QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Noombah**
TITLE OF COURT:	Coroners Court
JURISDICTION:	TOWNSVILLE
FILE NO(s):	2018/686
DELIVERED ON:	11 January 2022
DELIVERED AT:	Brisbane
HEARING DATE(s):	26 February 2021, 6-9 April 2021.
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, emergency examination authority, detention under *Public Health Act 2005*, death in custody, suspected self-harm, petrol sniffing, police restraint, lateral vascular neck restraint, ambulance response.

REPRESENTATION:

Counsel Assisting:	Ms Sarah Lio-Willie, Coroners Court
Family:	Mr Stewart Levitt, Levitt Robinson

Constable Schembri Constable Warren:	Mr Stephen Hollands, instructed by Gilshenan and Luton
Queensland Ambulance Commissioner:	Ms Melinda Zerner, instructed by Crown Law
Commissioner of Police:	Mr Mark O'Brien, QPS Legal Unit
ACP Gee ACP Wallman:	Ms Sally Robb, instructed by Corrs Chambers Westgarth
ATSILS:	Ms Kate Greenwood

Contents

Introduction

1. Noombah[1] was a 39 year old First Nations man who lived with his family at Mount Louisa in Townsville. Late on 9 February 2018, his partner called emergency services twice after she found Noombah sniffing petrol and threatening to hang himself. In the early hours of 10 February 2018, police located Noombah on the street near his home and immediately detained him under an Emergency Examination Authority (EEA). There was a violent confrontation with police. Noombah was restrained by police officers on the ground and handcuffed. He then became unresponsive.

2. After some delay, Noombah was transported to hospital in an ambulance. Within minutes of departure Noombah suffered a cardiac arrest and, after unsuccessful resuscitation efforts, he was declared deceased at the hospital.

The investigation

3. Noombah was told by police that he was being detained under an EEA under s157B of the *Public Health Act* 2005. As Noombah was detained under the authority of an Act of the State, in accordance with s10(2)(c) *Coroners Act* 2003 the death was a 'death in custody'. Although an inquest was not mandatory, the death was also a death that followed a police operation, and I was satisfied the circumstances of the death required the holding an inquest.[2]

4. Detective Sergeant Christine Knapp of the Internal Investigations Group, Ethical Standards Command conducted the investigation into the circumstances surrounding Noombah's death. A coronial report was provided in April 2019 with various annexures, including witness statements, body worn camera (BWC) recordings, QPS records and medical records.[3]

5. The investigation concluded that all the QPS officers involved complied with relevant legislation, policy and procedures, and should not be subject to any criminal or disciplinary action for their conduct. The investigation did not make any recommendations.

6. A post-mortem examination was conducted on Noombah's body by Dr Paull Botterill at the Townsville Hospital on 12 February 2018. Blood and urine samples were obtained and subject to further toxicological testing. An independent pathologist, Dr Johan Duflou, was also engaged by Noombah's family to review Dr Botterill's findings.

The inquest

7. A pre-inquest conference was held in Brisbane on 26 February 2021. Ms Lio-Willie was appointed counsel assisting and leave to appear was granted to Noombah's family, the Commissioner of the QPS, the police officers who first attended the scene, the Queensland Ambulance Service and the paramedics who first attended the scene. Leave was also granted to ATSILS on public interest grounds under s 36(1)(c) of the *Coroners Act 2003*.

---

[1] Trevor King's Aboriginal skin name was "Noombah". This is the name used by family and friends when a loved one has passed. He is referred to by that name in these findings.
[2] *Coroners Act 2003*, s27
[3] Ex A11 – Coronial Report

8. The inquest was held over four days in Townsville from 6 April to 9 April 2021. Twelve witnesses gave evidence, and 158 exhibits were tendered. I am satisfied that all information relevant to and necessary for my findings was made available at the inquest. The inquest considered the following issues:

   - The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he/she died and what caused his/her death;

   - Whether the actions of the attending police officers were appropriate in the circumstances;

   - Whether the actions of the attending QAS officers were appropriate in the circumstances; and

   - Whether there are ways to prevent a death occurring in similar circumstances in the future.

The evidence

9. A large amount of information was contained in the exhibits and oral evidence. These findings record only the evidence I believe is necessary to understand the findings I have made.

Personal Background

10. Noombah lived in Townville with his partner, Regina Matheson, and their four children, who were aged between 8 and 14 years. They had been together since they met in Mt Isa in November 2002. They lived there until 2016, when they moved to their home at Pankina Street. Noombah also had two children from a previous relationship, Gregory (born 1999) and Megan (born 2001). He was also stepfather to Shianne (born 2000), Ms Matheson's daughter from a previous relationship.

Criminal history

11. Noombah had a criminal history relating to domestic violence, assaults, possession of dangerous drugs, break and enter, public nuisance offences, and related breach offences between 1993 and 2015.[4] All matters had been finalised in the Magistrates Court.

Medical history

12. Noombah suffered from heart problems. In 2013, he had an angioplasty including the insertion of a stent. The following year he was diagnosed with ischaemic heart disease. In 2016, he was diagnosed with osteoarthritis in his spine. [5]

[4] Ex C17
[5] Ex D1 – Townsville Aboriginal & Islander Health Service records, p3

13. Noombah also had high cholesterol and high blood pressure. He was prescribed medication but had not been taking it. On 20 April 2017, Noombah did not attend an appointment at the Cardiology Clinic, and he was consequently removed from the appointment list for that clinic. He was told his referring doctor had been advised he required a new referral.[6]

14. Noombah last attended medical services on 7 January 2018 for the treatment of chronic back pain after a spasm in the right lower side of his back on 6 January 2018. He had tried unsuccessfully to manage the pain with paracetamol and presented to the emergency department of the Townsville Hospital. He was discharged the same day with basic pain medication.

Events Leading up to the Death[7]

15. On 9 February 2018, Noombah had spent the day with local elder, Uncle Alfred Smallwood. They took juvenile offenders fishing. Mr Smallwood dropped Noombah home around 11.00pm. Ms Matheson returned soon after and found Noombah in the backyard.

16. Ms Matheson told the inquest that she could smell petrol, so she ran to Noombah. He was glassy eyed but communicating. He was upset that his sons had not followed him on the cultural activities. Ms Matheson followed him to the shed, but he told her to go away and that he was going to hang himself. He then ran off with a plastic bag and a white cord. She said that she was very worried and thought Noombah needed to go to the hospital, and she had to call 000.

17. After Ms Matheson called 000 at 11.06pm she told the call taker:

> *I need police and ambulance right now. My husband is 41 years of age…*
> *… my husband is in the shed sniffing fuel and now he's threatening to hang himself. Now can youse please get someone here ASAP now.*
> *.. his name is Trevor King… he's sniffing but he's threatening me to say he's going to hang himself.*

18. Ms Matheson called back at 11.09pm to advise that Noombah had run off, and his son and neighbour were looking for him. At 11.14pm, Constables Schembri and Warren went to Ms Matheson's address at Pankina Street under lights and sirens. She told the police officers that Noombah had threatened to hang himself and she was worried for his safety. She told police that Noombah was not a drinker and had not drunk alcohol in four years, but he was "stressed out because of the kids". She also told them that he had heart problems and was not taking his medication. As a result, the QPS asked the Queensland Ambulance Service (QAS) to attend.

19. Before the QPS officers had arrived, Noombah and his neighbour, Jordan Gee-Hoy, had driven off together with his son, Gregory. The officers spoke with Mr Gee-Hoy's partner, Chellcee Ferris. She was not willing to assist police and refused to provide her partner's details. She spoke to Mr Gee-Hoy over the phone and told the police that they were five minutes away. When they did not return home, the constables spoke with the District Duty Officer and it was decided to finalise the job as a code 610 (community assistance).

[6] Ex D1 – Townsville Aboriginal & Islander Health Service records, p2
[7] Based on CCTV from 75 Banfield Drive and QPS body worn camera footage.

20. At 11.48pm the QPS and QAS officers left Pankina Street. Ms Matheson said she would call police when Noombah returned home.

21. Ms Matheson said that Noombah returned home a short while later and he appeared calm. He had a shower and took his medication. He and Ms Matheson discussed why he was upset. He told her that he wanted their sons to be more involved with their Aboriginal culture.[8]

22. Noombah later asked Ms Matheson if she had any cigarettes. When she told him she did not, he left the house around 1.15am and walked towards the shops on Banfield Drive. Unlike his earlier presentation, Ms Matheson said Noombah was not upset or threatening harm to himself or anyone else when he left the home. Unfortunately, emergency services were not called to advise that Noombah had returned.

