QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Blair Andrew Hamilton**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BOWEN
FILE NO(s):	2015/4923
DELIVERED ON:	28 June 2018
DELIVERED AT:	Brisbane
HEARING DATE(s):	11 April 2018,12-15 June 2018
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, Death in Police operations, mental health, physical health disability, LPG gas explosion, suicide

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis
Counsel for Queensland Police Union and officers Atwood and Murphy:	Ms D Firth i/b Gilshenan & Luton
Counsel for Mackay Hospital and Health Service	Ms S Gallagher i/b Mackay Hospital & Health Service
Counsel for Commissioner of Queensland Police Service:	Ms E Kennedy, QPS Legal Unit

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Introduction

1. At 8.10pm on 12 December 2015, a Triple Zero operator based at Cairns received a phone call from a male person stating '*we have a potential suicide here*'.

2. He gave his address, a unit in Bowen, and stated '*I advise officers not to approach, the unit's full of gas*'. He then stated '*I don't want to hurt anybody but, now you're advised*'.

3. He confirmed he was the resident of the unit and gave his name when asked as Blair Hamilton. He then stated '*please don't approach*'. The call then cut out.

4. A Bowen police vehicle with two junior Police Constables was detailed to attend the address given by Mr Hamilton. They arrived within two minutes of being despatched, and within six minutes of Mr Hamilton's Triple Zero call. Upon arrival one of the officers activated their body worn camera.

5. The two officers approached the unit, which was on the second floor of a two storey unit complex. As they got closer the officers detected a strong odour of gas coming from the unit. Around that time one of the officers made a radio call for fire and ambulance services to attend, telling the radio operator '*we are going to force entry as he is probably in imminent danger*'. The other officer can be heard telling her colleague '*If he's in there we've got to try. We can't just leave him there*'.

6. Upon reaching the door the officers called out to the person inside, asking him to open the door and threatening to force entry if he did not comply within three seconds. The door remained closed.

7. One of the officers then proceeded to kick the locked door, forcing it open after seven kicks. Within seconds of doing so, an explosion occurred. Flames engulfed the unit, causing burn injuries to the two officers.

8. Despite their injuries the two officers bravely continued their attempts to assist the occupant of the unit, who had survived the explosion but was badly injured. They succeeded in getting him outside and also began directing other occupants of the unit complex to evacuate.

9. Fire and ambulance services arrived and Mr Hamilton, was transported to Bowen Hospital. Unfortunately the burn injuries Mr Hamilton sustained in the explosion were extensive and he passed away from those injuries at around 1.30am the following morning, 13 December 2015. He was 54 years of age at the time of his death.

10. Mr Hamilton was known to both police (including the Police officers in attendance) as well as mental health services in Bowen and the Mackay District prior to the incident. There had been a number of presentations to emergency departments following previous self-harm attempts over ales than two year period from around April 2014, when he lost his wife suddenly due to a fatal brain aneurysm. Mr Hamilton had been diagnosed with chronic severe depression, severe grief and was also a heavy user of alcohol, with all of his self-harm attempts occurring whilst he was significantly intoxicated. Mr Hamilton also suffered from a debilitating skin condition.

11. As part of the subsequent investigation it was identified there were some issues with respect to communications between the police and with other emergency

agencies ,the supervision and support provided to the officers, and the decision making by the police officers and whether different actions were available that could have resulted in a different outcome.

Decision to hold an inquest

12. Given Mr Hamilton died in the course of a police operation as defined under the *Coroners Act 2003*, and given there may have been opportunities that evening for police to take different actions that may have resulted in a different outcome for Mr Hamilton, a decision was made to hold an inquest into Mr Hamilton's death.[1]

13. The intention was to hear from various witnesses to:

    a. Explore the police communications issues that were identified both by the initial QPS investigator and the QPS reviewer, by calling those involved as well as those who were in charge/responsible for those services.
    b. Calling the two officers who responded to the incident that evening and hearing their account of events, as well as giving them the opportunity to respond and add further light to the findings of the police investigation and review of the incident.
    c. Hearing from the two officers who investigated and reviewed the police response to the incident and formed opinions about potential opportunities for improvement.
    d. Hearing from those who knew Mr Hamilton well (his GP, counsellor and close friend/carer) to give an account of what was happening for Mr Hamilton, particularly since his wife's death and in the months leading up to the incident.
    e. Hearing from Mr Hamilton's close friend/carer who can speak to the above as well as his observations of Mr Hamilton on the day of the incident.
    f. Hearing from Mr Hamilton's GP, his most recent counsellor and someone from mental health/alcohol services regarding the health services provided to Mr Hamilton, and whether anything more could have been done to reduce the risk for Mr Hamilton in light of his depression and previous self-harm attempts.

Proposed issues for the inquest

14. The following issues were set at a pre-inquest hearing held on 11 April 2018, namely:-
    a. The findings required by s.45 (2) of the *Coroners Act 2003*; namely the identity of the deceased person, when, where and how he died and what caused his death.

    b. The circumstances surrounding the incident on 12 December 2015 where police attended the home of the deceased, at which time the deceased appears to have caused a gas bottle to explode, resulting in injuries to both himself and the attending Queensland Police Service officers.

[1] Section 27(1)(a)(iii) of the *Coroners Act 2003*.

c. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003*.

Autopsy results

15. Post mortem examinations confirmed Mr Hamilton's cause of death as due to extensive burns. Mr Hamilton was also found to have significant coronary artery narrowing which, together with the stress of having burns, may have contributed to his death.

16. No illicit drugs were found in Mr Hamilton's system. There were lots of drugs in his blood related to therapeutic intervention by the hospital.

17. The antidepressant drugs venlafaxine and mirtazapine were considered to be present as part of his longstanding medication along with the antipsychotic drug quetiapine and all appeared within the usual therapeutic range.

18. Alcohol was found in the blood at a low level of 0.033% but there was a high level of alcohol in his urine at 0.151%, suggesting that his alcohol level prior to the explosion was probably quite significant.

Personal Background History

19. Blair Andrew Hamilton was aged 54 years at the time of his death. He lived alone in rented premises owned by Queensland Housing.

20. Mr Hamilton was born in New Zealand and moved to Australia with his parents in 1975.He married in 1995 and the couple had three boys. The parties separated and the marriage ended in divorce around 2010 by which time his family moved interstate.

21. After the separation Mr Hamilton commenced living with Robert Mostyn, the brother of his first wife, and they remained close friends.

22. Mr Hamilton met his second wife in 2012 and remarried in 2013 and the newly married couple resided in Proserpine. However his wife died suddenly about 11 months into the marriage in April 2014 from neurological problems. Mr Hamilton moved back to Bowen.

