# CORONERS COURT OF QUEENSLAND

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the deaths of Corey James Christensen and Thomas Ian Davy** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | CAIRNS |
| FILE NO(s): | 2018/4350, 2018/4351 |
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| HEARING DATE(s): | 12 to 16 October 2020 |
| FINDINGS OF: | Jane Bentley, Deputy State Coroner |
| CATCHWORDS: | Coroners: stabbing, double fatality, police investigation, police response, QAS response, decision to charge. |

**REPRESENTATION:**

| | |
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| Jaye Christensen: | Mr J Godbolt instructed by Fisher Dore Lawyers |
| The Davy family: | Mr C Minnery instructed by Julia Jasper |
| Dean Webber: | Mr H Walters instructed by Lee, Turnbull & Co Solicitors |
| Louis Bengoa: | Mr J Greggory QC instructed by Purcell Taylor Lawyers |
| Candice Locke: | Ms C Grant instructed by Anderson, Fredericks, Turner Lawyers |
| The Commissioner of Police: | Mr M Fenlon |
| Queensland Ambulance Service: | Ms Melinda Zerner Instructed by Legal & Regulatory Services |
| DS Neal, Sgt Childs, Snr Const Arope, Const Dwyer, Const Manning, Kylie Biddle: | Mr T Schmidt instructed by FC Lawyers |

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## Introduction

1. Section 45 of the *Coroners Act* 2003 provides that when an inquest is held the coroner's written findings must be given to the family of the person in relation to whom the inquest has been held, each of the persons or organisations granted leave to appear at the inquest and to officials with responsibility over any areas the subject of recommendations.

2. These are my findings in relation to the deaths of Thomas Ian Davy and Corey James Christensen. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

3. These findings and comments confirm the identities of the deceased persons, when, where and how they died and the causes of their deaths.

## Background

4. Corey James Christensen was born on 30 January 1981. At the time of his death he was 37 years old. Mr Christensen married his wife, Jaye, on 6 June 2015 but they had been in a relationship since 2005. They had three sons who were aged between seven and ten years at the time of his death. Mr Christensen had worked at Sun Metals in Townsville for about fifteen years.

5. Mr Christensen was known to be "happy-go-lucky" and his friends and family had never known him to be aggressive or violent. Mr Christensen was a loving and loved husband and father who lived for his family.

6. Thomas Ian Davy was born on 20 December 1990. At the time of his death he was 27 years old. He was very close to his parents and his two siblings.

7. Mr Davy lived in Cairns. He had recently moved there for work from Newcastle, New South Wales. He was a qualified structural engineer in the aviation industry.

8. Mr Davy was a volunteer firefighter with Fire and Rescue NSW and a member of the Hawks Nest surf club. In New South Wales he had volunteered with the local Maritime Boating Safety Officer and at a local boxing gym. He was a keen fisherman, he loved the outdoors and his family was his number one priority. He was a loving son, brother, grandson and uncle.

9. Both Mr Christensen and Mr Davy were men of good repute and upstanding members of the community.

10. Alva Beach is located about 15.5km North East of Ayr (approximately 14 minutes drive) and about 103.5km from Townsville (approximately 1 hour and 20 minutes drive). Alva Beach is a small but close-knit community comprised of a number of long-term residents as well as families that hold holiday accommodation.

11. Mr Davy and Mr Christensen met each other for the first time on Sunday 30 September 2018 - the day of the National Rugby League (NRL) Grand Final.

12. Mr Davy and Mr Christensen both died in the early hours of 1 October 2018 at the residence of the Webber family at Topton Street, Alva Beach. The only person home at that address on the night of 1 October 2018 was Dean Joseph Webber who was then nineteen years old.

13. Mr Webber had no criminal history and was a normal happy young man. The Webber family were locals and known to Mr Christensen and Mr Bengoa.

14. Candice Locke moved from Sydney to Ayr in July 2018.

15. Ms Locke and Mr Davy came to know each other via a dating application shortly after she had moved to Ayr.

16. Louis Bengoa and Mr Christensen were close friends and had known each other since 1994.

17. On Friday 28 September 2018 Mr Davy went to Ms Locke's residence to stay for the weekend.

18. On 30 September 2018 Ms Locke and Mr Davy drove to Alva Beach to check crab pots that they had placed there the previous day. They travelled in Mr Davy's Landcruiser. They arrived there sometime before lunch. They remained at Alva Beach for the afternoon and fished off the main beach from about 3.30pm. They were both consuming alcohol.

19. At about 6pm Ms Locke and Mr Davy were approached by Mr Christensen and Mr Bengoa, who were driving along the beach in Mr Bengoa's Polaris ATV.

20. Ms Locke, Mr Davy, Mr Christensen and Mr Bengoa talked on the beach, mostly about fishing, for about 15 minutes. Mr Christensen invited Ms Locke and Mr Davy to join the NRL Grand Final party that was being held at Alva Beach that afternoon and evening.

21. It was customary for some of the Alva Beach residents to hold an NRL Grand Final party each year. In 2018 it was held on a vacant block of land next to the residence of David Christensen (the father of Corey Christensen) in Sandowns Street.

## The Party

22. Ms Locke and Mr Davy travelled in his Landcruiser to the party and arrived around the time the game commenced.

23. Ms Locke was drinking alcohol at the party and became more intoxicated as the night progressed.

24. At about half time in the game, Mr Davy became unhappy with her behaviour and decided to leave the party. He wanted Ms Locke to accompany him but she wanted to remain. They argued about this.

25. Mr Bengoa told Mr Davy that if Ms Locke wanted to stay she could do so.

26. At about 9.39pm Mr Davy left the party in his Landcruiser, leaving Ms Locke behind, although he continued to send her text messages until shortly before 10pm in which he offered to take her home.

27. Patricia Hughes, Michelle Kelly and Ann Phelan were at the party. They were all concerned for Ms Locke because of her level of intoxication.

28. Ms Phelan noticed that Ms Locke was upset after Mr Davy left. Ms Phelan told Ms Locke that she could sleep at her place that night but Ms Locke declined.

29. Mr Bengoa then walked over to them both and said, “She will be alright Ann. I’ll look after her.”

30. Ms Hughes was concerned about Mr Bengoa’s behaviour towards Ms Locke. She thought he was also very intoxicated and trying to “get close” to Ms Locke after Mr Davy left.

31. Ms Locke, Mr Christensen and Mr Bengoa were socialising with each other during the course of the night.

32. Ms Kelly saw the three talking together at the rear of Mr Bengoa’s Polaris buggy.

33. Ms Christensen asked Mr Bengoa for the buggy keys and threatened to lock him and Mr Christensen out of the house if she heard them start the Polaris due to their level of intoxication.

34. Ms Kelly then went over to the Polaris and offered to drive Ms Locke into town.

35. Mr Christensen said, “Nah we’re doing alright here I’m Louis’ wingman”.

36. At 10pm Ms Christensen and Mr Christensen left the party and went back to their house where they put their children to bed.

37. Sometime between 9.48pm and 10.07pm Mr Davy returned and parked in front of the surf club. He had a conversation with Mr Bengoa and

attempted to persuade Ms Locke to leave with him but she declined. Mr Davy left again and parked a short distance up Sandowns Street.

38. At about 10.30pm Mr Christensen left his residence and went back to the party with an alcoholic drink.

39. Between 10.30pm and 11.30pm Mr Bengoa and Ms Locke left the party together in the Polaris.

40. Mr Bengoa told police that it was because Ms Locke wanted to "have a ride".

41. Ms Locke initially told police that she asked Mr Bengoa to drive her to find Mr Davy although she was later unsure whether she had said that to him.

42. It was during this drive that Ms Locke sustained an injury to her left shoulder after falling from the Polaris.

## Circumstances of Ms Locke's Shoulder Injury

43. Ms Locke was taken to the Ayr Hospital later that night and then transferred to the Townsville Hospital. She was examined by an orthopaedic specialist at 7.30am on 3 October 2018 who noted that Ms Locke had pain and swelling of left humerus resulting from a displaced comminuted fracture of the proximal humerus.

44. Ms Locke underwent an open reduction of the fracture with internal fixation. The doctor was of the opinion that the injury amounted to grievous bodily harm.

45. It is clear that Ms Locke hurt her shoulder whilst she was with Mr Bengoa. However, it is unclear how the injury occurred.

46. Ms Locke gave five accounts of the cause of her shoulder injury.

47. She told Mr Webber that her shoulder was injured when Mr Bengoa pushed her out of the Polaris.

48. Whilst she was in the back of the ambulance on the night of the party she said that Mr Bengoa had pushed her out of the Polaris.

49. She told a doctor at the Ayr Hospital that she was pushed from the buggy.

50. At about 2am on 1 October 2018 at the Ayr Hospital Ms Locke also told police that her shoulder was injured when Mr Bengoa pushed her out of the Polaris. She said:

> *Ah, yeah, and what he just – I don't know what his demeanour – he was really rude and I said, "Look, I really want to get back to Tom and go home anyway," and he gave me a shove and I actually fell out of the buggy.*

51. Sometime after 2pm that same day at the Townsville Hospital, and in her written statement that was signed on 16 March 2019, Ms Locke said she fell from the Polaris and did not mention Mr Bengoa pushing her.

