OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Raymond Francis BOURKE**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Brisbane
FILE NO(s):	COR-1355/04(0)
DELIVERED ON:	**17 March 2006**
DELIVERED AT:	Brisbane
HEARING DATE(s):	10 March 2006
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: Inquest, Death Whilst attempting to avoid being taken into Custody, Suicide

REPRESENTATION:

Counsel Assisting:	Detective Inspector Gil Aspinall
Department of Corrective Services:	Ms Annie Little

Inquest into the death of Raymond Francis Bourke

Table of contents

Introduction... 2
The Coroner's jurisdiction.. 2
The basis of the jurisdiction 2
The scope of the Coroner's inquiry and findings 2
The admissibility of evidence and the standard of proof 3
The investigation 4
The Inquest 4
The evidence 4
Background 5
Conclusions 7
Findings required by s45 7
Comments and recommendations 7

The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system. These are my findings in relation to the death of Raymond Francis Bourke. They will be distributed in accordance with the requirements of the Act.

Introduction

On Monday 7 June 2004, members of the Queensland Police Service went a property at Reserve Road, Kin Kin to search for an illicit drug laboratory they believed was there. Raymond Bourke was suspected of being involved in the manufacture of methylamphetamine at this location.

Upon seeing the police at the shed where the illicit drug laboratory was located, Mr Bourke fled on a motor cycle and eluded the police. He was later located by a police officer behind a shed near his home with a bullet wound to his head. He died later that day as a result of that injury.

These findings seek to explain how that occurred.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because when he died, Mr Bourke was trying to avoid being placed into the custody of members of the Queensland Police Service, his death was a "*death in custody*"[1] within the terms of the Act and so it was reported to the State Coroner for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible, the coroner is required to find:-

- whether the death in fact happened
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

[1] See s10(1)(c)
[2] s8(3)(g) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state corners or deputy state coroner. S27 requires an inquest be held in relation to all deaths in custody

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as there is no contention around that issue in this case I need not need to examine those authorities here with a view to settling that question. I will, however, say something about the general nature of inquests.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[4] However, a coroner must not include in the findings or any comments or recommendations or statements that a person is or maybe guilty of an offence or civilly liable for something.[5]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate".* That doesn't 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 provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Brigenshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

---

[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[4] s46
[5] s45(5) and 46(3)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

When it became known that Mr Bourke had died, Detective Senior Constable Colfs of the Gympie police was directed to conduct a "death in custody" coronial investigation. Scenes of crime officers attended the place of death and fingerprint, photographic and ballistics evidence was obtained.

All relevant witnesses were interviewed and statements obtained and exhibits collected.

On 8 June 2004, an autopsy was conducted by Dr Beng Ong, a forensic pathologist at the John Tonge Centre in Brisbane.

I am satisfied that the investigation was sufficiently thorough and competently undertaken.

The Inquest

An inquest was held in Brisbane on Friday 10 March 2006. Detective Inspector Aspinall, the officer in charge of the Coronial Support Unit, was appointed to assist me. Leave to appear was granted to the Commissioner of the Queensland Police Service. A copy of the police investigation report was provided to Joanne Pinkerton, the daughter of the dead man, prior to the inquest. She advised that neither she nor any other family member wished to attend the inquest and the family had no matters they wished to raise during the inquest. The family indicated that they did not wish to challenge or examine any of the witnesses' versions as contained in the documents.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

I determined that the evidence contained in those exhibits was sufficient to enable me to make the findings required by the Act and that there was no other purpose, which would warrant any witnesses being called to give oral evidence.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

---

[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1990) 65 ALJR 167 at 168

Background

Mr Bourke was 49 years of age. He was a married man who had separated from his wife about 16 years before his death. He was the father or three children. Unfortunately one of his children died in a road accident in 2000. This apparently had a profound effect upon him. His other children believe that death predicated his using illicit drugs. Mr Bourke resided on a rural property at Kin Kin with his remaining son.

Criminal History

Mr Bourke was sentenced to eighteen (18) months imprisonment for drug related offences in the Brisbane Supreme Court on 11 November 2002, which was ordered to be suspended for two (2) years on 11 August 2003. Upon his release from prison, he returned to live in a shed on the Kin Kin property, where his son resided.

Events leading up to the incident

Noosa Detectives had received information that an illicit drug laboratory was located in a shed on a property on Reserve Road, Kin Kin, and Mr Bourke was suspected of being involved in manufacturing illicit drugs at the shed.

As a result, at about 7.30am on Monday 7 June 2004, Detectives Kruger, Duhig, Leavers and Harvey went to the Reserve Road property. It was not far from where Mr Bourke and his family lived.

When the police arrived, no one was present. A cursory search quickly located drug making equipment in the shed.

After police had been at that Reserve Road property for short time, a motor cycle was heard coming towards the shed. The police observed two males on the motor cycle. The police endeavoured to intercept the motorcycle, however it sped off. Detective Kruger recognised the motor cycle rider as Mr Bourke.