23. It was from that time Mr Hamilton began exhibiting symptoms of inconsolable grief, depression and self-harm behaviour. For a period of time he was cared for by Mr Mostyn and Mr Hamilton lived with him for a while. Mr Hamilton was later able to obtain Queensland Housing accommodation but continued to have regular contact with Mr Moyston. Mr Mostyn became his formal carer and visited him daily for a number of hours.

24. Mr Mostyn stated Mr Hamilton had suffered from depression for 10 years largely related to chronic alcoholism. During this period of time there were numerous attempts made by Mr Hamilton to self-harm. On each occasion he was intoxicated. Mr Mostyn told police that he would spend time with Mr Hamilton daily in order to keep him company and to try and divert him from further attempts.

25. Mr Mostyn stated that Mr Hamilton was devastated by the death of his wife who was caring for him due to his skin condition, which became symptomatic in the 18 months prior to his death. His depression worsened. Alcohol abuse was a constant factor.

26. There were a number of attempts at self-harm/suicide including on 26 April 2014–prescription drug overdose; 5 May 2014–attempted hanging; 30 July 2014 - presenting with suicidal thoughts; 22 August 2014–attempted cutting of throat; 10 June 2015–attempted suicide by overdose and hanging.

27. Mr Hamilton also suffered from a severe form of a debilitating skin disease known as Pityriasis Rubra Pilaris or 'PRP'. His GP, Dr Andrew Mallett had been treating Mr Hamilton regularly for over twenty years, and described Mr Hamilton's life after the death of his wife and the development of PRP as 'truly miserable'. He stated Mr Hamilton had never recovered from the death of his wife, and his chronic depression worsened significantly since that time. Mr Hamilton's skin disease was painful, intractably pleuritic (that is, causing inflammation of the lining of his lungs and chest cavity resulting in chest pain that is worse with breathing), deforming and embarrassing. Mr Hamilton had to wear head to foot paraffin soaked garments continuously, and his life was a series of dressings, medications, blood tests, and specialist appointments. He became socially isolated.

28. Dr Mallet had prescribed him drugs for hypertension and mental health over many years. These drugs were essentially reviewed by Dr Mallet and mental health services and at the end included Avanza, Effexor and Seroquel. Dr Mallet said Mr Hamilton was compliant with his medications, attended appointments and spoke freely. It is noted that all three medications were found at therapeutic levels at autopsy. There had been a number of occasions where Mr Hamilton had tried to stop smoking and had been prescribed Champix. Dr Mallet saw no suggestion of a deterioration in mental state when he was on this drug and any prescribing was well removed from the time of his death. Mr Hamilton was to his knowledge continuing to smoke.

29. Dr Mallet last saw him on 25 November 2015 where no mental health issues were raised.

30. Mr Hamilton had also accessed counselling and grief counselling over a number of years. Most recently this was with Ms Drazenka Stanko who provided counselling in April 2014 and most recently from September 2015 over a series of five sessions, with a last appointment on 5 November 2015. Ms Stanko stated Mr Hamilton was a very sad person for the reasons that are evident. He had made it clear that alcohol was the only joy he had left in his life and he was not going to change that. Ms Stanko thought there had been some positives arising out of some basic mindfulness sessions. She believed there was no suggestion he needed more counselling as at 5 November although that was completely open if he wanted it.

31. It is evident from what his GP said that Mr Hamilton had no trouble accessing mental health services in Bowen but did have some difficulty regarding the PRP in the sense he had to travel at times to access services. Dr Mallet said his skin

condition was never going to get any better and there were some financial constraints in respect to accessing some nursing care for dressing purposes.

32. Mr Moyston said he took Mr Hamilton to Townsville Hospital on 8 December 2015 and he seemed fine and normal.

33. On 12 December 2015 Mr Moyston went to see Mr Hamilton at his unit at 11 am. Mr Hamilton seemed well and he did not appear to be drinking. Mr Moyston knew Mr Hamilton had a gas bottle, which was kept on the front verandah hooked to a barbecue. On this particular visit he did not see the gas bottle but he also did not see it in the unit either. They watched a downloaded TV series and when he left Mr Hamilton seemed alright.

34. Mr Moyston went to the hospital after the explosion but by that time Mr Hamilton was medicated and sedated and Mr Hamilton did not say anything about the incident.

35. Dr Mallet stated that he had difficulty understanding Mr Hamilton's "suicide", if it was designed to knowingly harm other persons. He stated Mr Hamilton was never known to him to be aggressive, threatening or violent. Ms Stanko was also completely shocked at the nature of his method of death as she did not think he was capable of something like this and that resulted in injuries to others.

36. This issue is also of relevance to understanding the context of the decisions made by the first response police. Constable Atwood had a long interaction with Mr Hamilton over 4 or more hours as a result of his attendance on an earlier Emergency Examination Order. Constable Atwood described Mr Hamilton as softly spoken and a nice person and he did not consider he was a violent person. The history gained by Constable Atwood was that his wife had died, he was estranged from his children, he was depressed, had a skin condition and abused alcohol, the latter giving him courage to make attempts on his life. Importantly, to understand the context in which the police were operating, Mr Hamilton told Constable Atwood he was going to commit suicide one way or the other at some time.

37. Mr Hamilton told police at the scene he was sorry they had been hurt.

Mental Health History

38. Dr Isabelle Wesdorp, the Clinical Director for Mackay Hospital and Health Service Mental Health and Alcohol and other Drug Service provided a statement detailing an overview of the history of treatment provided to Mr Hamilton since 2014. She had not been personally involved in his care

39. Mr Hamilton's first presentation was to Proserpine Hospital on 26 April 2014. He presented after consuming alcohol and multiple tablets of Endone and Phenergan. He was admitted as a voluntary patient for seven days. On discharge the principal diagnosis was Major Depressive Disorder and alcohol abuse. He was referred to follow-up by the Whitsunday Mental Health Team and he was referred to Hospital social workers for grief counselling.

40. Mr Hamilton presented again on 6 May 2014 to the emergency department saying he felt unsafe at home and was suicidal. He was discharged on 8 May 2014 with a plan for follow-up. His risk of suicide was assessed as low as his mental state had improved and he had planned to move in with a friend that day.

41. On review on 2 June 2014 he indicated he was doing well and did not need further follow-up. He said he was seeing a psychologist in Bowen which had been helpful. He had no further thoughts of suicide and did not feel the need to continue access to mental health services. His case was closed.

42. However, on 30 July 2014 Mr Hamilton presented to Bowen Hospital expressing that he wanted to kill himself. He apparently had a Facebook argument with his son. He was admitted to Mackay Base Hospital and remained there until 4 August 2014. On discharge an appointment was made with his private psychologist as well as a referral to the Whitsunday team for follow-up. The diagnosis of Major Depressive Disorder and alcohol abuse remained. On follow-up he stated his mental state was stabilised. Two more follow-up telephone calls were made but he could not be contacted.