23. At 1.22am, Constables Schembri and Warren were responding to an unrelated domestic violence matter on Banfield Drive, near Pankina Street. As they were driving towards that address, they saw Noombah walking along Banfield Drive. They initially believed he may have been involved in the domestic violence incident. They drove alongside him and asked his name. Noombah told the officers his name was "Trevor" and "I live around here".

24. The officers can be heard on CCTV footage repeating Noombah's name.[9] He gestured to wave them off and continued walking towards his home without stopping. Constable Schembri then realised this was the man who they were trying to locate from the earlier job at Pankina Street.

25. As Noombah reached the corner of Pankina Street, Constable Warren drove the police vehicle and turned into Pankina St and drove up the street. As this occurred, Noombah crossed behind the police vehicle. He crossed Pankina Street to the opposite side from his home. As he reached the opposite corner of Pankina Street, the police vehicle reversed down Pankina, towards Banfield Drive. Noombah then turned again to walk up Pankina Street.

26. At 1.34am, Constable Schembri advised police communications that they had located Noombah. He informed them that Noombah needed an Emergency Examination Authority (EEA) and they were going to take up with him. Noombah was at the side of Pankina Street at that time.

27. Constable Schembri activated his BWC and got out of the car. Constable Schembri is heard saying "*Trevor you need to come speak to me mate*". Noombah then turned again in the direction of Banfield Drive. Ms Matheson can be heard saying "*come and talk to them please, they want to take you to the hospital*".

28. After a little over 60 seconds had elapsed from the initial interaction, the CCTV and Constable Schembri's BWC audio overlap. On both recordings Constable Schembri can be heard saying:

> "*come and speak to me mate… Nah stay there Trevor, yeah I'm going to detain you for the purpose of an emergency examination in the hospital. Don't walk away from me mate*".

[8] Ex H5 – Statement of Regina Matheson
[9] Ex F65

29. Noombah continued to walk around the corner and back onto Banfield Drive. Ms Matheson can still be heard in the background saying "*stop*". Noombah continued to walk away yelling "*fuck*". Constable Schembri jogged after him. Constable Warren reversed the police car again down Pankina Street and turned into Banfield Drive in the direction of Dalrymple Road.

30. Noombah crossed the road and Constable Schembri grabbed him by the hand and forearm. Noombah swung his left arm at Constable Schembri and yelled "*fuck, let me go, let me go*". Ms Matheson can be heard on the CCTV footage in the background saying, "*yeah he's stressed out just leave him*…". She continued to say something about stress that was not clear on the footage.

31. Noombah's arm did not connect with Constable Schembri.[10] Noombah continued to walk across the road, in front of oncoming traffic, yelling "*let me go*". As he reached the other side of the road, Constable Schembri put his hand on Noombah's left shoulder to guide him onto the verge. Constable Schembri told the inquest that his use of force options at that stage were OC spray, taser or open hand tactics. He elected to push Noombah towards a grassy area on the footpath.

32. At 1.35am, Constable Warren notified police communications from the police vehicle that Noombah had taken a swing at Constable Schembri and they required police assistance. He then crossed the road to assist, as the following transpired: [11]

Schembri	*You need to stop Trevor*
Noombah	*Let me go. I haven't done anything fucking wrong*
Schembri	*You haven't done anything wrong at all that's why we need to talk. Stop Trevor*
Noombah	*Fuck*
Schembri	*Stop Trevor, stop*
Noombah	*Fucking hell*
Warren	*Don't take a swing at a copper mate. Don't shape up.*

33. Constable Schembri attempted to handcuff Noombah, but he resisted and pulled away. Constable Warren tripped and fell to the ground. Constable Schembri dropped his handcuffs and lost hold of Noombah.[12] The two officers struggled with him for a few seconds.

34. Constable Schembri told the inquest that he attempted a restraint by positioning his left arm across Noombah's chest towards his right shoulder and dropped his weight to bring him to the ground. He said that although he described the manoeuvre as a Lateral Vascular Neck Restraint (LVNR) hold when interviewed about the incident that was not his intent. It is also at this time that Constable Warren said he was bear hugging Noombah to control his arms. He lost footing and all three fell the ground.

35. Ms Matheson said that she saw the police officers slam Noombah onto the ground after he took a swing at the police outside 78 Banfield Drive. She said that when she reached them, they were on the ground. An officer was on top of Noombah, who was face down. The officer had a forearm on his neck.

[10] Ex F65 – Schembri BWC at 00:51
[11] This occurs at about 1.39am.
[12] Ex F65 – Schembri BWC

36. After Ms Matheson ran across the road, she told Noombah to "*stay still, stop Trevor, stop, you're going to make your heart fucking go*." The officers were at the rear of Noombah. A hand can be seen on the base of Noombah's neck as Constable Schembri tried to pull Noombah's left arm out from under him to position it to the back. Ms Matheson held his head off the ground and repeatedly told him to settle down. Her children had come out on the street and yelled at police.

37. Shianne told the inquest she saw Constable Schembri applying pressure to the base of Noombah's neck with his forearm. She yelled at police that her father had a heart condition and was sick. She recorded part of the incident on her mobile phone. She then saw both officers leaning on Noombah while her mother was "stuck under" him and supporting his head. She recalled that after Noombah was placed on the stretcher the police and ambulance officers stood around for several minutes having a chat and laughing.

38. Ms Matheson alleged at the inquest that one officer had his knees on Noombah's central back and the other had knees on his ribs. She can be heard on the body worn camera telling her children, "*he's alright, they're just restraining him*."[13]

39. Ms Matheson asked Noombah to calm down telling him he was just stressed out. Noombah continued to resist and thrash about on the ground, yelling that police were arresting him "*for fucking nothing*".

40. Constable Schembri told Noombah he was not under arrest. Ms Matheson reiterated this, telling Noombah that police were trying to get him to the hospital because she did not want him to hurt himself. She agreed at the inquest that he was continuing to resist and was not compliant.

41. Noombah yelled out "*they're putting pressure on me*". Ms Matheson said to police "*his heart, sir*". At that point the handcuffs were secured. This was two minutes after Constable Schembri left the police vehicle. Constable Schembri said that he did not squat on any part of Noombah's body. He was squatting to his left and trying to pull his arm to apply the handcuff.

42. Ms Matheson said that Noombah was awake, alert and talking at this time. Her children continued to yell at police, and she told them to go "*back in the house… making this old man … stress out*." The QAS arrived at the scene 15 seconds after the handcuffs were applied after being flagged down by Constable Schembri.

43. Ms Matheson continued to cradle Noombah's head and tell him to calm down. She cried that she did not want him to hang himself because he was stressed out. Police rolled him into the recovery position, on his left side. Noombah was audibly groaning by this time. Ms Matheson said he was "gasping for air".

44. Constable Schembri said he held no concerns for Noombah after he was placed in the recovery position as he was quiet and compliant. In his view, the care of Noombah had transferred to the QAS. He was a junior police officer, and he was not going to tell the paramedics how to do their job. He said that when he flagged down the QAS vehicle he told the paramedics that Noombah had been sniffing petrol and had heart problems as well.

[13] Ex F65 – Schembri BWC at 1:56

45. Ms Matheson ran back into the house to get Noombah's medication. She returned about a minute later with Noombah's medication and a mug of water. She was advised not to give him the medication until he was assessed by paramedics.

46. After Noombah appeared to have lost consciousness, officers and Ms Matheson asked him to open his eyes but he did not. Ms Matheson was concerned for him. She asked, "*What's going on here, why isn't he moving*?" but paramedics assured her that he was alright, and was breathing and asleep.

47. One minute after Ms Matheson returned with the medication, the paramedics asked the QPS to move the handcuffs to the front. As they did this, Noombah appeared unconscious, and saliva was running from his mouth.[14]

48. Almost seven minutes after the QAS arrived police lifted Noombah onto the ambulance stretcher. No medical assessment was done by the paramedics and he was loaded into the ambulance. Constable Warren asked what ALOC meant, and Advanced Care Paramedic (ACP) Wallman replied an "*altered level of consciousness".* ACP Gee said, "*yeah he's steady …he's a bit unconscious*".