52. When she gave evidence at the inquest Ms Locke explained that when she stated that Mr Bengoa pushed her out of the buggy she believed that to have been the truth but, during her stay in hospital she discussed the matter with her family and considering that she was intoxicated at the time, she decided that she did not wish to make allegations against Mr Bengoa of which she could not be one hundred percent certain and so she retracted her statement that he pushed her and stated that she fell from the buggy.

53. Mr Bengoa also provided inconsistent versions of how the injury occurred.

54. On 1 October 2018 Mr Bengoa gave a statement to police in which he said that he and Ms Locke had both returned to the party together without incident. He said:

> *The trip was uneventful, Jacinta seemed to be having fun and she said the buggy was great.*

55. Mr Bengoa incorrectly referred to Ms Locke as Jacinta.

56. On 2 October 2018 Mr Bengoa provided an addendum statement in which he accepted Ms Locke had fallen from the buggy:

> *I recall that she fell out of the buggy at some stage. I recall that I did not play any part in her falling out of the buggy, I think she fell out by herself.*
>
> *I recall that Jacinta said something like, "Shit, I've hurt my arm". I told Jacinta something like, "You'll be right."*

57. Mr Bengoa did not explain at that time why his first statement was incorrect but gave evidence that it was due to his level of intoxication.

58. Mr Bengoa spoke to Mr Davy's family soon after his death. During that conversation he told them that Ms Locke had fallen out of the buggy after she was doing a "Titanic", standing up in the back. In evidence he explained that she was sitting beside him and then he stopped the buggy at some time and she got into the back and then stood up and fell out.

59. Under cross examination though, he said he could not see what she was doing while she was in the back of the buggy.

## After the Shoulder Injury

60. Ms Locke said that after the shoulder injury occurred she got back into the Polaris with Mr Bengoa. She said she asked him to get her medical assistance but he "laughed off" her request. She felt uneasy with him.

61. Ms Locke said her sense of unease motivated her to tell Mr Bengoa to stop the Polaris so that she could get out. She got out and hid behind a car and remained hidden and she could hear him calling out her name.

62. Numerous witnesses saw Mr Bengoa return to the party alone and were concerned and asked him where Ms Locke was.

63. Mr Bengoa had a conversation with Mr Christensen and they left the party together in the Polaris.

64. Ms Locke said after she heard the Polaris drive off she remained hidden for another ten minutes. She then heard the buggy return and this time could hear Mr Christensen's voice calling out for her.

65. Ms Locke stated that she was reassured by the sound of Mr Christensen's voice and expected that he would assist her to get medical attention. She came out of hiding and got back into the buggy with Mr Bengoa and Mr Christensen. They then drove off together.

66. Ms Locke said she then began feeling uncomfortable again because Mr Christensen was laughing and making jokes about her injury. When they approached the houses at the entrance to Alva Beach she asked them to stop the Polaris and they did so. She got out of the buggy and walked to the first house she could see which was Mr Webber's residence.

67. In his first statement, Mr Bengoa said that after they returned to the party "Jacinta" had some more drinks and then sometime after that she "sort of disappeared".

68. He stated that Mr Christensen then told him, "I think I know where she is going".

69. He said that they then walked to where Mr Davy was and had a conversation with him and told him they were going to find "Jacinta". He said the three of them then walked to Mr Webber's house. He said he had the impression that Mr Christensen knew where to look for "Jacinta".

70. In his second statement Mr Bengoa said that he went back to the party and told Mr Christensen that Ms Locke had fallen out of the buggy and they decided to go and look for her "out of concern for her safety".

71. On the way they came across Mr Davy but he couldn't recall any more of the conversation than he provided in his first statement. He said he parked the buggy around the sweeping bend and they walked back to Mr Webber's house as they thought that is where Ms Locke would have gone.

## Events at Topton Street

72. Ms Locke stated that when she got out of the buggy she is fairly sure that she told Mr Bengoa and Mr Christensen that she was going to get help and then walked towards the first house she could see.

73. Mr Webber was asleep inside the house.

74. Ms Locke knocked on the door and Mr Webber let her inside. She stated that she told him she just fell off a buggy on the beach, that she had been with a couple of blokes that she had just met, she needed an ambulance, they wouldn't call one and she needed help.

75. She said that Mr Webber made some phone calls. After a few minutes of being inside the house she heard Mr Bengoa and Mr Christensen yelling loudly and angrily at the door, banging on the door and calling out her name. She said she was very scared and Mr Webber turned off the lights and locked the door. She moved from the couch to sit on the kitchen floor with Mr Webber. She heard Mr Webber yell out to them to leave his property. She heard him call the police and advise that people were trying to break in.

76. Mr Bengoa said that when they got to Mr Webber's house he walked around the corner of the house to have a smoke and urinate and he heard Mr Davy yell out, "Come on Jacinta, it's time to go," a few times.

77. He then heard a male voice yell, "Get out, private property."

78. He heard Mr Christensen say something about a door.

79. He then heard a loud noise that sounded like a door breaking and he walked back in that direction. He heard Ms Locke screaming loudly.

80. Ms Locke told police that she realised that "they" had gotten into the house. She couldn't make out exactly who was inside. She saw shadows and shapes moving and pushing and shoving and shouting. She sat with her head between her knees on the floor most of the time.

81. Ms Locke said that she thought the struggle occurred in the front part of the house, not far from the door. She said that it happened inside the house.

82. Mr Webber told police he heard two males trying to get inside the house. They were outside checking window screens and doors. They were shouting and calling out for Ms Locke. He became fearful for their safety and armed himself with a knife.

83. Mr Webber told police that a short time later three people forced their way into the residence through a sliding door and began assaulting him in the kitchen. He said that the lights were off and he could not identify who they were.

84. Whilst in the ambulance Ms Locke said that she was pretty sure that three males entered the house.

85. Detective Sergeant Neal gave evidence of his initial conversation with Mr Bengoa when he arrived at Topton Street:

> *I spoke with him briefly down there and he – he informed me that – that they had been at the house, that Corey and – and Thomas had gone inside, that he had been over at – at one side – indicated the left-hand side of the house, and he said he saw Thomas come out, that he had blood on him. He was concerned about Corey, and Thomas told him that Corey had come out before him, and he looked over and saw him on the ground near the – near the pole.*

86. Ms Locke said that Mr Webber managed to get whoever was inside out the front door again and he closed the door again. She said he was frantic and upset and called the police asking for help.

87. Mr Bengoa stated:

> *As I ran up towards the bottom of the stairs Thomas came out of that house at me. I saw that Thomas had blood on his shirt.*

88. Mr Davy told Mr Bengoa to ring 000.

89. He asked where Mr Christensen was and Mr Davy indicated towards the road. Mr Bengoa said that he looked over and saw Mr Christensen lying on the ground not moving. He said he froze. Mr Davy asked him again to call 000 but he didn't have a phone.

90. Mr Bengoa said that he stayed with Mr Christensen until the ambulance arrived.

## Emergency Response

91. At 12.26am on 1 October 2018 Mr Webber made the first triple zero call. It was directed to the Queensland Ambulance Service (QAS). The call was made approximately 3 minutes after Ms Locke had arrived at the property and lasted 12 minutes and 35 seconds.

92. Mr Webber informed the call taker:

> *um I just had an injured lady knock on my door asking for help I believe she has a dislocated shoulder and there's, she's, she's come from uh I don't know how to explain it, a buggy or whatever - there's people waiting outside*

93. At about 12.31am (4 minutes and 27 seconds into that call) Mr Webber was heard to say:

> *look mate can you go, get off me property mate, get off me property, can you get off my property*

94. The call taker asked Mr Webber if he felt safe. He replied, “No I’m not safe.”

95. Whilst Mr Webber was on the phone to QAS he told the call taker that the buggy departed and then returned. The call concluded shortly after and Mr Webber was advised to contact 000 again if there was any change in circumstances.

96. The call between Mr Webber and the QAS Operator resulted in an ICEMS (Inter-agency CAD Electronic Messaging System) job being created and sent to the Queensland Police Service (QPS) requesting their assistance in the matter. That request was made at 12.32am and was tasked to Ayr Police Station.

97. Constable Noel Dwyer was on duty at the Ayr Police Station that night. He saw information on the QPS LCAD system in relation to the events at Topton Street, Alva Beach. He told his senior officer DS Neal who was then processing a person in custody and drafting an affidavit objecting to that person being released on bail.

98. DS Neal and a first-year constable, Constable Manning, left the station to have the affidavit witnessed by a Justice of the Peace.

99. At 12.39am Mr Webber sent a text message to a good friend in which he stated, “I’m about to die holy fuck I don’t know what to do.”

100. At 12.42am Constable Dwyer phoned Mr Webber. Mr Webber informed him Ms Locke was injured, she was scared, there were two males outside, whom he identified as Corey and Louis, and that they wanted her. Constable Dwyer advised that police should be there within 30 minutes and he should call 000 if the situation escalated.