43. On 22 August 2014 Mr Hamilton was brought in to Bowen Hospital on an Emergency Examination Order having cut his neck with scissors resulting in minor lacerations. He told ambulance officers he wanted to die. He had consumed 300 mls of rum. He was admitted to Mackay Hospital and discharged on 25 August to the Whitsunday team for follow up and to his GP. He received psycho education, counselling on coping strategies and alcohol counselling. Referrals were made to inquire as to whether or not he could be provided a service to assist him in managing his skin condition. A care package was not available and Mr Hamilton could not afford Blue Care services.

44. On 18 September 2014 Mr Hamilton's GP referred him to the Whitsunday Mental Health Team. He was provided with a psychiatric review by Telehealth services. Treatment advice was to remain on the same medication and to develop a crisis plan in liaison with Mr Hamilton and the local hospital, and to refer him for grief counselling and to assist him in developing a structured daily schedule.

45. On 22 October 2014 Mr Hamilton was admitted to Bowen Hospital after hanging a sheet over a balcony and threatening to hang himself. He called Beyond Blue who called police. He had been drinking. He was reviewed by a psychiatrist and was admitted to Mackay Base Hospital. He was discharged on 24 October as he had agreed to a plan for follow-up in the community, to cease his alcohol use and he would stay with his brother-in-law for extra support.

46. A Crisis Intervention Plan was developed. Alcohol counselling was offered but declined by Mr Hamilton. Blue Care referral was suggested but he was not willing to pay the fees. Assistance from Bowen Hospital to help with his dressings was offered but this was declined. Different types of counselling were suggested but he stated he would not be suited to engage in counselling. The Crisis Intervention Plan was discussed and Mr Hamilton and his caseworker agreed on closing the case.

47. On 10 February 2015 Mr Hamilton presented to Bowen Hospital after being brought in by ambulance following a polypharmacy overdose.

48. On 23 February 2015 Mr Hamilton called his caseworker following problems he was having with his deceased wife's family regarding burying her ashes. He stated he had come to accept the death of his wife. He had received some assistance with house work and he had daily contact with a supportive friend and was sleeping well. His skin condition was still causing concerns. He was not expressing suicidal thoughts and his risk was assessed as low.

49. On 10 June 2015 Mr Hamilton presented to Bowen Hospital having taken an overdose of Panadol, Effexor and alcohol. He then attempted suicide by

hanging. He ceased the attempt and rang QAS. He had received a call from Centrelink saying he owed it $9000. He was admitted as a voluntary patient and discharged on 13 June to follow up. He reported feeling much better.

50. During follow-up Mr Hamilton also reported he was feeling better and had been seeing his GP and was booked in to see a new skin specialist. He reported his mood as good and he had no suicidal thoughts. Treatment options were discussed but he declined psychological intervention, grief and loss counselling. He was counselled for strengthening his coping skills and his Crisis Intervention Plan was discussed and agreed upon.

51. On 26 August 2015 Mr Hamilton was brought into Bowen Hospital having been drinking heavily and more than usual. He was distressed about the management of his skin condition and the endless washing of his sheets, clothes and reapplying oil to his skin. He could not leave the house. He reported to be still struggling with the death of his wife and was depressed. He advised that he did not have an effective plan but he just wanted it all to end. He remained in hospital and was reviewed by a mental health clinician. He stated he did not want to die. He agreed to a referral for grief and loss counselling and his friend who was in contact with him daily was applying for a carer's pension to look after him. This referral was made and he had not been seen by mental health services again. It is noted that Mr Hamilton continued to see his GP and he commenced grief counselling with Ms Stanko.

52. On reviewing the files Dr Wesdorp stated it can be concluded that Mr Hamilton suffered from chronic depressive symptoms complicated by a chronic skin condition and intermittent alcohol misuse. She stated Mr Hamilton was equipped with poor coping strategies and avoidant traits and his mental state could fluctuate significantly depending on psychological stressors and alcohol intoxication.

53. Dr Wesdorp stated the service provided to him in the community by the health service seems to have been adequate and appropriate in the sense that the indicated treatment and services were offered, but not engaged by Mr Hamilton, including alcohol counselling.

54. Dr Wesdorp stated the community treatment could not be enforced under the *Mental Health Act* due to Mr Hamilton not meeting the legislative criteria. When seen by clinicians in the community on scheduled appointments he did not present as unstable or at risk. Enforcing treatment would have been considered illegal.

55. Dr Wesdorp stated the inpatient care Mr Hamilton received seems to have been adequate and appropriate, as he was discharged in an improved condition, with a safety plan and appropriate follow-up care organised. The last three admissions were short in nature as per the Crisis Intervention Plan, which had been developed in accordance with Mr Hamilton. Mr Hamilton did not want any lengthy admissions and agreed to short admissions to recover from the crisis and intoxication.

Police and Emergency Services at Bowen

56. It is apposite to describe the level of police and emergency services available in Bowen on the night in question.

57. On the evening shift of 12 December 2015 there were only two police officers on duty in Bowen. Constables Kimberly Murphy and William Atwood had less than three years experience as police officers at the time. Constable Murphy

was the senior officer by a few months. During the hours of 8 am to 4 pm, Monday to Friday their direct supervisor was the Officer in Charge of Bowen Station, Acting Senior Sergeant Craig McConnell. Snr Sgt McConnell stated he was not on call after hours but he was expected to take calls if needed. He was not contacted about the incident until after the explosion.

58. Constables Murphy and Atwood's direct supervisor outside of business hours were the District Duty Officers (DDO) on shift based in Mackay. Bowen and Collinsville police did not and still do not have direct radio contact with Mackay. If contact was to be made with a DDO the police in those areas needed to use their own mobile telephones .It is apparent Constables Murphy and Atwood rarely availed themselves of this support.

59. Constables Murphy and Atwood were pragmatic and not critical about what level of support they could expect and stated this was the way it was in Bowen, and police just had to deal with cases as they arose. Constables Murphy and Atwood were generally aware of the Operational Performance Manual (OPM) section 17.3 relating to hazardous incidents. It is noted this OPM related mainly to major industrial type incidents including LPG gas incidents. One requirement in the OPM was to ensure Queensland Fire and Emergency Services (QFES) were notified. Neither officer had received specific training dealing with a LPG gas bottle in a domestic situation. It was the general view of police who gave evidence this training would not be expected as OPMs and training cannot deal with the myriad of situations potentially faced by operational police on the ground.

60. Despite their supervising officer being the DDO in Mackay, due to the radio limitations any emergency calls for the attention of Bowen police were dealt with through the Townsville Communications Centre, with which there was radio contact. If an emergency call could not be picked up by Townsville Coms it would be diverted to another communications centre such as Cairns. At the time of this incident the DDO in Mackay was not, as a matter of routine, informed by Townsville Coms if Bowen had been called out to attend a serious incident. Snr Sgt Mark Sweetnam was the DDO on call at the time of the incident, and was only informed after the explosion. He immediately drove from Mackay to Bowen. He then took control of the incident from Snr Sgt McConnell to allow him to support his troops.

