QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND
FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Daniel Patrick Lewis**
TITLE OF COURT:	Coroners Court
JURISDICTION:	ROCKHAMPTON
FILE NO(s):	2018/3897
DELIVERED ON:	18 January 2022
DELIVERED AT:	BRISBANE
HEARING DATE(s):	18-19 October 2021
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, avoiding being placed into custody, use of force, police shooting, domestic violence, mental health response, incident command, entry into yard, police training.

REPRESENTATION:

Counsel Assisting:	Ms Rhiannon Helsen, Coroners Court
Commissioner of Police:	Mr Mark O'Brien, QPS Legal Unit
Diane Lewis:	Mr Matt Jackson, instructed by Michael Murray, Townsville Community Law
Snr Constable Grant Wynne-Jones Constable Jack Ziemins-Hill Constable Matt Dominick Sergeant Jeffrey Brandt:	Mr Craig Pratt, Gilshenan and Luton

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Introduction

1. Daniel Lewis was aged 36. He died on 31 August 2018 after being shot by Queensland Police Service officers responding to a 000 call from the 19 year old son of his partner, Ms McIntyre. The son told the call taker Mr Lewis had hit his mother, gone 'ape' and chased him outside.

2. Ms McIntyre also told the call taker Mr Lewis 'laid' into her and her son. When police arrived, Mr Lewis was inside Ms McIntyre's home. Ms McIntyre, along with her son and eight year old daughter, were on their neighbour's driveway.

3. One of the first crew of two police officers walked over to the locked screen door, announced he was a police officer and called out to Mr Lewis. Mr Lewis did not respond. The same officer heard what sounded like a Taser near the garage.

4. Two more officers attended the scene and jumped over a timber gate on the side of the house that was locked. They walked to the back of the yard and onto the patio. The officers announced themselves and yelled for Mr Lewis to come out. Police officers at the front and back of the house continually yelled for Mr Lewis to come out.

5. After around five minutes, Mr Lewis yelled he had a *"shot gun loaded"* and threatened the officers in the backyard. Soon after, Mr Lewis came out of a side door of the house armed with three knives. An attempt to Taser him was unsuccessful. He walked towards the back of the yard towards police and threw one of the knives at police. He was then fatally shot. The incident was captured on the attending officers' Body Worn Cameras (BWC).

6. An investigation into the circumstances surrounding Mr Lewis' death was conducted by Detective Sergeant Christine Knapp of the QPS Internal Investigations Group. DS Knapp provided a coronial report with various annexures, including witness statements, digital recordings, medical and offender records.

7. A post-mortem examination found Mr Lewis died from gunshot wounds to his chest and abdomen.

The inquest

8. Mr Lewis' death was reported as a death in custody under the *Coroners Act 2003*. He died while he was trying to avoid being put into custody. In those circumstances an inquest was mandatory. A pre-inquest hearing was held on 18 August 2021 at Brisbane. Following the pre-inquest hearing, the issues for inquest were settled as:

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

    2. The appropriateness of the actions of the attending police officers, including the decision by the police to enter the backyard of the residence;

    3. The sufficiency of the training provided to officers in responding to a similar incident, particularly involving an armed offender;

4. Whether any preventative changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice; and

5. The sufficiency and appropriateness of the investigation conducted by Ethical Standards Command.

9. The inquest was held at Gladstone on 18 and 19 October 2021. All statements, records of interview, photographs and materials gathered during the investigation were tendered at the inquest.

10. Oral evidence was heard from the following witnesses:

- Senior Constable Grant Wynne-Jones
- Constable Jack Ziemins-Hill
- Constable Matt Dominick
- Sergeant Jeffrey Brandt
- Inspector Corey Allen, Chief Operational Skills Instructor
- Detective Sergeant Christine Knapp

11. The evidence tendered, in addition to the oral evidence, was sufficient for me to make the necessary findings under s 45 of the *Coroners Act 2003.*

12. The primary purpose of an inquest is to inform the family and the public about the matters required by s 45 of the *Coroners Act 2003*, including how the person died and what caused the person to die.

13. Mr Lewis' family had many questions about the circumstances of his death. The officers involved in this incident, and the internal investigation into Mr Lewis' death, have also considered whether his death could have been avoided.

14. A coroner is not able to include in the findings or any comments or recommendations any statement that a person is, or may be, guilty of an offence or civilly liable.

15. However, the *Coroners Act 2003* provides that 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. Information about a person's conduct in a profession can be given to the disciplinary body for that profession if the coroner believes the information might cause the body to inquire into or take steps in relation to the conduct.

The evidence

Personal circumstances and history

16. Mr Lewis was born in Wellington, New Zealand, to Dianne Lewis and Gerrard Lane. He was one of three children. He was raised by his mother largely on her own. Mr Lane was reported to have left the family soon after Mr Lewis was born.

17. On 9 January 1994, at 11 years of age, Mr Lewis sustained a head injury during a fight with his brother. This injury, resulted in Mr Lewis having a cranial surgery and *'massive bleed to his brain'*.[1] Mr Lewis had temporal and frontal lobe damage. His mother reported that he had *'no consequential thinking because of his brain damage'*.[2]

18. Mr Lewis' mother said that his behaviour changed after he sustained the head injury in January 1994. He became violent towards his mother and at one point poured boiling water over his younger brother. At 11 years of age, Mr Lewis started smoking cannabis and drank alcohol.[3] Mr Lewis was often in trouble at school. He left school at Year 8.

19. Mr Lewis' mother said that he was vulnerable because of his disability and found solace in tropical fish. He was able to design and build complex filtration systems. He also cared for neglected animals that had been abandoned.

20. Mr Lewis had three children to two different partners. Two of the children live in New Zealand and one lives in Victoria. He also had a fourth child who died as result of sudden unexplained death in infancy.

21. On 17 November 2003, at the aged of 22, Mr Lewis moved to Melbourne to live with his father. In 2012 and 2014, he was sentenced to terms of imprisonment and served several years in custody. His mother said that he had been assaulted in prison and became reclusive after he was released.

22. After being released from prison in 2015, Mr Lewis moved to live near Emerald in central Queensland with his mother. In 2018, he moved to Rockhampton where he started dating Ms McIntyre in July. Mr Lewis was unemployed at the time of his death.

Criminal history

23. Mr Lewis had a criminal history in New Zealand, consisting of two charges of stealing property (under $500), assault and possession of a pipe. Between 2003-2004, there were family violence incidents involving Mr Lewis and his then partner and the mother of two of his children.

24. Mr Lewis had a Victorian criminal history between 2009 and 2012 with entries for offences of violence, resist police, property related offences, possession of a weapon, possession of methylamphetamine and using an unregistered vehicle.[4]

[1] F19
[2] F19
[3] Ex A8 – Police report
[4] C38.

25. On 3 May 2012, Mr Lewis was convicted in the Latrobe Valley Magistrates Court of one count of intentionally causing serious injury and one count of resisting police. He was sentence to a total of 3 years and 6 months imprisonment with a non-parole period of 1 year and 9 months.[5]

26. On 27 June 2014, Mr Lewis was sentenced to 12 months imprisonment for one charge of robbery, unlawful assault, entering a place likely to cause breach of peace, criminal damage and intentionally causing injury. He was sentenced to serve six months in custody with the remaining six months suspended for 24 months.[6]

27. There were five Family Intervention Orders between 2008-2014 against Mr Lewis in Victoria that had expired in 2014.

28. Mr Lewis did not have a criminal history in Queensland, but had outstanding charges before the Court that were not finalised at the time of his death. The following charges were alleged to have occurred on 17 March 2018:

    - 1 x Serious assault of a police officer;
    - 2 x Assault or obstruct a police officer;
    - 1 x Contravene direction;
    - 1 x Driving without a licence;
    - 1 x Attempt to put in motion while UIL.

