he waited in that place. He says he had a cigarette while he waited. In his statement he said he was there for about 5 minutes but in evidence he changed that to 10 minutes but he was not cross examined on the change and I don't consider either estimate to be precise.

When police did not arrive he became concerned that his description of Mr Coates' location may have confused them and that they may have gone to another lagoon downstream from the one where he had met Mr Coates. He therefore decided to drive to that lagoon in the hope of finding the police. That involved him driving further north along Wallace Street until its intersection with Tallon Street where he turned right and travelled in an easterly direction. As he drove down Tallon Street he saw two men near the TAFE college, one of whom he believed was Mr Coates.

He therefore drove the couple of blocks to his home, telephoned the police station and spoke to an administrative assistant, Ms Lacy. There is no evidence of exactly what Mr Teague told her but it seems that it included that he had previously reported to police the presence of an armed man at the Wallace Street North lagoon and that the man was now near the TAFE college in Tallon Street and was no longer armed. Ms Lacy reported this information to Sergeant Daly shortly before 11.00 am, just as the general duties officers were about to leave for the lagoon area.

This information caused Sergeants Daly and Burgess to change their plan. They now decided that two cars carrying five officers would go to the TAFE college and intercept Mr Coates. They left the station at about 11.00. The transcript of police radio communications between the officers records that at 11.03 those vehicles were approaching Tallon Street. A short time later, when

they arrived at the TAFE, it was quickly established that the only youth there was not the person they were looking for. They had ony been there a very short time when a third police car arrived. Before the officers could search further a field, Mr Teague who, after speaking to Ms Lacy on the phone, had again driven from his house to watch for Mr Coates, arrived at the TAFE. He told the officers there that he had taken another look at the men he'd seen earlier near the TAFE and he now realised that neither was the man he'd seen with the gun near the lagoon.

At about the same time, Keith Godfrey, one of the youths who had been with Mr Coates earlier at the lagoon, rode up Tallon Street to report to Constable Roberts that there was an armed man threatening violence in the bush near the lagoon at the other end of Tallon Street. Mr Godfrey gave evidence that Mr Coates' wild threats of shooting police and aeroplanes had frightened him and for that reason, when he and his friends left Mr Coates at the lagoon, he decided to report the matter to police. He said that when he rode along the track to Wallace Street and emerged from the bush he saw the car carrying Sergeant Burgess drive along Tallon Street towards the TAFE and followed it.

At about this time, in response to a request from Sergeant Burgess made over the police radio at 11.07, someone called Sergeant Burgess on his mobile phone. Call charge records show that this call was made from the Caboolture Police Station at 11.09. It lasted a little over 3 minutes. It is uncertain who the caller was. Sergeant Daly and Inspector Janke deny it was either of them. Sergeant Burgess says he can't remember who called him but he told that person what the officers at the TAFE had learned, namely that the person they were looking for was not at the TAFE college and that he was still at the Wallace Street lagoon.

Sergeant Daly gave evidence that he heard a broadcast over the police radio that the person being sought was in the bushland behind the TAFE college. The relevant portion of transcript reveals no evidence of such a conversation and Sergeant Daly was prepared to concede that he may have heard someone in the station saying this. In any event, in response to hearing this he called the Redcliffe Communication Centre and asked that an instruction be broadcast for all officers to get out of the bushland area. This did not happen. The officer in charge of the Redcliffe Communication Centre says he has no record of the request being made. The communication room operator who dealt with most of the calls dealing with this incident also has no memory of it happening.

All of the officers at the TAFE college who became aware of this fresh information say they recognised that it meant the person they were looking for was at the lagoon. All but the dog squad officer, whose version I shall return to later, say that these facts raised no immediate concerns as they did not know that Senior Sergeant Irwin, Senior Constable Murrell and Constable Hertslett had left the station at about 11.05 and travelled to the lagoon to try and retrieve the rifle from where they believed Mr Coates had secreted it.

Strangely, no one told the other officers already in the field at the TAFE college that this was happening. Sergeant Daly gave evidence that he expected that Senior Sergeant Irwin would first take up with Sergeant Burgess at that location before going to the lagoon. For that reason he did not contact Sergeant Burgess by radio or mobile telephone.

Mr Godfrey and his friends must have already left the lagoon and Buckle Street before Senior Sergeant Irwin and the other two officers arrived otherwise Mr Godfrey would have reported his concerns about Damien Coates to those officers.