61. On the night in question the Cairns Coms officer did not contact QAS and QFES to attend and left this to Townsville Coms. Constable Murphy's radio was faulty in that she was receiving communications over the radio but was not able to send a communication. The Townsville Coms officer on the night in question had turned down her speaker, leaving some delay in responding to calls for assistance from Constable Atwood when he requested the attendance of ambulance and fire services just prior to forcing entry and after the explosion.

62. Bowen does not have a 24 hour manned fire service. On the night in question the QFES was an on call service requiring fire officers on call to be assembled and attend the station before being deployed. Bowen is not a large town so the time delay would not be extensive but it was understood by the officers that any delay, in a best case scenario would be several minutes from Constable Atwood's perspective, and at least 15 minutes from the perspective of Constable Murphy. Constable Murphy was also of the opinion there may have been a QFES Christmas party being held. This is not meant to be a criticism of Queensland Fire and Emergency Service, which has to manage resources efficiently and cost effectively and is mentioned to paint a picture of the

operational context facing the police officers that evening and reflective no doubt of the difficulties faced in other regional areas.

Circumstances surrounding the Incident

63. At 8:10 PM on 12 December 2015 Mr Hamilton made a telephone call from his unit to emergency services utilising the triple 0 number. The call was answered by an operator at Cairns probably due to Townsville Coms being in overload.

64. Mr Hamilton stated "*you have a potential suicide here"* and that he was the *resident of the unit"*. He spoke calmly and identified himself by name and said "*I advise officers not to approach, the unit is full of gas. I do not want to hurt anybody, but now you are advised."* The call was then terminated.

65. The Coms officer in Cairns then completed a job card including details of the call and completed a QPrime check for any flags and warnings. The Coms officer endeavoured to send the job as a partial but the system would not let her do so until the call was terminated. At the time of the incident the Cairns Coms officer stated it was not her role to contact other services and Townsville Coms would do so. At the time she would have had to make a telephone call.

66. Other witnesses that the original call taker should have contacted QFES and QAS to notify them of the incident and arrange for their attendance.

67. The Coms officer gave an explanation that this would take more time than if this contact was made by communications operators in Townsville. However evidence from other witnesses is that this was not necessarily the case. She stated that with a new system upgrade in place that request could be made by her and it would be dealt with electronically.

68. The Townsville Coms officer received the job card and contacted Bowen 308 manned by Constables Murphy and Atwood and directed them to the job. Once that was done the Townsville Coms endeavoured to contact QFES at Bowen but the line rang out twice. She then contacted QAS who are linked to the QFES system. The Coms officer stated it was not unusual to not get an answer as it depended on what they were doing and what resources were available.

69. At 8.14 pm Constable Murphy and Atwood's Bowen 308 vehicle was detailed to attend the location and directed to proceed to "code 2" with lights and sirens.. The officers arrived at the scene at 8:16 PM and Constable Murphy activated her body worn camera. The recording continues for eight minutes and 46 seconds until it is terminated when Constable Murphy begins receiving medical treatment.

70. Townsville Coms advised the Constables that checks revealed there were no cautions or flags for Mr Hamilton and one previous mental health occurrence on 22 October 2014. It was reiterated that the occupant said the unit was full of gas and asked that police not to come to the unit.

71. The officers approached Mr Hamilton's unit situated on the upper level, having only access through the rear stairs. The officers smelt gas from the outside unit and could hear it hissing and called upon Mr Hamilton to exit his unit. When he refused Constable Murphy endeavoured to make a request for the services of Queensland Fire and Emergency Services (QFES) and Queensland Ambulance Services to attend. Her radio was not transmitting and she asked Constable Atwood to do this. Constable Atwood then called Townsville Coms

for QFES attendance and stated they could "*definitely smell gas coming from the apartment. We can hear it leaking pretty profusely".* Constable Atwood then says "*we are going to force entry as he is probably in imminent danger."*

72. This call was initially not heard by Townsville Coms because the operator's external speaker had its volume turned down.

73. Constable Murphy is heard to use forceful language to endeavour to have Mr Hamilton come to the door. She quickly gave him a three second countdown. Constable Murphy stated it was part of the training she received at the Police Academy to use direct and forceful commands to endeavour to get a response. At one point it appears Mr Hamilton turned off the gas bottle to tell the officers he was not coming out and then turned it back on.

74. After failing to get Mr Hamilton to open the door and evacuate they effected entry by forcing the entrance door. Constable Atwood is seen to have kicked in the door using up to seven kicks. Four were used initially with a short break when Mr Hamilton is asked to open the door .He is heard to respond in the negative and three more kicks are applied before the door breaks away.

75. Constable Murphy stated she had considered but not verbalised the possibility of gas igniting from sparks created by kicking the door and was looking for anything resembling that as the door was kicked and saw none. Constable Murphy's state of mind was that they were at an incident where a man with a history of attempted suicide was in a confined space and was trying to asphyxiate himself. She had not considered Mr Hamilton might ignite the gas bottle. Constable Murphy said she was not aware how long Mr Hamilton had been in this position and she was not aware of what time was available before he was overcome or affected by the gas. There were other time constraints impacting on her decision making, given by now she knew the QFES and QAS had not been called immediately by Communications and would be some time to arrive. Constable Murphy did not think she had the time to make a tactical withdrawal and wait for them. In her mind she could not just leave the scene and take no action.

76. Constable Atwood stated he and Constable Murphy had little time in their mind to conduct a Risk Assessment. They had a very brief conversation and the plan was to force entry quickly. Neither officer at any time considered the need to evacuate the unit complex. Constable Atwood did not think Mr Hamilton would try to hurt them but in his mind he thought Mr Hamilton was serious this time and he was going to die if they did nothing. Constable Atwood said his mind set was on the basis he was gassing himself. As he approached he said the gas smelt pungent and he knew it would be too late by the time the QFES and QAS arrived. He did not think they had time to negotiate. Constable Atwood had not considered the possibility of a gas explosion. He was thinking he was going to kick the door down and get him out. Constable Atwood did not think Mr Hamilton would light the gas as he would be putting others in danger and it would be a horrible way to die.

77. As the officers commenced entry an explosion occurred and flames engulfed the unit, also causing burn injuries to the two officers. Both Constable Murphy and Constable Atwood describe the explosion as coming towards them and whipping around the corner and the door.

78. The explosion caused windows, glass and doors to be blasted from the unit into surrounding carparks, adjoining business premises and across the street. The two officers were blown backwards. After stabilising themselves and

checking on each other's welfare, the two officers continued to endeavour to provide assistance to Mr Hamilton and the other occupants of the unit complex. They partly re-entered the unit telling Mr Hamilton to come out. The body worn video shows Mr Hamilton standing in the centre of the unit with the gas bottle clearly alight behind him.