49. At 1.46am Noombah was placed into the ambulance, and Constable Schembri rode in the back to escort him to the hospital, while Constable Warren followed in the police vehicle. This was 8 minutes and 10 seconds after the QAS officers arrived.

50. At 1.49am, ACP Gee identified that Noombah had suffered a cardiac arrest. He instructed Constable Schembri to commence CPR, 13 minutes after the QAS had arrived on the scene.

51. At 1.51am, the ambulance proceeded "lights and sirens" to the Townsville Hospital. Constable Schembri continued CPR until they arrived at the hospital at 1.57am.[15] CPR was ceased at 2.56am and Noombah was declared life extinct.

AUTOPSY RESULTS

52. An external and full internal post-mortem examination was performed by Dr Paull Botterill at the Townsville Mortuary on 12 February 2018. [16]

53. The external examination revealed evidence of bruising under the wrists with some grazes over the limbs and trunk.

54. The internal examination showed an enlarged heart with severe hardening and narrowing of two of the coronary arteries (75% narrowing of proximal left anterior descending and greater than 90% narrowing of proximal right coronary artery). There was evidence of past heart muscle scarring, evidence of past stenting of one of the arteries, an excess of fluid in the lungs, and some kidney scarring. There was no evidence of coronary artery thrombosis. There were no significant injuries to the head, face, neck, or internal torso.

55. Dr Botterill said that there was no evidence of bruising in the underlying neck tissue that could have resulted from neck restraint. He said that bruising is seen in most but not all cases of neck restraint where a person is resisting.

[14] 5 minutes 16 seconds after the handcuffs were secured.
[15] Ex E2 – Letter from QAS Commissioner
[16] Ex A3 – Autopsy report

56. Toxicological testing showed the presence of hydrocarbons, consistent with recent inhalation of petrol fumes, as well as an active cannabis metabolite. Alcohol was not detected. Dr Botterill explained that while cannabis may result in a degree of impairment of rapid and extremely complex motor skills, the level was not sufficiently high to result in death, but may be associated with behavioural changes which may have impacted upon the circumstances leading to his death.

57. Dr Botterill concluded that the cause of death was most probably an arrhythmia complicating underlying coronary artery atheroma, but inhalation of volatile substances (such as in petrol) is believed to affect the sensitivity of heart muscle to other stimuli, and result in a further increased risk of developing fatal heart rhythm disturbances. He told the inquest that heart disease alone could have led to the death.

58. Dr Botterill did not observe any specific injuries that appear to have significantly contributed to the death, but the physical and emotional stress associated with conflict and restraint in a confused subject are likely to have resulted in increased heart rate and blood pressure, and thus added to the impact on the already diseased heart of other stimuli, and it remains difficult to quantify the relative impact in any individual case. Dr Botterill noted that some pathologists would instead categorise a death occurring in such circumstances as "cardiac arrest during restraint".

59. Dr Botterill concluded that the direct cause of death was coronary artery atheroma. Other significant conditions contributing to the death were "cannabis and volatile hydrocarbon toxicity". However, he said that Professor Duflou's opinion as to cause of death was a reasonable alternative, noting that in non-restraint deaths pathologists do not refer to external factors such as restraint.

EXPERT FORENSIC PATHOLOGY REPORT

60. Noombah's family engaged Professor Johan Duflou, a Consulting Forensic Pathologist in New South Wales, to provide an expert opinion in relation to various aspects of Noombah's death.

61. Professor Duflou referenced several witness versions that are contained in the coronial report.[17] He also requested Noombah's medical records, ambulance records, autopsy photos and scenes of crime photos. Professor Duflou summarised Constable Schembri's BWC footage as follows:[18]

> *An altercation ensues, and eventually the deceased lands on the ground in a prone position. A woman, presumed to be Ms Regina Matheson holds the deceased up and talks to the deceased. The deceased's hands are placed behind his back and secured by handcuffs. The deceased continues to struggle for a period of time, then appears to stop struggling but continues breathing heavily for a while and is heard groaning. The deceased is placed on his left side. Ms Matheson leaves and returns after a period of time and tries to administer medication. Ambulance attend. The deceased is sat up and the left cuff is released, then returned to the wrist with the hands in front. The deceased is observed to be drooling and not obviously responding while in a seated position.*

[17] Ex A11 – page 24 of the Coronial Report
[18] Trevor King opinion report – para. 9

62. Professor Duflou was asked to comment specifically on the:
    - autopsy delay,
    - ambulance response,
    - cause of death,
    - effects of cannabis consumption,
    - effects of volatile hydrocarbon inhalation,
    - death as a result of physical restraint, and
    - death due to mental and physical stress

Autopsy delay

63. The autopsy was conducted on 12 February 2018 and the report was completed on 12 March 2019. Professor Duflou commented that the lengthy delay between examination and reporting results is not optimal, and a time interval of 2 months is considered acceptable, but this benchmark is infrequently met in Australia.[19]

Ambulance response

64. Despite Noombah appearing unresponsive and the information about his cardiac history, no form of cardiac monitoring was conducted at the scene. Professor Duflou raised concern that there may have been a significant delay in identification of an imminent lethal cardiac, arrythmia such as ventricular tachycardia; or a markedly low blood pressure, pulse or oxygen level, all of which would have required escalation of the case, and possible commencement of resuscitation at that time.

Cause of death

65. Given Noombah's significant heart disease and the extent of coronary atherosclerosis, and presence of scarring on the heart, Professor Duflou concluded that Noombah could have died at any time of a cardiac rhythm abnormality and a resultant cardiac arrest.

Effects of cannabis consumption

66. Cannabis intoxication may have had a contributory effect on the heart pathology as proposed by Dr Botterill, but it was Professor Duflou's opinion that cannabis toxicity was a most unlikely cause of death.

Effects of volatile hydrocarbon inhalation

67. Professor Duflou said that the major danger of petrol sniffing in this case was the effect on the heart. Acute cardiac toxicity is the most common cause of mortality associated with petrol sniffing. The term "*sudden sniffing death syndrome*" has been used to describe lethal ventricular dysrhythmias and sudden cardiac death in such cases. Professor Duflou said it is possible that Noombah's behaviour, together with his responses to police and his development of cardiac arrythmia and death were primarily the result of petrol sniffing.

[19] This was not an issue considered at this inquest but was considered in the Queensland Audit Office's *Delivering coronial services* report – Report 6:2018-10.

Death as a result of restraint

68. Professor Duflou said the most common explanation given for cardiac arrest during prone restraint is that there is asphyxia because of the weight of a person bearing down on the chest of the victim, and the person not being able to breathe for a prolonged period. He explained that a person restrained in the face down, or prone, position often has a subjective sensation of shortness of breath, and being restrained in such a position can result in increasing anxiety and panic and thereby added stress to the heart.

69. Professor Duflou told the inquest that LVNR could cause unconsciousness in less than 10 seconds because of compression of the coronary arteries. However, if it was maintained long enough it could result in death. He said that vagal stimulation resulting in cardiac arrest was not common, but that pressure on the neck was never safe. He said that LVNR should not be used in patients with coronary artery disease. The presence of other disease and medication was also an unknown factor and thrombotic material may be dislodged in the process. If enough pressure was applied there may be hypoxia as well.

70. Professor Duflou said that the BWC footage was equivocal as to whether there was any pressure on Noombah's body during the police restraint. The extent to which Noombah's torso was compressed is not clear, and there is the added unusual aspect of Noombah having an apparent cardiac arrest some minutes after the restraint was relieved. He said that the cardiac arrest was the primary problem and that it can be very difficult to resuscitate someone in those circumstances.

71. Professor Duflou said that from a pathophysiological perspective, delayed cardiac arrest following restraint should not be unexpected. He said it would be prudent for a patient who has been restrained to be carefully assessed by ambulance personnel at the scene. This assessment should have included checking and documentation of vital signs, determination of oxygenation levels, an ECG and potentially other investigations prior to transporting Noombah. This would be especially the case in a patient who is largely unresponsive when seen by the paramedics, where information is provided that the patient has a significant cardiac history, and where no obvious cause was identified for Noombah's condition at the time of examination.

Death due to mental and physical stress

72. Professor Duflou explained, in general, the greater the degree of physical activity involved, the greater the risk of sudden death due to heart disease in persons who had pre-existing cardiac pathology, whether clinically suspected or not in the period before death.