On the way to Wallace Street North, those officers heard Sergeant Burgess broadcast a request for someone to call him on his mobile phone. Radio transcript shows this broadcast occurred at 11.07.

The radio log also reveals that these officers booked off the air at the track leading to the lagoon at about 11.10. This involved them broadcasting their names and their location over the radio. This information was broadcast over the radio channel all officers with hand held radios or in cars were tuned to. Apparently none of them heard it.

Senior Sergeant Irwin and his crew then put on their protective vests and made their way along the track towards the lagoon.

Senior Constable Murrell and Constable Hertslett say they were quite relaxed as they believed that Mr Coates was else where. Indeed Senior Constable Murrell says he believed that, before he left the station, he'd been told by Sergeant Daly that the person of interest had been "*located*", which he took to mean that Mr Coates was in police custody or at least in their company.

As Senior Sergeant Irwin, Senior Constable Murrell and Constable Hertslett were walking along the track to the lagoon, it became apparent from conversation that they did not know exactly where the gun might be hidden and so Constable Hertslett was told by Senior Sergeant Irwin to telephone the station to see if Sergeant Daly could provide more precise information. He was also told to find out why Sergeant Burgess had requested to be contacted. During this call to Sergeant Daly, that seems to have commenced at 11.12, Constable Hertslett says he was told that Mr Coates was not at the TAFE college and that he might be returning to get the weapon. Sergeant Daly and Constable Hertslett agree that Sergeant Daly told Hertslett that they should get out of the bush. Both also agree that Constable Hertslett was not told that it seemed likely that Mr Coates had never been at the TAFE college nor that he was still at the lagoon where he had been seen by Messrs Teague and Godfrey earlier in the day. Sergeant Daly says he was not aware of this at the time he spoke to Constable Hertslett.

Constable Hertslett conveyed to Senior Sergeant Irwin, Sergeant Daly's advice that they leave the area. He says that after talking to Sergeant Daly he frequently scanned to the north and east as they continued down the track

towards the lagoon because he believed that was the direction the gunman would come from if he was returning to the area from the TAFE college.

Senior Sergeant Irwin did not act on Sergeant Daly's advice to leave; instead he decided that they would continue their search in the hope of finding the weapon before Mr Coates could return and reclaim it. He apparently decided however, that he should find out what it was that had prompted Sergeant Burgess to ask to be telephoned. Constable Hertslett had forgotten to do this when he spoke to Sergeant Daly. One could assume that Senior Sergeant Irwin correctly guessed that there was a connection between that request and what Sergeant Daly had told Constable Hertslett and that Sergeant Burgess could provide more information about the suspect's likely movements.

I mentioned earlier that when the officers at the TAFE college learned that the gunman was probably still at the lagoon they were not immediately concerned by this, even after shots were heard from that direction. The exception to that was Sergeant Chapman, the dog squad officer who had raced to the scene from Redcliffe. That officer gave evidence that when he arrived in Caboolture he went straight to Wallace Street North. Although he couldn't remember why he did so it is likely that he heard Senior Sergeant Irwin book off the air at that location. There was a message on the Information Management System (IMS) directing all officers to take up with Senior Sergeant Irwin at Wallace Street but it seems that this message was not broadcast over the radio. That message was posted on the IMS by the officer in charge of the Redcliffe Communications Centre who said he did so in response to advice from Sergeant Daly that Senior Sergeant Irwin was going to the scene to take charge.

Sergeant Chapman gave evidence that when he heard the sound of shots coming from the lagoon area he was with Sergeant Burgess and others at the TAFE college. He says that when this happened Sergeant Burgess said to him that there were officers on foot in the bush in that area but that they had no radio communication devices with them. This is inconsistent with the evidence of Sergeant Burgess who said that even after he spoke with someone at the Caboolture station he was unaware that Senior Sergeant Irwin and the other two officers had gone to the lagoon looking for the gun. Further, after the shooting he queried a claim from the Redcliffe Communications Centre that Senior Sergeant Irwin had been shot on the basis he believed that Senior Sergeant Irwin was not involved in the operation. I am unable to resolve this conflict in the evidence but it is difficult to understand why the caller from the station would not have told Sergeant Burgess that the other officers were in the field especially if Sergeant Burgess told the caller that the person they were looking for was still at the lagoon. It is an issue I will return to when discussing communication difficulties that beset this incident.

