QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Christopher Leslie Martin**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
FILE NO(s):	2015/3477
DELIVERED ON:	15 December 2017
DELIVERED AT:	SOUTHPORT
HEARING DATE(s):	10 November 2017 & 14 December 2017
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, restraint, domestic violence.

REPRESENTATION:

Counsel Assisting:	Daniel Bartlett
Police Officers:	Adrian Braithwaite instructed by Gilshenan and Luton
Commissioner of Police:	Michael Nicolson instructed by QPS Legal Unit

Contents

Introduction

1. Christopher Martin was 65 years of age at the time of his death on 6 September 2015.

2. Mr Martin lived at Robina with his elderly parents, Leslie Martin (85 years of age) and Mona Martin (84 years of age). Mr Martin had assumed the role of carer for his parents, who were extremely frail. Mr Martin Snr suffered from dementia. Police had previously attended the Robina address on several occasions in response to allegations of violence committed by Christopher Martin against his parents.

3. On the day of his death the Queensland Police Service had been called to Mr Martin's home. A neighbour, Gregory Wyatt, saw Mr Martin spit on his son's car as he walked past Mr Wyatt's house. As he drove to the Robina Police Station to report the incident, Mr Wyatt saw Mr Martin assault Leslie Martin on the footpath. As officers were not in attendance at the Robina Station, Mr Wyatt made a 000 call.

4. Officers from the Mudgeeraba police station arrived at Mr Wyatt's home several hours later at around 4:30pm. They saw Christopher Martin driving into his driveway nearby. He was subsequently detained for the purpose of a breath test. As his reading was over the limit he was told that he would have to accompany police back to the Mudgeeraba Police Station.

5. Mr Martin became agitated and proceeded inside his home, where a brief struggle ensued with the arresting officer, Sergeant Daniel Rahe. After he was handcuffed his condition deteriorated and he became unresponsive. Resuscitation attempts were unsuccessful and he was pronounced deceased at approximately 6:00pm.

6. These findings:

    - confirm the identity of the deceased person, when, where and how he died and what caused his death;

    - consider the adequacy and appropriateness of the decision to restrain Mr Martin in the lead up to his death;

    - consider the adequacy and appropriateness of the manner by which Mr Martin was restrained in the lead up to his death;

    - consider whether further recommendations can be made to prevent a death in similar circumstances from happening in the future; and

    - consider the adequacy and the appropriateness of the response of the Queensland Police Service to the various calls for assistance made between 1:57pm and 4:30pm on 6 September 2015 concerning the conduct of Mr Martin.

The investigation

7. The investigation was conducted by the QPS Ethical Standards Command (ESC) and a detailed report was prepared by Senior Sergeant Sandra Pfeffer, under the supervision of Detective Inspector David Hickey.

8. Senior Sergeant Pfeffer and Detective Inspector Hickey attended the scene on 6 September 2015 with other ESC officers. Prior to the attendance of ECS officers, the District Duty Officer, Senior Sergeant Jason Percival, had arrived at the scene and taken command. The scene was also attended by Regional Duty Officer, Inspector James Plowman. On ESC arrival it was noted that the two officers involved in detaining Mr Martin, Sergeant Rahe and Senior Constable Attardo, were separated and the relevant area secured. The officers' body worn camera footage was also secured.

9. Senior Sergeant Pfeffer and Detective Inspector Hickey conducted a recorded interview with Sergeant Rahe and a 'walk-through' re-enactment at the scene, and at the Mudgeeraba Police Station, in the early hours of 7 September 2015, concluding at 3:50am.

10. Senior Sergeant Pfeffer and Detective Inspector Hickey conducted a recorded interview with Senior Constable Attardo from 4:26am to 5:23am on 7 September 2015. It was not considered necessary to conduct a re-enactment with Senior Constable Attardo as she was not present during the entire incident involving the restraint of the Mr Martin, and her actions were adequately recorded by body worn camera footage.

11. Both officers voluntarily provided urine samples which were later tested for the presence of alcohol or drugs.

12. A forensic examination of the scene was undertaken and a detailed set of photographs taken. Senior Sergeant Pfeffer oversaw investigations into Mr Martin's background and into relevant aspects of QPS training and policy.