Professor Duflou's conclusions

73. Professor Duflou concluded that Noombah had several conditions and pre-conditions which made him vulnerable to sudden death. Specifically, he had severe heart disease such that he could have died at any time, irrespective of whether an altercation took place. Further, he was sniffing petrol, which has known significant effects on the heart including sudden death. He said it was not possible to isolate causative factors but the hydrocarbon intake and vigorous activity both increased the risk and likelihood of death. He said that the shift from vigorous resistance to sudden compliance and unconsciousness probably indicated an acute coronary event.

74. Professor Duflou said that Noombah was profoundly hypoxic when his oxygen levels were assessed in the back of the ambulance at 77% and he needed urgent airway support and ventilation.

75. Professor Duflou considered that the cause of death given by Dr Botterill risked limiting the cause of Noombah's collapse purely to his heart disease. As indicated by Dr Botterill some forensic pathologists would instead categorise this death as "*cardiac arrest during restraint*".

76. Professor Duflou considered it unlikely Noombah had his cardiac arrest during the restraint given his appearance in the video footage, and a more encompassing cause of death would be:

> *"cardiac arrest in a person with pre-existing severe ischaemic heart disease who was restrained and who consumed volatile hydrocarbons."*

THE POLICE RESPONSE

77. Constable Schembri explained to investigators that he applied an action "like the LVNR", by putting his arm around the neck/ collarbone area of Noombah and dropping his weight to bring him to the ground and handcuff. This is captured on his BWC. Constable Schembri also explained he chose not to use his taser given the information about Noombah's petrol sniffing and heart condition and threats of self-harm. In his opinion, the LVNR was the safest option as Noombah was a large man who was very strong.

78. Constable Schembri told the inquest that he detained Noombah under the *Public Health Act* because he was on the road and was a danger to himself. He had also tried to punch Constable Schembri. He said that at that time he did not appreciate the effects that chroming had on a person's health.

79. Section 157C of the *Public Health Act* provides as follows in relation to the detention of a person under an Emergency Examination Authority:

> ***157C What ambulance officer or police officer must tell person***
>
> *(1) The ambulance officer or police officer must—*
> *(a) tell the person that the officer is detaining the person and transporting the person to a treatment or care place; and*
> *(b)explain to the person how taking action under paragraph (a) may affect the person.*
> *(2) The ambulance officer or police officer must take reasonable steps to ensure the person understands the information given under subsection (1), including by telling the person or explaining the thing to the person—*
> *(a)in an appropriate way having regard to the person's age, culture, mental impairment or illness, communication ability and any disability; and*
> *(b)in a way, including, for example, in a language, the person is most likely to understand.*

80. It was put to Constable Schembri that his statement "*I'm going to detain you for the purpose of an emergency examination in the hospital*" did not comply with s 157C. Constable Schembri said that he had complied with the *Public Health Act* because he considered that Noombah's actions indicated that he was at immediate risk of serious harm as he had walked in front of traffic. He considered that Noombah would have understood what he meant, and he reiterated that he was not under arrest.

81. Constable Schembri denied that the real reason Noombah was detained was because he had taken a swing at him. He said that the swing would have constituted an assault offence. He had the power of arrest under the *Police Powers and Responsibilities Act* but elected not to exercise that power.

82. Constable Schembri said that it was a highly stressful situation. He was aware of the provision of the Operational Procedures Manual (OPM) relating to excited delirium and was aware that positional asphyxia may be a concern if a person was placed in a prone position after consuming drugs or alcohol. It was for that reason that Noombah was placed in the recovery position and he gave a prompt briefing to the QAS paramedics. He agreed that Noombah had gone from "100 to zero" very rapidly but could not recall if the QAS had checked his airways.

83. Constable Warren recalled seeing Noombah drooling with his head slumped. At that time, he considered that he was simply worn out. He had no recollection of what ambulance officers had said about his condition. He had assumed that the ambulance officers were monitoring his health. He said that he would now be more forceful with ambulance officers if he had concerns about the QAS response.

84. Constable Warren was asked why there was still a need for an EEA if Noombah was intending to return home where was safe. Constable Warren said that there was still a need and Ms Matheson had responded positively to the police officers' actions in detaining Noombah for the purpose of an EEA. He had not been privy to earlier conversations with Ms Matheson but was aware that Noombah had sniffed petrol and expressed suicidal ideation.

85. Constable Warren said that he had no opportunity to explain the provisions of the *Public Health Act* to Noombah. His objective was to minimise the risk of harm to police officers. He denied that he had embellished his account of events by describing Noombah's swing at Constable Schembri as a king hit. He denied that the police officers had created the incident and that he had abdicated responsibility in condoning the actions of Constable Schembri.

86. At the inquest Detective Sergeant Knapp agreed that the use of the LVNR and the application of handcuffs was appropriate as Noombah had taken a swing at police officers after they tried to detain him. Detective Sergeant Knapp did not consider it was feasible for the officers to engage elders to assist with Noombah's detention as that may take several hours. In her report she stated:

> *OPM 14.19.1 outlines QPS policy regarding the use of handcuffs and states 'a person exhibiting or threatening violence, or demonstrating intent to escape lawful custody, is to be handcuffed (high risk)'. The policy also advises a person should be handcuffed behind their back.*
>
> *King was exhibiting violent behaviours and was refusing to comply with directions being given. It was appropriate and in accordance with policy to handcuff King.*

87. Detective Sergeant Knapp said that, in her view, Constable Schembri had applied no pressure to Noombah's neck to activate the LVNR to cause unconsciousness, or it was at least minimal and accidental. In her view, although police officers were aware that Noombah had a bad heart and had been chroming, he was high risk and had to be restrained. The risk that the use of force might harm him was mitigated by the presence of the QAS officers who were given a handover by the attending police.

88. Sergeant James Donnelly from the QPS Front-Line Skills Training Unit provided a statement regarding the use of force used by police officers in restraining Noombah. His opinion was that Constable Schembri endeavoured to use tactical communication in attempting to negotiate with Noombah.

89. Sergeant Donnelly said that the QPS does not teach LVNR as an airway restraint. LVNR involves bilateral pressure to impede blood flow, resulting in unconsciousness. It is applied from a rear position to break a person's balance backwards. He thought it had been applied for only 2-3 seconds by Constable Schembri in transitioning Noombah to the ground.

90. Sergeant Donnelly's opinion was that LVNR should continue to be a use of force option employed by the Queensland Police Service in high risk situations. He agreed with Constable Schembri's assessment that this was a high risk situation because of the attempted strike, the presence of traffic and suicide risk. The constables had attempted lower level controls that were not effective. He did not consider that Constable Schembri had applied LVNR but had simply thrown Noombah off balance. He said that LVNR was a better option than closed hand tactics such as punches.

91. With respect to responsibility for the scene, Sergeant Donnelly said that the QPS had taught tactical first aid since 2018. However, the objective was to get the QAS involved as soon as possible. Officers were taught to appreciate the significance of agonal breathing, to place persons in a lateral position and monitor breathing. He considered that after Constable Schembri had given the briefing to the QAS officers it could be inferred that the paramedics were responsible for looking after Noombah's health.

92. Sergeant Donnelly said that police were trained to handcuff persons to the rear after they are arrested, and that a "three-point pin" had been applied to handcuff Noombah.

93. Sergeant Donnelly considered that detention under an EEA was justified given the level of concern expressed about Noombah by his partner. His interaction with the constables was initially coincidental, and they were concerned about his well-being if they did nothing. He said that it was also appropriate to guide Noombah off the roadway out of the way of traffic.

94. It was suggested to Sergeant Donnelly that Noombah was a "medical tinderbox", and the need for an EEA had passed as his intoxication level had reduced over time. Sergeant Donnelly said that while he was not qualified to comment in relation to that query, Ms Matheson had a very high level of concern about his risk of harm which had "not been rescinded".

Body Worn Camera

95. Constable Schembri activated his BWC as he got out of the police vehicle when he first identified Noombah walking towards Banfield Drive. The BWC provided the best evidence of the incident. Constable Schembri turned off his BWC when Noombah was loaded into the ambulance and reactivated it when he began compressions.

