QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Michael Shawn Sweeney**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2013/512
DELIVERED ON:	19 June 2015
DELIVERED AT:	Brisbane
HEARING DATE(s):	13 May; 15-16 June 2015
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, avoiding being placed in custody, suburban hostage situation, use of firearms, appropriateness of actions of attending police

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Queensland Police Commissioner:	Mr Craig Capper (Public Safety Business Agency)
A/Senior Sergeant Matthew Bowden, Senior Constable Paul McNamara, Senior Sergeant Trevor Deegan:	Mr Troy Schmidt (QPU Legal Group)

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Introduction

At the time of his death on 8 February 2013, Michael Shawn Sweeney, aged 42, was on parole. He had been released from prison just over a month earlier. His relationship with partner Angela Sands had recently deteriorated. They were not living together and she had obtained a Domestic Violence Order (DVO) under the *Domestic and Family Violence Protection Act 2012*.

On the morning of 8 February 2013, Mr Sweeney went to Ms Sand's home at 14 Akuna Way, Mango Hill. He wanted to see William, their six month old son. He said that he would leave after spending some time with William. Ms Sands called her sister, Kylie Vandenburg and she quickly went to the home with her partner, John Chester. While at the residence, Ms Vandenburg called the police, staying on the line to them as events unfolded.

While Mr Sweeney was holding William, he went over to his carry bag and retrieved a sawn-off rifle. He then gave William back to Ms Sands, who retreated to one of the bedrooms in the home. She stayed there, along with her teenage son and Ms Vandenburg.

Mr Sweeney then threw the keys to Ms Sands' vehicle to Mr Chester and requested that he drive. As both men exited the residence Mr Sweeney was holding the gun to the left side of his head. Police officers were in attendance and were establishing outer and inner cordons around the property.

Mr Chester entered the driver's seat of the vehicle, while Mr Sweeney entered the front passenger seat. Police approached the vehicle and yelled at Mr Sweeney to 'drop the gun'. Police were approximately 10m from the vehicle when Mr Sweeney shot himself through the right side of his head.

Police approached the vehicle and attended to Mr Sweeney. The Queensland Ambulance Service (QAS) was called at 12:03pm. Mr Sweeney was en route to the Royal Brisbane and Women's Hospital when he was pronounced deceased by an attending paramedic.

These findings:

- confirm the identity of the deceased person, how he died, the place and medical cause of his death
- clarify the circumstances leading up to the death
- consider the appropriateness of the actions and decisions made by the attending police in the immediate lead up to the death
- Consider the adequacy of the police investigation into the death.

The investigation

An investigation into the circumstances leading to the death of Mr Sweeney was conducted by Inspector Dale Frieberg from the Queensland Police Service (QPS) Ethical Standards Command (ESC).

Upon being notified of Mr Sweeney's death, the ESC attended and an investigation ensued. The investigation was informed by statements and recorded interviews with:

- police officers involved;
- attending QAS staff;
- persons who were inside the residence in the lead up to the death;
- neighbours of the residence; and
- Mr Sweeney's next of kin.

Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted and photographs were taken. All of the police investigation material was tendered at the inquest.

An external autopsy examination with associated testing was conducted by Forensic Pathologist, Dr Philip Storey. Further photographs were taken during this examination.

I am satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The inquest

Mr Sweeney's death was reported as a death in custody under the *Coroners Act 2003*. He died while he was trying to avoid being put into custody. In those circumstances an inquest must be held.

An inquest was held in Brisbane on 15–16 June 2015. All of the statements, records of interview, photographs and materials gathered during the investigation were tendered at the inquest.

Counsel assisting, Miss Cooper, proposed that all evidence be tendered and that oral evidence be heard from the following witnesses:

- Inspector Dale Frieberg;
- Angela Sands;
- John Chester;
- Kylie Vandenburg;
- A/Senior Sergeant Matthew Bowden;
- Senior Constable Paul McNamara;
- Senior Sergeant Trevor Deegan;
- Gary Blizzard.