79. Constable Atwood is heard to call Townsville Coms for urgent assistance stating they had forced entry and the place had exploded. No response is heard from Townsville VKR and the Ayr Station Officer is heard sternly calling for Townsville VKR to acknowledge Constable Atwood. Repeat calls were made to VKR to acknowledge the premises have exploded and emergency services are required as soon as possible. Constable Atwood is then acknowledged by VKR and he advised the occupant and both police officers received burns and the unit is on fire. The Coms officer acknowledged in her evidence the radio calls went unnoticed by her due to the external console speaker being turned down, and at the same time she was occupied on her headset making calls to QFES and QAS.

80. Townsville VKR advises QFES and QAS are on route to the location and Constable Atwood is heard to acknowledge when they are on the scene.

81. The officers continued to communicate with Mr Hamilton and coaxed him into leaving the unit and walking down to the rear car parking area. They continued to call upon other occupants and directed them from the unit complex to an area of safety.

82. QFES and QAS attended the scene and assisted. Mr Hamilton was taken to Bowen Hospital and the police officers were provided with assistance at the scene. Constable Murphy received quite serious burns whilst Constable Atwood's were minor. Mr Hamilton unfortunately bore the brunt of the fireball and died from his serious burns some hours later.

Investigations

83. The incident was subsequently investigated by both police and fire services, and the reports on those investigations have been provided to the Court.

Queensland Fire and Emergency Services

84. Queensland Fire and Emergency Services concluded that the cause of the fire was by manual ignition (probably by a hand-held lighter or similar) that resulted in an explosion of LPG gas from a cylinder that had been placed in the middle of the lounge room next to a recliner chair. The subsequent flame from the cylinder as LPG escaped from the opened cylinder valve, which then ignited lounge room contents.

85. The Body worn video showed a white flow behind the standing male figure's legs, which was the ignited plume of escaping gas from the horizontally directed opened cylinder valve outlet. The area of origin of the fire was in the lounge room. Due to the explosion damage the unit had access to adequate air to become a ventilation controlled fire. This resulted in a flash over fire in which surfaces exposed to thermal radiation reach ignition temperature more or less simultaneously and the fire spread rapidly through the unit.

86. The fire investigator was not able to determine if the male occupant was holding in either hand a lighter, matches or other source of ignition after the explosion. No lighter or other source of ignition was located in the fire debris. The failure to locate such an item could be easily explained by a logical inference that such

items would either be completely consumed by the fire or, if not completely consumed, the remains of which would be so small that they would be difficult to identify amongst the significant amount of burnt materials that littered the floor of the unit after the fire. They also perhaps may have been blown to an unknown location within the unit or exterior to the unit at the time of ignition.

87. The QPS video shows there was no flame in the kitchen area at the time of the police ascending the stairs to the ground level, however flame was seen to exit the kitchen window and doorway approximately five minutes later.

Queensland Police Service

88. The Queensland Police Service report of Detective Sergeant Inmon identified some issues related to police communications equipment, procedures and resourcing, which somewhat impacted on the ability of the two officers to call for assistance that evening. For instance it was identified that the portable radio carried by Constable Murphy failed to transmit. An inspection subsequently determined the battery had gone flat at the time.

89. Constable Murphy said this was the first time she had a radio problem and was unsure if there may have been problems other than the battery but she was certainly unable to transmit.

90. It was noted in the report there had been issues with handheld radios sometimes and a direction was subsequently made that all officers were to ensure they checked out a charged battery and also ensure they are placed in the cradle correctly when they are returned. No radio was to be handed over from one crew to the next unless the battery had been replaced.

91. Another communication issue noted was that the urgent call made by Constable Atwood to VKR Townsville was not responded to for some time. It is apparent there were a number of circumstances, which together resulted in this outcome. The review noted this could have been avoided by having the external speakers on the console used by the operator at the time turned up to an audible level. Police Coms applied both visual and oral indicators to avoid these issues. To rectify the matter a direction was given that at every shift change it is indicated on a handover sheet that the speakers supplied are at an audible level.

92. Detective Sergeant Inmon noted the issue of communications does need to be addressed. Bowen Division is managed by Mackay District, however Bowen Station only has radio communications and jobs/tasks assigned by Townsville Coms. There was evidence that during the incident the Bowen police officers only had a radio communications with Townsville Coms. There is no transmission available to the Mackay Coms Centre or Mackay area where the appointed District officer is responsible for supervising Bowen officers attending this type of incident.

93. It was noted that the current situation at Bowen requires officers to communicate with the DDO via mobile telephone. It was considered that during an incident such as this there should be immediate radio contact with the supervising DDO as well as the appointed communications centre.

94. DS Inmon's report was thorough and explored appropriately the roles of the two police officers and identified the pertinent issues relevant to understanding the circumstances of Mr Hamilton's death, and to considering whether anything more might have been done from a policing perspective in terms of QPS' response to the incident that night.

95. Detective Sergeant Mark Inmon concluded that the actions of the first response officers could best be described as 'heroic' having regard to the fact that they acted without fear for their own safety and continued to evacuate the remaining unit complexes after being severely burnt themselves by the explosion. He stated there was no evidence to support any breach of discipline or misconduct by any officer involved in the incident.

Review by Senior Sergeant Hayden

96. Additional QPS review of the incident by Senior Sergeant Hayden was conducted, particularly focused on the use of force by the two officers that evening.

97. Snr Sgt Hayden is the Officer in Charge of the Operational Skills Section located at the Queensland Police Service Academy. The Section runs basically as an instructor school, facilitating Operational Skills and Tactics training courses. The Section is also responsible for the generation of the ongoing Operational Skills Training in-service skills and tactics training curriculum. Snr Sgt Hayden has lengthy experience and qualifications suitable for this his role. He is recognised by the courts as an expert witness with respect to use-of-force, police arrest and control techniques and tactics and TASER matters and has given expert evidence over a wide range of Court jurisdictions including coronial inquests.

98. The policy relating to the QPS use of Force matters are contained in the Operational Procedures Manual (OPM). This specifies the five conditions that must be satisfied for application of force to be regarded as appropriate.

99. Snr Sgt Hayden concluded that the level of force used to break down the door was reasonable and proportionate given they were attempting entry with a view to preventing the death of the occupant of the unit. The reviewer found the officers appeared to have assessed the incident as being an act of suicide occurring in 'real time' on the other side of a locked door, with Mr Hamilton attempting to gas himself within the unit. There was otherwise little time to formulate a full assessment of all the potential risks associated with operating in a gas saturated environment, including the risk of a gas explosion. Based on the interview and body worn camera footage it appeared that the immediate mission priority was the prevention of Mr Hamilton's asphyxia due to gas. It appears at no stage during the police intervention did the responding officers seriously consider the possibility of a gas explosion, despite the clear fact they were operating in a gas saturated environment. The intended outcome of the tactics used by the officers was to prevent Mr Hamilton committing suicide and obtain medical treatment for him.