13. Enquiries were also made by the QPS of the occupants of over 20 neighbouring residences in relation to their knowledge of Mr Martin, and of the events of 6 September 2015.

14. A post mortem examination was conducted on the body of Mr Martin at the Gold Coast university Hospital on 8 September 2015. Blood, urine and vitreous humour samples were subject to further toxicological testing.

15. I am satisfied this matter has been thoroughly and professionally investigated and all sources of relevant information have been accessed and analysed.

The inquest

16. Following a pre-inquest conference 10 November 2017, the inquest was held at Southport on 14 December 2017. The following persons were called to give oral evidence at the inquest:

- Detective Sergeant Pfeffer – Investigating Officer
- Sergeant Daniel Rahe – first response officer
- Senior Constable Amanda Attardo – first response officer
- Darren Haworth – QPS Training Officer, Operational Skills and Tactics
- Dr Malcolm Dodd – Senior Forensic Pathologist, Victorian Institute of Forensic Medicine
- A/Superintendent David Nevin

The evidence

Social history

17. Christopher Martin was born on 24 January 1950 in Nottinghamshire, England. He is survived by his parents and younger brother, David Martin. The family relocated to Sydney, Australia when Christopher was around 18 years of age. He worked as a security officer and in hotels in Sydney, and in hospitality on the Gold Coast.

18. Mr Martin lived with his parents, Leslie and Mona, as their primary carer at the time of his death. He had lived at his parent's residence for approximately 25 years after having moved to the Gold Coast following the breakdown of two marriages. At the time of his death he was unemployed, and did not have any children.

19. Mr Martin had a minor criminal history from 1982. His driver licence had been cancelled for medical reasons in October 2014. There was a history of five police interventions in relation to alleged acts of violence committed by Mr Martin against his parents, primarily his father, from September 2005 to April 2015.

20. Mr Martin's parents were largely dependent on him for their day-to-day care, including cooking, cleaning and shopping, and other household tasks. His mother was confined to a wheelchair due to arthritis and Mr Martin Snr had diminished mental capacity due to dementia, among other medical comorbidities.

21. Despite the increasing need for high level care as a result of Mr Martin Snr's physical and mental disabilities, Mr Martin's parents were resistant to most forms of intervention and would persistently decline any assistance from community welfare agencies. Robina Hospital records indicate that, against the advice of clinical staff who recommended that Mr Martin Snr be considered for nursing home placement, he remained in the family home under the care of Mr Martin.

22. Mr Martin's brother, David Martin, lived interstate. He had some awareness that Mr Martin was verbally abusive and, on occasion, physically violent, towards his parents. In his opinion, his brother struggled to cope with their father's deteriorating mental state and the increasing burden of care that accompanied this.

23. Review of the available records identified that Christopher perpetrated several forms of domestic and family violence towards his parents while they were in his care, including:

    - use of physical violence;
    - verbal abuse;
    - destruction of property;
    - threats to commit suicide while in possession of a weapon; and
    - intimidation while in possession of a weapon.

24. Between 2005 and 2015, police were called to the family home to respond to reports of domestic and family violence on a total of five occasions. Concurrently, the family presented to, or were admitted to, hospital on at least seven occasions with domestic and family violence related injuries or concerns. No criminal charges were laid with respect to Mr Martin's use of violence within his family. His parents were generally reluctant to assist with police inquiries in relation to these incidents.

Medical History

25. Mr Martin's parents believe that he had suffered a brain injury following a motor vehicle accident, the date of which cannot be ascertained. The post-mortem examination confirmed the existence of an '*old head injury – multiple old cavitated cerebral contusions involving both basal frontal lobes, right lateral frontal lobe and right temporal pole*'.[1] It was not considered that this injury contributed to his death, apart from affecting his behaviour.

26. Mrs Martin also told investigators that Mr Martin was prone to seizures and had been experiencing them for many years (at least since moving to Robina in 2003). She also said that he had been prescribed Valium for the seizures but he would not take it because he did not like taking medication. Mrs Martin said that he was not well on the morning of his death. He had told his mother that he "ached everywhere" including his legs, back and groin.