I consider that the evidence tendered in addition to the proposed oral evidence was sufficient for me to make the necessary findings under the *Coroners Act 2003*.

The evidence

Personal circumstances and correctional history

Michael Sweeney was born in Brisbane, Queensland on 26 May 1970. He was one of five children. His parents separated in the early 1980s and he lived with his siblings and his father, John, in Brisbane's northern suburbs.

Mr Sweeney's criminal history in Queensland began in 1985, when he was charged with murder, together with his brother and his mother. In 1986, he was convicted of manslaughter and served 2 years in a juvenile detention centre under a care and control order. Sadly, his mother committed suicide upon her release from prison in 2005.

From that time, Mr Sweeney spent most of his life in and out of prison on offences including dangerous operation of a motor vehicle causing grievous bodily harm, and property related offences. In October 2008, he was sentenced to seven years and six months imprisonment for the offences of burglary with violence whilst armed and in company, and armed robbery in company with wounding.

Mr Sweeney was released on parole in 2011, and subsequently began working for his father in Mackay. He also commenced a relationship with Angela Sands at around this time. Ms Sands said that she had known Mr Sweeney for approximately seven years before they commenced their relationship. They had one child together, William John Edward Sweeney, who was born on 15 July 2012. Mr Sweeney also had three adult children from previous relationships who did not live with him.

In late 2012, Mr Sweeney breached his parole after failing a urine test. As a consequence, he was returned to prison for 28 days and was released on parole on 3 January 2013.

Medical history

The information relating to Mr Sweeney's medical history was mostly provided by his father, John Sweeney who attended over both days of the inquest. His interview with police was tendered and it was deemed unnecessary for him to give oral evidence. In his interview he confirmed that Michael had commenced taking drugs, including ecstasy, when he was in his mid-twenties. He believed Michael was taking drugs again in the lead up to his death. Michael did not consume alcohol or take other medication.

John Sweeney suspected his son had medical problems which developed as a result of his lengthy periods of imprisonment. He believed that Michael was becoming more psychotic and suspected he may have suffered schizophrenia (his mother was a diagnosed schizophrenic).

John Sweeney believed Michael was unable to with cope everyday life when he was released from the prison system. He struggled to reintegrate into the community after having everything done for him in prison. Mr Sweeney voiced

his concern to me at the conclusion of the inquest that Michael's parole officer could have referred his son for treatment at an earlier time.

John Sweeney indicated he had spent many hours talking to Michael who repeatedly told him he would 'never do what his mum did to them' and commit suicide, but he did also say he would never go back to jail.

In the course of the coronial investigation I was provided with evidence confirming that, on 10 January 2013, Mr Sweeney had presented to his parole officer in an upset state. Discussions were held in relation to Mr Sweeney attending his general practitioner to seek a referral under a mental health care plan. This referral would allow him to access counselling through Medicare. Mr Sweeney was to have been referred to a forensic psychologist for assistance in the areas of relapse prevention, relationships, parenting and historic family matters.

Unfortunately, he had not accessed these services at the time of his death. Michael was not otherwise receiving any ongoing medical treatment in the lead up to his death.

Events leading to the death

On 3 January 2013, Mr Sweeney was released from prison on a parole order. He was residing with his father at Narangba, north of Brisbane.

At the inquest I heard evidence from Mr Sweeney's ex-partner, Angela Sands. She said the relationship with Mr Sweeney had started to deteriorate following the birth of their son in July 2012 when Mr Sweeney appeared to become isolated from the rest of the family. He was missing his older children and started using amphetamine with increasing frequency.

She had ended the relationship during Mr Sweeney's final period of incarceration, asking him to move out so he could 'get himself sorted out'. However, she visited him twice during this period and would still accept phone calls from him. Ms Sands gave evidence to the effect that, upon his release from prison, she and Mr Sweeney would try and work things out. She accepted in her evidence that Mr Sweeney would have held some hope that they might get back together.