101. At 12.51am Mr Webber made a second telephone call to 000. That call was answered by Police Communications Centre at Beenleigh. That call lasted for 4 minutes and 47 seconds and Mr Webber advised that persons were now attempting to gain entry to his house. Mr Webber was distressed and expressing concerns his safety and that of Ms

Locke. He was recorded repeatedly telling persons to "get off" the property.

102. For reasons unclear, the call taker, Senior Constable Luke Weiks, did not believe what he was told by Mr Webber. Mr Webber put Ms Locke on the phone to SC Weiks who told Ms Locke to stop lying when she tried to explain the circumstances to him and was pleading for help. He said:

> *You've already spoken so much shit to me though and you do sound that you do know them. I'm putting a job on and sending them up to Ayr. Thank you. Bye.*

103. At 4 minutes and 40 seconds into the call (approximately 12.56am) shouting can be heard in the background. The call concluded 7 seconds later with Ms Locke screaming.

104. SC Weiks recorded on the police database that the "call was terminated with the female screaming."

105. During that call Ms Locke told SC Weiks:

> *I got in the buggy; one of them – they ended up getting real crazy and pushed me out. This brings me to being right here now with this guy. They're really psycho and don't know what to do. Are you able to help us? Is there any way?*

106. At 12.58pm Mr Davy initiated a telephone call to 000 that was directed to QAS. He was unable to convey the nature of his call for assistance but was able to communicate that he was at Alva Beach.

107. At 12.59pm Mr Webber made a third 000 call that was directed to a Police Communications Centre. During that call he informed the call taker that he had just stabbed "a bloke who broke into my house". He said, "There's three assailants, big blokes, males".

108. He said they broke into his house and he thinks he's "killed him".

109. He said, "I'm scared …. The other guy's going to kill me. I don't want to die."

110. He was asked whether he could lock himself in and replied that they had ripped the door off.

111. Mr Webber said that three men came into his house but he only stabbed one of them.

112. Mr Webber said he did everything he could to protect himself because "he was going to kill me".

113. Mr Webber said he was still holding onto the knife he had used to stab the male. He was told to place the knife on a wooden table in the kitchen. It was later located on the table by the first police officer who entered the house.

114. Constable Dwyer called Constable Manning and told her, "The job just got upgraded to a Code 2, someone's been stabbed and could be dead you have to come back now and we have got to leave."

115. DS Neal and Constable Manning left the residence of the JP and returned to the police station.

116. The first police officers at the scene were DS Neal, Constable Dwyer and Constable Manning. They arrived at 1.16.51am, having left the police station shortly after 1.08am.

117. QAS had been waiting for police at Beach Road from 12.30am to 1.03am when they moved to the corner of Topton and Torilla Streets. They waited there until they saw police drive past and then followed police to the scene.

118. Mr Christensen was not breathing and had a weak slow pulse. Mr Davy had no pulse.

119. Despite the efforts of paramedics Mr Christensen was pronounced deceased at the scene at 1.49am and Mr Davy was pronounced deceased at the scene at 1.52am.

## Autopsies

### *Mr Christensen*

120. Mr Christensen sustained two wounds - a 55mm long stab wound to the left upper anterior chest wall and a 15mm 'V-shaped' laceration to the left occipital scalp.

121. Mr Christensen had an area of subcuticular bruising over the dorsum of the left 4th metacarpophalangeal joint i.e. some bruising under the knuckle of the left hand.

122. Toxicology was negative for any drugs but positive for alcohol. Blood alcohol concentration was 0.211% which, in the opinion of the Forensic Pathologist, whilst not sufficiently high to cause death, would result in a degree of impairment of rapid and extremely complex motor skills and may be associated with behavioural changes.

123. The stab wound was approximately 1.43 metres above the heel. It was 55mm long. The wound perforated the pericardial and the full thickness of the anterior wall of the right ventricle of the heart. The path of the wound was from front to back, downwards and slightly from left to right to a minimum depth of in excess of 70mm. There was a fine variegation noted along the medial edge of the wound and a relatively sharp edge at the superior end of the wound.

124. The Forensic Pathologist stated:

> *In plain terms, post mortem examination showed a stab wound to the upper front of the left side of the chest, damaging the front of the right side of the heart, with a serious collection of blood in the sac surrounding the heart and air within the tissues of the chest as well as a tear of the back left of the scalp and some bruising under the knuckles of the left hand.*

125. The Pathologist confirmed that the wound was consistent with being caused by the knife seized by police from Mr Webber's kitchen table.

126. The Forensic Pathologist concluded that the cause of Mr Christensen's death was a stab wound to the chest and at the time of death he was intoxicated by alcohol.

127. Mr Christensen weighed 84.3kg and was 177cm tall.

***Mr Davy***

128. Mr Davy sustained six distinct knife wounds the two most serious of which were to the left and right anterior chest walls. Both of those wounds perforated the pericardial sac. Mr Davy also had a number of abrasions to his upper and lower limbs. He had a number of incised wounds to his left hand.

129. Mr Davy sustained:

- A roughly vertically orientated gaping stab wound over the right upper anterior chest wall, approximately 1.49 metres above the heel which was about 19mm long. There was a very fine regular variegation of the lateral wound edge;
    - The wound perforated the subcuticular tissues of the right upper anterior chest wall, perforating the right 4th costo-chondral cartilage, perforating the middle lobe of the right lung and perforating the pericardial sac.
    - The wound was associated with blood within the pericardial sac, the mediastinal tissues and both pleural cavities.
- A roughly horizontally orientated gaping stab wound defect was situated over the left anterior chest wall, centred approximately 50mm to the left of the anterior midline, approximately 15mm below the level of the nipple and approximately 1.41 metres above the level of the heel. It was approximately 31mm long.

- A roughly vertically orientated stab wound defect situated over the left cheek, at the level of the lateral angle of the mouth, which was 20mm long;
    - The path of the track of the wound was downwards, from front to back and neither to the left nor right, to a depth of 70mm.
- A 10mm long incised wound over the left palm at the base of the left index finger.
- A 30mm long wound over the medial aspect of the base of the left hypothenar eminence;
- A 5mm long wound over the medial aspect of the base of the left little finger;
- A 2mm diameter punctate defect over the posterior aspect of the left upper back-neck region.
- Multiple abrasions over the ventro-radial ulnar aspect of the right forearm and wrist.
- Linear abrasions over the proximal ulnar aspect of the right forearm which may be consistent with a glancing contact with a serrated edged surface.
- Pair of 25mm long superficial linear abrasions over the lateral aspect of the proximal left leg.
- Multiple abrasions over the lateral aspect of the distal left forearm.
- Abrasions over the volar aspect of the left forearm, ulnar aspect of the mid left forearm and posterior aspect of the left elbow.

130. Toxicology was positive for Desmethylvenlafaxine (an anti-depressant) and alcohol (0.53%).

131. The Forensic Pathologist stated:

*Post mortem examination showed two stab wounds to the front of the chest, both breaching the sac surrounding the heart, one of which also breached the front wall of the right side of the heart, with associated bleeding in the chest cavity spaces. A stab wound of the left side of the face, extending down to the left neck, cuts over the left hand and grazes over the upper and lower limbs were also noted.*

132. The stab injuries were consistent with having been made by the knife seized by police.

133. The cause of death was blood loss caused by the stab wounds of the chest.

134. Mr Davy had bruising under the knuckles of both hands.

135. Mr Davy weighed 133kg and was 188cm tall.

## Medical Examination of Mr Webber

136. Mr Webber was examined on 1 October 2018 and found to have sustained bruising to his head, face and limbs.

137. He had a right side forehead abrasion and early bruising, three centimetres long and a centimetre and a-half wide. He had bruising on his forehead, two centimetres long and a centimetre wide. A right eyebrow swelling along the entire eyebrow with early bruising. The bridge of his nose was red and swollen. His upper lip from the midline to the entire right side was swollen with purple bruising measuring three centimetres by one centimetre wide. His right elbow had swelling. His right-hand revealed abrasions where the true skin was broken on the dorsal aspect of the hand. He had broken skin on his thumb and other abrasions and his left calf muscle had medial swelling, about four by seven centimetres. He had injuries inside his mouth and marks on his neck that could be consistent with finger-marks.

138. Mr Webber was of slight build and weighed 57kg at the time.

139. The injuries were consistent with an assault.

## Forensic Analysis

### The Knife

140. Analysis of the knife recovered from the wooden table confirmed the presence of a mixed DNA profile belonging to Mr Christensen and Mr Davy. Analysis of other knives retrieved from the dwelling did not identify the presence of any DNA.

### Locations of the Stabbings

141. Blood pattern analysis and DNA testing indicates that Mr Davy sustained a knife wound inside the dwelling in front of the fridge.

142. A large quantity of blood on the right forearm of Mr Bengoa was identified as being Mr Davy's despite Mr Bengoa denying physical contact with Mr Davy inside or outside the house. The evidence suggests the blood came to be there by transfer rather than by projection.

143. No blood or DNA attributable to Mr Christensen was located within the dwelling, however a transfer bloodstain was detected on an exterior railing of the veranda. That blood was located within 1.2m of the door by which entry was gained to the dwelling. The fact that it was a transfer blood stain indicates that the wound that resulted in the bleeding was inflicted at a different location.