27. Mr Martin's medical records were obtained as part of the QPS investigation. He was working as a labourer in 2005 and initially attended a medical centre after experiencing chest discomfort. He was referred to the Gold Coast Heart Centre where he refused to have a recommended coronary angiography, despite elevated Triponin levels indicating damage to his

[1] Exhibit A8, page 12

heart.[2] He presented to Robina Hospital in December 2009 with chest pain and an outpatient exercise tolerance test was recommended.[3]

28. In August 2010 Mr Martin was required to attend a 'show cause medical examination' by the QPS to see if he was still capable of driving. In September 2010 Mr Martin's brain injury was detected during a CT scan. The diagnosis stated '*there is extensive encephalomalacia involving the inferior frontal lobes bilaterally. Presumably the aetiology of this change is known and is probably traumatic in origin*'.[4]

29. In September 2014 a medical condition notification was submitted to Queensland Transport by Robina Hospital staff following another car accident. It was assumed Mr Martin had suffered a seizure and it was recommended he be referred to a neurologist. However, it was evident Mr Martin continued to drive despite the medical findings and recommendations.

Events leading up to the death

30. On the afternoon of 6 September 2015 Mr Greg Wyatt saw Christopher Martin walk past his house and spit on Mr Wyatt's son's car which was on the street. Mr Wyatt said that it was relatively common for Mr Martin to spit on the car, and this happened after Mr Martin had been drinking. Mr Wyatt did not know Mr Martin but was familiar with him and his elderly parents, as they lived on the same street. Mr Wyatt decided to drive to the nearby Robina Police Station to report the spitting incident.

31. As he neared the police station, Mr Wyatt saw Christopher Martin on the corner of Scottsdale Drive and Firebird Street, Robina. He saw him hit his father across the chest causing Mr Martin Snr to fall heavily. Mr Wyatt then continued across the road to the station to report both incidents.

32. As there was no one in attendance at the station Mr Wyatt returned to assist Mr Martin Snr. Christopher Martin had left the scene and an unidentified woman was assisting Mr Martin Snr. Mr Wyatt then called the Police Communications Centre ('PCC') at 1:57pm to report the incident. He took Mr Martin Snr back to his home.

33. Mr Wyatt's call was recorded on a PCC incident log. While initially assigned a 'priority code 1' it was later reassigned as a routine 'priority code 3' in accordance with section 14.24 of the QPS Operational Procedures Manual. The incident log noted no primary police response was available as there were nine jobs waiting to be detailed. Mr Wyatt made four further calls to the PCC to ascertain when police would respond. The last call was made at 4:11pm.

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[2] Exhibit D5, page 49
[3] Exhibit D5, page 47
[4] Exhibit D5, page 15

34. Around the time of the last call, Mr Wyatt sought advice from off-duty Sergeant Glenn Whittle, who was at his parents' house adjacent to Mr Wyatt's home mowing their lawn. Sergeant Whittle knew the Martin family and attended Mr Wyatt's address to speak to Mr Martin Snr.

35. Sergeant Whittle asked Mr Wyatt to call Mrs Martin and let her know Mr Martin Snr was being cared for at his home. When Mr Wyatt called Mrs Martin she handed the telephone to Christopher Martin, who told Mr Wyatt he was coming to get his father. This caused Mr Wyatt to become concerned, and he went across the road and asked Sergeant Whittle to return to the house. Mr Martin arrived at Mr Wyatt's house in a silver Toyota Yaris.

36. Christopher Martin approached Mr Martin Snr and told him he should go home. Mr Martin Snr then asked Christopher Martin why he had hurt him. This led to an angry response from Christopher Martin. Christopher Martin then got back into his vehicle and drove back to his home. This coincided with the arrival of Sergeant Rahe and Senior Constable Attardo from the Mudgeeraba Police Station.

37. Sergeant Rahe and Senior Constable Attardo were rostered on a 3:00pm to 11:00pm shift. They were detailed to attend the incident upon booking on for their shift via police radio at the station. The incident was outside of their police division but they were assigned to it as there were a lack of available crews in the Robina police division.

38. Sergeant Rahe was sworn into the QPS on 29 June 1990. He has performed a variety of duties throughout his career and is an appointed detective. He has been an Operational Skills Trainer since 1996. Senior Constable Attardo has been a police officer since 2006, performing general duties work.

