# CORONERS COURT OF QUEENSLAND

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Jesse Aaron Kermode** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | BRISBANE |
| FILE NO(s): | 2018/4149 |
| DELIVERED ON: | 3 June 2022 |
| DELIVERED AT: | Brisbane |
| HEARING DATE(s): | 1 and 20 December 2021 |
| FINDINGS OF: | Terry Ryan, State Coroner |
| CATCHWORDS: | Coroners: inquest, death in custody, police shooting, edged weapon, avoiding being put into custody, mental health, parole supervision. |

REPRESENTATION:

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| Counsel Assisting: | Ms Rhiannon Helsen |
| Sergeant Jude<br>Senior Constable Robertson<br>Constable Rettke: | Mr Calvin Gnech, Gnech and Associates |

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| Commissioner of Police: | Ms Navina Thirumoorthi (QPS Legal Unit) |
| Queensland Corrective Services: | Ms Amanda Bain (Crown Law) instructed by QCS Legal and Strategy |
| West Moreton Health: | Ms Prudence Fairlie |
| Metro South HHS: | Ms Fiona Banwell |

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## Introduction

1. Jesse Aaron Kermode was just 24 years of age. He died at the Ipswich Railway Station after he was shot by police officers on 16 September 2018. Just after 4:00pm police officers attended the Ipswich Station to intercept Mr Kermode after receiving several reports of a male brandishing a knife in the Ipswich CBD. Police located him seated on a train.

2. When Mr Kermode, who was affected by methylamphetamine, saw officers enter the train carriage he produced a knife which he waved in a threatening manner as he walked towards the officers. They retreated from the carriage onto the platform. Despite repeated calls to drop the knife, Mr Kermode continued to advance at police. He was subsequently struck by 6-7 bullets when officers discharged their weapons.

3. While Mr Kermode's death was investigated as a 'death in police operations' under the *Coroners Act,* as he died while avoiding being placed in custody the death is more appropriately characterised as a death in custody.[1] In those circumstances an inquest was required.

## The inquest

4. Following a pre-inquest hearing on 1 December 2021 the hearing of evidence in relation to Mr Kermode's death took place in Brisbane on 20 December 2021. All statements, records of interview, photographs, body worn camera footage and other materials gathered during the investigation were tendered at the inquest.

5. The following witnesses gave oral evidence at the inquest:

    - Senior Sergeant Christy Schmidt
    - Senior Constable Stuart Robertson
    - Constable Dale Rettke
    - Sergeant Jonathan Jude
    - Acting Senior Sergeant Brendan Werth

6. In addition to the findings required by s 45 of the *Coroners Act 2003*, the following issues were considered at the inquest:

    - Consideration of the circumstances leading up to the shooting of Mr Kermode by police on 16 September 2018, including his mental health treatment and engagement after his release from custody in March 2017, and his engagement with Queensland Corrective Services after his release from custody;

[1] *Coroners Act 2003*, s 10(1)

- Whether the police officers involved acted in accordance with the Queensland Police Service (QPS) policies and procedures then in force and whether their actions were appropriate;

- Whether the training provided to officers in responding to a similar incident is sufficient.

7. I consider that 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*. I received helpful submissions from those represented at the inquest, which have assisted in the preparation of these findings.

## The evidence

### *Personal circumstances*

8. For a short time before his death, Mr Kermode had been living at Riverview with a friend and that friend's partner. He had previously lived with his grandparents in South Brisbane after release from prison in 2017. He had sought assistance for a long-standing drug problem that started when he was in high school. He was single and unemployed.

9. Mr Kermode had a significant mental health history, and according to his parents, had been addicted to drugs for some time. He had experienced drug induced psychosis as a result. In the weeks prior to his death, it was suspected that he had resumed using methylamphetamine.

10. Mr Kermode also had a significant criminal history in Queensland, which included convictions for robbery with violence, stealing, fraud, public nuisance, and drug related offences.[2] In 2017, he served time in custody and was the subject of a probation order following his release. This order was in effect at the time of his death.

11. In June 2018, Mr Kermode was found to have breached his probation order by committing a minor public nuisance. He was sentenced to the rising of the court.