144. Whilst there is no blood pattern analysis by which the precise location Mr Christensen sustained his knife wound might be identified, there is other evidence on the issue.

145. Results from other forensic analysis confirmed Mr Davy and Mr Christensen were in close physical proximity at the dwelling:

- Transfer bloodstain from Mr Davy onto the interior of Mr Christensen's right arm;
- Passive drip bloodstain from Mr Davy to Mr Christensen's interior right forearm;
- DNA from Mr Christensen on the shorts of Mr Davy;
- DNA from Mr Christensen and Mr Davy on an exterior door handle where entry was gained.

146. When interviewed by QPS, Mr Webber gave a version that three males entered his dwelling. He was standing near a chair and bin at the end of a kitchen bench when they entered. They gained entry by lifting the door (that was locked) off the runner. After the males entered the dwelling Mr Webber became involved in a physical altercation. He was holding a knife in his left hand during that altercation but was unable to recall his actions with the knife.

147. Mr Webber was later unsure whether two or three males entered his house.

148. Mr Bengoa consistently stated that Mr Davy came out of the house after being stabbed. At that time Mr Christensen had already left the house and was lying on the footpath.

## The inquest

149. The inquest into the deaths of Mr Christensen and Mr Davy commenced on 12 October 2020 and concluded on 16 October 2020 (although there were further applications and submissions after the evidence concluded). Final submissions were received on 30 August 2021.

### *Issues for the Inquest*

150. The issues for inquest were:

1. The findings required by s.45 (2) of the *Coroners Act* 2003; namely the identities of the deceased, when, where and how they died and what caused their deaths.
2. The circumstances surrounding the death of Thomas Ian Davy and if any person caused his death.
3. The circumstances surrounding the death of Corey James Christensen and if any person caused his death.
4. The adequacy of the emergency response provided by the Queensland Ambulance Service and whether the response was consistent with authorised policies, practices and procedures.
5. The adequacy of the emergency response provided by the Queensland Police Service and whether the response was consistent with authorised policies, practices and procedures.
6. Whether any internal review or investigation was conducted by the Queensland Police examining the police response to the emergency, the outcome of those reviews or investigations, and the adequacy of those reviews and investigations.
7. Whether the officers on duty at the Ayr Police Station at the relevant times, performed their duties in a manner that complied with the authorised policies, practices and procedures of the Queensland Police Service.
8. The decision by Queensland Police not to charge and/or prosecute any person in relation to the deaths of Thomas Ian Davy and Corey James Christensen.
9. Whether earlier intervention by the Queensland Police Service may have prevented the deaths of Thomas Ian Davy and/or Corey James Christensen.

10. Whether earlier intervention by the Queensland Ambulance Service may have prevented the deaths of Thomas Ian Davy and/or Corey James Christensen

151. Nineteen witnesses gave evidence at the inquest:

- Jaye Christensen
- Ann Phelan
- James Phelan
- Michelle Kelly
- Candice Locke
- Emma Savatovic
- Michael Arope
- Kylie Biddell
- Tania Child
- Noel Dwyer
- Hayley Manning
- Gavin Neal
- Dr Paul Botterill
- Kate Taylor
- Louis Bengoa
- Sean Hanlen
- Naomi Lockhart
- Joe Nixon
- Dr Stephen Rashford

## Submissions

152. Each of the parties, except for Mr Webber, provided written submissions and I have considered those in making my findings.

## Findings and Conclusions

### *The scope of the Coroner's inquiry and findings*

153. An inquest is not a trial between opposing parties but an inquiry into a death. The scope of an inquest goes beyond merely establishing the medical cause of death.

154. The focus is on discovering what happened; not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred and, in appropriate cases, with a view to reducing the likelihood of similar deaths.

155. As a result, a coroner can make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future. A coroner must not include in the findings or any comments or recommendations, statements that a person is or may be guilty of an offence or is or may be civilly liable.

156. Proceedings in a coroner's court are not bound by the rules of evidence. That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

157. A coroner should apply the civil standard of proof, namely the balance of probabilities. However, the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, then the clearer and more persuasive the evidence needs to be for a coroner to be sufficiently satisfied it has been proven.

158. If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence and, in the case of any other offence, the relevant department. A coroner may also refer a matter to the Criminal Misconduct Commission or a relevant disciplinary body.

159. I make the following findings based on the evidence tendered at the inquest as well as the oral evidence of the witnesses.

## *Findings*

### The circumstances surrounding the deaths of Mr Davy and Mr Christensen (Issues 1,2 and 3)

160. I find that the following is the chronology of relevant events occurring at Alva Beach from about 9.30pm on 30 September 2018.

161. At about 9:39pm, an argument occurred between Ms Locke and Mr Davy following which he left the party. Sometime between 9:48pm and 10:07pm, Mr Davy returned to the party and attempted to convince Ms Locke to leave with him, but she declined. Mr Davy then drove away from the party, but parked a short distance up Sandowns Street and was not seen again until the events in the early hours of 1 October 2018.

162. At or about 10pm, Mr Webber left the private dwelling where he had been watching the Grand Final and returned to his own dwelling at Topton Street, Alva Beach.

163. Sometime between 10:30pm and 11:30pm, Ms Locke requested Mr Bengoa take her for a drive in his buggy. They then departed together with Mr Bengoa as driver. Whilst the buggy was in motion Ms Locke fell from it and sustained a comminuted fracture of her left surgical humeral neck with significant superior displacement. After the fall, Ms Locke rejoined Mr Bengoa in the buggy but shortly afterward asked him

to stop the buggy so she could exit. After exiting the buggy Ms Locke hid from Mr Bengoa.

164. Mr Bengoa searched for Ms Locke for a period of time but she did not present herself. He then drove back to the party on Sandowns Street where he had a conversation with Mr Christensen. Mr Bengoa and Mr Christensen then drove together in the buggy in search of Ms Locke. Ms Locke heard Mr Bengoa and Mr Christensen calling out her name and presented herself and joined them in the buggy. Shortly after joining them in the buggy Ms Locke asked them to stop so she could exit. After exiting the buggy, Ms Locke approached the dwelling of Mr Webber where she sought his assistance in getting medical attention for her fracture. Mr Webber then permitted Ms Locke to enter his dwelling.

165. Mr Bengoa is the only person who might have been able to give an account of the events that occurred outside Mr Webber's residence after Ms Locke entered it. Unfortunately Mr Bengoa was an unreliable and unhelpful witness. He initially provided a self-serving version of events to police on 1 October 2018 which was inconsistent with his later statements. Throughout the investigation and his evidence at the inquest he minimised his own conduct as much as possible.

166. I do not accept Mr Bengoa's account that he and Mr Christensen approached Mr Webber's house because Mr Christensen guessed that Ms Locke had gone there. She could have been hiding anywhere. It is more likely that Mr Bengoa saw her go into the house. It is likely that Mr Bengoa was very anxious that the police not be called due to the circumstances of her being injured when he was driving the buggy.

167. Mr Bengoa knew that Ms Locke would not come out of the house for him and Mr Christensen (possibly they had already been calling out to her which is why she told police that she only heard Corey and Louis calling out), so they went and woke up Mr Davy.

168. It is unknown what Mr Davy was told by Mr Bengoa. It is unlikely that Mr Bengoa told Mr Davy that Ms Locke had hurt her shoulder falling

from the buggy in which he was driving her along the beach and they were going to look for her. Mr Bengoa did not want anyone to know that Ms Locke had hurt her shoulder while he was driving her in the buggy. It is likely that he was concerned that he would face consequences for driving her in the buggy whilst he was significantly intoxicated and during which she suffered an injury.

169. Had that not been the case Mr Bengoa could have assured Ms Locke that he would take her back to the party and get her medical assistance or he could have taken her to Mr Davy.

170. The likelihood is that Mr Bengoa told Mr Davy something that convinced him that Ms Locke was in danger if she stayed in the house with Mr Webber. Mr Bengoa and Mr Christensen knew the Webber family but Mr Davy did not. It is probable that, due to what he was told by Mr Bengoa, Mr Davy considered that it was necessary as a matter of urgency to remove Ms Locke from the house.

171. I doubt Mr Bengoa's evidence that he was not involved at all in the entry to the house. It was Mr Bengoa who had been determined to find Ms Locke after she left the buggy. To that end he had enlisted Mr Christensen and then Mr Davy to assist him.

172. Once she had entered Mr Webber's house, had Mr Bengoa genuinely been concerned for the wellbeing of Ms Locke all he had to do was knock on Mr Webber's door and calmly explain that he was worried about her shoulder injury and wished to ensure she was safe. Presumably Mr Webber would have told him that he had called an ambulance and he could have left. Alternatively, he could have contacted police or ambulance himself on his phone which was in his buggy.

173. I find that Mr Bengoa had no interest in Ms Locke's welfare or concern for her safety. Mr Bengoa had one concern only that night and that was the possibility that he would be in trouble. That concern for himself caused him to enlist Mr Christensen and Mr Davy (most likely by

misrepresenting the situation) to get Ms Locke out of Mr Webber's house.