96. Constable Warren did not activate his BWC. He explained that as he was getting out of the police vehicle, he saw Noombah throw a punch at Constable Schembri and it slipped his mind to activate his BWC, as his main goal was to assist his partner.[20]

97. Constable Cairns and Constable Thompson were the only two other officers who had activated their BWCs when they attended Banfield Drive to assist. Constable Cairns' footage does not depict Noombah, but it does capture the audio of people asking if Noombah was OK to which the replies could be heard, "*he's breathing*".[21] Constable Thompson's footage was only 44 seconds in length, capturing the walk to Banfield Drive.[22]

98. Constable Hutchings explained that her BWC was malfunctioning and therefore not in use. She sent an email dated 8 February 2018 advising of the issue with the BWC and asking for a replacement.[23]

POLICE RESPONSE - EXPERT OPINION

99. Mr Emmett Dunne APM was engaged by the Coroners Court to provide an expert opinion in relation to the actions of the involved officers in restraining Noombah in the lead up to his death, including whether the officers complied with relevant QPS policies. He also commented on the adequacy of those policies and whether changes to policy or practice should be made.

100. Mr Dunne was Assistant Commissioner with Victoria Police for seven years up to 2015. He has over 39 years policing experience including 22 years in operational roles. This included work as a physical skills instructor, prosecutor and in the Force Response Unit. I consider that he was well qualified to comment on the issues related to this inquest.

101. Mr Dunne's opinion was that overall, the involved officers complied with relevant policies and the use of force was reasonable. However, he noted that during the restraint of Noombah on the ground the visibility of images captured on BWC was poor, and it was hard to comment on that part of the restraint.

102. Mr Dunne said that policing is unpredictable and use of force policies of Australian police services do not mandate that specific tactical options or techniques be applied. This is reflected in OPM 14.3. Decisions to employ techniques and tactics are delegated to the responding officers as they are aware of the circumstances and risks. Mr Dunne also referred to OPM 6.6:

[20] Ex B9; F8 – Audio statement of Constable Warren
[21] Ex F67
[22] Ex F68
[23] Ex C24

Restraining mentally ill persons

POLICY

Officers should treat and transport mentally ill persons with respect and in a manner which is mindful of their right to privacy and retains their dignity. Restraints should only be used as a last resort to prevent the person causing injury to themselves or someone else.

103. Mr Dunne said that Constable Schembri's approach was reasonable in that he moved Noombah from the roadway and had displayed no anger in his interactions with him. This was an example of situational containment. It was not possible for a formal or informal plan to be developed in response to the situation because the contact with Noombah was coincidental.

104. Mr Dunne said the officers were unsuccessful in attempting to communicate with Noombah. He said they made "genuine ongoing attempts to communicate" but the circumstances made it difficult to do so. Constable Schembri told Noombah that he was being detained for treatment and care, and took reasonable steps to ensure he understood that information. The officers were authorised to detain Noombah for treatment and care based on several clauses in the OPM including the following:

- The risk of Noombah suffering serious harm including suicide;
- The risk resulted from a major disturbance in Noombah's mental capability; and
- Noombah required urgent examination, treatment and care.

105. Mr Dunne said that the application of LVNR by Constable Schembri was consistent with QPS policy as was the application of handcuffs.

106. LVNR is included among open handed tactics as a skill that officers might use to control a policing situation when that cannot be otherwise achieved. The OPM provides:

Police officers should not use a lateral vascular neck restraint hold unless:
(i) an incident is assessed as high risk and there is an immediate operational necessity to apply the restraint; or
(ii) acting or aiding in self-defence.

107. Mr Dunne said that Constable Schembri complied with the OPM's LVNR application instructions in that:

- He applied the hold from behind;
- He gave instructions to Mr King not to resist police;
- He immediately ceased compression but maintained control of Mr King when he was able to transition into another use of force technique in that he applied handcuffs.

108. Mr Dunne said that the police had a duty to intervene to prevent harm to Noombah. He said that Mr King had threatened suicide and his strong ongoing resistance of the officers meant they were unable to control him. In the circumstances, the use of the handcuffs by the officers was justified and complied with QPS policy.

109. Mr Dunne said that he had significant personal reservations about the use of LVNR except in high risks situations involving a "fight for life". Those situations would be rare.

110. Mr Dunne said that the police response to Noombah's medical decline was appropriate, but he was unsure if police had been trained in responding to rapid decline, which requires continuous monitoring. He said that the officers should have asked for a medical assessment to be undertaken after the circumstances have changed rapidly. This would have called for earlier QAS involvement. He said that there appeared to be role confusion between the police officers and the paramedics at the scene.

111. The OPM notes that "officers in arrest situations may encounter persons who, due to their physical resistance to the arrest or other unknown pre-existing conditions, may be at risk of collapsing or suffering from a fatal incident whilst being taken into custody. It is highly likely that there will be little or no warning of the onset of a person collapsing." Officers are required to monitor and medically assess persons taken into custody.

112. The OPM provides that officers are to be aware that the risk of a person collapsing or suffering from a fatal incident may be increased by:

> *(i) a pre-existing medical condition; and/or*
> *(ii) the use of alcohol or other drugs; and/or*
> *(iii) the effects of a psychostimulant-induced episode and excited delirium*
> *(iv) positional asphyxia; and/or*
> *(v) the use of:*
> *(a) mechanical restraints (handcuffs);*
> *(b) physical restraint holds; and*
> *(c) multiple officers restraining the individual.*

113. It was clear that many of those factors applied to the circumstances of Noombah's arrest. Although the OPM provides detailed instructions to officers in responding to incidents such as this, Mr Dunne recommended that:

> *The QPS consider including instructions in the OPM that where officers believe it is necessary and appropriate, they request paramedics advice on the subjects' health status at the earliest and safest opportunity.*

114. Mr Dunne also recommended that the QPS:

> *The QPS consider including in its scenario training the replication of situations involving physical encounters between officers and role players where they unexpectedly display a rapid physical decline to reinforce the potential for subjects to suffer from heart or other conditions.*

THE AMBULANCE RESPONSE

115. As noted previously, QAS Advanced Care Paramedics Gee and Wallman were waved down by attending police and arrived on scene at 1.44am.[24] ACP Wallman was driving the ambulance. They were advised that Noombah was being detained under an EEA for threats of suicide, and was a higher priority than the DV incident the QAS officers had originally staged for.

116. Paramedics observed Noombah lying at a 45 degree angle to the ground, between a lateral and prone position, with Constables Warren and Schembri supporting him. They said they did not conduct a detailed assessment due to the low light. However, an initial visual assessment revealed no obvious injuries. Noombah responded to sternal rubs by opening his eyes and making a groaning sound.[25] His Glasgow Coma Score was recorded as 11 out of a possible 15.

117. ACP Gee told the inquest that he had previously worked in the military and was apprehensive when he encountered the officers restraining Noombah. He spoke to Ms Matheson after she presented with a coffee mug and heart medication. He said that he was concerned about an aspiration risk if Noombah was given the medication despite Ms Matheson's concerns about his heart condition. He said that he did not assess Noombah while he was handcuffed to the rear as he was not able to effectively assess a patient in that position. His role was to provide medical attention when it was safe to do so.

118. ACP Gee asked for the handcuffs to be moved to the front. He believed that Noombah was not unconscious at that time although he had no verbal interaction with him or made any other assessment as the lighting was very poor. He said that there was an element of tunnel vision because of the presence of the two police officers and Ms Matheson in a highly distressed state. His objective was to get Noombah to the ambulance, which was a place of safety.

119. ACP Gee said that in his opinion the QPS controlled the scene when he arrived. He and ACP Wallman were responding to a post assault incident and had been told to stage until it was safe. He had no information about the scene that he had been hailed down to stop at.

120. ACP Wallman agreed that they had been tasked to attend a domestic violence case and had been directed to stage. He saw that a male was being restrained on the footpath by police and waited for the scene to be made safe. He did not recall receiving a briefing from the police officers at the time. He agreed that no observations were carried out by him while Noombah was on the ground, but he saw him groaning and drooling when he was placed on the stretcher. ACP Gee had conducted the assessment. He also considered that the police oversaw the scene as Noombah was in their custody. The QAS officers oversaw the clinical side. He had a limited recollection of events.

121. When the QPS officers lifted Noombah onto the stretcher, the ACPs described Noombah as calm and not agitated or exerting himself. However, the BWC showed he was unconscious after Noombah was loaded into the ambulance and it left for the hospital at 1.46am.