29. The offences involved Mr Lewis being pulled over by police in his car after witnesses saw him driving erratically on Glenmore Road, Rockhampton. He was seen to stumble out of his car and appeared intoxicated. When police asked him to submit to a breath test, he failed to comply on two occasions. He argued with police and became aggressive. As a result, he was arrested and taken to Rockhampton police station. At the station he continued to pull away from police and push back against them. He allegedly kicked an officer and spat on another.

30. Mr Lewis was due to appear in the Rockhampton Magistrates Court on 8 October 2018.

31. There was a current Domestic and Family Violence Protection Order against Mr Lewis made on 6 November 2017. The aggrieved on the order was Mr Lewis' ex-partner and her children.

Mental Health/Medical History

32. In addition to his acquired a brain injury, Mr Lewis had a history of chronic Hepatitis C which he received treatment for whenever it was active.

33. Medical records as early as October 2016 showed Mr Lewis being referred to a psychiatrist and a Patient Assessment and GP Mental Health Care Plan was completed on 26 October 2016.[7] At that time, he reported having a rough past, being in prison, having many fights, beaten by a gang on many occasions and had flashbacks of this. He felt anxious most of the time and had trouble sleeping. He was diagnosed with PTSD and depression/anxiety.

[5] C38.
[6] C38.
[7] Ex E1.

34. On 7 November 2017, Mr Lewis and his mother presented to the Emergency Department of Emerald Hospital. He advised that he had injected 'ice' 40 minutes prior and had been injecting 'ice' over the last couple of months after having a relationship breakdown. Mr Lewis was noted to have swelling on his right hand and had been drawing blood clots from his left arm.[8] Mr Lewis was not interested in being referred to the Mental Health Team and only wanted to see a psychiatrist who could prescribe him medication. There was a discussion with Mr Lewis and his mother in relation to him ceasing drugs with the help of medication and reconnecting with the Mental Health Team.

35. On 15 November 2017, Mr Lewis presented to the Emergency Department of Emerald Hospital. After being assessed, he was discharged and voluntarily admitted to the Mental Health Inpatient Unit of the Rockhampton Hospital (MHIU). Mr Lewis expressed paranoid ideas. He had locked himself and his mother inside their house as he believed someone was after them, collected stray animals from the street and removed random number plates from cars. Mr Lewis reported a relationship breakdown that occurred three weeks earlier. As a result, he started using 'ice'. His arm was infected from injecting 'ice'.[9] Mr Lewis was admitted for 13 days.

36. As part of his treatment, Mr Lewis was provided Olanzapine (anti-psychotic medication) and Promethazine and transferred to the High Dependency Unit (HDU) for observation. After eight days in the HDU, he was transferred to the Low Dependency Unit and continued to be monitored until he was discharged on 28 November 2017. Medical records indicate Mr Lewis' symptoms improved while he was an inpatient at the Mental Health Unit.[10] It was considered that he was suffering from drug induced psychosis based on his presentation and progress while under supervision.[11]

37. Mr Lewis was co-operative and kept a low profile during his stay in the Mental Health Unit. He engaged well with staff and while he expressed low moods, aggression and paranoia from time to time his overall presentation was good. He denied any suicidal ideation or thoughts of harming others.

38. On 20 November 2017, medical staff from the MHIU sent a notice to Weapons Licensing in the QPS to advise that Mr Lewis had been diagnosed with Drug Induced Psychotic Symptoms and disclosed that he had three samurai swords at home.[12]

39. On 28 November 2017, prior to being discharged, Mr Lewis was seen by Clinical Nurse (CN) Whittington from the Alcohol and Other Drugs Services (AODS) to establish what assistance Mr Lewis required to manage his substance use. Mr Lewis spoke of having to attend rehabilitation to manage his acute brain injury. He disclosed that he had used five points (5 grams) of methamphetamine in the weeks before being admitted into hospital. He started smoking methamphetamine but changed to injecting it over time. Mr Lewis also disclosed he was a heavy drinker and smoker. He admitted to injecting Benzodiazepines while in prison.

[8] Ex E1.
[9] Ex E7.
[10] Ex E7.
[11] Ibid.
[12] Ex E7.1.

40. Mr Lewis told CN Whittington that this was the first time he had been admitted to a mental health unit. He blamed his admission on a drug induced psychosis and paranoia because he had been taking 'meth' for three to four weeks.

41. Mr Lewis was deemed to meet the DSM5 criteria for severe alcohol, cannabis, methamphetamine and nicotine substance use disorder. CN Whittington assessed that Mr Lewis would need psychotherapy to manage his substance abuse.[13] Harm minimisation, psychoeducation, the importance of engaging in medium/long term psychotherapy and accessing needle and syringe programs were all discussed with Mr Lewis.

42. Mr Lewis said he considered substances to be a waste of money and he had the willpower to stop using. Mr Lewis was provided the AODS business card and encouraged to engage with AODS within the community and access psychotherapy in Emerald on a weekly basis. Mr Lewis stated he lived in Comet (48kms from Emerald) and he did not have a car. He was advised of online options, but this was unlikely to be successful due to literacy issues. He was given referrals to AODS rural services including 24-hour telephone services. Mr Lewis' mother was happy for Mr Lewis to be discharged and liaised with MHIU to collect him.[14]

43. On 11 January 2018, Mr Lewis was reviewed at the Emerald Hospital by Dr Satarasinghe. He stated that 'shit is happening again' and that he wanted 'out'. He stated that his sleep was poor, and he had started injecting 'ice' again.[15] Mr Lewis was happy to continue with his medication but did not believe he had a mental illness.

44. On 4 February 2018, Mr Lewis was contacted by staff from the Central Queensland Mental Health Service – Acute Care Team (ACT) but did not answer. Staff left a message for Mr Lewis to call back.[16]

45. On 12 February 2018, clinical notes from Emerald Community Adult Mental Health indicated Mr Lewis had declined mental health services when he was offered a referral as he was relocating. Dr Kamineni, psychiatrist, wanted his mother to be contacted when Mr Lewis declined services and for his mother to call Rockhampton Mental Health if she was concerned about him. A message was sent to his mother to that effect.[17]

46. On 19 March 2018, Mr Lewis attended the Rockhampton Hospital and was assessed at the Mental Health Services Triage and Rapid Assessment. He reported that he stopped taking his medication (Olanzapine) as it was making him angry, and he had recently been charged with assaulting police and drink driving. He reported using 'ice' in January 2018 but had replaced 'ice' with alcohol.[18] He left messages with AODS to assist him with his alcohol abuse. Mr Lewis was booked for medical review on 22 March 2018 and was provided the contact number for ACT to call in a crisis.

[13] Ex E7.
[14] Ex E7.1
[15] Ex E1
[16] Ex E7.1.
[17] Ex E7.1.
[18] Ex E7.1.

47. On 22 March 2018, Mr Lewis attended his medical review, and no changes were made to plans provided to him by the hospital. He was prescribed Sertraline, an antidepressant medication.

48. On 29 March 2018, Mr Lewis was seen by Dr Malla from ACT as an outpatient, along with his support worker. He attended the clinic to get some help and medication if required. Mr Lewis mentioned events that led to his previous hospital admission including people being on the roof of his house, his dogs being attacked, his fish tank being broken, and fish stolen. Mr Lewis admitted to bingeing on alcohol and being charged for offences. He claimed that he was assaulted by police.

49. Mr Lewis expressed a willingness to engage with AODS and had an appointment on 29 April 2018. A plan was discussed with Mr Lewis, including the provision of psychotropic medications, mindfulness and distraction techniques, education on substance abuse, and support calls.[19] He was again prescribed Sertraline.