174. I find that Mr Davy and Mr Christensen removed the glass door from its runners and entered Mr Webber's house. It is probable that Mr Davy entered the house due to his false belief that Ms Locke required his assistance – possibly he believed that she was vulnerable due to her intoxicated state. Mr Christensen may have aided him due to his impaired judgement arising from his significant level of intoxication.

175. At 4 minutes and 40 seconds into the second 000 call (approximately 12.56am) shouting can be heard in the background. The call concluded 7 seconds later with Ms Locke screaming. I find that it was at that time that Mr Christensen and/or Mr Davy entered Mr Webber's house.

176. I find that Mr Webber stabbed Mr Christensen very close to the door. It is probable that Mr Christensen was stabbed first and then left the house.

177. I find it most likely that Mr Christensen was stabbed by Mr Webber just inside the house. The consistent statements of Mr Webber and Ms Locke that two or three males had entered the house. As Mr Christensen and Mr Davy sustained knife wounds, the only reasonable inference is that they were the two of the two or three males who entered the house.

178. The presence of a discrete pair of wounds to Mr Christensen versus the constellation of injuries to Mr Davy indicates that Mr Davy was at the epicentre of events inside the house.

179. I find that, once inside the house, Mr Davy struck Mr Webber a number of times, causing injury to Mr Webber and bruising to his own knuckles. Mr Webber's pocket was ripped from his shirt during the struggle.

180. The projected blood of Mr Davy on the fridge and kitchen cupboard indicates that he entered further into the house than Mr Christensen and he was stabbed near the fridge.

181. Mr Davy left the house after being stabbed by Mr Webber.

182. I find that it is likely that Mr Bengoa was standing behind Mr Christensen and Mr Davy as they entered the house.

183. I do not accept that Mr Bengoa was not with Mr Davy and Mr Christensen at Mr Webber's door. It is inherently unlikely that after enlisting first Mr Christensen and then Mr Davy to help him to find and retrieve Ms Locke, Mr Bengoa became suddenly disinterested in events and went to the other side of the house to have a cigarette and urinate. However, I cannot be satisfied to the requisite standard that he entered the house.

184. As Mr Davy left the house he asked Mr Bengoa to call an ambulance but Mr Bengoa had left his phone in the buggy and did not think to go back to get it.

185. Mr Davy then walked over to where Mr Christensen was lying on the footpath resulting in his blood dripping onto Mr Christensen.

186. At 12.58am Mr Davy called 000 and was unable to communicate anything other than the fact that he was at Alva Beach. He then collapsed outside the house.

187. It is likely that, in his last moments, Mr Davy was concerned not only for his own welfare but also that of Mr Christensen and exhausted his last reserves to walk to where he was lying and call an ambulance.

188. I find that Mr Webber was genuinely concerned for his own safety and wellbeing and that of Ms Locke when he made the first call to 000 and continued to be so until the arrival of the police. His fear was caused by Ms Locke appearing injured at his house in the middle of the night and telling him that she was pushed from the buggy and that she needed help in the context of males being outside his property who he believed wanted to get her. His fear was compounded when the three men refused to leave his property and then began trying to get into the house. During a later 000 call she told police and Mr Webber heard, that the person who pushed her from the buggy was "crazy" and that

Mr Bengoa and Mr Christensen were “psycho”. Whilst this was clearly not true, it no doubt caused Mr Webber’s fear to intensify and it was shortly after that that Mr Davy and Mr Christensen forced entry to the house.

189. I find that by the time Mr Christensen and Mr Davy removed the glass door Mr Webber was very much in fear for his life.

190. I find that Mr Webber was immediately assaulted by Mr Davy and possibly by Mr Christensen. He retaliated by lashing out with the knife in his hand, stabbing first Mr Christensen and then Mr Davy. The stabbings occurred in the dark and Mr Webber was unsure who he had stabbed.

191. I find that the knife recovered from the wooden table was the only knife used to inflict wounds to Mr Christensen and Mr Davy.

192. I find that Mr Christensen and Mr Davy died from stab wounds inflicted on them by Mr Webber.

## Adequacy of the Police and QAS Response (Issues 4 and 5)

### *Incident 96*

193. There were four separate incidents generated by QPS in relation to the events - 96, 191, 199 and 222.

194. QAS also generated four separate incidents - 10594566, 10594616, 10594636 and 10594566.

195. Mr Webber’s first 000 call at 12.26am (that was directed to the QAS) set two things in motion:

- At 12.29am dispatch of a QAS crew (Unit 1202), to the location (Incident 10594566); and
- At 12.32am a request for assistance from QAS to QPS via ICEMS (incident 96).

196. The QAS job was coded ‘1B’ lights and sirens. Unit 1202, which was active in the town of Ayr, proceeded immediately to Alva Beach and was staged on the outskirts of town by 12.42am. The purpose of staging was to allow the QPS to attend the scene first to clear the scene as safe for QAS to attend. The decision to stage was consistent with authorised policies, practices and procedures as contained within QAS Standard Operating Procedure 099 (Situations Involving Violence and Crew Safety).

197. In response to the ICEMS request from QAS, a QCAD incident (96) was created and approved by Senior Constable Michael Arope (tasking officer) at 12.34am.

*198.* The incident was coded ‘513’ – QAS assistance, and ‘310’ – Disturbance and assigned a Priority Code 3 (Direct Response). That coding and prioritisation was based on information provided by the QAS which was:

> *Caller says he is not safe people outside callers property are from the incident pt was pushed out of buggy*

199. QPS were also notified via ICEMS that QAS had classified the matter as ‘Urgent’.

200. The tasking officer did not hold the necessary authority to approve the incident, however the incident was reviewed by the Communications Supervisor (“Comco” Sgt Tania Childs).

201. The creation and approval of incident 96 was done within an adequate time albeit not in accordance with Communications Group guidelines.

202. The assigning of Priority Code 3 was automatic (based on the incident codes). It was the opinion of the QPS Ethical Standards Command, there was sufficient information for the incident to have been coded manually as Priority 2 (Urgent). This did not occur.

203. The QPS OPM states that Code 3:

*May be assigned to all other matters which are considered to be routine and not requiring classification of code 1 or 2.*

204. Code 2 identifies a job as urgent and is applied in a situation where there is an incident involving injury to a person or a present threat of injury to a person or property.

205. SC Arope gave evidence that the information he had didn't warrant the job being assigned a Code 2 even though it was said that there were people outside and the caller didn't feel safe. He said:

*The majority of jobs we have people don't feel safe so we'd have – every job we'd go to say it's – this isn't a present threat but it's a perceived threat.*

206. He said to assign a Code 2 he would have required information that:

*Maybe they were armed and actually not outside but they were actually kicking the door down and something like that. Because, like, you'd assume you'd be safe inside, people outside.*

207. The Commissioner's Instructions with respect of Priority Codes (OPM 14.24) that were in effect at the time, required a tasking officer receiving details of a call to determine whether a call related to a threat to personal safety or property security, and in the case of determining such a threat exists, to further establish whether that threat was known, potential or perceived and to take those matters into account in deciding whether to allocate a higher priority code.

208. Inspector Hanlen gave evidence at the inquest. He was an inspector responsible for the management and coordination of operations of the police communications centres. He concluded that incident 96 could have been coded priority 2 rather than 3 which was "questionable". He stated:

*The initial incident received would reasonably be considered a priority 3 incident. However, after receiving the urgent message from QAS, while they were processing of the incident, this should*

*have been upgraded to a priority 2 incident or at least warranted a phone call to QAS to verify the severity.*

209. It is his opinion that even if it remained a Code 3 incident 96 required immediate attendance given the information provided that QAS were staging, that there was injured person inside the house who had been pushed from a buggy, that the persons who had pushed her were outside the house, that the persons inside the house were locked inside and did not feel safe.

210. In circumstances where the tasking officer was not the call taker, and where a discretion existed as to whether a higher priority code should have been assigned, steps should have been taken, by way of a direct call to QAS Communications Centre, to obtain more details about the incident. Neither SC Arope nor the Comco took any such step. It is more likely than not, that SC Arope allowed extraneous, personal and irrelevant considerations to affect his decision-making process.

211. In that regard, Snr Constable Arope told the ESC investigator that, in his opinion, QAS staged too frequently. He said:

*It happens every job just about.*

*Because they said there's people there. They want us to hold their hand for most jobs, that why, there's people there other than the patient.*

212. He was asked whether that happened often and he said:

*Ninety-nine percent of their jobs.*

213. He was asked if he knew where QAS were staging and he said:

*Their stage could be at their station having a cup of tea which is often the case.*

214. Comco Tania Childs was asked about QAS staging at the inquest and said that it was the view of officers in Communications Centres that QAS frequently staged waiting for QPS. However, it became evident that she was not aware of any statistics on which to base that

information and the only QAS jobs she became aware of were those in which they were requesting police assistance. Her evidence was:

> *Had there been any views or opinions expressed to you by any other person within the Communications Room about the frequency with which the Queensland Ambulance Service stage on a particular job?---Yes.*
>
> *All right. And what are those views?---That they stage a lot.*
>
> *Is that a view that you hold?---I believe so. Yes.*
>
> *What do you base that view on?---That a lot of the time QAS won't attend an incident or a job unless we go with them.*
>
> *And is there any particular data that you're relying on in that respect or this just an opinion that's just been formed out of your own interactions over the course of - - -?---Just what I've seen.*
>
> *Right.*
>
> *DEPUTY STATE CORONER: So would you – do you get information from QAS about jobs that they attend where they're not staging for you?---Sometimes we do, yes. Like a traffic crash. They'll go without us.*
>
> *But otherwise you wouldn't have any idea how many matters they attend where they don't stage for Queensland Police?---No.*

215. SC Arope said that when the QAS mark a job as urgent it "just means they want you to read it."

216. I accept that "urgent" may have a different meaning for QAS than it does for QPS. For QAS it may mean that a patient urgently requires treatment whereas QPS consider the matters set out in the OPM in allocating a priority.