The male pillion passenger jumped off the motor cycle into a creek and was apprehended by the police. The officers then notified the Police Communications Centre of the situation and Senior Constable Horn of Pomona Police was directed to attend Mr Bourke's property at 225 Gympie Kin Kin Road to try and locate him.

Mr Bourke rode the motorcycle to a neighbour's place where he borrowed a light truck which he drove the sort distance to his home. He went upstairs into the house.

Rodney Starkey is the partner of Mr Bourke's son, Gerald. He was watching television in the lounge room when Mr Bourke entered, shortly after 7.30 am. Mr Bourke asked Mr Starkey to get him the .22 rifle. Mr Starkey went into a bedroom to get the gun and Mr Bourke followed him. A friend of the couple, Megan Saxon, was sleeping in that room and she woke up when Messrs Bourke and Starkey came in. She saw them get the rifle from a cupboard in the room. She saw Mr Bourke leave the room with the rifle.

Mr Bourke then asked Mr Starkey if there were any bullets for the gun and Mr Starkey went and got a few from Gerald's four wheel drive vehicle and gave them to Mr Bourke.

Mr Bourke then asked him for a pen and paper, so he handed him a blue biro and a notepad.

Mr Bourke advised Mr Starkey that he needed to shoot a horse, which had broken its leg. Mr Bourke then asked Mr Starkey to take the light truck he had arrived in back to the neighbour who owned it.

Mr Starkey agreed to do this and as he was preparing to leave, he observed Mr Bourke walking towards a shed on the property putting bullets into the gun.

Mr Bourke's son, Gerald awoke to the sound of his father and Mr Starkey conversing as they were leaving the house. He looked out the window and saw their neighbour's truck driving down the road. He assumed his father was in the truck.

A short time later, he saw Senior Constable Horn from Pomona Police arrive at their property in a police vehicle and park near the shed. He began walking down to the shed to see what the officer wanted. He heard a gun shot but wasn't sure where it came from and did not think much of it. He continued walking towards the shed.

As Senior Constable Horn drove past the shed he saw Mr Bourke behind it, sitting on the ground, leaning against a pile of logs. The officer saw that Mr Bourke had a lever action rifle lying across his lap. He got out of the car and approached Mr Bourke with his service revolver drawn. The officer quickly realised that Mr Bourke had a serious injury to his head. Senior Constable Horn took the rifle and placed it in his car. At the same time he contacted police communications and requested an ambulance and the assistance of other officers.

Gerald Bourke arrived at the shed as Senior Constable Horn was attempting to provide some first aid. He saw his father. Senior Constable Horn told Gerald that his father had shot himself and that the ambulance was coming. Mr Bourke was seriously injured and was lapsing in and out of consciousness. His son stayed with Mr Bourke and tried to comfort him until he was airlifted to Gympie Hospital.

Other police officers soon arrived. One located a note in the shed. It was in Mr Bourke's handwriting and on the note paper he had been given by Mr Starkey earlier in the morning. It made clear his intention to kill himself.

The Queensland Ambulance Service arrived and commenced treating Mr Bourke. He was transported to the Gympie Base Hospital. His condition was critical and he was later transferred to the Royal Brisbane Hospital for further treatment. He passed away later that evening in an operating theatre at the Royal Brisbane Hospital.

Autopsy results

Forensic pathologist, Doctor Beng Ong conducted an autopsy examination at the John Tonge Centre on 8 June 2004. In his opinion, Mr Bourke died from a "*gunshot wound to the head*".

Dr Ong advised that "*The appearance of the gunshot wound is consistent with the barrel being inserted inside the mouth. This type of gunshot wound is commonly described in suicidal gunshot wounds.*"

Ballistic examinations revealed that the projectile located in Mr Bourke's head at autopsy, had been fired from the .22 rifle found in his possession at the scene of the shooting.

A toxicology analysis of Mr Bourke's blood revealed an elevated concentration of methylamphetamine.

Conclusions

All of the evidence indicates that Mr Bourke died as result of a self inflicted gunshot wound and that no other person was directly involved in his death.

It seems likely that when Mr Bourke saw the police at the premises where he had been involved in manufacturing illicit drugs, he realized that it was likely that he would be charged with criminal offences and sentenced to a lengthy term of imprisonment. As a result, he decided to commit suicide.

I find that police officers involved in this matter did not cause or contribute to Mr Bourke's death and they acted appropriately during and after the death.

Findings required by s45

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. I have already dealt with this last aspect of the matter, the manner of the death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was Raymond Francis Bourke

Place of death – He died at the Royal Brisbane Hospital at Herston in Queensland.

Date of death – He died on Monday 7 June 2004

Cause of death – He died from a self-inflicted gunshot wound to the head.

Comments and recommendations

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. I make no such comments or recommendations in this instance as I do not consider that any changes to policies or practice of any of the authorities involved could reasonably have prevented the death.

Michael Barnes
State Coroner
Brisbane
17 March 2006