50. After the meeting, Dr Malla sent a referral to Dr Vignarajah, a general practitioner at Mandalay Medical centre for Mr Lewis' ongoing care. Dr Vignarajah saw Mr Lewis the next day. He deemed Mr Lewis eligible for a Mental Health Care Plan. Mr Lewis saw Dr Vignarajah once in April and twice in May 2018.

51. On 21 May 2018, Mr Lewis was referred to Dr Keen, a clinical psychologist, who saw him on 25 May 2018.[20] Dr Keen recommended psychotherapy to manage Mr Lewis' feelings, actions and maladaptive thoughts. It was also recommended that Mr Lewis have monthly contact with his GP.

52. On 28 May 2018, Mr Lewis saw Dr Vignarajah for a follow up consultation and a prescription for his medications. On 28 August 2018 (three days prior to death), Mr Lewis saw Dr Vignarajah for a prescription for Sertraline. Mr Lewis was advised to return in two days for a mental health plan review.

53. On 30 August 2018, (the day before his death) Mr Lewis saw Dr Vignarajah for his mental health plan review. Mr Lewis told Dr Vignarajah that he had smoked 'ice' two weeks prior and had been smoking cannabis daily. Dr Vignarajah 'strongly' advised Mr Lewis to go to AODS as his symptoms were significantly connected to his substance use. Dr Vignarajah drafted another referral to Dr Keen.

Relationship with Ms McIntyre

54. Mr Lewis and Ms McIntyre met through an online dating site 14 weeks before Mr Lewis' death. They started off as friends then started dating. Ms McIntyre described her relationship with Mr Lewis as 'really good'. They could both relate to each other due to issues that occurred in their lives. As their relationship continued, Mr Lewis spent a lot of time at Ms McIntyre's house with her son and daughter. According to Ms McIntyre's son, Mr Lewis *"never officially moved in but started never leaving the house and started bringing things like fish tanks"* to the house.

[19] Ex E7.1.
[20] Ex E2

55. Ms McIntyre admitted that while they had arguments, Mr Lewis had not been physically violent towards her until the night of his death. She was aware of Mr Lewis' brain injury and that he was on medication and drank alcohol excessively. She said he tried to get help but "it fell on deaf ears".

56. Ms McIntyre described him as being *"like a 15 year old trapped in a man's body"* when he drank and became 'hyper'. Mr Lewis smoked cannabis every day and took 'ice' every now and then. Mr Lewis would have around 10-15 'cones' a day and, as far as she knew, he had not had 'ice' for a while as she hated 'ice'. She knew he had been in trouble with police in Melbourne.

57. Ms McIntyre stated that on the morning of the incident Mr Lewis had told her he was feeling numb. She thought he made this comment as Father's Day was approaching and she knew he did not have much to do with his children. The anniversary of the death of Mr Lewis' daughter was also coming up. He also believed he was going to be imprisoned because of the recent charges before the Court. Ms McIntyre said that on the morning of his death he repeatedly asked her whether she would come to his funeral.[21]

58. Ms McIntyre's children also described Mr Lewis a good person. However, his behaviour changed when he consumed alcohol. They agreed he had not been aggressive towards them or their mother until the night of his death.

Events leading up to the death

59. On 31 August 2018 at around 2.45pm, Mr Lewis and Ms McIntyre went to the shops. Mr Lewis went to the bottle shop and purchased eight cans of bourbon. They returned home at around 3.00pm and Mr Lewis started drinking. Ms McIntyre noticed that prior to drinking Mr Lewis did not seem himself. Ms McIntyre was not feeling well so she went to bed. She did not know if Mr Lewis had also started drinking the 'home brew', but she saw that on the kitchen bench when she woke up.

60. When Ms McIntyre woke up, she saw her niece and a friend in the kitchen. She saw Mr Lewis was drunk. He was just 'off' and stumbling. One minute he argued with her and then would want to cuddle. Mr Lewis said something inappropriate to her niece and her niece's friend, so she told him to leave them alone. This led to an argument between her and Mr Lewis in the bedroom.

61. Ms McIntyre sent a text message to Mr Lewis' mother at around 6.00pm which said he was drunk, and he should not be drinking. His mother called him. He did not answer so she phoned Ms McIntyre. Ms Lewis said that she could hear her son in the background saying he was useless, was not worth anything to anyone and would be better off dead. Ms McIntyre said she would look after him.

62. Mr Lewis subsequently threatened to kill Ms McIntyre and her children and burn her house down. She tried to calm him down, but saw 'pure rage' on his face and felt scared. He started 'going off' and said he would kill her niece and walked out of their room. As he walked out, he grabbed her by the throat and pushed her against the wall.

[21] Ex F22

63. Ms McIntyre's son heard what was happening and came out of his room. He saw his mother and thought she had just been hit by Mr Lewis. Mr Lewis and Ms McIntyre's son scuffled, and punches were thrown. Mr Lewis threw Ms McIntyre's son over the kitchen bench causing glasses to smash and knives scattered across the bench. Although Ms McIntyre tried to get between the two, they continued to fight.

64. Ms McIntyre and her son managed to drag Mr Lewis to the couch. They tried to hold him down and told him to calm down. Mr Lewis repeatedly said he was going to kill Ms McIntyre's son. Mr Lewis kicked Ms McIntyre's son off and Ms McIntyre told her son to get out of the house. Her son started walking down the hallway, but Mr Lewis continued to yell at him and grabbed a knife and threatened him. Ms McIntyre's son then ran out of the house. Mr Lewis then started breaking items in the house. Ms McIntyre also ran out of the house with her daughter.

65. As they stood outside, they could hear Mr Lewis smashing items and furniture inside the house. Ms McIntyre's son borrowed a neighbour's mobile phone and called 000 at around 7.12pm. He told the call-taker Mr Lewis had hit his mother and chased him out of the house. Ms McIntyre then told the call-taker Mr Lewis 'laid' into her and her son. She told the call-taker Mr Lewis might need an ambulance because he was suicidal. Ms McIntyre's son told the call-taker he would not be surprised if Mr Lewis was armed as there were knives in the kitchen.

66. During the call Mr Lewis could be heard yelling in the background. The call-taker spoke to Ms McIntyre again and asked if Mr Lewis was armed. Ms McIntyre informed the call-taker that he had knives and a Taser.

Police attendance

67. The attendance by QPS officers was captured on their body worn cameras (BWC). The information provided by the officers who were interviewed after the incident largely matched the footage depicted on the BWC.

68. At 7.21pm, Senior Constable Grant Wynne-Jones and Constable Megan Lyons arrived at the address. On their way, Senior Constable Wynne-Jones received information that Mr Lewis was armed. Upon arrival, Senior Constable Wynne-Jones spoke to Ms McIntyre and established that Mr Lewis was the only person inside the house. This information was relayed to police communications. Police communications advised there were flags/warnings on Mr Lewis and to stand by.

69. Senior Constable Wynne-Jones and Constable Lyons walked to the front of the house. Senior Constable Wynne-Jones was by the slightly ajar garage roller door when he heard what sounded like a Taser. The screen door was locked but the hallway was visible. Senior Constable Wynne-Jones checked the wooden gate on the left side of the house and found it was locked.

70. At 7.23pm, Constables Matt Dominick and Jack Ziemins-Hill arrived at the scene. Both officers were tasked by Senior Constable Wynne-Jones to cover the back of the house. He told them the left side gate was locked but did not know if the gate on the right side was locked. He said that Mr Lewis' name was Daniel and he had heard what sounded like a Taser.