100. With respect to the appropriateness of the police response Snr Sgt Hayden noted both officers had to quickly weigh up the information they had available at the time and arrive at an effective response. Factors which influenced their decision making included they had been assigned a Code 2 job which would have increased the sense of urgency. They had also received information of gas being released within the confines of a dwelling unit and Constable Atwood had previous knowledge of Mr Hamilton's mental health and previous suicide attempts and chronic illness issues.

101. As the officers approached the unit they detected the strong odour of gas being emitted. They asked that QAS and QFES attend. They then detected a stronger smell of gas and could hear hissing of the gas. They then came to the view that

Mr Hamilton was in the act of attempting suicide by gassing/asphyxia and made a decision to force entry prior to the arrival of QFES and QAS.

102. Snr Sgt Hayden considered both officers were acting in a high stress situation with a perceived time pressure, and as a result their immediate mission priority became focused on directly dealing with Mr Hamilton. There was no meaningful conversation held between the officers regarding the risk to other residents of the dwelling units, or the potential for explosion.

103. Snr Sgt Hayden did note the officers did not make a concerted effort to communicate or engage with Mr Hamilton through the door before attempting to force entry. They called for him to open the door, and then advised him that if he did not come out they were going to kick the door in. They then gave him three seconds to comply with that request, counting from one to three. They then began kicking the door.

104. Snr Sgt Hayden stated a preferred option would be for one of the officers to attempt to speak and negotiate with Mr Hamilton through the door or by calling Mr Hamilton on his phone, rather than go in 'hard' as an initial tactic, shouting at him to open the door. The reviewer suggested that as long as Mr Hamilton was able to converse through the door or speak over the telephone, this would be some indicator that he was not being overwhelmed by the gas inside the unit and officers may have been able to influence his behaviour whilst also allowing time for a more integrated emergency services response to the situation.

105. Snr Sgt Hayden expressed a concern that the direct approach of demanding the door to be opened, issuing an ultimatum, and then kicking it in may have been the trigger that unintentionally escalated the situation and 'forced the hand' of Mr Hamilton to ignite the gas being released from the gas bottle.

106. Snr Sgt Hayden did note that the officers experienced considerable difficulty in gaining access to the unit, with it taking over half a dozen kicks to break open the door. Apart from significantly increasing the risk for the officer, this situation would have also significantly increased the stress for Mr Hamilton and may have influenced his decision making. The reviewer commented that if the officers had access to a specialised tool for gaining entry, such as a 'hux bar' or 'halligan tool' that could be kept in the boot of their police vehicle, they possibly could have quickly pried open the door, retreated from the stairs, and allowed the gas to ventilate from the unit significantly reducing the risk of an explosion in a confined space.

107. Snr Sgt Hayden also noted a lack of direct and effective radio communication can be seen to be a contributing factor to the incident. There was a communication gap between the two officers and their immediate field supervisor who was the Mackay DDO. This circumstance caused a situation too occur where a field supervisor was unaware of the call to the service regarding Mr Hamilton. Two officers were denied access to a valuable immediate supervisory resources. If aware of the situation, the DDO could have proactively intervened in real time via radio and offered advice or direction as to how the two officers could respond to this situation. Alternatively he could have been a sounding board for any proposed response from the officers.

108. Snr Sgt Hayden said the preferred option would have been to have Bowen Station vehicles/resources operating on the same radio network as the rest of the Mackay Whitsunday District so as to have immediate and ready contact with their district duty officer. He stated a reliance of having to utilise personal

mobile signs to communicate with supervisors due to poor radio reception is clearly inadequate for frontline police operations.

109. Snr Sgt Hayden also stated that it appeared the officers lacked awareness of the dangers associated with a gas explosion. Both officers had limited policing experience (both under three years). Access via radio to a field supervisor could have given valuable assistance to the response to this incident. Enquiries with the QPS bomb squad indicated that if responding to a situation where LPG gas was released in a confined space that extreme caution should be exercised due to the very high risk of explosion. Operational priority would be to evacuate the surrounding units, isolate any potential electrical sources of ignition and ventilate the premises. This could be achieved by breaking windows manually or have QFES direct a high pressure blast of water by a hose. Snr Sgt Hayden noted that at no time did the officers appear to consider evacuating the units due to the potential risk posed by the gas saturated environment. There were residents within metres of the source of the gas emission. Snr Sgt Hayden suggested the officers responded to the cues they were receiving at the time, such as the increase in the smell of gas as they got closer to the unit. They lost situational awareness (in that they did not consider the projection of possible outcomes of the actions), and became task oriented on dealing with Mr Hamilton instead of reassessing their mission priorities and possibly considering evacuating the units first, then, attending to Mr Hamilton.

110. Snr Sgt Hayden agreed in evidence the situation Constables Murphy and Atwood faced that night was "an absolute dilemma". He pointed out there were clear cues that Mr Hamilton was in the act of taking his own life, and the officers could have very well be criticised if they had not taken action to attempt to prevent that and Mr Hamilton had died behind the closed door. Snr Sgt Hayden also acknowledged that these were junior officers, in their early years of service, and that this was a clear factor *and "we need to extend a degree of understanding in that respect".* Snr Sgt Hayden described the decision of Constable Murphy and Atwood to prioritise attempting to save Mr Hamilton's life that night as logical, appropriate and consistent with their oath of service and basic human decency.

111. Snr Sgt Hayden noted that the incident highlighted the incredible responsibility for decision making performed by junior frontline police working within the various communities in Queensland, and acknowledged the courage of the two officers in prioritising Mr Hamilton's welfare and attempting to render assistance to him, even after receiving injuries themselves from the explosion. The reviewer concluded that the officers' intention that evening was to prevent Mr Hamilton from taking his own life, and to obtain medical treatment for him. For reasons beyond their immediate control they did not succeed.

Responses of Constables Murphy and Atwood to the review

112. Constable Atwood was asked about his response to the suggestion that a preferred option may have been to speak to Mr Hamilton and negotiate. Constable Atwood frankly agreed that there were a number of ways they could have approached this situation rather than the option of going in hard. He said they were junior officers with the adrenaline pumping. If faced with a similar situation he would now approach it very differently .He was aware of the Situational Use of Force Model and had found that training useful, but in the field he was not thinking about the options the model provided like that. At the time he did not think he had the time to negotiate with Mr Hamilton.

113. Constable Atwood agreed there was at the time a communication gap with the Mackay DDO. He said they are removed and out of the picture for them in Bowen and officers have to figure out what to do for themselves.

114. Constable Atwood agreed he had a degree of tunnel vision about the risk only to Mr Hamilton and focussed on that. In his mind it was far removed there would be an explosion.

115. Constable Atwood agreed the use of better entry equipment may have helped. In retrospect he could see how Mr Hamilton may have found it scary hearing and seeing the door kicked in.