39. The two officers checked QPS databases and saw that there was a history of violence by Christopher Martin against his parents. They also saw an intelligence report from November 2014 indicating that Mr and Mrs Martin frequently presented at Robina Hospital with injuries believed to have been caused by Christopher Martin. The Q-Prime database indicated that Christopher Martin had a 'flag' stating he had a brain injury that caused him to be erratic and unpredictable and may become violent and refuse to comply with or follow instructions.

40. Upon arriving at Mr Wyatt's home the officers saw abrasions on Mr Martin Snr's right knee and arm. He told the officers that he had been watching television when all of a sudden Christopher Martin started using abusive language. Mr Martin Snr said he went for a walk and Christopher Martin came and pushed him over. He said it had happened many times before and Mr Martin would deny everything. Mr Martin Snr said Christopher Martin assaulted him because he could not get his own way, and was 'brain damaged' because he was an alcoholic.

Circumstances of the death

41. Sergeant Rahe and Senior Constable Attardo then escorted Mr Martin Snr to their vehicle in order to take him back to his home. Senior Constable Attardo said that Mr Martin Snr was very frail and unable to walk. It was planned to return him home so the officers could speak with all occupants of the home. At the same time Christopher Martin was seen walking up the other side of the street, and his approach was recorded by the in-car camera.

42. Sergeant Rahe went across the street and commenced a recorded conversation with Christopher Martin. He told him that he wanted to discuss the incident with his father. Christopher Martin asserted that his father had 'slipped' in the bathroom and he had not pushed him over. The following events were recorded on Sergeant Rahe's body worn camera.

43. Sergeant Rahe advised Christopher Martin that he was required to submit to a roadside blood alcohol test. Mr Martin became increasingly agitated and, due to technical issues with the testing device, failed to provide a sample on at least four occasions. He told Senior Constable Attardo to 'shut up' on several occasions. On his fifth attempt he recorded a reading of 0.07%, and was detained for the purpose of a breath analysis.

44. Sergeant Rahe's evidence was that he required Mr Martin to undergo a breath test because it provided an opportunity for him to talk to him and assess whether he was intoxicated.

45. Sergeant Rahe had instructed Senior Constable Attardo to take Mr Martin Snr back to his home. He also instructed Christopher Martin to stay with him. At this point Christopher Martin walked off towards his home while Sergeant Rahe followed him on foot. He told Sergeant Martin that he was going to 'tell my mother'. While he was walking back to the house, Christopher Martin is seen on the body worn camera footage to turn and raise his fists towards Sergeant Rahe.

46. Sergeant Rahe told Mr Martin he would be handcuffed if he continued to 'shape up' to him. Mr Martin resumed walking toward his residence. Footage shows the garage door lower, then raise as Mr Martin approached and lower again after Mr Martin gained entry. It is likely that Mr Martin had control of the garage door via a remote that was located in his shorts.

47. Sergeant Rahe said that he allowed Mr Martin to return to his home because he did not want the situation to escalate. He was confident that Mr Martin would not be able to outrun him. He was conducting an ongoing risk assessment. The risk shifted from unknown to high after Mr Martin shaped up to him and then closed the garage door behind him.

48. Although Sergeant Rahe was able to enter Mr Martin's residence before the garage door closed, this resulted in his separation from Senior Constable Attardo. Sergeant Rahe followed Mr Martin through a hallway into a living

room where Mrs Martin was seated. Mr Martin is heard saying to his mother on the footage '*Mum these people say that I'm as pissed as a fart and I've got to go to the police station'*. He then started pacing around the living room.

49. Sergeant Rahe told Mr Martin to relax. He reminded him he was detained and told him to sit down. Mr Martin then raised his fists towards Sergeant Rahe who responded by pushing him in the chest with his palm, causing Mr Martin to fall backwards. He landed in a seated position on a lounge chair.

50. Sergeant Rahe then attempted to restrain Mr Martin by taking hold of his arms. Mr Martin struggled against Sergeant Rahe, drew back his left fist and said, '*I'll belt you'*. After unsuccessfully attempting to handcuff Mr Martin, Sergeant Rahe transitioned him to the floor and intermittently applied a lateral vascular neck restraint (LVNR).

51. Sergeant Rahe's evidence was that Mr Martin was agile and may have been affected by alcohol and something else, possibly mental health issues, was causing his behaviour to be 'elevated'. Sergeant Rahe stated people affected by these conditions can have a high pain threshold and these factors almost eliminated the difference in age between him and Mr Martin.