12. On 10 July 2018, Mr Kermode's grandmother raised concerns with Community Corrections about his mental health. She reported that he was talking about God and referring to himself as being "God's leader". However, she also indicated that she did not think there was a risk he would harm anyone, and she was encouraged to speak to his treating doctor.[3]

[2] Ex C15
[3] Ex H2

13. On 16 August 2018, after a period of supervision with Brisbane South Community Corrections, Mr Kermode reported to Ipswich Community Corrections for an initial transfer interview. This was his last known contact with QCS.[4] At that time he was speaking positively about his return to church and described other help-seeking behaviour. While some of his behaviour seemed "odd" to his new case manager it was not considered necessary to escalate those concerns.

14. On 13 September 2018, Mr Kermode failed to report to Community Corrections as part of his probation order. This was one business day before his death, and I accept that QCS staff had insufficient time to follow up Mr Kermode after this failure to report.

***Mental Health History***

15. Mr Kermode had received treatment in the Mental Health Unit at West Moreton Health and the Princess Alexandra Hospital in relation to paranoid schizophrenia. The records suggest that this had been largely treatment resistant. In addition, Mr Kermode had a long-standing substance use problem, and regularly used cannabis and amphetamines intravenously. He had been referred to Alcohol Tobacco and Other Drugs Services (ATODS) to assist in this regard.

16. In June 2012, at the insistence of his family, Mr Kermode presented to the Princess Alexandra Hospital Emergency Department. It was feared that he may harm his father, whom he had threatened. The Queensland Ambulance Service (QAS) were called to take him to the Emergency Department. The intake summary noted that he acknowledged he had anger management issues and used cannabis as well as speed. He had been referred to ATODS and was scheduled to commence engagement the following week. It was noted that he was admitted with schizophreniform psychosis. He described a five year history of worsening auditory hallucinations, which he thought may have started because of substance misuse.[5] He was discharged to the care of his grandmother at Moorooka.

17. In July 2012, Mr Kermode was brought into the Ipswich Emergency Department by the QPS after punching his fist through a glass window at home. He asked for a psychiatric review because he wanted his medication reviewed. He reported that he was taking Risperidone that had been effective in managing his auditory hallucinations, but he felt he needed a higher dose in the morning. Following discharge, a referral was made to West Moreton Acute Care Team for follow-up. His wounds were sutured at the PAH on 9 July 2012. He reported that he was homeless and had ongoing distress about auditory hallucinations.[6]

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[4] Ex H2
[5] Ex D1
[6] Ex B75

18. In March 2013, Mr Kermode was brought to hospital by the QAS in the context of an IV amphetamine binge lasting seven days with no sleep and no compliance with medication. He had reported command auditory hallucinations to inject himself with weed killer. Consideration was given to using depot medication.

19. In July 2013, Mr Kermode's category of involuntary treatment order was changed to a community category. In August 2013, Mr Kermode was admitted after concerns from his mother that he was experiencing paranoia. He expressed feelings that his family was against him. Drinking alcohol seemed to increase his delusional thinking. As of October 2013, he was self-presenting for depot medication.

20. In June 2014, Mr Kermode was in rehabilitation at Questcare in Ipswich in relation to his history of substance abuse. His diagnosis of drug induced psychosis was confirmed. While he was largely compliant with treatment, he required great prompting to attend appointments.

21. His ITO was revoked in September 2014 and Mr Kermode continued to be treated voluntarily. He continued to reside at Questcare, with a plan to remain in treatment until December 2014. He had ceased the depot medication in December 2014 after becoming a voluntary patient. He was also closed to the Continuing Care Team at Ipswich.

22. In June 2015, Mr Kermode self-presented at the PAH. He was not on antipsychotic medication. It had been withdrawn after a period of abstinence. Mr Kermode complained of feeling depressed and anxious and reported suicidal ideation in the context of the negative effects of resuming ice use.

23. In August 2015, Mr Kermode called QAS as he was suffering from auditory hallucinations and was requesting a mental health review. He had been placed back on Risperidone but had not been compliant with his medication for 2-3 weeks.