71. Constable Dominick checked the wooden gate to the right side of the house and found it was also locked. Constable Dominick climbed over the gate into the side yard of the house. Constable Ziemins-Hill also followed when he was told by Senior Constable Wynne-Jones that he wanted two officers at the back. Both officers walked to the back of the house and onto the patio. As Constable Dominick approached the patio, he drew his Taser.

72. At the front of the house by the screen door, Senior Constable Wynne-Jones called out to Mr Lewis and announced the police presence. At the back of the house by the patio, Constable Dominick also announced himself. Senior Constable Wynne-Jones could see Constable Dominick at the back (through the screen door). Both confirmed they did not have "eyes on" Mr Lewis. Other officers arrived at the scene but stayed at the front yard.

73. Senior Constable Wynne-Jones told another officer that Mr Lewis may have left the home by the time they had arrived. He called out to Mr Lewis again and stated it was the police, and they may have to come into the house to check on him. He told Mr Lewis they wanted to see if he was alright.

74. After the Constables had entered the back yard, Sergeant Brandt from the Dog Squad arrived at the scene. As the senior officer he assumed the role of police forward commander. He told the inquest that he had limited information about the job from the police radio apart from the possibility of violence and the presence of knives. He spoke to the civilians at the front of the house. He agreed that it was necessary to isolate and contain the scene while he gained situational awareness. He considered that entry into the backyard was appropriate for the purpose of making initial inquiries. Once contained, a negotiation process could commence.

75. Constable Dominick announced himself again and asked for Mr Lewis to come out. Despite repeated calls from police there was no answer from Mr Lewis or any noise from inside the house. Police had been on the scene for five minutes before Mr Lewis replied.

76. At around 7.28pm, Mr Lewis yelled *"I've got a shotgun loaded."*[22] Constable Dominick broadcast Mr Lewis' threat of having a loaded shotgun and to come back and isolate the incident. Both Constables Dominick and Ziemins-Hill walked away from the patio and took cover behind a patio awning/shade. They discussed organising for other officers to bring their vests. Constable Dominick told the inquest that after he heard this threat, he considered the situation was high risk. He said that he believed that he and Constable Ziemins-Hill were able to find adequate cover in the back yard and he did not hear any call to retreat.

77. Constable Ziemins-Hill also said that he had no concerns about entering the yard. It was general practise for two officers to be stationed at the front and two at the rear to contain a situation. He checked where the doors were located but was not able to identity that there was a side door to the house. After the shot-gun threat was made he did not think it was safe to retreat over the front fence as they would need to pass a large open window that had been smashed by Mr Lewis. He also considered that they had adequate cover in the back yard, and could see that Mr Lewis was not in possession of a shotgun or any other weapons.

[22] Ex G4 - Body Worn Camera Footage.

78. Mr Lewis was inside the house and yelled something about having enough and pushing a button and *"you'd all be gone"*. Constable Dominick and Ziemins-Hill told him to come outside and to put his hands up. They saw Mr Lewis had nothing in his hands.

79. Sergeant Brandt said that after he became aware that Mr Lewis made threats involving a shotgun, he requested a tactical withdrawal from the yard. However, that was conditional on it being safe to do so. If it was unsafe to withdraw and the officers could get cover in the yard it was preferable for them to stay. By that time, it was a matter for the Constables to decide the safest option.

80. Mr Lewis walked into a room and walked out again swearing under his breath. He then walked into the kitchen and rummaged through a kitchen drawer. Senior Constable Wynne-Jones had advised the crew that Mr Lewis had no access to firearms after speaking to Ms McIntyre.

81. Mr Lewis then exited a door to the right of the house. Police were unaware of this door before he appeared. Mr Lewis continued to walk to the back of the house and towards Constable Dominick who was by the patio. Mr Lewis was swearing but was not visible to Constable Dominick at this point. Constable Dominick yelled *"mate Taser, this is a Taser get on the ground, this is a Taser get on the ground"*.

82. As Mr Lewis came into Constable Dominick's view, he saw that Mr Lewis was holding two knives (it was later ascertained that there were three knives in total).

83. During this time, Constable Ziemins-Hill, who was around the corner, came running around and saw Mr Lewis. Constable Dominick told Constable Ziemins-Hill *"Mate Jack he's got a knife'*. Mr Lewis was pacing side to side and threw a knife in Constable Dominick's direction. Constable Dominick deployed his Taser, but it missed Mr Lewis and the probe penetrated the timber fence behind Mr Lewis.

84. Constable Ziemins-Hill drew his gun and pointed it at Mr Lewis and yelled *'gun gun gun knife get on the ground*'. Mr Lewis did not get on the ground. Constable Ziemins-Hill said that he saw that Mr Lewis had both arms up in a throwing motion and still had a knife with his arm raised above his head after the Taser was ineffective. Fearing serious injury to him or his partner, Constable Ziemins-Hill fired two shots causing Mr Lewis to fall to the ground. Constable Ziemins-Hill immediately informed the other crews that shots had been fired.

85. It was difficult to see from the BWC footage whether Mr Lewis was advancing on the officers as light from Constable Dominick's Taser shone on him before he was shot. He appears to step back a little as he was taken aback by the light.

86. Constable Ziemins-Hill yelled that shots had been fired and for Mr Lewis to stay on the ground and not to move. Constable Dominick walked over to Mr Lewis and kicked two knives away that were by Mr Lewis' hands. Mr Lewis was still alive.

87. The time from when police arrived at the house to the shooting was approximately six minutes. Mr Lewis was shot within one minute of his threats towards police.

88. The officers who were at the front of the house went to the backyard after the locked gate was kicked in and paramedics were called.

First Aid treatment

89. Constable Dominick and Senior Constable Wynne-Jones were the two main officers who assisted Mr Lewis. Constable Ziemins-Hill assisted by providing lighting. Constable Dominick rolled Mr Lewis into the recovery position. Mr Lewis repeatedly said *'just let me die, please just let me die'* as police endeavoured to help him. Shortly after, he repeatedly said that he was not able to breathe.

90. Senior Constable Wynne-Jones yelled for someone to obtain a tactical first aid kit from the police vehicles. He repeatedly told Mr Lewis *'we have stuff to fix you'*. Constable Dominick repeatedly told Mr Lewis to stay awake and applied pressure to the chest wound. They could not find any exit wounds.

91. Mr Lewis' breathing started to slow. Senior Constable Wynne-Jones applied a bandage to the wounds on Mr Lewis' chest and arm. They placed Mr Lewis on to the right side of his body to get air flow to his left lung. They continued to speak to Mr Lewis and told him *'stay with us'*. Mr Lewis started gasping for air and another officer started cardiopulmonary resuscitation (CPR).

92. Senior Constable Wynne-Jones asked for a resuscitation mask however none could be found on any of the first aid kits. Chest compressions continued and Senior Constable Wynne-Jones performed an expired air ventilation.

93. Officers took turns in performing chest compressions on Mr Lewis for around six minutes until paramedics arrived. Officers then continued CPR as instructed by paramedics.

94. At 7.36pm, Advanced Care Paramedics (ACP) Robert Peach and Maryanne Peach arrived at the scene. ACP Robert Peach observed police providing 'effective' CPR on Mr Lewis. ACP Maryanne Peach heard the request for a resuscitation mask. She told police to disregard the immediate need for a mask and to continue chest compressions. She saw that Mr Lewis was unconscious, had fixed and dilated pupils and a clear airway.

95. The ACPs attempted to establish IV access but were unsuccessful in doing so. ACP Maryanne Peach provided a situation report that Mr Lewis was suffering a cardiac arrest and CPR was in progress. She placed defibrillation pads on Mr Lewis and found him to have a rhythm of pulseless electrical activity (PEA) at a rate of 80 beats per minute.