However, it is apparent there was a further breakdown of the relationship with Ms Sands, resulting in Ms Sands obtaining a DVO. The order contained restrictions on Mr Sweeney contacting Ms Sands or her children, including six month old William. Additionally, Mr Sweeney was restricted from approaching Ms Sands or her place of residence at 14 Akuna Way Mango Hill.

Ms Sands gave evidence that despite the conditions of the order, she had met with Mr Sweeney on a couple of occasions in public places so he could see William. Ms Sands confirmed that Mr Sweeney was at her house on the night before his death, and she had met up with him in the days before that as well.

She described that visit as ‘good’ and she did not feel any concerns about his presence.

The night before his death, Mr Sweeney had phoned Ms Sands, asking for a lift to an address at Lawnton. Ms Sands agreed to provide the lift, and told police in her interview that during the drive Mr Sweeney sought information from her about whether they were going to get back together. There was some discussion about where to drop Mr Sweeney, before Ms Sands drove him back to her place.

Ms Sands gave evidence that her sister, Kylie Vandenburg and partner, John Chester were staying with her at that time. Mr Chester confirmed to the inquest that he saw Mr Sweeney take what he assumed was ‘speed’ on this particular night. Ms Sands recalled that there was some talk about William, during which Mr Sweeney became upset. Ms Sands then gave him a lift to another residence and she said it was at this time that she saw Mr Sweeney had a gun which was in a bag. When she returned to her house she informed her sister of this.

On the morning of 8 February 2013, Ms Sands returned home from dropping her children at school when she received a number of phone calls from Mr Sweeney. She was able to ascertain from Mr Sweeney that he wanted another lift. Ms Sands then received a call from her teenage son’s school, to say that her son was sick and needed to be picked up. On the return trip home from the school, her son took a call on her phone from an unidentified caller. The caller informed her son that Mr Sweeney was at the front of their house. Ms Sands then told her son that he should call the police when they returned to their home.

Upon returning home, Ms Sands gave evidence that she pulled into the driveway and observed a black bag at the front of the house on a bench, which she knew was Mr Sweeney’s bag. She could not see Mr Sweeney and entered the house along with her two sons.

Ms Sands then saw Mr Sweeney sitting on a couch out the back of the house. Mr Sweeney said to Ms Sands that he wanted to see his son. Ms Sands gave evidence that she let him and he spent some time with William. Mr Sweeney then told her that he was going to leave and put William down. She went to lock the back door and told her older son to take William to the bedroom.

Ms Sands said that she then managed to get Mr Sweeney to head out the front door, after which she locked it behind him which seemed to agitate him. He said to her ‘Ange, I want to show you something’. Knowing that the gun may have been in the bag, her response was ‘no’. Ms Sands said she then called her sister who was at the nearby shops and warned them not to return to the home.

I heard evidence from Ms Vandenburg and Mr Chester; they both confirmed they had walked to the local shops that morning when they received a call from Ms Sands to say that she was heading to the school to pick up her son. They then received a further call from Ms Sands where she told them not to come back to the house and that Mr Sweeney was there. They could not recall which one of them took the second call, and it is unclear whether a gun was mentioned

at this time. Ms Vandenburg gave evidence that they returned straight to the house upon receiving this second call.

Ms Vandenburg and Mr Chester arrived home to find Mr Sweeney sitting on the bench at the front of the house. He seemed calm at that time and told them that Ms Sands would not let him back in the house. Ms Sands let her sister and Mr Chester inside, but Mr Chester gave evidence that he stayed outside and spoke to Mr Sweeney saying words to the effect that this was not the best way to go about getting what he wanted. I am satisfied that by this stage Ms Sand's older son was inside the house and had already made, or was making, the first 000 call to police.

Mr Sweeney then came back into the house with Mr Chester. He brought his bag with him. He said that his phone needed to be recharged so that he could call someone to collect him.

Ms Vandenburg called 000 after going to the bedroom with William and Ms Sand's older son. By this stage, Mr Sweeney was becoming aggressive towards Ms Sands, she confirmed in her evidence that he was calling her a slut and a whore.