24. In April 2016, a recommendation for assessment was made in relation to a major depressive episode in the context of schizoaffective disorder with chronic treatment resistant psychotic symptoms. It was noted that Mr Kermode required immediate assessment for medication review.

25. In November 2016, a further recommendation for assessment was completed in relation to schizoaffective disorder, with treatment resistant symptoms. Mr Kermode was reportedly experiencing command hallucinations to kill himself. It was noted in the progress notes that he had continued to deteriorate over the past few weeks and was experiencing intense psychotic symptoms and depressed moods. It was noted that he required inpatient treatment.

26. In February 2017, Mr Kermode was in prison at the Arthur Gorrie Correctional Centre and was subject to psychiatric review. He was medicated with clozapine, sertraline and hyoscine hydrobromide. His schizophrenia was in remission and no acute psychotic symptoms were noted.

27. Mr Kermode would suffer from increased auditory hallucinations when he was not compliant with his medication and was abusing illicit substances. It was noted that he had a risk of his mental and physical health deteriorating when he was unmedicated, with an ongoing high risk of substance misuse. He continued to be at risk of relapse of psychosis and permanent deterioration in his mental state and cognitive functioning.

28. In March 2017, following his release from prison Mr Kermode was referred to the Woolloongabba psychosis clinic for follow up. His diagnosis at that time was treatment resistant schizophrenia and he was being treated as a voluntary patient. He was commenced on clozapine and denied any mood or psychotic symptoms. By July 2017, concerns were expressed that he may not be fully compliant with his clozapine.

29. In August 2017, Mr Kermode confirmed that he had not taken clozapine for around four months. However, he presented well and there was no evidence of any psychotic symptoms. It was agreed that the mental health service would monitor his mental state and consider introducing an alternative antipsychotic if there was any sign of deterioration in his mental state.

30. On 31 August 2017, police took Mr Kermode to the PAH after he was found running in front of cars. He reported that someone had been murdered and was trying to get help. This deterioration in his mental state was said to have been associated with amphetamine use. He was discharged from the Emergency Department with follow up arranged with the PAH community mental health service and the drug and alcohol service.

31. From October 2017 to March 2018 numerous attempts were made by Mr Kermode's case manager to contact him. He did not have a functioning phone for part of that time. In February 2018, Mr Kermode informed his caseworker that he did not want to engage further with the community team. Further attempts to engage or contact him were unsuccessful. He was advised that if no contact was made, he would be closed to the service. In April 2018, it was concluded that he had disengaged from the service and was "lost to follow up" and Mr Kermode was advised that his care would be transferred to his General Practitioner.[7]

[7] Ex D2, p 88

### *Events leading up to the death*

32. Mr Kermode's movements on 16 September 2018 were captured on CCTV footage from railway stations, trains and shopping centres, together with police body worn camera footage.[8]

33. Mr Kermode travelled from the Redbank Railway Station to Redbank Plaza Shopping Centre at around 12:30pm. Just before 1:00pm, he entered Big W where it is suspected he took a pack of six steak knives. A short time later, Mr Kermode was observed near the KFC store at the shopping centre kicking at cars, yelling and screaming.

34. At 1:17pm, Mr Kermode was seen near the Redbank Railway Station. CCTV footage showed him holding the set of packaged knives in his hand and he appeared to be waving a knife around. While at the station, Mr Kermode was reportedly rambling and had a verbal interaction with a civilian witness. He then boarded the train at 1:40pm.

35. After exiting the train at Riverview Station at around 2:00pm, he returned to his residence at Riverview. He spoke to his friend's partner and told her that '*everything's free*'. He said that he tried to get food without placing it in his bag. However, security tried to get him so he '*went to Big W and got a knife and was gonna stab someone*'. His friend's partner reported feeling scared. While it appeared that Mr Kermode was largely speaking to himself, he did produce the knife.

36. At around 2:30pm, Mr Kermode again left his residence and went to the Riverview Station where he boarded the Ipswich train. He spoke to a female passenger during this trip. He exited the train at the Ipswich Station just after 3:00pm.

37. After leaving the Ipswich Station, Mr Kermode followed three skateboarders, who were unknown to him, as they walked down Bell Street towards Bremer Street.