52. Sergeant Rahe's evidence was that he detained Mr Martin on the floor in a seated position for approximately 30 seconds, intermittently applying a LVNR. He was unable to apply the handcuffs as he was alone with Mr Martin who was struggling.

53. Senior Constable Attardo gained entry to the house after Mr Martin was transitioned to the floor. Her body worn camera footage briefly depicts Sergeant Rahe applying (or having the capacity to apply) an LVNR upon Mr Martin with his left arm.

54. Senior Constable Attardo is then seen to immediately pick up Sergeant Rahe's handcuffs from the floor. Soon after, her footage clearly shows Mr Martin had both hands handcuffed behind his back. Her evidence at the inquest was that these events happened very quickly. When she entered the home she saw Sergeant Rahe wrestling with Mr Martin. Sergeant Rahe had his arm around his neck and asked Senior Constable Attardo to handcuff him.

55. After Mr Martin complained that the handcuffs were too tight Sergeant Rahe loosened one cuff. Mr Martin requested the other cuff also be loosened and the request was declined. Shortly after, Mr Martin said '*You hurt me please you hurt me my chest, my stomach, my heart'.*

56. Sergeant Rahe removed the handcuffs and re-handcuffed Mr Martin's hands to the front of his body. At about 5:00pm both officers attempted to communicate with Mr Martin without success. After failing to get a response from Mr Martin by applying a sternum rub, Sergeant Rahe instructed Senior Constable Attardo to request the Queensland Ambulance Service (QAS) attend 'code one' and commenced cardiopulmonary resuscitation (CPR).

57. The PCC responded to Senior Constable Attardo's call at about 4:58pm. At around 4:59pm a sound, believed to be Mr Martin inhaling loudly, can be heard. Sergeant Rahe said '*He's breathing*' and placed him into the lateral recovery position.

58. Sergeant Michael Clift of Robina Station arrived soon after and took over CPR under the guidance of Sergeant Rahe. Sergeant Rahe obtained a resuscitation mask, placed it on Mr Martin and declared him to be breathing. Mr Martin was returned to the recovery position and officers continued to monitor him. About 90 seconds later CPR was recommenced and Sergeant Rahe administered breaths to Mr Martin.

59. CPR was continued for seven minutes under instruction via telephone from a QAS officer. QAS officers arrived on scene about 5:10pm and continued resuscitation attempts until 6:01pm at which time QAS officer Rhett Finlayson declared life extinct.

60. Senior Constable Attardo's evidence was that she did not have a current first aid certificate at the time of Mr Martin's death. Her certificate had expired in 2011. Since the death she has completed a full day of first aid training and has undertaken CPR training as part of annual OST training. Sergeant Rahe is a senior surf life saver and has a high level of CPR training as an OST trainer.

Autopsy results

61. An experienced forensic pathologist, Dr Dianne Little, conducted a post mortem examination of Mr Martin's body on 8 September 2015 at the Gold Coast University Hospital.

62. Mr Martin's brain was retained for analysis, and a neuropathology report was completed by Dr Thomas Robertson. As noted above, Dr Robertson found evidence of an old head injury and petechial haemorrhages in the floor of the fourth ventricle. Dr Robertson concluded 'petechial haemorrhages in the floor of the fourth ventricle are consistent with an asphyxia mode of death but are not specific'.

63. Relevant to the application of the LVNR, Dr Little's internal examination of neck showed fresh bruising in the right thyrohyoid muscle, in the prevertebral tissues adjacent to the right carotid bifurcation and a fracture of the right superior horn of the thyroid cartilage with surrounding bruising.

64. Dr Little also reported that Mr Martin showed '*significant single vessel coronary artery atherosclerosis (right coronary artery narrowed to pinpoint*

lumen) with diffuse scarring throughout the posterior and lateral free walls of the left ventricle and posterior interventricular septum'.

65. Dr Little was unable to attribute a precise cause of death from the post mortem examination. In her opinion, the immediate cause of his death was ventricular fibrillation. This was most likely caused by his ischaemic heart disease (narrowed coronary artery with scarred heart muscle), and probably precipitated by the application of the neck restraint. However, as the sequence of events could not be proven unequivocally, the cause of death was given as 'not determined'.