[24] Ex F65 – the Ambulance comes into view and stopped at 2.50 minutes into Constable Schembri's BWC
[25] Ex B2 – Statement of ACP Allan Wallman

122. At 1.49am, ACP Gee observed Noombah's consciousness level had decreased so he started the process of obtaining vital signs. When he attached the leads to gain an electrocardiogram (ECG) he identified that Noombah had gone into cardiac arrest, and subsequently he could not locate a carotid pulse.

123. ACP Gee instructed Constable Schembri to commence CPR. The defibrillator was attached and a shock was delivered. ACP Gee asked for a Critical Care Paramedic (CCP) Code One, but the QAS had no CCP rostered on shift. Given the distance to the Townsville Hospital was about four kilometres the ambulance proceeded Code 1 to the hospital.[26] They arrived at the hospital at 1.57am.

124. Dr Stephen Rashford, Medical Director, QAS provided a letter with respect to the death of Noombah.[27] Dr Rashford indicated that he had concerns about the level of assessment and treatment provided by QAS paramedics. He considered that the body worn camera footage and sequence of clinical events did not align with the QAS electronic ambulance report form that had been completed by the paramedics.

125. Dr Rashford said that Noombah's decline was obvious in the BWC footage from the time Ms Matheson returned and asked, "*What's going on here, why isn't he moving*?" Dr Rashford said that by the time Noombah is seen drooling he was deeply unconscious. He had no motor tone, was not making any breathing efforts and was not maintaining his airway. Dr Rashford said that QPS and QAS officers did not identify the significance of this change in condition that was recognised by Ms Matheson. He said that

> *Essentially, Mr King has gone from '100 miles per hour to zero' in a very short period - from being verbally aggressive/agitated to nonverbal, most likely unconscious.*

126. Dr Rashford agreed that no assessment had been made of Noombah's condition and no clinical intervention occurred after ACP Gee first appeared to look at Noombah on the ground until he was placed in the rear of the ambulance. This should have included vital signs assessment, such as heart rate, cardiac monitoring, oxygen saturation level or blood glucose monitoring. Contrary to the score recorded by the ACPs, Dr Rashford's evidence was that "*at no stage did Mr King exhibit a GCS score of 11/15 whilst in the care of the paramedics*".

127. Dr Rashford said that the vision of Noombah being lifted onto the stretcher "*demonstrated his precarious condition, including a barely patent airway*". He suspected that he was in a "*peri-cardiac arrest or cardiac arrest state at this time*". Once a cardiac monitor was attached to Noombah inside the ambulance, ventricular fibrillation (VF) was noted on the monitor – this is "a malignant cardiac rhythm whereby there is chaotic uncoordinated activity within both cardiac ventricles, resulting in no cardiac output and this rhythm proves rapidly fatal unless treated".

128. Dr Rashford frankly concluded that it was likely that an inadequate level of assessment resulted in a delay detecting Noombah's clinical deterioration and his subsequent cardiac arrest.

[26] Ex B1 – Statement of ACP Gee
[27] Ex E3

129. However, Dr Rashford considered that there were situational factors that may have contributed to the paramedics' actions. First, as the paramedics were initially dispatched to attend a female patient who had been assaulted, they may have been concerned that the situation they encountered was a dangerous scene. He said that the QAS has prioritised paramedic safety and has instituted a multifaceted approach to reducing occupational violence towards paramedics. First responder safety must always take priority.

130. Dr Rashford noted that the QPS officers had waved the paramedics down at the side of the road, with an unknown male restrained on the ground. The hesitation of the QAS officers was evident as the paramedics stood near their ambulance for some time, likely making a broader safety assessment. These factors have potentially complicated the paramedics' approach to this case. He thought the time of night, the evolving circumstances and the patient's undifferentiated condition in the context of potential personal danger would have all contributed to anxiety and possible effects upon performance.

131. In Dr Rashford's opinion, the decision to transport under lights and sirens to Townsville Hospital was flawed. He considered that this resulted in "suboptimal cardiac arrest care during the period where successful resuscitation is most likely". There was no benefit in driving to Townsville Hospital directly without instituting appropriate levels of care by both paramedics in the stationary ambulance, rather than involving the QPS officer in providing CPR in the back of the vehicle on the way to the hospital. The expectation was that high quality CPR would commence with defibrillation to re-establish cardiac rhythm unless it was dangerous to do so.

CONCLUSIONS ON INQUEST ISSUES

Were the actions of attending police officers appropriate in the circumstances?

132. When Ms Matheson first found Noombah in the shed of the family home late on 9 February 2018, he was very distressed. He was sniffing petrol and threatening to hang himself. Understandably, Ms Matheson called triple zero for police and ambulance assistance. Her level of distress and concern was clear on the two triple zero calls she made.

133. Ms Matheson told police when they initially attended her home that Noombah had a heart condition. She reiterated this during the period of restraint. She repeatedly asked Noombah to calm down during the police interaction, and tried to calm him so he could be transported to hospital. She was cradling his head off the ground to allow him to breathe. Notwithstanding the presence of paramedics, it was also Ms Matheson who identified that Noombah was critically unwell after she returned to the scene with his medicine.

134. Section 157L of the *Public Health Act 2005* provides:

> ***Use of force to detain and transport***
>
> *An ambulance officer or police officer may exercise the power to detain and transport a person under this chapter with the help, and using the force, that is necessary and reasonable in the circumstances.*

135. Police officers are also given power under s 615(1) of the *Police Powers and Responsibilities Act 2000* to use force against individuals. That section provides:

> *It is lawful for a police officer exercising or attempting to exercise a power under this or any other Act against an individual, and anyone helping the police officer, to use reasonably necessary force to exercise the power.*

136. In the *Commissioner of Police v Flanagan*[28] McMurdo JA held:

> *The operation of s 615 is not according to the state of mind of the police officer. The question under s 615 is whether, on an objective view, it is reasonably necessary to use the force which is used in the purported exercise of the power. In my opinion, that question is to be answered by reference to the facts and circumstances which then present themselves to the police officer, rather than to the true facts and circumstances as they may emerge by the time of the trial.*

137. I am required to consider whether actions of the attending police officers and paramedics were "appropriate in the circumstances". Consistent with the judgment of McMurdo JA, in doing so I cannot apply a retrospective lens. In assessing the actions of the officers, I am also mindful of hindsight bias - the tendency of those with knowledge of an outcome to overestimate the predictability of what occurred relative to alternative outcomes that may have seemed likely at the time of the event.

138. The inquest heard the sequence of events according to the witnesses' recollections. It is not uncommon nor unreasonable that witnesses may have different accounts of what occurred, given the different places they witnessed events, the time they became involved, and what details were important to them.

139. The overall sequence of events was reasonably clear from the CCTV and BWC footage that was in evidence at the inquest. Noombah was agitated from the start of his encounter with police. As recorded on the BWC he repeatedly told police to go away and to leave him alone.

140. With the benefit of hindsight, it would have been preferable if the police officers had allowed Noombah to return to his home and then attempted to engage with him. However, while the reason for the police presence on Banfield Drive may have been unclear to Noombah, I accept that the QPS officers could not simply leave him without some form of intervention. As Constable Warren said, "*we couldn't ignore the fact we've seen him*". They knew he had been sniffing petrol, they knew he had a heart condition, and they knew that two hours earlier he had taken an electrical cord. He was threatening to hang himself and fled the house. The police officers coincidentally came across him and when they tried to speak to him, he walked off in the path of oncoming traffic.

141. Unfortunately, it was not entirely clear from the body-worn camera footage how Noombah was taken to the ground. There was clearly a brief but violent struggle. Constable Schembri indicated he was behind Noombah when he performed a type of neck or chest restraint and lowered his own body weight to bring Noombah down in a controlled manner.

[28] [2019] 1 Qd R 249 at 73

142. Constable Warren thought that he was behind Noombah in a bearhug position, and they lost their footing and fell to the ground. It is possible that both events took place in sequence or in combination. Constable Warren was located at Noombah's waistline in the camera footage and Constable Schembri was to the left of him once Noombah was on the ground.

143. I accept that a LVNR was not actually achieved in this situation, although that was how Constable Schembri described the restraint he used. He said it was basically an LVNR without the actual restriction of the carotid arteries or squeezing of the sides of Noombah's neck.

144. Constable Schembri accepted that some pressure could have been applied to Noombah's neck for several seconds because of falling to the ground and the way they fell. He stated at no time did he have his body weight on Noombah while on the ground. He denied kneeling or leaning on his back in any way resulting in his chest or face being compressed against the ground.