38. The three skateboarders went to the old mall car park on Bremer Street. They were approached by Mr Kermode, who initially asked for directions before producing a serrated steak knife and asking whether they knew who he was, and why they were playing his game.[9] Mr Kermode reportedly stated that he was a "Holy Spirit".[10] He walked away after a short time still holding the knife. It appeared that he was affected by drugs at the time, as his speech would go from normal to fast "really quickly".[11] The skateboarders informed a female stationmaster of the encounter.

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[8] Ex E11, E12
[9] Ex B28 [7]
[10] Ex B63.1, [14]
[11] Ex B28 [10]

39. At 3:08pm, Mr Kermode was seen walking along the Bradfield Bridge towards Riverlink Shopping Centre. He seemed to be talking to himself.

40. At 3:12pm, the Police Communications Centre created a job in relation to an 'Armed Person' following a call from one of the skateboarders. The details provided were that the male had approached the skateboarder and his friends asking where the car park entry was. The male then left and returned a short time later. He said that his name was 'Jesse' and that they should not be using his name. He produced a knife from his jacket. It was reported that the male was affected by drugs.

41. At 3:13pm, Mr Kermode went to the Riverlink Shopping Centre. At around 3:30pm, Mr Kermode entered Woolworths in the shopping centre. He produced a knife to the shop attendant when he was asked to pay for a plastic shopping bag.

42. At 3:41pm, Mr Kermode returned to the Bradfield Bridge from the Riverlink Shopping Centre with the Woolworths plastic bag and a bottle of water in his hands. Mr Kermode then travelled to the Ipswich Station by walking through the Ipswich Mall before traveling down Brisbane Street and Bell Street. At 3:53pm, he entered the Ipswich Railway Station.

43. At 3:54pm, a further Police Communications Centre job was created in relation to an 'Armed Person', as it was reported that a male had pulled a knife on a female employee at the cash register in Woolworths after he was refused a bag after objecting to paying 15 cents. He reportedly produced the knife and decamped.

44. At 3:59pm, the Ipswich Safe City monitoring program advised police that the male with the steak knife (Mr Kermode) had exited the Ipswich Station at 3:00pm and was now back at the station where it appeared that he intended to catch a train within the next 10 minutes.

45. At 4:03pm, Ipswich General duties crew PM404, Constable Rettke and Constable Robertson[12] were assigned to respond to Job 2458, which they proceeded to Code 3.[13]

46. At 4:05pm, the Comco at PCC called Queensland Rail, who agreed to hold the train. The job was upgraded to a Code 2 and PM404 were advised. At 4:06pm, Ipswich Police shift supervisor PM400, A/Sergeant Jonathan Jude was assigned Job 2458 and proceeded Code 2.[14]

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[12] Now Senior Constable
[13] The QPS Operational Procedures Manual, Chapter 14, provides that Priority Code 3 requires a direct response and is assigned to matters not requiring Code 1 or 2 responses.
[14] Priority Code 2 requires an urgent response.

47. At 4:08pm, Constable Rettke and Robertson arrived at the Ipswich Station and located Mr Kermode in a stationary train on platform 1. The CCTV footage showed him seated on the train waiting for the train to depart before police entered the carriage.

48. Mr Kermode started behaving in an erratic and threatening manner when officers Robertson and Rettke entered the carriage. He stood up from his seat and placed his hand in his jacket. When told to remove his hands, he produced a knife gesturing towards the officers. He approached another passenger, who was sitting adjacent to him, before moving towards police and forcing them backwards off the train and onto the train platform.

49. Constables Rettke and Robertson exited the train with their service weapons drawn as Mr Kermode continued to walk towards them waving the knife. The officers repeatedly yelled "*drop the knife*", which he refused to do.

50. Constable Rettke described Mr Kermode as "heightened and fixated", as though he was not surprised that police had arrived. As the officers continued to retreat, Mr Kermode progressed at a faster rate. He was speaking loudly at the officers and appeared to be lunging while holding the knife. Both officers were attempting to tactically retreat to create distance while their firearms were drawn. This was described as an effort to de-escalate and resolve the situation.