217. SC Arope said he didn't look at the message again until he had another ICEMS job pop up after 1am and he saw that a person walking down the road had found someone dead and someone nearly dead. He said

he didn't look at the job again before then because he was, "doing other stuff."

218. In this case, time was of the essence. In circumstances where the officers that would ultimately respond to the incident (from Ayr Station), might take up to 20 minutes to drive to Alva Beach under ordinary conditions, or 15-16 minutes under lights and sirens, and knowing that entry was gained into Mr Webber's dwelling at about 12.56am, this meant that any response from those officers needed to have commenced by 12.36am at the earliest or 12.40am at the latest.

219. I find that it was open for QPS incident 96 (Mr Webber's first 000 call with the information sent to QPS from QAS) to have been assigned a Priority Code 2 in circumstances where there was an incident involving an injury to a person, or present threat of injury to a person or property.

220. However, given the priority codes that were available at the time, whilst another officer may have allocated a different priority code, the decision is obviously subjective and dependent on the exercise of discretion.

221. I also accept that, at that time, the allocation of a Code 2 would require police to employ urgent duty driving, which involves risk to officers and others and, as such, should not be allocated unless necessary.

222. I find that the initial emergency response of the QPS, with respect to assessing the incident in accordance with the Commissioner's Instructions and assigning of Priority Codes was inadequate. I accept the evidence of Inspector Hanlen that further information should have been obtained by SC Arope or Comco Childs, which should have resulted in the matter being assigned Code 2.

223. The attitude of SC Arope to the procedures relating to staging by QAS (provided in his ESC interview and repeated by him in evidence at the inquest) indicates a concerning lack of knowledge and understanding and has the potential to put lives at risk in the future considering his position at the Police Communications Centre.

224. It is concerning that the Comco, Sergeant Tania Childs, holds the same views as SC Arope. It is clear from their evidence that their attitudes are not based on any statistics or factual information.

225. There was then a failure by the QPS to respond to the QAS request for assistance within QAS 'acceptance times', this resulted in an ICEMS 'bounce back' to QAS at 12.36am.

226. QAS phoned QPS and provided further information in regard to the matter. SC Arope said he was not aware of that further information.

227. Whilst there was a failure to acknowledge the QAS request within 'acceptance times' this did not prejudice the response of either QAS or QPS, noting Unit 1202 was then already dispatched and QPS Communications Centre were already coordinating incident 96 with officers at Ayr Police Station.

### *Attendance by QPS at Alva Beach*

228. At the time incident 96 entered the system there were three officers on duty at the Ayr Police Station DS Neal (the most senior officer on duty), Constable Noel Dwyer and Constable Hayley Manning, a first-year constable.

229. Constable Dwyer was aware of incident 96 having observed it on the LCAD system at Ayr Station, prior to hearing the dispatch call from the QPS Communications Centre.

230. Upon sighting incident 96, Constable Dwyer discussed the incident with DS Neal, and informed him that a female was injured, that two persons were outside the dwelling, that it was Code 3 (QAS assist), and that the persons did not feel safe. DS Neal felt satisfied the incident was properly coded and did not consider there was any need to obtain additional information before deciding to delay attendance at the incident.

231. The only competing task being managed by officers at the Ayr Police Station, at that time, was an objection to bail affidavit in relation to a person being held in watch house custody. Arrangements for a Justice of the Peace (JP) to witness that objection to bail had been made minutes earlier at about 12.20am. DS Neal decided to take Con Manning to attend on the JP first, following which he said he intended that they would attend Alva Beach.

232. In the ordinary course of events arrangements would be made to transfer the prisoner to Townsville at a half-way meeting point, however at the time of the objection to bail was being taken to the JP, there were no such arrangements in place. Those arrangements would have been a matter for either Constable Dwyer or Constable Manning to facilitate. Whilst consideration was given to calling another crew to attend incident 96, DS Neal formed the view that the fastest way to respond was for himself and Constable Manning to attend, however priority was given to having the objection to bail signed by the JP first. There was no impediment to calling in more assistance, and there was another officer (A/Sgt Justin Luke) living very close to the station, who could have been called in.

233. The reason for not commencing any steps to call in additional personnel was because incident 96 was deemed to be “non-urgent”. There was no policy that required DS Neal to attend the JP first in time. He said it was considered a matter of courtesy the JP be attended on first.

234. In fact it seems there was little urgency in having the bail affidavit sworn as DS Neal had been on duty since midday and shortly after that made the decision to object to the prisoner’s bail but had only phoned the JP to arrange for swearing the affidavit at 12.20am.

235. In circumstances where no arrangements had been made for the transfer of that prisoner, and there was sufficient information to identify a present threat of injury to person or property regardless of the code that had been assigned, I find that incident 96 should have been given

priority over having the objection to bail signed. DS Neal was unable to provide a reasonable explanation as to why the bail affidavit was given priority other than as a matter of courtesy to the JP who was expecting his arrival.

236. I accept the evidence of Inspector Hanlen that, even though incident 96 was assigned a Code 3, it still required an immediate response.

237. I find that this element of the QPS response was inadequate as prioritising the objection to bail represented an unacceptable delay in the response to incident 96. If QPS officers had responded to incident 96 first, it is possible they could have arrived at Alva Beach by 12.55am, thus prior to the stabbing event and it is likely that neither of the deaths would have occurred.

238. I find that the deaths of Mr Christensen and Mr Davy would have been prevented had police officers and/or QAS personnel arrived at the house prior to them entering the house.

239. I find that Sgt Neal did not deal with the matter appropriately. There was no valid reason for him to attend to the bail affidavit prior to going to Alva Beach.

240. Had he gone to Mr Webber's residence on being advised of the matter it is highly likely that the situation would have been defused immediately and two lives saved.

241. However, in this regard I accept that the matter is now being considered in light of the terrible tragedy that occurred and DS Neal could not reasonably have foreseen that outcome at the time that he made the decision to attend the JP.

242. Constable Dwyer established contact with Mr Webber at about 12.43am. It was his evidence that there was nothing in the nature of that call that caused him to consider that incident 96 should have been given a higher priority code. However, even if Mr Webber had provided information to Constable Dwyer that may have given him a concern, it

is more likely than not that a different response could not have been effectively deployed by that time.

243. DS Neal and Constable Manning had already departed the Ayr Police Station by the time of that call. Only Constable Manning had her accoutrements.

244. It is submitted for DS Neal that there was no requirement for DS Neal to comply with the OPM requiring officers to wear accoutrements as he was not on "rostered duties" as set out in the OPM but had come into the office on a day off to deal with the bail matter. I do not accept that this is a practical interpretation of the OPM. The clear intent is that officers performing the duties of a police officer wear accoutrements. If DS Neal intended to attend the job at Alva Beach he was clearly required by the OPM to take accoutrements.

245. It is accepted Constable Dwyer first attempted to contact Mr Webber at 12.37am. That call was unsuccessful as Mr Webber was then still engaged in his first Triple 0 call to QAS that ultimately lasted 12 minutes and 35 seconds. Whilst there was a delay between Constable Dwyer becoming informed of incident 96 and establishing contact with Mr Webber, that delay is not attributable by any failure by him to act, rather it was due to circumstances that were not within his control.

246. I find that element of the QPS response (establishing contact with Mr Webber) was adequate.

247. I find that Constable Dwyer dealt with the matter in a professional manner. He phoned Mr Webber to obtain further information and kept in contact with DS Neal. As events unfolded he made appropriate decisions whilst under considerable pressure and, for the most part, without the benefit of advice from any senior officers.

248. Whilst Constable Manning had access to a Q-Lite device from which either she or DS Neal could continue to monitor incident 96, neither she nor DS Neal made use of that device. It is accepted however, that QPS and QAS Communications Centres maintained contact with each

other throughout the incident. As at 12.44am, QPS were still operating on the basis that QAS were staged and awaiting attendance by QPS. QAS were entitled to continue operating in accordance with their Standard Operating Procedure and maintain staging. There was then no additional information indicating there had been any escalation in events at Topton Street.

249. It remained appropriate for QAS to decline the QPS request to do a "drive by" in the absence of QPS.

***QPS Incident 191***

250. With respect of the second 000 call by Mr Webber at 12.51am, and with the benefit of hindsight, there was no effective and meaningful response that could have been initiated by the call taker by that time, however the response of the call taker was inadequate.