96. At 7.43pm, Critical Care Paramedic (CCP) Matthew Hill and ACP Michael Dixon arrived at the scene and were briefed by ACP Maryanne Peach on Mr Lewis' condition. CCP Hill observed on the monitor that Mr Lewis' PEA was 30 beats per minute. Medical treatment including the insertion of laryngeal mask, bilateral needle chest decompression, intubation and direct laryngoscopy were provided to Mr Lewis with no positive change. His cardiac rhythm deteriorated to asystole.

97. Mr Lewis' airways were soiled with saliva and what appeared to be gastric contents, which required extensive suctioning. At one point, gastric contents were forced under pressure through a gastric port of the laryngeal mask which resulted in two police officers being sprayed in the face. Those officers were removed from the scene and referred to Rockhampton Hospital for further testing.

98. At 8.03pm, CCP and Senior Operations Supervisor Darren Pirie arrived at the scene and was briefed by CCP Hill. CCP Pirie observed significant management had been provided to Mr Lewis. After approximately 32 minutes of active resuscitation, CPR was ceased. Mr Lewis was declared life extinct at 8.12pm.

99. Constable Ziemins-Hill was separated from the scene by Sergeant Brandt and directed not to speak to anyone. Senior Sergeant Faria spoke to Constable Ziemins-Hill and information provided by Constable Ziemins-Hill was consistent with what was depicted on his BWC. Senior Sergeant Faria seized Constable Ziemins-Hill's gun and Taser.

100. Constable Dominick assisted by providing first aid to Mr Lewis for a short period of time until he was relieved by another officer. Sergeant Brandt also took Constable Dominick to the side of the house and told him not to speak to anyone. Senior Sergeant Faria asked Constable Dominick to take his accoutrements and place them on the ground. Both officers were then transported to Rockhampton Police Station and separated.

Autopsy results

101. On 3 September 2018, an external and full internal post-mortem examination was performed by experienced forensic pathologist, Dr Nigel Buxton. Toxicology, radiology and histology tests were also conducted.

102. Dr Buxton identified the following four major injuries:
    a. Wound in the right lateral abdomen measuring 10mm in diameter;
    b. Wound in the right chest measuring 22 x 10mm;
    c. Wound on the lateral aspect of the right upper arm measuring 10mm in diameter with slight bruising around the edge and small amount of fat extruding; and
    d. Wound on the inner aspect of the right arm with 45mm bruising around it.

10. An incised wound measuring 35mm in length was observed on the back of the left little finger as well as an incised wound 5mm long on the left middle finger. These wounds were examined. The irregular contours demonstrated the possibility that glass rather than a bladed weapon had caused them. It was not possible to determine whether they were obtained because of a defensive or an offensive action.

103. The internal examination showed fresh a bullet wound in the lower right abdomen that passed through and downward perforating the bowel, the mesentery, the superior mesenteric cascade and lodging in the left iliac crest. The wound to the chest showed the bullet had fractured the sixth rib.

104. There was mild degree of oedema in the brain and an old burr hole site was found in the right occipital region. There was no evidence of any significant natural disease that would have contributed to death.

105. Histology results of the brain, heart, kidneys and spleen were otherwise unremarkable apart from mild oedema and congestion on the brain.

106. The CT scan showed the bullet entry in the right chest and the bullet adjacent to the thoracic spine. It also showed what is presumed to be a second bullet adjacent to the left sacroiliac joint.

107. Toxicology testing of vitreous humour showed alcohol to be present at 153mg/100ml. This is equivalent to a blood-alcohol reading of 0.153%. A sample of subclavian blood showed:

- Alcohol 174mg/100ml;
- Diazepam 0.20mg/kg
- Nordiazepam 0.14mg/kg
- Sertraline 0.16mg/kg
- Desmethyl Sertraline 0.27mg/100kg
- Tetrahydrocannabinol (THC) 0.017 mg/kg.

108. Dr Buxton concluded that the cause of death was gunshot wounds to chest and abdomen.

The investigation

109. Detective Sergeant Christine Knapp from the QPS Ethical Standards Command (ESC) conducted an investigation into the circumstances leading to the death. The investigation commenced the next day and Constables Dominick and Ziemins-Hill participated in video walk-through re-enactments. Police also obtained audio recorded statements from the neighbours in the area. Those witnesses who heard the incident provided evidence including hearing a disturbance, police arriving and announcing themselves, a shotgun being mentioned, police warning Mr Lewis and hearing gun shots.

110. Constable Ziemins-Hill was sworn into the QPS on 23 July 2015. Constable Dominick was sworn into the QPS in November 2015. Both constables were stationed at the North Rockhampton Police Station at the time of this incident. Both had completed training relating to the Taser, Pistol, and the Use of Force Online Training Product in August 2018.

111. DS Knapp said that the entry into the yard was authorised under s 609 of the *Police Powers and Responsibilities Act*. That sections authorises entry to a place if a police officer reasonably suspects there is an imminent risk of injury to a person or an offence involving damaging property, or domestic violence has occurred before the officer's arrival. It was apparent that Ms McIntyre had also consented to the police presence.

Situational use of force model

112. The QPS uses the Situational Use of Force Model, Threat Assessment and Tactical Decision Making Process as operational tools to train officers to assist in a confrontational situation that may require them to use force. The Situational Use of Force Model assists police officers to select the most appropriate option(s) to resolve an incident. Section 14.3 of the QPS OPM reminds officers that they should only use the minimum amount of force necessary to resolve an incident, despite having statutory authority to use lethal force against a person in certain situations.

113. Officers are instructed to continually assess threat by considering the level of risk to a person, object or other officers, and having an understanding that there are "high" and "assessed" risks involved in an incident. High risk involves an obvious risk such as responding to a person who is armed. Assessed risk is the consideration given to a response based on an officer's assessment of a person, the situation, information known at the time and the officer's past experiences and training.

Assessment of the use of force by Constables Dominick and Ziemins-Hill

114. Constable Dominick had drawn his Taser as he arrived at the patio. He endeavoured to use his Taser as a minimum force option to try and resolve the incident without causing death and to achieve a better outcome.

115. Constable Ziemins-Hill drew his gun after seeing Mr Lewis was armed with two knives and the use of Taser had been ineffective. To end the threat of serious injury/death to Constable Dominick and himself he yelled for Mr Lewis to drop the knives and fired his gun when Mr Lewis did not drop the knives and started to move forwards.

116. According to Constable Ziemins-Hill, Mr Lewis would have been five to six metres away from him. He believed there was no other option available to him but to use lethal force.

117. DS Knapp engaged Sergeant Ricky Smith, a training officer in the Operational Skills Section at the QPS Academy to provide an expert opinion on Constable Dominick's decision to use his Taser and Constable Ziemins-Hill's decision to use his gun, and whether these actions in all the circumstances were justified. Sergeant Smith has been a QPS training officer since February 2005.

118. Sergeant Smith concluded that the action of Constable Dominick in deploying his Taser was reasonable and appropriate. The action of Constable Ziemins-Hill to use lethal force was also considered appropriate by Sergeant Smith considering the imminent threat of grievous bodily harm and death posed by Mr Lewis.

119. Sergeant Smith explained that Mr Lewis' acts with the knife could reasonably be construed as being offensive in nature and would cause a reasonable person to form a genuine belief that they were going to either suffer grievous bodily harm or die.

120. Sergeant Smith was of the belief that Constables Dominick and Ziemins-Hill's actions were legally defensible and there were not in breach of policy or legislation. He also stated both officers fulfilled their duties to provide necessaries of life.