51. Each of the three involved officers described their understanding of the QPS use of force model at the inquest, including that it does not involve escalating steps and the objective is to use the minimal force necessary to resolve a situation. Each said they had undertaken annual training in relation to use of force options, including dealing with active armed offenders and mental health scenarios.

52. Senior Constable Robertson told the inquest that he was not aware of Mr Kermode's location when he and Constable Rettke entered the Railway Station. However, the only train was sitting at platform 1. Senior Constable Robertson could not recall Mr Kermode saying anything except "my name is Jesse". He said that the risk was elevated as soon as Mr Kermode placed his hand inside his vest.

53. Senior Constable Robertson said his objective was to de-escalate the situation. He gave forceful commands and endeavoured to move Mr Kermode away from civilians on the train. He said that Mr Kermode had adopted a "fighter style" pose on the train. He formed the opinion that he was under the influence of drugs based on his gaunt and unkempt appearance and the presence of bodily sores.

54. Senior Constable Robertson told the inquest that he could have used lethal force from the time that Mr Kermode was waving his knife near passengers on the train and then advanced at police officers. However, he was concerned about discharging his firearm on the train. He said that he was within Mr Kermode's striking range for the entire duration on the railway platform. He was concerned that he was not wearing body armour to protect him if Mr Kermode assaulted him with the knife.

55. Senior Constable Robertson said that he discharged his firearm when Mr Kermode was within less than 2.5 m of Sergeant Jude. He apprehended that there was an immediate risk of grievous bodily harm or death to Sergeant Jude.

56. Constable Rettke was unable to recall at the inquest any words spoken by Mr Kermode. However, he acknowledged that in his ESC interview following the incident he said that Mr Kermode had used words such as "*come on you", "you wanna do this"* and *"shoot me".*

57. Constable Rettke said that his focus was on trying to resolve the situation peacefully. However, when Mr Kermode confronted Sergeant Jude and moved towards him "at a rate of knots", he saw that Mr Kermode was shot by Sergeant Jude and Constable Robertson. Constable Rettke said that after Mr Kermode was shot, he staggered backwards and adopted an aggressive pose towards Sergeant Jude with the knife. He then fired a further 2-3 shots at Mr Kermode. Constable Rettke said that there were no other options available given that Mr Kermode was in possession of an edged weapon and was moving at speed near Sergeant Jude. He had no time, for example, to holster his weapon and produce a taser to immobilise Mr Kermode on the railway platform.

58. Sergeant Jude told the inquest that he was the shift supervisor at the time of the incident. At around 3:00pm he became aware that there was a male with a knife threatening persons at the Ipswich station. On approaching the platform, he could hear yelling from his colleagues and said that there was "terror" in their voices. At that point he was concerned that someone had already been shot and ran down the ramp to the platform.

59. Sergeant Jude said that he saw Mr Kermode hiding to the left of a wall. Mr Kermode then came charging towards him, causing him to fear for his life. He said that Mr Kermode was saying "*kill you*" or "*kill*". Sergeant Jude was saying "*armed police, drop the knife*". He said that he was the focus of Mr Kermode's threats, and Mr Kermode came within 2.5 m of him. He said that he then used a string of shots in accordance with his training to stop the threat.

60. Nineteen rounds were discharged in total, with 6-7 bullets striking Mr Kermode. At that time, the distance between the officers and Mr Kermode was approximately between 2.5 m (Sergeant Jude) and 8.3 m (Constable Rettke).[15]

61. First aid was immediately commenced by police. A torniquet was applied to Mr Kermode's left upper arm and several chest seals to his chest and the side of his torso. A bandage was also wrapped around the gunshot wound to his stomach. CPR was commenced, including chest compressions and breaths via a face mask, which continued until QAS officers arrived at the scene.

62. At 4:11pm, PM400 called via the radio that shots had been fired. QAS attendance was requested, and it was confirmed that Mr Kermode had been arrested and secured. It was reported that he had multiple chest wounds and first aid was being rendered.

63. At 4:15pm, QAS were called and were enroute by 4:17pm. They arrived on scene to assist at 4:19pm. It was determined that Mr Kermode was unconscious and had a GCS of 3. A large amount of blood was visible at the scene. Resuscitation efforts were continued, however, were unsuccessful. Mr Kermode was declared deceased at 4:28pm by QAS Paramedic Smith.