At some stage, Ms Vandenburg was asked by the police on the phone to confirm whether there was a gun. It is unclear whether she or Mr Chester checked Mr Sweeney's bag which had been brought inside by Mr Chester. Ms Vandenburg recalled that she had checked inside the bag, and Mr Chester recalled that he had checked inside the bag. Either way, the presence of a gun in the bag was confirmed, and Ms Vandenburg relayed this information to police on the phone.

Mr Sweeney's father queried at the inquest why the police did not instruct Ms Vandenburg or Mr Chester to remove the weapon. However, I consider that to do so while Mr Sweeney was in close proximity would have been likely to escalate his anger.

Ms Sands went down to the bedroom to collect William from her sister, at which point Mr Sweeney approached and took William out of Ms Vandenburg's arms. I am satisfied that the evidence supports that Mr Sweeney knew at this point that Ms Vandenburg was on the phone to the police. Evidence was heard at the inquest that she was describing his actions to the police in his presence, and he acknowledged this fact to Ms Vandenburg by calling her 'fucking scum' and saying words to the effect of 'thanks a lot'.

While still holding William, Mr Sweeney went back to his bag and Mr Chester recalled that he had William on his lap. He then gave William back to Ms Sands, and Ms Sands headed back down the hallway to the bedroom with Ms Vandenburg and her older son. Ms Vandenburg was still on the phone to police. They shut the bedroom door, placed furniture against it, and barricaded themselves in. They remained in this position until the conclusion of the event.

Mr Chester and Mr Sweeney remained out in the living/dining area of the house. Although there were no sirens, Mr Sweeney said that police were already there

and probably had the place surrounded. Mr Sweeney asked Mr Chester to find the keys to the back door, but Mr Chester recalled the keys could not be located. Mr Sweeney then said he was not going back to jail and he was going to shoot himself. Mr Chester gave evidence that Mr Sweeney, who appeared to be under the influence of drugs, put the gun to his head and pulled the trigger, but it did not work and seemed to misfire.

Mr Sweeney then told Mr Chester to go outside and tell the police he was not going to harm anyone but himself. I heard evidence that Mr Chester complied with this request, and when he returned inside, Mr Sweeney threw him the keys to Ms Sands' car. Both men walked outside, Mr Chester in front (wearing a red/maroon shirt) and Mr Sweeney behind him (wearing a black shirt). Mr Sweeney was holding the gun to his own head as they walked to the car.

Mr Chester entered the driver's seat of the car and turned on the ignition, and Mr Sweeney made his way around to the front passenger seat. Mr Sweeney was still holding the gun to his head. Once he was in the car, Mr Sweeney said to hurry up, and Mr Chester heard the gun misfire as it had before. Mr Sweeney then tried again, and the gun fired.

The QAS were called at 12:03pm, and Mr Sweeney was being driven down Akuna Way (en route to the RBWH) when he was pronounced deceased by one of the paramedics.

Autopsy results

An internal examination was conducted by experienced Forensic Pathologist, Dr Philip Storey, on 11 February 2013.

Toxicology testing confirmed the presence of amphetamine at a level of 0.05mg/kg and methamphetamine at a level of 0.25mg/kg. The quantity of these substances in Mr Sweeney's system suggests he had ingested the drug in the form of methamphetamine. Dr Storey considered the levels of the drugs to be non-toxic.

External examination identified a single gunshot wound to the head with entry at the right temporal region together with a faint region of mildly split skin, where the projectile did not quite exit, at the left temporal region.

Internal examination and CT scan of the head identified a small circular entry wound at the right side of the head. This wound had characteristics of a contact range entry wound. The projectile entered the cranial cavity travelling right to left, slightly backwards and slightly upwards.

There was severe disruption to the substance of the brain particularly involving the base of the brain and the mid-brain with interruption to vital structures within the brain. In addition, there was severe injury to several of the major blood vessels that supply the brain with blood.