Further expert evidence

66. Dr Malcolm Dodd, a Senior Forensic Pathologist from the Victorian Institute of Forensic Medicine reviewed Dr Little's report and other investigation material. He was called to give evidence at the inquest.

67. Dr Dodd concluded that the cause of death was, in simplified terms, a 'heart attack occurring during a period of restraint'. He highlighted Mr Martin's pre-existing heart condition in coming to this conclusion. He said that Mr Martin had significant comorbidities, including his age, the fact he was an ex-smoker, a previous cardiac event where he had refused an angiogram, hypertension, ischaemia and an enlarged heart.

68. Dr Dodd noted that Mr Martin's coronary arteries were found to be narrowed at autopsy. He said that the stress associated with the struggle with police and the period of restraint likely tripped Mr Martin's heart into an abnormal rhythm. He agreed that there were no obvious indicia of his condition prior to the restraint.

69. Dr Dodd did not consider that asphyxia played a role in Mr Martin's death. He had reviewed the relevant camera footage which demonstrated that the application of a LVNR was transient and Mr Martin did not lose consciousness during this period. There was no evidence of petechial haemorrhage of the conjunctival membranes at autopsy to suggest asphyxiation.

Investigation findings

70. Senior Sergeant Pfeffer concluded that Sergeant Rahe's entry to Mr Martin's residence was authorised under s. 21 of the *Police Powers and Responsibilities Act 2000*.[5] After he entered the residence he was authorised to use such force as necessary to take Mr Martin to a police station, hospital or other place authorised under the *Transport Operations (Road Use Management) Act 1995*.[6]

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[5] General power to enter to arrest or detain someone or enforce warrant

[6] S 80(6) provides "*If a person required by a police officer under subsection (2) or (2A) to provide at a police station or other place a specimen of breath for a breath test, or of saliva for a saliva test, by the person fails to go voluntarily to the police station or other place for that purpose, any police officer, using such force as is necessary, may take the person to the police station or, as the case may be, other place for that purpose*."

71. At the time of Mr Martin's death, the policy in regard to neck restraint holds was outlined in OPM 14.3.3 and the Lateral Vascular Neck Restraint Good Practice Guide. The policy states '*when properly applied, a lateral vascular neck restraint hold is unlikely to cause death or serious injury, and therefore is considered a 'less than lethal force' option'*. The policy also indicated that a LVNR should not be used on the elderly.

72. Senior Sergeant Pfeffer concluded that Sergeant Rahe was justified in his decision to use a LVNR upon Mr Martin. She also concluded that as Mr Martin was exhibiting violent behaviours in an attempt to prevent his detention, it was appropriate and in accordance with policy to handcuff him.

73. Senior Sergeant Pfeffer concluded that there was no evidence to suggest misconduct or breaches of discipline by any members of the QPS. She found that the attending officers made every attempt preserve Mr Martin's life when his condition deteriorated.

74. Senior Sergeant Pfeffer recommended that the QPS consider the implementation of compulsory annual CPR training along with triennial first aid training.

Conclusions

The adequacy and the appropriateness of the response of the Queensland Police Service to the various calls for assistance made between 1:57pm and 4:30pm on 6 September 2015 concerning the conduct of Mr Christopher Martin.

75. Mr Wyatt first called the police about the incident at 1.57pm. At that stage he and Mr Leslie Martin were in Firebird Street, Robina. Mr Wyatt then took Mr Martin back to his home ensuring his immediate protection.

76. At 2.06pm the matter was characterised in the police incident log as a domestic violence matter, and its category was reduced to level 3. At 2.34pm Mr Wyatt expressly told the PCC that he was concerned that Christopher Martin had returned home, and Mr Martin Snr was worried about his wife being home by herself.

77. The fact that the matter remained at category 3 despite the various calls taken by the QPS during the afternoon of 6 September 2015 was explored at the inquest. A statement was received under the hand of Inspector David Nevin, QPS Inspector and State Co-ordinator for Police Communications Centres. Inspector Nevin stated that at 2.13pm the incident was reviewed and appropriately assigned as category 3 as the complainant had been removed from any danger.