In any event, as Senior Sergeant Irwin moved to higher ground in order to improve his mobile phone reception but before he could make contact with Sergeant Daly, he was shot by Mr Coates who had been obscured from view in a below ground concrete culvert or bunker that housed pipes installed to convey water from the lagoon. He immediately fell to the ground.

The other officers heard the shots but could not see the shooter. Constable Hertslett began walking towards his fallen colleague with his service revolver drawn. As he did so, he saw Mr Coates run to Senior Sergeant Irwin's prone body and reach towards his holster. Constable Hertslett yelled at Coates to leave the officer alone. Mr Coates ran away from Senior Sergeant Irwin out of sight and Constables Hertslett and Murrell took cover. Constable Hertslett very quickly called the station. This call commenced soon after 11.17.

Soon, more shots were fired in their direction. Again they could not see the shooter and so they scurried around behind a large log lying on the ground nearer to the lagoon and remained there for nearly an hour until another officer arrived and they discovered Mr Coates dead in the bunker referred to earlier.

Expert evidence

The body of Perry Irwin was formally identified by another officer who had known him for many years. Damien Coates' body was identified by way of finger prints as in view of the injuries he suffered it was not appropriate to ask his family to view his face.

Both bodies were transported to the John Tonge Centre where autopsies were conducted by a forensic pathologist.

Perry Irwin's body was found to have two gunshot wounds; one to the base of the neck, the other to the right side of the abdomen. Both caused extensive internal injuries sufficient to cause almost immediate death.

Damien Coates' body was found to have a gunshot wound to the roof of the mouth that led to a shattering of his upper head. He had powder stains on his thumb and fingers suggesting they were near the muzzle of the rifle when it discharged.

Fragments of lead projectiles recovered from Perry Irwin's body were examined and found to have been fired from the rifle that was also used to shoot Damien Coates.

The firearms of Senior Sergeant Irwin, Senior Constable Murrell and Constable Hertslett were examined and found not to have been recently fired.

Findings required by s43(2)

I am required to find, so far as has been proven, who each of the deceased was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings.

Identity of the deceased – The deceased persons were Perry James Irwin and Damien Lawrence Coates

Place of death – Both men died near Lagoon Creek in Caboolture, Queensland

Date of death – Both men died on 22 August 2003

Cause of death – Both men died as a result of gunshot wounds sustained when Damien Coates shot Perry Irwin and then shot himself.

Impact on the families and on the community

Expressing those details in such clinical terms can mask the immense personal loss the families of both men suffered in consequence of the deaths. It is not appropriate to diminish the magnitude of that loss of one of those deaths just because one of the deceased caused them both: all lives have the same value; all parents, children and partners grieve the loss of their loved ones and I extend my sympathy to the families of both men. That does not mean however, that the special attributes of either man should not be noted. I therefore consider it appropriate to mention some of the qualities referred to by the witnesses that made Senior Sergeant Irwin such a valued member of the QPS.

One of the detectives from another division noted how knowledgeable and well disciplined he was. He commented that Senior Sergeant Irwin was "*a very pro-active police officer - very active policeman*", and concluded with the observation "*I found him to be a very good police officer*"[9] Another officer made this assessment; "*Perry was such a massive breath of fresh air … That man was a Godsend to the area and it just needed someone like him.*"[10]

That commitment and dedication was graphically exemplified by the circumstances of his death. When warned of the possibility that the gunman was returning to reclaim the weapon, Senior Sergeant Irwin did not take the easiest course open: he did not leave as he could have done, indeed should have done. Instead, he put his duty as the protector of the community ahead of his own safety and continued to search for the gun, to try and neutralise the threat to the community.

"Tragedy" is a term that has been devalued by over use. In its classical context it refers to a noble or heroic man destroyed by some unforseen flaw or mistake. Perry Irwin's death would truly seem a tragedy in that sense.

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[9] T p244
[10] T p171

Issues of concern and recommendations

All coroners' cases are sad, involving as they invariably do, sudden and often violent death. However in many, if not most, the latent danger that strikes is not obvious until the fatal event occurs: the gas drilling rig explodes, the car spins out of control with little or no warning. In this case however, when the police officers in the Caboolture Station were told of Mr Coates' circumstances, they knew they were required to resolve a dangerous and volatile situation but there was no immediate emergency that would justify impetuous action. They had the time, the resources and the experience to make a considered and controlled response.