64. At 4:30pm, a crime scene was declared.

## Autopsy results

65. An external and full internal post-mortem examination was performed by Senior Forensic Pathologist, Dr Nathan Milne, on 18 September 2018.[16] Several histology and toxicology tests, as well as a CT scan, were also undertaken. Dr Milne had attended the scene on the day of the incident, observing Mr Kermode on the platform. He also viewed the relevant CCTV footage.

66. The external post-mortem examination revealed 12 gunshot entry and exit wounds (6 to 7 bullet strikes), none of which appeared to be from close or contact range. The internal examination showed that only two gunshot wounds entered the body cavities and caused significant injuries. The first was an entry wound to the central lower chest, which involved organs, most notably the heart. The other shot entered the left upper quadrant of the abdomen, which caused a lesser injury. Two small fragments of projectile were located, one within each of the above-described wounds.

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[15] As depicted in Ex E12
[16] Ex A3

67. Toxicology testing revealed a level of methamphetamine (0.35 mg/kg) that was at a potentially lethal range. Amphetamine was also detected (0.06 mg/kg) at a non-lethal level.[17]

68. The cause of death was found to be gunshot wounds to the chest and abdomen. It was noted that while the high level of methamphetamine in the blood did not contribute directly to death it possibly had a significant effect on Mr Kermode's behaviour prior to the shooting.

## The investigation

69. A comprehensive investigation was conducted by Detective Sergeant Christy Schmidt from the Ethical Standards Command, who subsequently prepared a detailed coronial report with various annexures, including witness statements, footage, forensic analysis, and various photographic exhibits.

70. The involved officers were separated at the scene and drug and alcohol testing was undertaken which subsequently produced negative results. ESC investigators conducted extensive directed interviews and video re-enactments with the officers involved. Records of interview or statements were obtained from all police officers having any connection to the incident, civilian witnesses who observed aspects of the incident, persons who had been in contact with Mr Kermode earlier in the day, and Mr Kermode's friends and family members.

71. A QPS ballistics expert examined the service issued firearms used by the officers.

72. Detective Sergeant Schmidt accessed documentation relating to police intelligence and prior dealings with Mr Kermode. Mr Kermode's body was identified by fingerprint analysis. The fingerprints from the body were found to match those held on QPS records.

73. In considering whether the conduct of the officers involved was appropriate, Detective Sergeant Schmidt obtained a statement from Senior Sergeant Damien Hayden, who was previously the officer in charge of the QPS Operational Skills Unit.

74. Senior Sergeant Hayden assessed the conduct of the officers involved, whether the use of lethal force was in accordance with the relevant legislation, the QPS Operational Procedures Manual, relevant QPS policy and whether there were any less than lethal use of force options open to the officers involved.

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[17] Ex A4

75. Having considered the situational use of force model in chapter 14.3.2 of the OPM, Senior Sergeant Hayden noted the following with respect to the use of force by officers in response to the threat posed by Mr Kermode:[18]

- All officers were on duty at the time of the incident. The level of force used by Sergeant Jude was 'reasonably necessary' to preserve his life and prevent grievous personal injury. The level of force used by Constables Robertson and Rettke was 'reasonably necessary' in coming to the assistance of Sergeant Jude to prevent him from being maimed or killed by Mr Kermode.

- Senior Sergeant Hayden was of the view that the decision by Sergeant Jude to use lethal force was justified, as the fear of death or grievous bodily harm was reasonably formed in response to the actions of Mr Kermode, which included that he was in possession of a knife, police had been called to respond Code 2 to provide assistance in relation to a person who had threatened people with a knife, and that he advanced on Sergeant Jude while brandishing the knife. Similarly, the decision by Constables Rettke and Robertson to discharge their firearm was justified given the threat posed.

- Senior Sergeant Hayden was of the view that the decision by Sergeant Jude to shoot Mr Kermode was objectively reasonable, and not an overreaction, based on the imminent risk of death or grievous injury that was posed. The actions of Constables Rettke and Robertson in coming to Sergeant Jude's aid were not inappropriate or unwarranted given the threat posed by Mr Kermode.