251. I find that SC Weiks failed to treat the call as legitimate. This failure more likely than not contributed to a failure to properly code the incident as 'Code 2', instead coding as 'Code 3'.

252. Incident 191 was not created until 12.58am, approximately two minutes after the call with Mr Webber had ended with the sound of screaming. There was therefore an unacceptable delay in creating the incident.

253. Whilst SC Weiks identified the link between incidents 191 and 96, he failed to update incident 96 with relevant details they had taken during the call. This meant QPS crews that were still responding to incident 96 were unaware of the escalation in events.

254. Inspector Hanlen stated that incident 191 was not treated as legitimate by SC Weiks and he should have applied a Code 2 priority to it rather than the Code 3 which was automatically applied by the system.

255. I find that SC Weiks dealt with Mr Webber and Ms Locke inappropriately. He swore at them, accused them of lying to him (although it is not clear why he came to that conclusion) and hung up

on them whilst events were escalating to the fatal conclusion. His dismissive attitude resulted in him failing to prioritise the matter appropriately.

***QPS Incidents 199 and 222 | QAS 1059461610 and 10594636***

256. Incident 199 was the first occasion QPS became aware of the stabbing event at Topton Street.

257. That incident was created at 12.59am and Constable Dwyer became aware of it almost immediately. Upon becoming aware of Incident 199 Constable Dwyer made a telephone call to Constable Manning and advised her of the stabbing incident and escalation of events at Alva Beach.

258. This was the first occasion he spoke with either Constable Manning or DS Neal since they left Ayr Station approximately 20 minutes earlier. Rather than proceeding directly to Alva Beach, DS Neal and Constable Manning first returned to Ayr Police Station, arriving at about 1.08am. Constable Dwyer and Constable Manning then proceeded to Alva Beach sometime before 1.10am. There was diverging evidence as to the reason why DS Neal and Constable Manning returned to the Station.

259. It was the evidence of Constable Dwyer that he considered the incident to be "high risk" and therefore two officers with accoutrements should attend. He was aware that DS Neal did not have his accoutrements, and this informed a decision for them to first return to Ayr Police Station. It was the evidence of DS Neal that he considered it more appropriate to return to Ayr Police Station.

260. It is more likely than not, DS Neal's return to the Ayr Police Station was due to his lack of accoutrements. DS Neal did not satisfactorily explain why, when he intended to proceed directly to Alva Beach after attending on the JP, he did not take his accoutrements with him initially.

261. I find that DS Neal's and Constable Manning's return to Ayr Police Station, caused a delay, of potentially 8 minutes, in QAS Paramedics being able to access the site where Mr Christensen and Mr Davy were requiring treatment.

262. SC Luke was at home nearby and was phoned by Constable Dwyer and advised that two people had been stabbed at Alva Beach. He went immediately to the station. He called the Comco, Sgt Childs, and requested further officers be called in to assist. At the inquest SC Luke set out his reasons for believing more officers were required - to protect the crime scene, perhaps apprehend offenders, assist victims and conduct the investigation. They were reasonable considerations. However, Sgt Childs refused to authorise calling in more officers. SC Luke said he was very disappointed and annoyed by the response and hung up on her.

263. SC Luke phoned the Ayr Acting Senior Sergeant who came into the station. Immediately upon his attendance SC Luke went to Alva Beach himself.

264. Overall, I find that this aspect of the QPS response to the emergency was inadequate. However, I have no criticism of SC Luke's response to the emergency and find that he acted appropriately.

265. I accept the evidence of Dr Rashford, QAS Medical Director, that the QAS response in relation to QAS incidents 10594616 and 10594636 was adequate.

266. Whilst the adequacy and appropriateness of the treatment provided to Mr Christensen and Mr Davy by attending paramedics was not an issue for inquest, there was a line of cross-examination taken by Counsel for the family of Mr Davy with Dr Rashford about that treatment specifically concerning fluid resuscitation. In that regard, I accept the evidence of Dr Rashford at inquest and in his written statement, that the treatment and care provided to Mr Christensen and Mr Davy was adequate and appropriate.

**The ESC Investigation (Issue 6)**

267. An internal review of the QPS response was undertaken by Ethical Standards Command following a request by the Northern Coroner by letter dated 13 March 2020.

268. That report, detailing the outcomes of that review, and investigation material were exhibited as part of the coronial brief at inquest.

269. The review included interviews with all relevant personnel from the Ayr Police Station and Townsville Communications Centre. The review assisted by identifying the second 000 call that had been made by Mr Webber (incident 191) which had not been identified in the initial police investigation.

270. The ESC investigation concluded:

1. The emergency response provided by the QPS was consistent with authorised policies, practices and procedures.
2. The officers on duty at the Ayr Police Station performed their duties in a manner that complied with the authorised policies, practices and procedures of the QPS.
3. The decision by officers from Ayr Police Station to delay their response was reasonable based on the information available to them at the time.
4. The fact that Ayr Police Station is a small centre with minimal police, along with a change of shift into a public holiday, impacted on the policing response time.

271. I find that the review conducted by Ethical Standards Command was inadequate as it failed to investigate in any depth or address appropriately the failures of the QPS to comply with relevant policies and procedures and, significantly, the failure to give appropriate heed to the urgent nature of the incident and the need to assist the QAS when requested to do so.

272. There was no consideration given to the actions of SC Weiks by the ESC investigation.

273. The senior investigator, DSS Lockhart, was asked whether DS Neal was acting in accordance with policies and procedures when he took a first year constable to attend to job 96 and left the station without accoutrements. She said:

> *I didn't ask him any questions in my record of interview with him about that. It wasn't on my radar at the time. So I'm not sure what his response to that was. So I probably can't comment.*

274. It is difficult to see how the conclusions reached by the ESC investigation can be relied upon when the reasons for the delay in DS Neal attending at Topton Street were not on the senior investigators "radar at the time".

275. DSS Lockhart was questioned further about the issue:

> *in the normal course, a detective, even a plainclothes officer, who was intending to attend a code 3 job should take his accoutrements, pursuant to OPM 14.4?---Pursuant to that OPM, he's rostered on duty and is about to attend a job, yes.*
>
> *Okay. All right. And is there any – can you see any issue with him taking a first year constable to a code 3 job? He wasn't a field training officer. He's given that evidence?---Okay. I wasn't aware of that either. That sort of wasn't in my line of questioning. Broadly, I could envisage some issues should the job turn into something much more than a code 3 routine type scenario.*
>
> *Yes. Which it did. And it would seem which eventuated in him not being able to go very – had to go back to the station. You're aware of that?---Yes. Yes. I think in my questioning he told me had to get some things, but I didn't qualify that further with him.*

276. DSS Lockhart stated that she did not review the decision not to charge any person with offences arising out of the incident as she was "only looking at the police response to the death on the night."

**The Conduct of the Officers at the Ayr Police Station (Issue 7)**

277. Because Constable Manning was a first year Constable, pursuant to Section 18 of the First Year Constable Guidelines, she was precluded from operating in any capacity without supervision. DS Neal was not a Field Training Officer, and therefore was unable to supervise Constable Manning during any of her shifts during her Mentor Period. DS Neal was also unable to supervise any more than 50% of Constable Manning's shifts during her General Training Phase.

278. In those circumstances it was not possible for Constable Manning to remain at Ayr Police Station and supervise the prisoner on her own.

279. QPS policies required that "where possible" persons in custody at a police station should not be left unattended. The policy does not prohibit a person being left in custody unattended but, where it is decided to adopt that course, officers should consider whether suitable alternatives exist, including recalling another officer to duty.

280. Whilst there was compliance with policies and procedures, to the extent that Constable Manning remained supervised, and the person in custody was not left unattended, the confluence of three persons being on duty (one of whom was a first year Constable) along with the need to respond to incident 96, warranted greater consideration of calling in additional personnel. Any consideration that was given, was cursory.

281. DS Neal's failure to take his accoutrements when he left Ayr Police Station with Constable Manning, was not in accordance with Operations Procedure Manual (14.4). There were no exceptions that may have applied in this instance. In the normal course, an officer that

is rostered or duty, and is responding to a Code 3 should take their accoutrements.

**The Decision Not to Charge (Issue 8)**

282. It is beyond the scope of any coronial findings to include any finding or statement that is person is guilty of an offence, or civilly liable for something. The purpose of the following findings is not to consider whether Mr Webber or any other person should have been charged with an offence (or not) nor what that charges may have been, the purpose is instead to examine the investigative and decision-making process taken by the Investigating Officer, DS Gavin Neal.

283. The QPS investigation only gave consideration as to whether Mr Webber should be charged with an offence or not. That consideration was set out in a Criminality Review completed by Detective A/Senior Sergeant JA Nixon with the Homicide Investigation Unit. That criminality review was ultimately adopted, with some changes, by DS Neal in a report to the Coroner dated 1 November 2019.

284. The Criminality Review and Report to the Coroner each concluded that no charges should be commenced against Mr Webber. There was further evidence at inquest that the decision not to charge Mr Webber was formed within four days of the deaths of Mr Christensen and Mr Davy.

285. Therefore, a decision was made before a complete brief of evidence had been assembled. I accept, however, that should further evidence have been obtained, that decision could have been reconsidered at any time.