The projectile lodged at the left side of the head, in the temporal region. It impacted against the skull resulting in a second defect in the skull bone. The projectile had insufficient energy to exit the body and halted beneath the skin.

The injuries were classified by Dr Storey as severe and immediately life threatening. The cause of death was determined as gunshot wound to the head.

The QPS response

The ESC investigation revealed that, on 8 February 2013, police from Mango Hill Station, North Lakes were detailed the job, a code three response to a domestic disturbance at 14 Akuna Way, Mango Hill, following the receipt of a 000 call from a twelve year old juvenile male.

The child had explained to the police communications operator that his mother (Ms Sands) had a DVO against Mr Sweeney who had arrived at the house and would not leave. He stated Mr Sweeney has previously been violent towards his mother.

A short time later a second 000 call was received at police communications from Ms Vandenburg stating Mr Sweeney was there, he was violent and had a gun. She stated he had threatened to shoot himself in front of the children. As a result of the continued information being provided by Ms Vandenburg, the police response to the incident was upgraded to code two.

Numerous police units responded to the job, forming up at a staging point at the corner of Akuna Way and Freshwater Drive at Mango Hill.

As police arrived, neighbours in the near vicinity to 14 Akuna Way were directed by police back into their homes. Inner and outer cordons were being established in order to contain the situation and prevent both pedestrian and vehicular traffic from approaching the stronghold. Throughout the incident and lead up to Mr Sweeney taking his own life, Ms Vandenburg continued to provide information to police communications about Mr Sweeney's movements and behaviour. This information continually provided situational updates to the officers at the scene.

To assist me in determining the appropriateness of the police actions, I was taken to the various police training, relevant legislation and QPS policies and procedures. In particular, Chapter 14 of the Operational Procedures Manual (OPM) provides that police officers up to and including the rank of Senior Sergeant must undertake annual Operational Skills and Tactics (OST) training. This training includes the use of force options available to police and involves various role play scenarios. I am satisfied that each of the primary officers

involved in this incident were up-to-date with respect to this training requirement.

Chapter 14.3.2 of the OPM provides for a 'Situational use of Force Model' which is depicted in the image below:

The evidence before me confirms that the QPS has adopted a philosophy of 'Consider all Options and Practice Safety'. Police officers should consider all options available to them and all the circumstances of an incident when determining the most appropriate use of force option/s to be used.

Chapter 17.3.7 of the OPM contains the policy relating to tactically dangerous situations. It says:

Tactically dangerous situations include: armed offenders involved in criminal activities, hijacking, terrorism, explosions, suspect devices, siege situations or crowd management incidents.

When responding to tactically dangerous situations officers should consider the following issues:

(i) safety:

(a) conduct a risk assessment:

- *assess all situations with regard to any threat from any PERSON, OBJECT or PLACE;*
- *categorise the risk as either HIGH or UNKNOWN; and*
- *consider the Situational Use of Force Model and choose an appropriate option (see s. 14.3.2[8]: 'Situational Use of Force Model – 2009' of this Manual); and*

(b) where appropriate, consider evacuating persons in the vicinity (see s. 17.4[9]: 'Evacuation' of this chapter);

(ii) tactical:

(a) establish inner and outer cordons in accordance with s. 2.4.9[10]: 'Guarding an incident scene' of this Manual;

(b) where applicable notify:

- *the Special Emergency Response Team (see s. 2.19.13[11]: 'Special Emergency Response Team' of this Manual);*
- *negotiators (see s. 2.19.9[12]: 'Negotiators' of this Manual); and*
- *other emergency services including any requirement for a doctor, clergy or an interpreter, etc.*

In the lead up to Mr Sweeney's death, officers Bowden, McNamara and Deegan had made threat assessments and determined it was a tactically dangerous situation. There was a firearm and potential for death or grievous bodily harm. I heard evidence that Mr Sweeney was known to police as having knowledge of firearms and for the use of firearms, and this knowledge contributed to the threat assessments that were made. A warrant had also been issued for his return to prison.