121. After considering all the evidence, I agree that if Mr Lewis had not been shot by Constable Ziemins-Hill he would have proceeded to throw another knife or attack the officers with the knives in his possession at the time.

122. The ESC investigation concluded that the actions of Constables Dominick and Ziemins-Hill were lawful, authorised and justified. It also found there was no misconduct displayed by any of the officers involved and further concluded that no disciplinary proceedings were warranted.

123. DS Knapp was asked at the inquest whether the attending police should have engaged other options such as SERT, negotiators or a medical professional. In her opinion the incident evolved too quickly for any of those options to be engaged. Her view was that the entry to the yard was justified because of the need to get "eyes on" Mr Lewis to isolate and contain. She also noted Inspector Allen's opinion.[23]

124. Inspector Allen was asked to provide an opinion about the appropriateness of the police decision to enter the backyard of the residence and details of the training provided to officers with respect to Active Armed Offenders and Incident Command. He said that there is no restrictive direction that police must or will use any particular use of force option when attempting to resolve a situation - for example police are not trained or expected to always use lethal force when they identify a person with a knife, or use a baton when they identify a combative violent person. Officers are expected to make decisions regarding the resolution of situations using tools such as the Situational Use of Force Model 2016, and the threat assessment and tactical decision making process.

125. Officers are expected to use the minimum amount of necessary force to resolve situations, if any force at all, and are accountable for their choices, decisions and assessment of that situation as an individual decision for which each officer will be held accountable.

126. Inspector Allen said that the threat assessments of Constable Dominick and Constable Ziemins-Hill were conducted in accordance with established QPS policy, training and doctrine. He said that the officers' decision to move into the back yard was consistent with attempts to locate, engage and contain Mr Lewis. There had been minimal contact with Mr Lewis and there was little information about his intentions, whether he had self-harmed or other information to enable a continuous threat and risk assessment. While the decision to enter the back yard partially limited the officers' ability to withdraw, he considered there was "ample room in the back and side yard of the property which would have afforded the officers avenues to create distance or seek some cover".

Other issues arising out of the ESC investigation

Issue with Police Communications regarding flags/warnings relating to Mr Lewis

127. A triple zero call made by Mr Wieck was answered by a communications call-taker from Ipswich. Information was then provided by the call-taker to North Rockhampton police communications. The incident was described as DV incident and was given Priority 2, which meant officers were to proceed under lights and sirens as there was danger of a serious injury or death to a person.

[23] Ex B25

128. The incident was identified as 'partial' which meant that the call-taker in Ipswich was still on the phone to Ms McIntyre's son trying to get further details. At the same time, he was sending the job to Rockhampton communications through the QLD Computer Aided Dispatch (QCAD) system. The job was approved by Sergeant Mark Dean who was the Communications Supervisor at the time. In approving the job Sergeant Dean did not see any flags/warnings for Mr Lewis.

129. After approval, the job was provided to the dispatcher and then to the crews. Senior Constable Jennifer Henry, a communications room operator, was the dispatcher on the night. Her job was to provide as much information about Mr Lewis and any previous incident at the address to the crews attending. When Senior Constable Henry looked up Mr Lewis' details the address attached to his name was incorrect. Senior Constable Henry did not find any flags or warnings about Mr Lewis.

130. Zanda Clews, a Civilian Radio Operator on the night conducted further searches and found several flags/warnings for Mr Lewis. The flags/warnings related to Mr Lewis' current charges before the Court for assault/obstruct/spitting on police, that he had an extensive criminal history in Victoria, the current DV order against Mr Lewis and that he was unsuitable to hold a weapons licence. Ms Clews advised Senior Constable Henry of this and told her to advise the police crew. The information is supposed to be provided to first responders on their way to the address.

131. Senior Constable Wynne-Jones recalled receiving the above flags/warnings when he was already at the address but by that time, he was not able to fully pay attention to them as *'there was just too much information overload by that stage'*.

132. According to Sergeant Dean and Ms Clews, the triple zero call taker should have added this information when they communicated the job to Rockhampton. However, given that Ms Clews found the flags/warning through further searches this is something that Senior Constable Henry could have also found in the system. Senior Constable Henry could not recall whether she broadcast the information to the attending crews about the flags/warnings.

133. Sergeant Brandt said that if he was aware that Mr Lewis had a mental illness it would not have changed his consideration of the use of force options. That would become relevant in the negotiation phase.

Issue with the QLite Device on the night of the incident

134. On the night of the incident, there were issues with the QLite device. QLites are devices issued to police officers and provides information like flags/warning mentioned above. This is in addition to Police Communications providing first responders with the flags/warnings. However, on this occasion Senior Constable Wynne-Jones advised he had trouble accessing the QLite. He was not able to access the information and was later provided the flags/warnings when he was already at the address.

135. Senior Constable Wynne-Jones stated that it would have been beneficial for him to be verbally provided the flags/warning by Police Communications so that he and his partner could concentrate on the road en route to the incident. Senior Constable Wynne-Jones stated that he did not believe that receiving the flags/warnings about Mr Lewis would have changed his response unless he had to go inside the house (i.e., to give first aid to Mr Lewis if he self-harmed). He said he would have been more cautious as they would have all been at a greater risk.

136. Senior Constable Wynne-Jones stated issues with QLite devices are a rare occurrence.

Issue regarding the lack of resuscitation mask in the Tactical First Aid Kit

137. After Mr Lewis was shot, police attended to him to provide first aid. When Mr Lewis' breathing slowed down Senior Constable Wynne-Jones asked for a disposable resuscitation mask, but none could be found in the available first aid kits. Senior Constable Wynne-Jones performed Expired Air Resuscitation to get Mr Lewis' lungs going again. When he heard movement in Mr Lewis lungs, compression was continued by another officer.

138. Senior Constable Wynne-Jones stated that a resuscitation mask was usually in the first aid kits however none could be found at the time of this incident.

Family Concerns

139. Mr Lewis' brother who lived in New Zealand raised concerns with police when they spoke to him a few days after Mr Lewis' death. His concerns revolved around the media portraying Mr Lewis as a bad person, why were there so many police at the address as well as concerns about how the head of 'CIB' had dealt with Mr Lewis' death. He said that his mother was told by an officer that *'when police shoot, they intend to kill',* which upset his mother.

140. Mr Lewis' brother also raised concerns about whether the police officer Mr Lewis previously had made a complaint about following his March 2018 arrest was present on the date of his death. Constables Dominick and Ziemins-Hill had not previously encountered or had dealing with Mr Lewis.

Conclusions on inquest issues

The appropriateness of the actions of the attending police officers, including the decision by the police to enter the backyard of the residence.

141. Whether the actions of the officers were appropriate should not be determined retrospectively. In my view, it is necessary to consider this question objectively from the perspective of the officers at the time of the incident.

142. The officers who attended the scene gave evidence in the inquest of their assessment of the circumstances they faced on arrival and as events unfolded. It was clear that the attending officers engaged in ongoing risk assessments.

143. The confrontation between the officers and Mr Lewis was captured on BWC. It is evident that Constable Ziemins-Hill had given repeated warnings for Mr Lewis to drop the knife and get on the ground. In the circumstances, it was reasonable for Constable Ziemins-Hill to form the belief that he or Constable Dominick would have suffered serious injury or death if Mr Lewis was not shot.

144. Constable Dominick made an effort to use nonlethal force by way of the Taser to de-escalate and mitigate the risk. Unfortunately, Mr Lewis had continued to advance on Constable Dominick with two knives in his possession after the effort to Taser him was unsuccessful. He was only 5-6 metres away from the officers at that time.

145. I accept the submissions from Counsel Assisting that Constable Ziemins-Hill acted appropriately in firing his weapon in response to the threat posed by Mr Lewis. I also agree that Constable Ziemins-Hill's application of lethal force was appropriate in the circumstances.