286. The Criminality Review and Report to the Coroner only considered 000 calls and versions taken from Mr Webber, Ms Locke and Mr Bengoa. They each failed to consider any other evidence collected as part of the investigation, including forensic samples, that may have informed the decision-making process around charging. In circumstances where

further evidence was available by the time of the Report to the Coroner, that document could have provided a more rigorous assessment of that evidence and the conclusions that were available.

287. Within the Report to the Coroner (and Criminality Review) there was a difference in the versions given to police by Mr Webber and Mr Bengoa. The version given by Mr Bengoa only supported two persons as potentially entering the dwelling. On Mr Webber's versions, he was described as remaining "consistent in relation to three males attending his address and 'bashing' his door".

288. Both the Criminality Review and Report to the Coroner regularly referred to a version that three males entered the dwelling. The conclusion ultimately expressed in both documents was that "the versions of Webber have been corroborated in the versions supplied by Locke and Bengoa". This was not entirely correct.

289. When called to give evidence at the inquest, DS Neal expressed the view that he did not believe that a third person was involved in entering the dwelling. Such a view is inconsistent with manner in which the Criminality Review and the Report to the Coroner were both prepared. If such a view was held at the time those documents were prepared, then it was not reflected.

290. At inquest DS Neal said that his belief was based on two factors:

   a. The absence of any DNA or fingerprint evidence at the dwelling being linked to any person other than Mr Christensen and Mr Davy; and,

   b. Considerations of credit with regards to the evidence of Mr Webber and Ms Locke.

291. Those considerations were not reflected in either the Criminality Review or Report to the Coroner.

292. Whilst Ms Locke was known to be present in the dwelling for a significant period of time, neither her DNA nor her fingerprints were

detected. The absence of such evidence from any other person should not therefore have assumed any exculpatory weight.

293. There was forensic evidence that Mr Davy and Mr Christensen were present at and/or in the dwelling. Mr Webber consistently maintained that three persons entered the dwelling which gives rise to the presence of a third unidentified person. There was a failure to reconcile that issue against the versions of the other witnesses.

294. Whilst these considerations may not have changed the final decision it is not apparent that they were adequately considered in making a decision that no charges should be brought.

295. Further, it is apparent that DS Neal gave no consideration as to whether Mr Bengoa should be charged with any offences in circumstances where there was information that may have established that he had been driving under the influence of alcohol when Ms Locke was seriously injured. When asked about that aspect at the inquest DS Neal said that he was preoccupied with the more serious aspects of the investigation.

296. At the inquest DS Neal gave evidence that he formed a view, very early on in the investigation (at least by 2 October 2018) that Mr Webber had been acting either in self defence or in defence of his own dwelling.

297. By 5 October 2018 DS Neal had discussed the matter with officers of the State Crime Command and advised that he was not charging Mr Webber with any offences.

298. I accept that DS Neal's initial decision not to charge Mr Webber in the early days of the investigation was based on his assessment of the evidence available to him at that time and there was no bar to charges being laid at a later time should further evidence come to light.

299. DS Neal was an experienced police officer who considered the evidence available, the need to establish a prima facie case and decided that there was insufficient evidence to charge Mr Webber with any offences. I find that he exercised his discretion appropriately and

in accordance with police procedures and policies. There is no reason to believe that, had new evidence emerged (such as the forensic evidence) or, in fact, was to emerge in the future, the decision would not or could not be revisited.

300. I find that the decision-making process in relation to whether Mr Bengoa should be charged with any offences in relation to his driving of the buggy and the injury caused to Ms Locke was inadequate as, according to DS Neal, the matter was not given any consideration at all.

**Whether Earlier Intervention May Have Prevented the Deaths (Issues 9 and 10)**

301. Whether earlier intervention by QPS or QAS may have prevented the deaths of either Mr Christensen or Mr Davy is considered by reference to when entry was gained at Topton Street and whether intervention before or after may have prevented the deaths.

302. I find that it is very likely, had either paramedics or police officers attended before the stabbings occurred the situation would have very quickly de-escalated and the deaths of Mr Davy and Mr Christensen would have been prevented.

303. On the basis that Mr Christensen and Mr Davy sustained their wounds sometime between 12.56am and 12.59am, and QPS and QAS were unable to proceed to the site until 1.17am, this represents a potential delay of approximately 20 minutes before treatment could be initiated by paramedics.

304. As to whether intervention between the time Mr Davy and Mr Christensen were stabbed and 1.17am might have prevented the deaths of Mr Christensen and Mr Davy, I accept the evidence of Dr Botterill and Dr Rashford.

305. It was the uncontested evidence of Dr Botterill, that the nature of Mr Christensen's injury was such that the damage to his heart wall allowed bleeding to occur in the sac surrounding the heart, and that unless there

was “immediate surgical intervention” in a hospital setting, it would be very unlikely he could have survived.

306. In the case of Mr Davy, the two wounds he sustained to the chest were each associated with damage to the heart wall with significant bleeding into the chest cavity. Again, in the absence of “immediate operative treatment” (in a hospital setting), those wounds were not survivable.

307. Dr Botterill explained:

> *no matter how young and healthy one is, eventually the amount of blood loss that occurs gets to a critical point. And so a person – yes – can sometimes be engaging in – in what appears to be extraordinary physical activity, but within – usually it takes minutes, but within a number of minutes, one gets to that critical point and then, unfortunately, there’s a very rapid deterioration in their – in their state*

308. I find that there was no earlier intervention by either QPS or QAS that might have prevented the deaths of either Mr Christensen or Mr Davy once they had sustained the fatal wounds.

### *Comments and recommendations*

309. QPS officers were aware of a situation at Topton Street, some 30 minutes before the stabbing of Mr Christensen and Mr Davy. The closest station that was able to respond was Ayr Police Station. A response from that station needed to commence no later than 16 minutes before 12.56am if there was to be any effective response.

310. There were two critical circumstances that contributed to a delay in officers responding in a timely manner:

    a. A failure to code incident 96 as a Code 2 rather than a Code 3; and

b. The decision by DS Neal to prioritise attending a Justice of the Peace to have an objection to bail signed before attending Alva Beach in response to incident 96.

311. The evidence at inquest highlighted a misapprehension held by SC Arope, who approved incident 96, about the roles and responsibilities of QAS Paramedics. That misapprehension was shared by his supervising officer, Sgt Childs and, apparently, other officers in Police Communications Centres. In circumstances where both agencies were operating on a shared platform (ICEMS), designed to share information in real-time, it is essential for officers in those centres to understand the role paramedics perform and the policies that inform their decisions to stage.

312. In circumstances where QPS represents an increasingly critical role in ambulance functions, and the ICEMS shared platform has QPS, QAS and the Queensland Fire and Emergency Service (QFES) interacting with each on high volume, real-time information, I find there is a need for ongoing and further education to police officers, particularly those working in communications centres, regarding the roles and responsibilities of each agency and how they interact.

313. The Townsville Police Communications Centre has been upgraded since the deaths of Mr Christensen and Mr Davy. Inspector Hanlen gave evidence that the QPS is doubling its quality assurance team and almost quadrupling its training team to ensure consistency of approach across the state in relation to the communications staff which resulted from recognition of the need to provide consistent call taking training across the state and more quality assurance and training.

314. Effective 20 December 2020, the Commissioner’s Instructions with respect of priority codes and the role of tasking officers has been amended. The amended instructions have reclassified ‘Code 3’ as requiring a ‘direct response’, Code 4 as ‘for alternate resolution’ and the insertion of the new Code 5 ‘no police response’.

315. I am satisfied that the amendments will assist responding officers in their decision-making process regarding timeframes for prioritising and attending an incident. They will also assist removing ambiguity for a communications officer receiving information via ICEMS as to how the matter should be triaged.

316. Taking into account the further resources that are being provided by QPS to training and quality assurance in the communication centres and the new classification of priority codes I make no recommendations in relation to QPS policies or procedures.

317. It is a concerning interpretation that the OPM which requires officers to wear accoutrements whilst “rostered on duty” does not apply to officers who may be called in on overtime to perform policing duties. Such an interpretation has the potential to impact upon future police responses to serious situations.

318. I recommend that consideration be given by the QPS to amending the OPM to remove any such ambiguity.

## Findings required by s. 45

| | |
|---|---|
| **Identity of the deceased** – | Corey James Christensen and Thomas Ian Davy |
| **How they died** – | Mr Davy died from blood loss from stab wounds inflicted on him by Dean Webber after he entered Mr Webber's house after he and Mr Christensen removed the door from its tracks.<br><br>Mr Christensen died from a stab wound to the chest inflicted on him by Dean Webber either inside Mr Webber's house or at the doorway after he and Mr Davy removed the door from its tracks. |
| **Place of death** – | Topton Street ALVA QLD 4807 AUSTRALIA |
| **Date of death**– | 1 October 2018 |
| **Cause of death** – | Mr Christensen died from a stab wound to the chest.<br><br>Mr Davy died from blood loss caused by stab wounds of the chest. |

I close the inquest.

Jane Bentley
Deputy State Coroner
CAIRNS