145. Constable Warren accepted that while falling to the ground his body weight did land on Noombah, who was underneath him. Within seconds he propped himself up so that his lower half was on Noombah's waistline. He denied otherwise applying his body weight on Noombah by kneeling, leaning or some other application of force.

146. I consider that if the police officers applied pressure to Noombah's chest or neck, it was not for a sufficient period to cause positional asphyxia or cause cardiac arrest or loss of consciousness. As indicated in the evidence of Professor Duflou, for such pressure to result in positional asphyxia it would require a greater level of pressure than can be achieved in most circumstances.

147. There was some focus during the inquest on section 157C of the *Public Health Act* in relation to EEAs and the requirement for officers to tell a person the officer is detaining the person and transporting the person to a treatment or care place; and explain to the person how taking action may affect the person.

148. Section 157C(2) provides that the officer must take reasonable steps to ensure the person understands that information. I accept the submission that Constable Schembri made reasonable attempts in the circumstances to inform Noombah he was being detained for the purpose of an EEA, that he was going to the hospital, and that he wanted to help Noombah. However, I also acknowledge that the presence of uniformed police officers in trying to take Noombah to the hospital was likely to have increased rather than decreased his level of agitation at that time.

149. As was noted by the former Assistant Commissioner of Victoria Police, Mr Dunne, given the short period of time over which these events transpired, in such a dynamic manner, the officers did not have time to discuss the use of force method they would employ. It is not the case that they had two hours to formulate a plan following the initial callout because that job had been finalised. Mr Dunne agreed that the footage showed Noombah was obstructive and aggressive, and he was still pushing back against the officers when he went to ground.

150. Mr Dunne provided the inquest with an independent analysis of the QPS response in accordance with the relevant QPS policies. His evidence was that he could not be critical of the decisions made by police in their interactions with Noombah, particularly where decisions were made as the situation evolved.

151. Mr Dunne concluded that Constable Schembri clearly communicated with Noombah from the outset that he was going to be detained for the purpose of an emergency examination authority. He told him that he was not under arrest and continued to reassure Noombah he was not in trouble and the police wanted to get him help. Ms Matheson also tried to assist by attempting to reassure Noombah. As Mr Dunne noted, it was extremely difficult for anyone to communicate with Noombah in the circumstances when he was likely affected by inhaling petrol, other than continually speaking with him.

152. I agree with the conclusions of Mr Dunne and the ESC investigation that the decision to restrain Noombah and take him to the ground was an appropriate use of force in this instance given the risk level. It was also tactically sound not to use other use of force options such as a baton, taser, or OC spray.

153. The investigation ultimately concluded that Constable Schembri and Constable Warren's actions on 10 February 2018 were lawful, authorised and justified in the circumstances and were not in breach of any QPS policy and procedures. I accept those conclusions.

Were the actions of attending QAS officers appropriate in the circumstances?

154. Constable Schembri's BWC footage demonstrated that the paramedics failed to undertake any meaningful assessment of Noombah on the roadside. It was also apparent that there were was no urgency from police or paramedics in a situation where Noombah was critically unwell.

155. Paramedics Gee and Wallman accepted in their evidence that they failed to carry out any medical assessment or take any of Noombah's vital signs by the roadside.

156. Consistent with the possible rationale for their apparent caution presented by Dr Rashford, the paramedics' evidence was that they were apprehensive about the scene for various reasons. These included that they were flagged down by police, it was not the job they were originally tasked to attend and there were many people at the scene. They said that it was a matter of situational awareness and safety.

157. ACP Gee had been given several briefings about Noombah, including by Constable Schembri when the ambulance first arrived on the scene and then by Ms Matheson when she returned with Noombah's medicine. He was made aware that Noombah had a heart condition (including a stent), had been sniffing petrol and had been threatening to hang himself.

158. However, I accept the submission from the paramedics that they were not made aware that any urgency attached to Noombah's condition by the attending police. When they arrived, Noombah was on the ground restrained. As Dr Rashford, noted the police officers were also unlikely to have appreciated the significance of the rapid change in Noombah's presentation. If the QAS communications centre had been advised that Noombah was unresponsive two crews would have been despatched to the scene.

159. Dr Rashford frankly acknowledged the assessment provided by the paramedics was suboptimal. They failed to conduct a basic assessment of his vital signs and to accurately record those signs. That resulted in a delay in detecting Noombah's clinical deterioration and his subsequent cardiac arrest. After it was identified that he was in cardiac arrest the level of treatment was also suboptimal. The ACPs did not provide adequate cardio-pulmonary resuscitation and rapid defibrillation of malignant cardiac rhythms. The requisite level of care should have been provided in the back of the ambulance by both ACPs instead of involving the police officer in the CPR effort.

160. Dr Rashford was not able to conclude that the outcome would have been any different if the ACPs had acted in accordance with best practice. He said that in the most optimal circumstances around 25% of patients who arrest in the presence of paramedics do not survive. That is consistent with the findings at autopsy, and I agree with that assessment. However, Dr Rashford accepted that what did occur did not optimise Noombah's chances of survival.

161. I note that neither ACP Gee nor ACP Wallman continue to practice as paramedics.

Findings required by s. 45

162. I am required to find, as far as is possible, who the deceased person was, how he died, when and where he died and what caused his death.

163. As a result of considering all the material contained in the exhibits and the evidence given by the witnesses, the material parts of which I have summarised above, I am able to make the following findings.

Identity of the deceased – Trevor King (Noombah)

How he died – Noombah died after he was restrained by police officers who used force to detain him under an Emergency Examination Authority.

Police and ambulance officers had responded to a call for assistance from Noombah's partner after he threatened to harm himself. He had significant heart disease and had sniffed petrol several hours before the confrontation with police.

Noombah became unresponsive while he was retrained after a struggle with police, but the extent of his clinical decline was not identified until after he was placed in the ambulance vehicle, over eight minutes after paramedics arrived on the scene.

Place of death – Townsville Hospital, Townsville

Date of death– 10 February 2018

Cause of death – Cardiac arrest in a person with pre-existing severe ischaemic heart disease who was restrained and had consumed volatile hydrocarbons.

Comments and recommendations

164. Section 46, in so far 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.

165. One of the matters that became apparent during these proceedings was that there was confusion about whether the QPS or QAS has primary responsibility for the care of a person such as Noombah who was detained and handcuffed when both agencies were on the scene during his very evident clinical decline.

166. Constable Schembri's evidence was that he believed he was responsible for Noombah's wellbeing while he was briefing QAS on the situation. However, the QAS assumed responsibility for his wellbeing once that briefing was completed. Sergeant Donnelly supported this position, believing that Noombah's wellbeing was the responsibility of QAS once they were briefed about him.

167. ACPs Gee and Wallman believed the scene was the responsibility of the QPS because Noombah was in the custody of police as evidenced by the fact that he was handcuffed and remained so during ambulance transport.

168. Dr Rashford's evidence was that it is implied that QAS paramedics are responsible for the clinical health and management of patients in scenarios such as this as soon as it is safely practicable. He said that while police are responsible for oversighting the safety of paramedics, clinical care certainly falls upon the QAS and "if we've got concerns about a person's condition, we need to make sure we articulate that to our police colleagues".

169. Constables Schembri and Warren assumed that because the QAS were on site and had been briefed on Noombah and his health concerns that the paramedics would be monitoring Noombah. In fact, when he was loaded into the ambulance and Constable Warren queried Noombah's condition with paramedics he was told that Noombah had "an altered level of consciousness" but it was a good level of consciousness.

170. Both police officers, with the benefit of hindsight, acknowledged that they should have been more forthright in asking QAS to medically assess Noombah on the roadside particularly when he appeared to be unconscious.

171. Dr Rashford gave evidence that the QPS and QAS are working together on training modules to assist police officers in their understanding and recognition of a rapid change in clinical condition, manifested by a change from a highly agitated state to a depressed level of consciousness in the setting of restraint following strenuous activity. As recommend by Mr Dunne, that is a matter that requires continuous training and education.

172. Dr Rashford noted that law enforcement officers who have a person in custody who has been very agitated and is suddenly no longer agitated are likely to consider that they have achieved a positive outcome. However, recognising that someone who is apparently compliant is suffering a complication due to an underlying medical condition or is unresponsive as the result of a combination of the circumstance that led up to that is extremely difficult. In his view, police officers and paramedics should assume that a person who has suffered a form of agitation and is ultimately restrained is a critically ill patient requiring a priority response until proven otherwise.