Further, by the time Senior Sergeant Irwin arrived at the commencement of the track to the lagoon at about 11.10, Mr Godfrey and Mr Teague had spoken to the officers at the TAFE college and told them that Mr Coates was still armed and still at the lagoon. In the ensuing 7 minutes until Senior Sergeant Irwin was shot this information was not conveyed to him. Had it been, it is at least possible that he would not have been killed.

Some of the factors that contributed to the fatal outcome of this incident were avoidable. It is a case that exemplifies the analysis developed by Professor James Reason in his ground breaking work on root cause analysis that postulates that catastrophic outcomes usually only occur when numerous barriers fail and the opportunity for a serious mishap presents because, co-incidentally the gaps in safety systems combine or coincide.[11] Graphically, he uses the analogy of a stack of slices of Swiss cheese. Only when the holes in the cheese slices align do the errors that are by themselves minor, result in serious consequences. The death of Perry Irwin was, in my view, preventable in this sense. It resulted from numerous mistakes all falling the same way. It is important to accept that it is systems failures that contribute to such outcomes rather than the actions of individuals. It is wrong to scapegoat any individual by focussing on one of the mistakes, when, without numerous other failings, none by itself would have caused the fatal outcome.

I therefore set out below issues of concern that may have contributed to the death. Pursuant to s43(5) of the Act I am authorised to make riders or recommendations designed to reduce the occurrence of similar deaths to the one investigated by this inquest. In accordance with that power I make the following observations and recommendations.

The response of the Department of Corrective Services to an intensive correction order imposed on Mr Coates.

Damien Coates' propensity for violence had come to the attention of the authorities before and so it is appropriate to consider whether those authorities

[11] Reason JT, *Understanding adverse events: human factors*, In, Vincent C.A.,ed., *Clinical risk management*, London BMJ 1995

should have taken more action to address the youth’s underlying psychological dysfunction.

On 12 April 2002, in the District Court in Brisbane, Mr Coates pleaded guilty to a number of offences of personal violence and damage to property. The Court made an intensive correction order (ICO) which required Mr Coates to take part in any counselling, attend any programs and perform any community services as directed by an authorised Corrective Services officer.

In accordance with that order, Mr Coates attended upon a psychiatrist for assessment after an incident involving his community services supervisor led his case worker to suspect he might be suffering from some undiagnosed mental illness. That doctor reported that Mr Coates did not display any psychotic features but that he could benefit from an anger management course. Accordingly, in September 2002, Mr Coates was instructed to attend an anger management program which he successfully completed; indeed the report of his involvement in that program speaks glowingly of his insight and contribution to the learning of other participants.

On 21 January 2003 he completed the ICO with no contraventions. He was assessed as having made good progress and to be suitable for further community service orders in future.

Seven months later he shot Senior Sergeant Irwin and himself in circumstances that strongly suggest there were more deep-seated problems in Mr Coates’ psychological condition than the reports referred to above would indicate.

Never the less, I am of the view that none of the medical practitioners who had contact with Mr Coates, nor the staff of the Department of Corrective Services could have been expected to take more interventionist action in relation to him; indeed it is unlikely that they had any authority to do so. As the futile efforts of Mr Coates’s father to persuade his son to seek treatment demonstrate, the deceased did not consider a therapeutic response to his problems was feasible. And, as his general practitioner Dr Evans commented if coercive action was taken in relation to every angry young male who abused drugs, the mental health services would soon be overwhelmed.

I do not consider this case provides any evidence on which to recommend changes to the way intensive correctional orders are administered.

Access to a firearms and ammunition

As the conduct of Mr Coates on the day of his death graphically demonstrates, he was not a suitable person to possess a firearm. However the investigation established that he obtained the weapon by purchasing it from a person who had stolen it from its licensed owner. The authorities had no opportunity to become aware that Mr Coates had the weapon and the circumstances of his possessing it do not demonstrate any flaw in the system of regulating access to firearms.

The sale and possession of small arms ammunition is controlled by the *Explosives Act 1999* and the *Weapons Act 1990*. At the time of this incident however, anyone could sell ammunition and anyone could buy it so the fact that Mr Coates was not licensed to use a firearm was not something the seller needed to be concerned about. Now, such ammunition can only be lawfully sold by someone licensed to do so under the Explosives Act or the Weapons Act and it can only be sold to someone licensed to use a firearm under the Weapons Act.