During their interviews with ESC, all officers demonstrated a knowledge of section 17.3.7 of the OPM and were able to articulate reasoning behind their decisions. Once Mr Sweeney was seen to exit the house, Sergeant Bowden stated he believed it was time to challenge so he moved forward to do so.

Sergeant Bowden said he was on duty at the time of Mr Sweeney's 2008 offences and was aware of his propensity for violence. His aim on 8 February 2013 was to contain the situation. He had called for the Special Emergency Response Team to be engaged while he was en route to Akuna Way. He was concerned that if Mr Sweeney was permitted to leave the location, lives of others in the vicinity, including the apparent hostage, Mr Chester, would be at risk.

Police commenced to move towards the 'stronghold' and ultimately towards Mr Sweeney and Mr Chester in the driveway. As a result of the information they were receiving, they were of the belief that both males were going to get into the vehicle and attempt to leave. Evidence was heard regarding the potential hazards this would present for the surrounding area and community, and although wheel stingers were ready to be deployed, this was not a containment method that could be solely relied upon.

Sergeant Bowden was the primary officer with Senior Constable McNamara (with police dog 'Asco') behind him and Senior Sergeant Deegan following closely. A number of other uniformed officers and two plain clothed officers were in the group moving forward with the primary officers. Sergeant Bowden's evidence was that he was not aware Mr Chester had been dispatched earlier to signal that Mr Sweeney was not intent on harming anyone other than himself.

As the approach was made to the boundary of the residence, Sergeant Bowden and Senior Constable McNamara called on both Mr Sweeney and Mr Chester

and yelled at them to ‘drop the gun, drop the gun’. They had their police firearms drawn, pointing directly at Mr Sweeney.

Mr Sweeney looked at the officers but continued to walk to the passenger side of the vehicle. He entered the vehicle and shut the door. Mr Sweeney then looked directly at Sergeant Bowden. He moved the gun from his left hand to his right hand and pressed it up against his right temple. Although he appeared to look at Sergeant Bowden, he did not comply with his instructions.

While approaching the driveway, a noise akin to a misfire was heard by Sergeant Bowden, along with a number of the other responding police and independent witnesses. Sergeant Bowden called on the males to get out of the vehicle. Mr Chester complied with this direction and lay onto the driveway where he was handcuffed by other police.

Sergeant Bowden was unaware the weapon had discharged. He continued to move to the front of the vehicle with the objective of securing Mr Sweeney. Senior Constable McNamara and Asco approached the vehicle from the rear.

It was confirmed at the inquest that the officers, who regularly worked together, triangulated. Sergeant Bowden’s evidence was at the time he believed Mr Sweeney may have been ‘playing possum’ with him. He clarified that the reason he thought this was the earlier situation report from police communications that Mr Sweeney had tried to shoot himself inside the residence and the gun had misfired.

As Sergeant Bowden approached Mr Sweeney he could see the firearm in his hand with the finger still on the trigger. He said he still thought he may be shot at this time. He stated he then saw a trickle of blood coming down the right side of his head. Sergeant Bowden then opened the door and it was at this time he could see a considerable amount of blood coming out of Mr Sweeney’s head and had the immediate thought of obtaining first aid. He and other officers pulled Mr Sweeney from the car and commenced first aid. They were relieved by QAS paramedics a short time later.

The actions of police were corroborated by the versions supplied by many neighbours. I heard evidence via telephone from Gary Blizzard who was in the residence directly across from where the incident occurred. He had an unobstructed view of the front yard and the vehicle in which Mr Sweeney died. Mr Blizzard confirmed that the police were 4-5m away from the car and Mr Sweeney when the shot was fired, and that they could be clearly heard to yell ‘get out of the car’ and ‘drop the gun’ on multiple occasions.

The ESC investigation concluded that the actions of each of the officers would meet the expectations of the community with respect to preserving the peace and keeping the community safe.

No evidence was heard at the inquest to indicate that the police responded in any way but in accordance with QPS policy and procedure. Each of the primary officers was asked whether there was any other way of dealing with Mr Sweeney on the day. Each officer confirmed that because of the presence of

the firearm, the response to challenge Mr Sweeney by using their own firearms was the only option.