116. Constable Murphy stated she had not considered that Mr Hamilton would ignite the gas bottle. She had received training in the Situational Use of Force model but did not consider a tactical withdrawal or to attempt to negotiate and communicate with Mr Hamilton. She was operating under the time constraint facing them and the risk of asphyxiation.

117. Constable Murphy was not concerned about the communication gap with supervisors. She explained this was how you did it in Bowen and you learnt how to do your job on your own and as you were there.

118. Constable Murphy agrees that in looking back she was focussed on what was happening to Mr Hamilton in his unit and not on the other units. Constable Murphy acknowledged that there may have been some opportunity, as they were approaching the unit, to begin calling out for residents in other units to evacuate.

119. Constable Murphy agreed the use of entry tools would be useful. It had not gone through her mind at the time that the forced entry would increase any stress on Mr Hamilton.

120. Constable Murphy was aware of the changes to the 2009 Situational Use of Force Model coming into play in 2016 and that this new model places communication at the centre and the use of calming communication and de-escalation and getting other resources are now keys. She stated even if she had this guidance it may not have changed what she did. Under the current model rapport needs to be built and this takes time and she did not have that time or know what time she had.

121. Constable Murphy agrees in hindsight they should have isolated and contained more and evacuated the complex. She has received training in managing incidents since 2015.

Improvements since the Incident

122. A number of senior QPS officers gave evidence about changes to how things are managed now. Some of these are minor changes of practice and protocol and came out of what specifically happened in this tragic incident. Other improvements have been part of ongoing projects at a larger structural level as resources became available.

123. Acting Snr Sgt McConnell stated he is confident the issue with Constable Murphy's radio was a low battery and a local protocol has been put in place to ensure radios are charged before going on shift and recharged when they return. He thought the provision of an entry tool as suggested by Snr Sgt Hayden was not a bad suggestion as QFES is not always available. There of course would be training and resourcing implications.

124. It is evident that at this point in time the DDO in Mackay and police in Bowen and Collinsville do not have direct radio contact. Contact remains by mobile and mobile coverage is problematic due to black spots. Bowen crews now have access to one QPS mobile but if there are two crews on roster personal mobiles are still used.

125. Snr Sgt Sweetnam, the DDO in Mackay on roster at the time of the incident, agreed that contact with a supervisor such as himself with 28 years experience may have made a difference. Snr Sgt Sweetnam extolled the virtues of the QLite pads being rolled out across the State. He and others consider QLites to be a large leap forward for operational policing but by no means have all operational police been provided with them. He noted the scene was very dynamic and the radio was not flash at the time and it may have been a QLite may also not have been useful. He considers the officers bravely did the best they could with what was available. Snr Sgt Sweetnam confirmed DDOs in Mackay are now advised by Townsville Coms of all code 1 and 2 incidents affecting Bowen.

126. Snr Sgt Robert Eley is the Coordinator of Police Communication Centres. At the time of this incident there were 15 PCCs operating on two systems. Cairns and Townsville were operating amongst seven systems on the QCAD system. Snr Sgt Eley said at the time the Cairns operator would not call Bowen QFES/QAS to attend. They would call their own local centre only.

127. Since 2015 more PCCs have been brought into the QCAD system including Mackay with three remaining around the State. Since July 2017 QPS, QFES and QAS QCAD systems are now linked and requests for other services to attend are now advised electronically rather than by direct call. Snr Sgt Eley stated that they are looking at a transition of radio communications from Bowen and Collinsville to Mackay Coms. He explained there are some technical issues that have to be worked through and it is not as simple as flicking a switch. The QWN network in place is also being considered as a suggestion to broaden the footprint.

128. The OIC of Townsville Coms Snr Sgt Hussey agreed that with the QCAD systems linked there is no need to ring other services. He would have expected the operator in Cairns to have made the first contact. A local protocol has been put in place by way of a handover sheet and handover to ensure all equipment including speakers on consoles are in working audible order .He was not aware of a local practice to turn them down at times .There would have been an indication on the screen if a radio call was coming through but you had to be looking at the screen, hence the need to maintain audible contact.

129. Supt Bruce McNab for the Mackay District stated he expects Bowen communications will be migrated to Mackay in August 2018. Mackay was linked to QCAD in February this year. He agreed that there is not complete coverage with QLites at the moment but it seems some excess obtained for use in the Commonwealth Games will become available.

130. Supt McNab acknowledged there will be gaps in communications with operational police and the best that can be done is to train officers so they can make critical decisions in a short time frame. Sometimes decisions are made that on later reflection they may not make. He was not sure if there would have been any change in this case.

Conclusions

131. In reaching my conclusions it should be kept in mind the *Coroners Act 2003* provides that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something. 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.

132. 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. This means 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 is needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

133. When determining the significance and interpretation of the evidence the impact of hindsight bias and affected bias must also be considered, where after an event has occurred, particularly where the outcome is serious, there is an inclination to see the event as predictable, despite there being few objective facts to support its prediction.

134. Mr Hamilton had faced significant and extreme difficulties in the last two years of his life, including his severe skin disorder (which his GP described as "hell"). This was in exacerbated by the death of his partner only 11 months after they had married, and in circumstances where he had depended so much on the care and assistance she was able to provide when he became so unwell with his skin condition. Her death affected him very deeply. These stressors came on a background of decades of chronic depression and alcohol misuse, and also in the context of what Dr Wesdorp described as poor coping skills and avoidant traits. Accordingly Mr Hamilton was reluctant to engage with services or take up offers of assistance,

135. Mr Hamilton had made previous self-harm/suicide attempts but generally was not willing to discuss those things with the person closest to him, his friend and carer. He also did not discuss any plans with his GP Dr Mallet, and was also not very forthcoming about his feelings when speaking with his grief counsellor, Ms Stanko.

136. He did discuss some of his stressors with Constable Atwood who was left with a very strong impression that Mr Hamilton was "very very depressed" and really did intend to end his own life, "one way or another".

137. There is sufficient evidence to find Mr Hamilton intended to end his own life that night. Compared with earlier attempts to end his life, on that night, Mr Hamilton chose to place himself in a situation where, without intervention, he was very likely to die by asphyxiation by gas. When Constables Atwood and Murphy intervened to try and save his life, Mr Hamilton took that one further step to place himself in a situation where, unfortunately, he was then very likely to die from the ignition and resulting combustion of that gas.