However, there would still appear to be some gaps in the legislative regime governing the sale of small arms ammunition. For example, the right to possess ammunition is not limited to ammunition that is for use in the type of firearm that the possessor is licensed to use. Nor do the requirements to record details of the persons buying the ammunition and the type and quantity purchased that apply to other explosives, apply to the sale of ammunition.

It may be that the administrative burden of doing this would be too great but I consider it warrants review.

Recommendation 1

I therefore recommend that the Queensland Police Service in conjunction with the Explosives Inspectorate of the Department of Natural Resources and Mines review the regulations governing the sale and possession of ammunition to determine whether amendments are needed to address the anomalies identified above.

The command and control of this critical incident

As Sergeant Chapman was driving from Redcliffe to Caboolture he called the station and said no one should advance toward the scene of the incident until he arrived and the deployment of officers could be properly planned. Initially, this advice was accepted and the appropriate preparations were made: maps were obtained; copies of the photograph of Mr Coates were printed from the QPS computer system and discussion centred around how the lagoon could be cordoned off.

However when Mr Teague telephoned the station, after he mistakenly believed he had seen Mr Coates near the TAFE college, providing to the administrative assistant who took the call what Sergeant Daly conceded was “very scant information”[12] adherence to appropriate command and control principles was abandoned.

Without any police officer speaking to Mr Teague or making any assessment of the veracity of this new information, Sergeant Burgess and four other officers rushed to the scene. Two other officers who arrived at the station as the first group was leaving simply joined in.

[12] T p47

Senior Sergeant Irwin and the two officers that went with him into the field did not communicate with those already out looking for Mr Coates and neither Sergeant Burgess nor the officers with him reacted with urgency to inform others involved in the operation of the information they had gleaned from Messrs Teague and Godfrey because they say they were not aware that others were in the field.

The laxness of the command and control in place can be exemplified by a comment made by a witness when asked who was in control.

> *"It was a dynamic command. Initially Sergeant Burgess was in command but by going out to the scene Senior Sergeant Irwin takes command and if the Inspector goes out he takes command."*[13]

When Sergeant Daly was asked was there any discussion about setting up a forward command post he responded:-

> *"I can't really recall any because people were coming and going, it was very very busy"*[14]

It seems the job got off to a bad start when Sergeant Daly failed to take a description from either Mr Coates senior or Mr Teague as to the clothing being worn by Damien Coates on that morning. In evidence he said he didn't do this because he wanted to get things moving; he thought he could do that later.

Tendered into evidence was the QPS Incident Command Course material which introduces officers to the Incident Command System (the ICS). It is a comprehensive and well researched bundle of tools designed to "*create an incident response environment that coordinates the efforts of individuals and agencies.*"[15] It stresses the need to recognise the separate functions of command, planning, operations, intelligence, administration and logistics. It recognises that as an incident unfolds phases of command with different functions will arise and need to be addressed. I am not qualified to critique the ICS or the course that seeks to teach it but from a fair degree of familiarity with policing operations and law enforcement theory in a number of contexts I am able to say that no flaws are apparent in either.

I consider the evidence demonstrates that the ICS was not properly applied to the incident reported to the Caboolture Police Station by Mr Teague on 22 August 2003. Further, I find it highly likely that had the ICS been more closely followed in this case a different outcome may have resulted.

The inquest did not receive evidence of which of the officers involved in this incident had undertaken the Incident Command Course although, if I understood the evidence of Superintendent Casey, that course is part of the

[13] T p86
[14] T p72
[15] QPS Incident Command Course para 1.3

Management Development Program offered only to Senior Sergeants seeking promotion to the rank of Inspector. As this incident demonstrated, in many cases it will be shift sergeants who will need to take control of potentially dangerous and volatile incidents.

Recommendation 2
I therefore recommend that the QPS undertake a training needs analysis to determine whether the ICS has been adequately implemented within the Service.

Police commication systems and equipment

Neither Senior Sergeant Irwin nor either of the two officers with him had a hand held radio when they were attacked because there were only four hand held radios available to all officers attached to the Caboolture Station and they had been taken by other officers.