The evidence confirmed that the doors to the car were shut, and the windows were closed. Given this and the fact that Mr Sweeney was armed with a gun, as well as the distance each of the officers were from the car when Mr Sweeney shot himself, other methods of force such as Tasers were not an option.

Adequacy of Ethical Standards Command investigation

The ESC investigation found that once Mr Sweeney and Mr Chester exited the house and were getting into the vehicle, Sergeant Bowden made the tactical decision to move forward towards the vehicle with Senior Constable McNamara behind him, with Senior Sergeant Deegan following behind. The officers were approximately 7-10m away from the vehicle, on the front lawn, when the gun went off.

In the days following Mr Sweeney's death, Inspector Frieberg attended to the photographing of Mr Sweeney's property, at which time she located a handwritten note in his bag. The note was dated 3 February 2013 and addressed to Ms Sands. It essentially outlined how Mr Sweeney felt about Ms Sands and William. It described his own pain and indicated that he was never going back to prison and would rather be dead.

The investigation covered relevant sections of the OPM. All police witnesses were interviewed with respect to their knowledge and application of the relevant sections. Each of the police officers was separated after the incident and tested for drugs and alcohol and interviewed in the company of a police union representative. None of the officers involved was able to identify anything that could have been done differently, or in a better way.

The investigation concluded that Mr Sweeney was determined to end his life, as he had made up his mind he was not going to return to prison. There was no evidence implicating any other person as being directly involved in the death. There was no evidence that any of the police officers involved acted inappropriately or contrary to QPS policy or training.

Conclusions

I conclude that Mr Sweeney died from a self-inflicted gunshot wound to the head. I find that none of the police officers or other witnesses at 14 Akuna Way, Mango Hill caused or contributed to his death in any way.

I am satisfied the actions and decisions made by the attending police officers in the immediate lead up to Mr Sweeney's death were appropriate and timely. Mr Sweeney's death could not have reasonably been prevented by the attending officers.

I am satisfied that the investigation conducted into Mr Sweeney's death by the ESC was appropriate, thorough, and covered all relevant areas of investigation. I am satisfied that the protocols established to investigate deaths in custody in

accordance with the *Coroners Act 2003*, and Queensland Police Operational Procedures Manual were complied with.

Findings required by s. 45

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

Identity of the deceased – The deceased person was Michael Shawn Sweeney.

How he died - Mr Sweeney died from an intentional self-inflicted gunshot wound to the head. The death occurred after he went to his ex-partner's residence in contravention of a Domestic Violence Order and while he was on parole. He shot himself in the presence of a witness while police officers were approaching.

Place of death – He died at Akuna Way, Mango Hill in the State of Queensland.

Date of death – He died on 8 February 2013.

Cause of death – Mr Sweeney died from a gunshot wound to the head.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

It has been said by the former New South Wales State Coroner[1] that the purposes of an inquest into a death during the course of police operations are to fully examine the circumstances of any death in which police have been involved to enable the public, the relatives and the Police Service to become aware of the circumstances. He noted that in most cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will have been thoroughly reviewed, including the quality of the post-death investigation.

[1] Waller's Coronial Law & Practice in New South Wales 4th Edition, page 106

In this case I have found there are no grounds for criticism of the police officers involved. They responded professionally and in accordance with their training in a rapidly changing and highly charged situation involving a man with a known propensity for violence, potential hostages (including young children) and a weapon that was apparently loaded.

I was particularly impressed by the courage displayed by each of the three officers who gave evidence at the inquest. It is clear that the events of 8 February 2013 had a significant impact on them. The officers risked their own lives when they sought to contain Mr Sweeney in circumstances where he had the potential to harm not only himself and Mr Chester, but also others in the immediate vicinity.

My findings will be referred to the Queensland Police Commissioner and the Secretary of the Australian Bravery Decorations Council for consideration of appropriate bravery and service awards.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
19 June 2015