78. Acting Superintendent Nevin (as he was at the time of the inquest) gave evidence with respect to whether the information received from Mr Wyatt at 2.34pm should have resulted in the allocation of a higher priority job code. His evidence was that this call was taken by PoliceLink and there were no triggers to change the coding from a category 3. He said that if the call

indicated a need for an urgent response there was capacity for the PoliceLink operator to transfer the call directly to the PCC.

79. Acting Superintendent Nevin's evidence was that call takers all receive training in relation to domestic violence, and the importance of a timely QPS response. He said that there had been no significant changes to the policy relating to call coding or domestic violence responses by call takers since the date of Mr Martin's death. He reiterated that the call would have been reprioritised if there was evidence of an imminent risk to the safety of an individual, the presence of weapons, the offender remained at the scene or there was a threat to Mrs Martin's safety. The information conveyed at the time was that Mr Martin Snr had a very minor injury and had declined ambulance assistance.

80. Acting Superintendent Nevin acknowledged that there might have been better clarification of the caller's concerns at 2:34pm. However, he said that if the same situation arose today, attending officers would be able to access call data relating to changed circumstances directly from their portable QLite devices.

81. Sergeant Rahe also acknowledged in his evidence that he could have escalated the priority of the job if he was aware of increased risk factors. On the date of Mr Martin's death he did not receive any updates from the PCC. At that time he did not have access to live call details from his QLite device, but agreed the device now has that capability.

82. Having regard to the large number of competing priorities being managed within the local police district on the day of Mr Martin's death, the evidence of Sergeant Rahe and Senior Constable Attardo in relation to their planned approach to the job, and Superintendent Nevin's overview, I am satisfied that the response of the Queensland Police Service to the calls for assistance made between 1:57pm and 4:30pm on 6 September 2015 concerning Mr Martin's conduct was adequate.

The adequacy and appropriateness of the decision to restrain the deceased in the lead up to his death.

83. After his breath test indicated he was over the limit, Mr Martin walked back to his house, refusing to comply with a lawful direction issued by Sergeant Rahe. Sergeant Rahe was entitled to detain him at that time.

84. I found Sergeant Rahe to be a candid and impressive witness. He obviously approaches the task of policing in a considered way, applying his knowledge and skills to the situation at hand in a highly professional manner. He was able to give a detailed explanation of his approach to the use of force in this situation, which consisted primarily of tactical communication and open hand techniques.

85. Sergeant Rahe's evidence was that he followed Mr Martin back to the house (rather than immediately arresting Mr Martin on the street) in order to de-escalate the situation. I consider that his reasoning in doing so was sound.

86. Once inside the house Mr Martin was clearly agitated and became increasingly aggressive. He said "*Leave me alone*" on more than one occasion. Sergeant Rahe may have withdrawn (creating space between him and Mr Martin) in an attempt to diffuse the situation. However, he said that he did not consider this to be a sound option as Mr Martin's elderly mother was present and his father was returning with Senior Constable Attardo.

87. In addition, Mr Martin's behaviour was unpredictable and he could have either absconded or gained access to weapons in another part of the house if he was permitted to leave the lounge room. I find that Sergeant Rahe's decision to restrain Mr Martin was appropriate.

The adequacy and appropriateness of the manner by which the deceased was restrained in the lead up to his death

88. The relevant QPS training modules and Operational Procedures concerning the use of force, including the application of restraint, are comprehensive. The QPS utilises a Situational Use of Force Model to assist police in understanding the selection of the most appropriate use of force option in any given incident.

89. The model is a guide only and is used in conjunction with the philosophy 'Consider all Options and Practice Safety' ('COPS'). This assists police to select the most appropriate options to resolve an incident. The options available to Sergeant Rahe in dealing with Mr Martin included withdrawal, closed hand takedown, Taser, OC spray or baton.

90. Sergeant Rahe sensibly ruled out higher level uses of force such as his service weapon or Taser. He demonstrated a high degree of situational awareness, and was concerned for the safety of not only himself and his partner, but that of Mrs Martin and Christopher Martin throughout the incident.

91. Sergeant Rahe's evidence was that, as an OST instructor, he was aware that he should use only minimal force against Mr Martin. His reason for his use of force choices was clearly articulated. He stated he was mindful of his restraint technique while the deceased was on the ground with respect to positional asphyxia.