RECOMMENDATION 1

I recommend that Queensland Police Service include in the Operational Procedures Manual a mandatory requirement for police officers to request a priority response from the Queensland Ambulance Service, requiring a medical assessment and monitoring of vital signs, when officers observe a person in custody whose demeanour rapidly declines from a state of heightened emotion and agitation to one of apparent compliance.

173. Irrespective of whether a Lateral Vascular Neck Restraint was activated in the detention of Noombah, there were conflicting views before the inquest about whether this type of restraint has a place in modern policing.

174. Sergeant Donnelly was of the belief it is a reasonable use of force option to be employed by police officers. He said that the application and use of LVNR is something that officers are required to requalify in annually during Operational Skills and Tactics training.

175. During his evidence, Professor Duflou also stated that the correct application of an LVNR was relatively safe. However, he also said that if it was maintained long enough it could result in death. He said that while vagal stimulation resulting in cardiac arrest was not common, pressure on the neck was “never safe”, and that that LVNR should not be used in patients with coronary artery disease. The presence of other disease and medication was also an unknown factor and thrombotic material may be dislodged in the process. If enough pressure was applied there may be hypoxia as well.

176. Mr Dunne also indicated that in his opinion a LVNR or any restraint that is designed to restrict blood flow to the brain should not be used. When asked if such a technique should form part of policing tactics his response was that it is a type of restraint that should only be used in a “fight for your life” situation. Submissions on the behalf of the Commissioner supported the recommendation from Counsel Assisting that the QPS should review its continued use.

RECOMMENDATION 2

I recommend that the Queensland Police Service review the inclusion and training of Lateral Vascular Neck Restraint in the situational use of force model.

177. The submissions from Noombah's family highlighted the challenges in responding in a culturally appropriate way to First Nations people who are either mentally ill or experiencing a situational crisis. On the night of his death, Noombah was a man whose distress was closely related to his perceptions of a loss of connection to culture. I consider that while the attending police officers may have been well intentioned in their efforts to take Noombah to hospital, it was inevitable that they would struggle to communicate effectively with Noombah about those issues.

178. The family also expressed concern that the presence of police officers who use force to take persons into custody has the potential to result in the escalation of a confrontation where a person resists the application of force. There is also the potential for such persons to be charged with criminal offences such as obstruct police, resist arrest, and assault police arising from their interactions with police in these circumstances.

179. The family submitted that the provisions of the *Public Health Act* relating to Emergency Examination Authorities could not be implemented successfully in a place like Townsville because of the "poor relationship between the police and the Indigenous population". The consequence was the "criminalisation of mental illness".

180. The family also submitted that alternative responses need to be developed, and referred to the work of the National Indigenous Critical Response Service operated by Thirrili[29] and the Townsville Community Suicide Prevention Action Plan.[30] The family highlighted the importance of a "whole community approach" that "involves consultation with community members during the planning and implementation stages to ensure it is community-led".

181. While there was limited evidence before the inquest about the current situation relating to responses to suicide by First Nations people in Townsville, I agree with those submissions. Correspondence from the Georgatos Foundation indicated that in recent years the Townsville region has comprised around 10% of First Nations suicide in Australia.[31]

182. One of the suggested options was that police call an elder to assist in dealing with persons such as Noombah, or alternatively have a list of contacts to assist with mental health crises when first approached. There was no specific evidence about whether existing services had the capacity to support QPS and QAS responses after hours and on short notice. ATSILS submitted that the Queensland Government should establish a task force to examine those matters.

183. Dr Rashford informed the inquest that the QAS had a range of initiatives in place to enhance its responsiveness to First Nations patients including an Indigenous paramedic program across the State. The QAS accepts that First Nations peoples often require a slightly different approach, and paramedics are provided with education with respect to interacting with First Nations people in a culturally sensitive way. However, Dr Rashford did not think that it would be practicable to wait for an Indigenous paramedic (assuming one was available) in emergency situations. In those cases:

[29] thirrili.com.au
[30] tspn-community-action-plan-final.pdf
[31] Ex I1.

the most appropriate person to start off with, is a trained, professional paramedic and we would respond the closest appropriate vehicle and our expectation is that all paramedics who work for the QAS, and in fact, all paramedics who work across this country, would have cultural sensitivity and understanding to the requirements of First Nations people.

184. Dr Rashford indicated that the QAS would be willing to explore whether it could implement a process where paramedics can access culturally appropriate support to assist in mental health crises. In that regard he advised that the QAS was implementing a co-responder model in Townsville, in which QAS will attend primary mental health emergencies with a mental health clinician. A 24-hour mental health liaison service has also been established in QPS headquarters in Brisbane with specialist mental health clinicians who are available to paramedics for advice about person with a history of mental health presentations. However, he was concerned about adding processes that would delay an emergency response to persons who may be actively suicidal.

185. With respect to whether the QAS should be the first responders to mental health crises rather than the QPS, Dr Rashford indicated that there was a need to educate staff constantly on the appropriate use of the police service in co-response. The QAS had started further education, particularly scenario-based education for civilian emergency medical dispatchers. The premise is if there is no danger, then it is an ambulance response, seen as a health issue.

186. Research published in 2020 by the Queensland Forensic Mental Health Service and the Queensland Centre for Mental Health[32] demonstrates that there are over 200 suicide related calls to the QPS and QAS each day. The number is increasing. That research also found that formal and informal collaborative suicide crisis responses between Queensland Police, Ambulance and health services are operating and, consistent with the submission from the family in this inquest, "individuals with lived experience of suicide identified a need to develop alternative pathways for individuals in crisis".

187. As noted in the *Partners in Prevention* research, first responders, including police officers, will continue to play a role in helping people through suicide crises and facilitating appropriate intervention and follow up. However, the research also noted that there was "limited, if any, peer-reviewed evidence that transportation to hospital is always an optimal response". In Noombah's case that was the only option considered by the attending police.

188. The limitations of placing reliance solely on hospital emergency departments to support persons in mental health crisis have been recognised in Queensland. In its 2019 publication, *Improving outcomes from police interactions (a systemic approach)*[33], the Queensland Mental Health Commission indicated:

---

[32] Queensland Forensic Mental Health Service, Metro North Hospital and Health Service, and Queensland Centre for Mental Health Research. 2020. *Partners in Prevention: Understanding and Enhancing First Responses to Suicide Crisis Situations* – Summary Report. Brisbane: Queensland Health.

[33] https://www.qmhc.qld.gov.au/sites/default/files/final_progress_report_improving_outcomes_from_police_interactions_april_2019.pdf

The Commission has commenced work to examine alternative models of emergency care, including options for safe spaces for people experiencing a mental health crisis and improved connections to primary care.

189. I note that in July 2021 the Queensland Government extended the QAS Mental Health Co-responder Program to Townsville. This program pairs a specialist Paramedic with a Senior Mental Health Clinician from the local Hospital and Health Service to provide a health response to patients experiencing a mental health crisis.

190. The Queensland Mental Health Commission is also supporting discrete Aboriginal and Torres Strait Islander communities to co-design community led initiatives to strengthen mental health and social and emotional wellbeing, respond to problematic alcohol and other drug use, and reduce suicide.[34] These matters are also included within the scope of the Joint Regional Wellbeing Plan for Northern Queensland Mental health, suicide prevention, and alcohol and other drugs.[35]

RECOMMENDATION 3

In the context of existing commitments, I recommend that the Queensland Government work with First Nations peoples in Townsville, the Northern Queensland Primary Health Network and an organisation such as Thirrili to develop culturally appropriate referral pathways for First Nations people in mental health crisis as an alternative to assessment in hospital emergency departments.

191. I extend my condolences to Noombah's family. I thank them for participating in the inquest and giving evidence about what happened on the night of his death. I appreciate that the events were most distressing for them to witness. It was clear that Noombah was loved and is missed by his family and the wider community.

192. I close the inquest.

Terry Ryan
State Coroner
BRISBANE

[34] Queensland's 2021 Closing The Gap Implementation Plan
[35] https://www.nqphn.com.au/sites/default/files/2021-03/Joint%20Regional%20Wellbeing%20Plan%20for%20Northern%20Queensland.pdf