146. Mr Lewis' mental health was deteriorating in the lead up to his death. He was prescribed medication just three days before his death. He was advised to return for assistance from AODS the day before he died. Mr Lewis was aware that his drug and alcohol consumption triggered negative behaviours. This was evident from his previous help seeking after consuming drugs. Unfortunately, Mr Lewis did not seek help in the hours prior to his death. Instead, he had been drinking during that time.

147. While the investigation identified several issues with the QLite device, police communications and the absence of a resuscitation mask, those were not outcome changing. The flags available through police communications were limited to violent past offences, domestic violence history and weapons licensing suitability.

148. Senior Constable Wynne-Jones stated that his response to the incident would not have changed had he received the flags/warnings about Mr Lewis unless police were required to enter the house.

149. Police provided first aid to Mr Lewis. The need for the resuscitation mask became apparent when Mr Lewis' breathing slowed down. This was close to when paramedics arrived. Despite the absence of the mask, Senior Constable Wynne-Jones performed effective resuscitation.

The decision to enter the yard

150. Senior Constable Wynne-Jones' direction to Constables Dominick and Ziemins-Hill to enter the backyard when they arrived as opposed to waiting, or deploying to a safer location for containment purposes, was explored at the inquest. Senior Constable Wynne-Jones knew Mr Lewis was the only person in the house, possibly armed and was not an immediate threat to anyone but himself.

151. The police action of entering the backyard may have escalated Mr Lewis' level of aggression. On one view, as the incident was contained there was no need for police to enter the yard.

152. It was submitted by counsel for Ms Lewis that the decision to enter the backyard was not considered "ideal" by Inspector Allen as it limited the capacity of the Constables to withdraw. It was also noted that Sergeant Brandt indicated that the purpose of entering the yard was to conduct initial enquiries and to get "eyes on". It was submitted that the decision to enter the yard inhibited the capacity of the QPS to move from isolation to containment, where Mr Lewis might have been able to wander around the backyard during a period of negotiation.

153. Counsel for Ms Lewis submitted that the communication techniques deployed by the Constables in telling Mr Lewis to "come outside and put his hands up" resulted in an escalation of his behaviour as he responded directly to that challenge. This was contrasted with the communication style of Senior Constable Wynne-Jones, who was using Mr Lewis' first name and checking on his welfare. Mr Lewis made no response to that communication. It was submitted that the inference could be drawn that the challenge changed his behaviour.

154. Counsel for Ms Lewis also submitted that Constable Wynne-Jones indicated that there was insufficient use of the mental health coordinator role in Rockhampton, and there was a lack of reference to the flags relating to Mr Lewis' mental health history. He noted that Sergeant Brandt was preparing to transition to the negotiation phase after Mr Lewis was contained. It was submitted that apart from Sergeant Brandt there were no genuine enquiries made about Mr Lewis' mental health status.

155. It was submitted for Ms Lewis that I should find that the conduct of the officers viewed collectively was less than appropriate. There were objective features that should have alerted those responsible to proceed with more caution, allowing the creation of time and space for the officers and the establishment of a broader cordon. It was submitted that the entry to the backyard escalated the incident and there were opportunities to leave the backyard after the police had gained situational awareness.

156. I accept that the triple zero calls did indicate that Mr Lewis may have been suicidal, was agitated and may have been experiencing mental health issues.

157. Guidance for officers on Incident Command is provided in the QPS Operational Procedures Manual. The OPM outlines the establishment of an Incident Action Plan (IAP) as the situation calls for it. An IAP assists in *'defining a situation, the setting of the plan's objectives, the allocation of tasks and the coordination of staff'*.[24]

158. An IAP could be a mental process for immediate decision at an incident scene depending on the scale, complexity, time factors and risk of the incident. The IAP is a course of action to accomplish one or more of the following objectives collectively known by the acronym ICENRIRE (Isolate, Contain, Evacuate, Negotiate, Resolve, Investigate, Rehabilitate, Evaluate).

[24] OPM 1.12.7

159. At most incidents, the primary consideration for the Police Forward Commander and first responders is to Isolate, Contain and Evacuate (ICE). The remaining objectives of ICENRIRE can be addressed as the situation needs or dictates. Putting these in action can minimise the risk of potential harm from occurring and allow the Forward Commander time to put into action the remaining objectives as required.[25]

160. As the most senior officer on the scene when police first responded to this incident, Senior Constable Wynne-Jones was in command and responsible for determining the initial actions of police. Command and the responsibility for decisions transferred to higher ranking officers as they arrived at the incident. In this case that was Sergeant Brandt.

161. Incidents are contained to minimise the loss of evidence and escalation of the incident, prevent or minimise the risk of the offender escaping and being mobile, minimise contamination of the crime scene or allow for agencies to focus on how to deal with the incident. These are achieved through the deployment of cordons or considering other possible scenarios that may arise.[26]

162. As discussed in the OPM, there are several options available to an offender in a siege situation, including for an offender to project threat outwards as Mr Lewis did in using knives to confront police.

163. Constables Dominick and Ziemins-Hill established a cordon in the backyard as opposed to using a neighbouring property. Constable Dominick was aware of utilising ICENRIRE and believed it was his job to isolate and contain the incident, and establish a line of communication with Mr Lewis. Similarly, Senior Constable Wynne-Jones said in his interview that the situation needed to be contained given the information that Mr Lewis was by himself in the house.

164. Sergeant Brandt arrived at the scene around four minutes after the first responders. Constables Dominick and Ziemins-Hill were at the back of the house by then. Within a minute or so of Sergeant Brandt's arrival, Mr Lewis made the threat regarding the shotgun and Sergeant Brandt commented that Constables Dominick and Ziemins-Hill needed to be pulled out of the yard. However, within a minute of this occurring, Mr Lewis came out of the house and confronted the two officers at the back of the house.

165. Constables Dominick and Ziemins-Hill stated that by the time the threat was made, they did not feel it was safe for them to retreat and the best outcome was to try and get cover. They would have had to jump back over the fence to get out of the yard.

166. Constable Wynne-Jones' reasoning for asking Constables Dominick and Ziemins-Hill to cover the backyard was to have "eyes on" Mr Lewis. He was aware that Mr Lewis was alone in the house and was possibly armed with knives from the kitchen. At one point Constable Wynne-Jones indicated that Mr Lewis may have also escaped prior to police attendance. This comment was made after he asked Constables Dominick and Ziemins-Hill to go to the back of the house.

[25] OPM 1.12.7
[26] OPM 1.12.7

167. It is clear from the evidence that the incident transpired over a short period of time. Police were required to respond to a dynamic situation which escalated quickly because of the actions of Mr Lewis.

168. The attending police, at the direction of Senior Constable Wynne-Jones and then Sergeant Brandt, implemented an Incident Action Plan. This consisted of isolating and containing Mr Lewis while attempting to engage with him. It was unknown if he was in the residence, or whether he may have self-harmed and required assistance, when the decision was made for officers to enter the backyard. Senior Constable Wynne-Jones told the inquest that he conducted a risk assessment which took into account the safety of people in the vicinity, the safety of officers and the safety of Mr Lewis. He said that the cordon could have been moved further back after more officers became available.

169. The evidence of Sergeant Brandt was that to establish a full inner and outer cordon at least 12 officers would be required. However, Inspector Allen thought that seven would be sufficient. He also said that it was not unusual for country policing to be carried out by one or two officers and necessary adjustments had to be made to the approach in those circumstances. The submission from the Commissioner indicated that the diagrams relating to cordons in the OPM were for the purpose of guidance only.