92. Sergeant Rahe said at the inquest that his specific memory of the incident was 'cloudy'. He initially thought that it was better for Mr Martin to be seated on the lounge as this gave the Sergeant a height advantage and would facilitate the application of handcuffs. After Mr Martin started swinging punches at him from the couch he transitioned him to the floor.

93. The evidence given by Mr Haworth at the inquest confirmed Sergeant Rahe's evidence that the use of the higher levels of containment was unwarranted. He said that Sergeant Rahe used very good tactical communication skills, as would be expected of an OST instructor. Mr Haworth agreed that after Sergeant Rahe engaged with Mr Martin his open hand attempts to control Mr Martin, including the use of a lateral vascular neck restraint, were justified in the circumstances. Mr Haworth said its application was consistent with QPS training and procedures.

94. I am satisfied that the level and type of force used by Sergeant Rahe prior to the application of handcuffs was reasonably necessary. The comparative sizes of the men, Mr Martin's aggressive demeanour in the initial stages of the scuffle, and the fact Sergeant Rahe was initially alone with Mr Martin were relevant considerations in arriving at this conclusion.

95. The brief and intermittent application of the LVNR was also consistent with Sergeant Rahe's training. I am satisfied that the use of force was reasonably necessary in a situation where Mr Martin was threatening Sergeant Rahe with his fists. I also accept that there is no evidence to suggest Mr Martin lost consciousness at any stage throughout the application of the LVNR.

96. I accept the evidence of Sergeant Rahe and Senior Constable Attardo that Mr Martin was moved into a more comfortable position as soon as he displayed signs of distress. When his pallor changed the officers immediately commenced skilful resuscitation efforts and called for emergency assistance.

97. Having regard to his comorbidities, there is no evidence to suggest that Mr Martin would not have died from cardiac arrest had he not been restrained by Sergeant Rahe on the relevant day.

Findings required by s. 45

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

Identity of the deceased – Christopher Leslie Martin

How he died – Mr Martin died after trying to avoid being detained by police for a drink driving offence. He wrestled with an officer and a lateral vascular restraint was briefly applied. This level of physical exertion, combined with underlying cardiac disease, greatly increased his risk of cardiac arrest due to an arrhythmia. He was unable to be revived by police and ambulance officers and died at the scene.

Place of death – 1/38 Leopardwood Circuit, Robina, in the State of Queensland

Date of death– 6 September 2015

Cause of death – Mr Martin died from spontaneous lethal arrhythmia on a background of cardiomegaly, myocardial fibrosis and ischaemic coronary artery disease in the context of stress and restraint.

Comments and recommendations

99. 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.

100. On 20 October 2017, I made a number recommendations in relation to issues identified in the inquest into the deaths of five men as a result of police shootings. These included a recommendation that the QPS revise its policy regarding first aid training for operational police so that it is consistent with the current guideline issued by the Australian Resuscitation Council.

101. At this inquest I heard evidence from Sergeant Rahe and Mr Haworth in relation to changes to QPS training in tactical first aid, which includes a CPR component, with proposed additional enhancements in 2018. All QPS officers will be trained in tactical first aid by July 2018.

102. The circumstances of the QPS' and other agencies interactions with Mr Martin and his parents over the years preceding his death highlight the vulnerability of frail and aged persons who are dependent on their children for their care. While the QPS took appropriate action under relevant legislation to protect the interests of Mr Martin Snr and his wife, it was apparent that Christopher's capacity to care for them diminished as their frailty increased.

103. The response of the wider service system to the presentations of Mr Martin's parents was not considered in any detail at this inquest. It was apparent that despite the efforts of the QPS and other agencies, his parents, particularly his mother, wished to continue to have Mr Martin care for them and his actions were often minimised.

104. I note that in June 2017, the Australian Law Reform Commission published its report on Elder Abuse — A National Legal Response. The ALRC made 43 recommendations for law reform to safeguard older people from abuse and support their choices and wishes. It recommended that these outcomes should be further pursued through a National Plan to

combat elder abuse and new empirical research into the prevalence of elder abuse.

105. In the circumstances, I do not consider that there are any useful recommendations that I can make connected with Mr Martin's death to prevent deaths from happening in similar circumstances in the future.

106. I close the inquest.

Terry Ryan
State Coroner
Southport
15 December 2017