As a result, after they had left their vehicle, in order to issue instructions to other officers or to receive information about the incident they were involved in, Senior Sergeant Irwin had to use his mobile phone. It also meant that the three could not hear information that might be passed on the police radio by officers who did have access to hand held or car radios. If another officer needed to contact them, that officer had to be aware that Irwin, Hertslett or Murrell had a mobile phone with him and be familiar with its number. The evidence that these numbers were kept in a notebook in the station that was usually in the duty sergeant's office did not impress me as particularly effective.

Obviously the inability of Senior Sergeant Irwin to have immediate access to radio communications when he was out of his vehicle in the field had the potential to hinder the effectiveness of his response and to expose him and those with him to unnecessary risk. It seems likely that when he was shot and killed Senior Sergeant Irwin was moving to higher ground in order to improve his mobile phone reception. He was making a call to the station because before he had left his vehicle he had heard over the car radio Sergeant Burgess asking to be called and he had no other way of discovering what Burgess knew. If both had radios, Irwin and Burgess could have spoken directly to each other.

It can not be demonstrated that had Senior Sergeant Irwin had a hand held radio he would not still have been shot and killed because it can not be shown with sufficient precision where he was when the officers at the TAFE college became aware that Mr Coates was still at the lagoon. However, it could only have improved his chances.

The community expects police officers to undertake dangerous tasks in the pursuit of public safety. Officers are entitled to expect that they will be given all equipment they reasonably need to do that work as safely as possible. In this case that did not happen and that omission is even more concerning in view of the numerous reports that had previously been submitted by Senior Sergeant

Irwin and others drawing attention to the shortage of hand held radios at the Caboolture Station.

There is another aspect of the communication facilities which also warrants comment. The Caboolture Police Division is part of the Redcliffe Police District that has a current establishment of approximately 300 officers. They have access to one radio channel. Even if only one third of those officers are on duty at any one time it is easy to see that the competition for air space could make effective communication difficult.

That was graphically demonstrated by numerous incidents in this case. For example:-

- When the cars from the Caboolture station were en route to the TAFE college where they thought the gunman was to be found, their attempts to co-ordinate their arrival had to compete with unimportant communications concerning the other routine jobs being undertaken by officers from across the district.

- Such is the congestion on that one channel that the shift sergeant at Caboolture Station is prohibited from making direct contact with his officers in the field. Instead he telephones the Redcliffe Communications Centre and they relay his messages.

- Sergeant Burgess said that when he discovered that Mr Coates was still at the lagoon he asked to be telephoned rather than just conveying that information over the radio because the single radio channel was being used by other crews.[16]

- After Senior Sergeant Irwin had been killed and Constable Hertslett had raised the alarm using his mobile phone, an ambulance was dispatched. It arrived at the TAFE college and was sent away, told by one of the officers there that no one had been shot.

- And finally, it is impossible to escape the conclusion that had there been another channel available, it would have been dedicated to this obviously dangerous operation, in which case it is likely that at least one of the seven officers at the TAFE college would have heard Senior Sergeant Irwin book off the air at the lagoon and recognised the danger he was in when Messrs Teague and Godfrey made those officers aware that Mr Coates was also at the lagoon.

Recommendation 3

I therefore recommend that the QPS:-

(a) review the adequacy of the number of handheld radios issued to the Caboolture Station, and

[16] T p 132

(b) review the adequacy of the radio channel available for use within the Redcliffe District.

The protective apparel worn by Senior Sergeant Irwin

Senior Sergeant Irwin was, at the time he was shot, wearing body armour. One of the shots penetrated the vest and one struck him in an unprotected area. The failure of the body armour to protect the officer caused me to seek some evidence as to its adequacy.

As a result of considering that evidence I accept that neither the design nor the condition of the body armour contributed to the death and that the vest conformed to a standard developed by the National Institute of Justice in the United States.

Paragraph deleted in accordance with a non publication order made on 7 October 2005

However, I also accept that the armour plate in the vest worn by Senior Sergeant Irwin exceeded the manufacturer's recommended replacement age and that numerous other vests in service at Caboolture station should also have been replaced and/or inspected using specific x-ray equipment. I stress that the failure to comply with the manufacturer's recommendations in this regard in no way contributed to the death of Senior Sergeant Irwin but it is obviously undesirable that such recommendations are not complied with unless there has been a properly considered decision to depart from them.

Recommendation 4

I therefore recommend that the QPS undertake an audit of all body armour in service to determine whether the inspections and replacements recommended by the manufacturers of that equipment have been complied with.

This inquest is closed.

Michael Barnes
State Coroner
7 October, 2005