170. On balance, I agree with the submission of counsel assisting that the decision to enter the yard was reasonable in the circumstances. Both Constables understood that they were required to get “eyes on” Mr Lewis to ensure there was containment of the threat posed. Given the information that was known to police at the time about the events that had transpired shortly before they arrived at the scene coupled with the layout of the residence, including the fencing and adjoining properties, I am satisfied that this decision was consistent with police policies and procedure and was necessary given the unknown threat posed.

171. I accept the evidence of Inspector Allen that those actions were necessary to gain further situational awareness and information to be able to make the necessary continuous risk and threat assessments. As Inspector Allen said, the police officers had to choose whether to stay in the yard or “accept a level of risk and do the job”. I also accept Inspector Allen’s evidence that the request for Mr Lewis to come out of the residence was appropriate as entering the residence would have been extremely dangerous. Mr Lewis had access to weapons inside the house and had a detailed knowledge of the layout of the house.

172. After Mr Lewis engaged with police by way of threat, including that he had a shot gun, there was a plan to remove the Constables from the yard. However, the Constables took cover by standing behind concrete pillars and continued to provide situational reports of Mr Lewis’ actions inside the residence. I accept the evidence from the Constables that it was not safe to retreat over the front gates, particularly after Mr Lewis indicated he was in possession of a firearm.

173. I also accept that the structure of the backyard and the height of the fencing did not allow for an effective cordon to be established with the Constables located in adjoining properties as opposed to inside the perimeter. There was initially an insufficient number of officers for an effective cordon to be established outside the fence line.

174. In addition, it is unlikely that the presence of the police officers within the backyard was outcome changing. Mr Lewis elected to arm himself with knives and confront the police officers which led to the application of fatal force. It is possible, considering his earlier statements to Ms McIntyre and subsequent request that police officers let him die, that he had little regard for his own well-being at that time.

175. I agree that it was important, having regard Mr Lewis' assault on his partner and her son, to ensure that he had not left the residence or self-harmed and required assistance. Had the situation evolved into a prolonged siege it may have been possible to safely extract Constables Dominick and Ziemins-Hill. The reality was the situation was brought to a head by Mr Lewis.

176. In my view, it was not possible in the five or six minutes over which this incident evolved for other measures such as the engagement of a negotiator or the Mental Health Liaison Service to be used.

The sufficiency of the training provided to officers in responding to a similar incident, particularly involving an armed offender.

177. Inspector Allen said that OST training is a yearly mandatory requirement to be completed by all police officers. OST training is delivered to regionally based OST instructors who attend yearly curriculum update workshops. Regionally based part time instructors are then tasked with the facilitation of OST training to all sworn police officers. The same curriculum is also reflected in recruit training.

178. Each of the officers who gave evidence at the inquest was asked about the training they were provided by the QPS.

179. Senior Constable Wynne-Jones said he had received incident command training prior to the April 2018 Commonwealth Games. He said that he had also received training in responding to mental health incidents including the engagement of negotiators. He said that in this incident a negotiator would not have been called until the situation was contained.

180. Sergeant Brandt said that he was familiar with the QPS situational use of force model and the principles of situational containment. When undertaking a risk assessment, he considered "person, action and place". He had received incident command training 4-5 years prior to the inquest. He was familiar with incident action planning and had also undertaken QPS mental health training via an online course.

181. Constables Dominick and Ziemins-Hill told the inquest that they had received training in the situational use of force model at the Police Academy and this was refreshed in annual OST training. Both had undertaken mental health awareness training. Constable Dominick had also undertaken incident command training after this incident.

182. It was submitted on behalf of Ms Lewis that more in depth face to face training on mental health issues should be carried out. Inspector Allen said that the QPS carried out many training scenarios involving persons who are in crisis and armed – such as Mr Lewis. He said that police officers regularly encounter these scenarios. It is the QPS' core business, and officers are trained to bring a humane rather than a tactical mindset to these situations.

183. Inspector Allen said that officers are trained to adopt a slower approach to urgent situations, enabling a more planned response. This was facilitated by the design of the Bob Atkinson Operational Capabilities Centre at Wacol. The Commissioner also submitted that this was adequately covered in initial training at the Academy. Firearms training also involved a consideration of mental health issues and tactical communication skills are central to that.

184. Chapter 6.6.13 of the OPM deals with mental health intervention coordination and training. The OPM notes that the QPS can initiate a request for consultation with Queensland Health to prevent or lessen the risk of harm to the person or others. Officers are required to seek Queensland Health advice where they identify that the call for service may fall within the definition of a mental health incident.

185. Recommendation 12 from the 2017 recommendations following the inquest into the deaths of five men shot by police was that the "*Queensland Government conduct a comprehensive review of the mental health intervention portfolio/project (MHIP) to ensure the revitalisation of the MHIP as recommended by the violent confrontations review (VCR) recommendation 2, and its sustainability*".

186. Recommendation 14 from that inquest was that the "*Queensland Police Service retain mental health training as a core component of the recruit and first year constable training programmes"*. I am satisfied that the QPS has made substantial progress in the implementation of those recommendations. [27]

187. After considering the evidence of Inspector Allen, I am satisfied that the training given to police officers with respect to the situational use of force model, armed offenders, threat and risk assessments, as well as incident command and dealing with those in mental health crisis is sufficient to ensure that officers are trained effectively to respond to dynamic and challenging incidents such as that confronted on the night of Mr Lewis' death.

The sufficiency and appropriateness of the investigation conducted by Ethical Standards Command

188. The factual circumstances leading up to Mr Lewis' death were thoroughly and professionally investigated by Detective Sergeant Knapp from the Ethical Standards Command. Those were detailed in the coronial report and associated annexures. The factual circumstances as set out in the report were not in contention at the inquest. Neither was the adequacy of the investigation.

[27] https://www.justice.qld.gov.au/__data/assets/pdf_file/0011/577343/qgr-policeshootings-20211209.pdf

Findings required by s. 45

189. 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. As a result of considering all the evidence, including the material contained in the exhibits, I make the following findings:

Identity of the deceased – Daniel Patrick Lewis

How he died – Mr Lewis had a significant history of addiction to alcohol and other substances which had affected his mental health, as did an acquired brain injury.

On the day of his death, he had assaulted his partner and her son at his partner's home, where he had been living for several months. Police officers were called to attend the incident following a 000 call. The first police crew arrived at the property at around 7:20pm on 31 August 2018.

Mr Lewis refused to come out of the property. After two police officers went into the backyard of the property, he informed officers that he had a shotgun. Soon after, Mr Lewis came out of a side door armed with three knives. He threw one of knives at a police officer.

Mr Lewis repeatedly ignored calls from police to drop the knives. An attempt to immobilise him with a Taser was unsuccessful. After Mr Lewis was poised to throw another knife at the police officers and came within 5-6 metres of them, he was shot by a police officer acting in the course of his duties.

Place of death – Geoff Wilson Drive, Norman Gardens, Queensland

Date of death– 31 August 2018

Cause of death – Gunshot wounds to the chest and abdomen

Comments and recommendations

190. A specific issue considered at this inquest was whether any preventative changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice. Any comments must be connected with the death investigated.

191. I have considered the matters for potential comment identified by Mr Lewis' mother and the QPS response to those matters. I do not consider that there are any useful recommendations that I can make connected with Mr Lewis' death to prevent deaths from happening in similar circumstances in the future, or would otherwise contribute to public health and safety or the administration of justice.

192. I extend my condolences to Mr Lewis' mother, siblings and children. It was clear from the statement that his mother read at the conclusion of the inquest that he was deeply loved, and the family share many positive memories of their times with him.

193. I close the inquest.

Terry Ryan
State Coroner
BRISBANE