138. There is also sufficient evidence to support a finding that Mr Hamilton ignited the gas. In particular support for this proposition includes:

- The description given by the officers as to the origin and path of travel of the ignited gas – that is, from behind the opened door and further inside the unit towards the living area (where Mr Hamilton was likely sitting or standing at the time of the ignition) and travelling towards the kitchen and around the opened door towards them.
- The fire investigation report provided by the QFES investigator, which concluded that the likely source of ignition was by portable manual method – that is, a cigarette lighter or match.
- That no other likely source of ignition was identified within the unit (that is, that other appliances within the unit were either switched off, such as the oven, or were not in a state that suggested to the QFES that they might be a source of the ignition, such as the television and fridge)
- That the kicking of the door, and the possibility this may have in some way resulted in sparking related to the metal components of the door and frame, is not supported by the evidence of Constable Murphy, who was looking for sparks, nor is it supported by the evidence of the origin and path of travel of the ignition and combustion of the gas.
- The timing of the ignition of the gas being at the very moment Mr Hamilton realised his door had been kicked open and his intended death by asphyxiation was therefore unlikely to occur.

139. Mr Hamilton had no history of aggression or violence towards police, and both his GP and grief counsellor found it hard to understand how Mr Hamilton would take the actions he did that night, if those actions were intended to hurt others.

140. It remains uncertain what was going through Mr Hamilton's mind when he made the Triple Zero call. It could be he was wanting to indeed warn the authorities of the dangers they may face if they entered the unit. Counsel Assisting submitted he may have remained in two minds about his plans that night, even up until that final moment just prior to him igniting the gas. However, whatever is the case, Mr Hamilton placed himself in extreme danger. The harm he caused to the two officers who tried to remove him from that danger was clearly something he regretted, consistent with his apologies to those officers after the explosion. It is probable, based on the totality of the evidence, it was not Mr Hamilton's intention to hurt anyone else, and that was not the reason he ignited the gas. When he lit the gas that evening he held an intention to cause himself serious harm that was very likely to end his life.

141. There was some evidence led as to the Situational Use of Force Model 2009, which was in place in 2015 and how that has since changed after a review by QPS following four fatal police shootings and the subsequent Inquests conducted by the State Coroner.[2] QPS initiated the Violent Confrontations Review and I was taken to parts of the review noting the previous model had an emphasis strongly on tactical communication involving forceful-aggressive directions at the point of crisis and typically immediately before the application of use of force, rather than more peaceable conflict resolution skills.

142. I do not intend to look further into that issue given this was one of the issues addressed by the State Coroner only recently. I make mention of this particularly noting that the forceful directions given by Constable Murphy were

[2] Inquests into the Deaths of Anthony William Young, Shaun Basil Kumeroa, Edward Wayne Logan, Laval Donavan Zimmer and Troy Martin Foster, delivered 20 October 2017

consistent with the previous model and consistent with her training and there should be no criticism of her using that tactic.

143. There were clearly some issues relating to radio communications. It is unlikely that even with immediate referral to QFES and QAS this would have changed the outcome. Those services were going to take some time and this was a factor for the police officers when they made the decision that they needed to take immediate action to force entry, rather than wait for those services to arrive. As well the failure to initially respond to the urgent radio call for assistance had no direct impact on the outcome as by that time the explosion had already occurred and Mr Hamilton had suffered un-survivable injuries.

144. It is evident there have been improvements to the police and emergency services communication systems since 2015, such that QFES and QAS now receive notification from QPS electronically via QCADS, which now has interagency communication abilities. There are also a range of further developments and planned for all police and emergency services to move to this. There have also been minor local protocols introduced to deal with the radio issues and it is also noted Bowen and Collinsville will migrate to the Mackay communication system by August 2018. Accordingly any recommendations that may have been made have either been introduced or are in the course of being introduced and no specific recommendation needs to be made.

145. Counsel assisting did submit that a recommendation could be considered that QPS give appropriate consideration to making available a hux bar or halligan tool to frontline police officers who may be attending incidents that are of a nature where such tools may improve the ability to provide a safe and effective policing response. Counsel for the Commissioner noted there are a range of cost, training and other considerations that need to be taken into account before implementing such tools and I should be mindful of such issues before making a recommendation. I accept and comment the usefulness of such tools are readily apparent in the circumstances of cases like this, however, as I have not heard sufficient evidence to make an assessment of the practicalities of introducing such tools I will not make a specific recommendation. This is a matter for the QPS to consider.

146. A review of the medical records of Mr Hamilton, as well as the overview of services provided to Mr Hamilton by Dr Wesdorp, indicates to me there is no evidence of any gaps or missed opportunities in the mental health and alcohol services provided to Mr Hamilton. There may at times have been a reluctance on his part to engage, but it is apparent he did engage regularly with his GP and with both inpatient and community mental health services, and appeared to be compliant with his medications. Further, in times of crisis when Mr Hamilton had made some attempt to end his own life, but then appeared to change his mind, he was proactive in making contact with emergency and other 24 hour services for help. It is also clear that on all recorded occasions when mental health services were needed or sought out by Mr Hamilton, whether they be inpatient, community, crisis care or primary mental health services, they were readily available, including through both the Mackay HHS and his GP Dr Mallet, who appears to have provided a high level of care to Mr Hamilton over a significant period of time.

147. The availability of mental health clinicians for frontline police officers was explored with a number of police witnesses. Dr Wesdorp gave evidence as to recent training and initiatives within the Mackay District that suggests frontline police do have some access to services and training. It is unclear whether

police are aware of such services and in any event in this particular incident it is unlikely the police officers would have thought they had the time to access such services.

148. Counsel for Mackay HSS did not cavil with the submission of counsel assisting that I might be minded to comment that those recent efforts and initiatives continue to be rolled out and supported, and I therefore so do.

Findings required by s. 45

Identity of the deceased – Blair Andrew Hamilton

How he died – Mr Hamilton had been diagnosed with chronic severe depression, severe grief as the result of the sudden death of his wife and care and was also a heavy user of alcohol. There was a history of self -arm in the period after his wife died in April 2014, with all of his self-harm attempts occurring whilst he was significantly intoxicated. Mr Hamilton also suffered from a debilitating skin condition. On 12 December 2015 he had placed a BBQ LPG gas bottle in his unit and allowed the gas to escape. I find he was at the time intending to take his own life by asphyxiation. He telephoned emergency services and warned them not to approach unit. Two relatively junior police officers attended and made a decision to immediately intervene to prevent his death from asphyxiation. They had not considered it likely he would ignite the gas bottle. Mr Hamilton appears to have been determined that he did not want to be saved on this occasion and lit the gas bottle with an intention to take his own life. The subsequent explosion was large and injured the two police officers and caused un-survivable burns to Mr Hamilton who died in hospital some hours later.

Place of death – Bowen Hospital BOWEN QLD 4805 AUSTRALIA

Date of death– 13 December 2015

Cause of death – 1(a) Extensive burns, due to, or as a consequence of
1(b) Detonation of LPG Gas Cylinder
2. Coronary atherosclerosis

Comments and recommendations

Other than what has been referred to in the decision and commented upon I do not consider it necessary to make any specific recommendations.

I do comment that Constables Murphy and Atwood should be commended for their brave and courageous actions in endeavouring to save Mr Hamilton.

I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
28 June 2018