- The actions of Sergeant Jude were defensible under s 271(2) of the Criminal Code, which relates to self-defence from an unprovoked attack. The actions by Constables Rettke and Robertson are also defensible pursuant to s 273 of the Criminal Code, which relates to aiding in self-defence.

- The decision by Sergeant Jude to use lethal force to defend himself was tactically sound given the relevant considerations, such as location, circumstance, and the possibility of injury.

- Prior to the use of firearms, Mr Kermode was directed many times, verbally and by way of hand gestures, to put down his knife while he was in the carriage and on the train platform. The techniques and tactics used by the officers involved in this incident were in accordance with the QPS firearms training that use of lethal force was a last resort in the preservation of life. Edged weapons could rapidly inflict catastrophic injuries. In this case, Mr Kermode was near Sergeant Jude, and as such, the other use of force options, such as a taser or OC spray would be inappropriate for the situation. Sergeant Jude's decision to use his firearm was the most effective means of

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[18] Ex B27

preserving his life and wellbeing by immediately reducing the threat posed by Mr Kermode.

76. Senior Sergeant Hayden noted that QPS officers are trained to use tools such as the Situational Use of Force Model and the Threat Assessment and Tactical Decision-making process to assist in competently, carefully, and continually assessing the circumstances of a situation to inform the minimum use of force necessary to resolve an incident. These guidelines are not restrictive but assist officers to ascertain what the necessary use of force may be to escalate or deescalate a situation. To do this, officers must conduct a continual threat assessment to determine the real and potential risk of each situation. This model is taught to recruits during the Initial Service Officer Safety Training course and is also reinforced during cognitive skill building and scenario-based firearms training provided to sworn officers on an annual basis

77. During this incident, Sergeant Jude fired a string of shots when he rapid fired his service handgun at Mr Kermode while he moved backwards up the ramp. In such situations, officers are taught to fire a string of shots while withdrawing or retreating from a threat. The QPS do not have a ‘shoot to wound’ policy with respect to the operational deployment of firearms for various reasons, including the extreme burden this would place on police and the need for an offender to be immediately incapacitated to stop the threat posed.

78. Senior Sergeant Hayden noted that while both Constables Rettke and Robertson intended to take Mr Kermode into custody using the minimum amount of force required, given the extreme high risk and threat posed by his actions, Mr Kermode was eventually engaged by police and ultimately sustained fatal gunshot wounds to his upper torso and arms. He was of the view that the attending police complied with requisite policy and procedure consistent with the requirements of the OPM and did not breach the applicable legislation.

79. Acting Senior Sergeant Werth gave evidence at the inquest in relation to these issues after reviewing Senior Sergeant Hayden’s statement. He agreed that there was no misconduct displayed by any of the officers involved and further concluded that no disciplinary proceedings were required. He said that all use of force options were available to the officers in the circumstances.

80. Acting Senior Sergeant Werth said that a Taser was unlikely to have been an effective response given that Mr Kermode was within 2-4 metres of the officers and was wearing a thick ‘hoody’, which may have prevented the barbs from being effective. He said that OC spray would have potentially affected the officers and other passengers in the enclosed space of the train.

81. A baton would not have been an effective response to a bladed weapon. He said that it was appropriate for the officers to produce their service firearms to create distance between themselves and Mr Kermode. The officers' tactics in using forceful communication and repositioning were sound. The use of a string of shots to stop the threat posed by Mr Kermode was also in accordance with QPS training and policy.

82. Detective Sergeant Schmidt also concluded that the officers had acted in accordance with their training. She agreed that the officers had attempted to negotiate with Mr Kermode while he was within very close proximity while threatening the officers with an edged weapon.

***Description of the scene***

83. The shooting occurred at the Ipswich Railway Station with two platforms below the main entry. Access to the platform was gained via a ramp. There are multiple concrete posts spread throughout the platforms and these posts support the main building above. At the time of the incident, there was only one train, which was stationary and situated to the right of the entry ramp.

84. An extensive forensic and ballistic examination of the incident location was conducted, and photographs taken of the scene and Mr Kermode in situ. Projectiles and damage from the projectiles were located at various points around the platforms, including on the tiled and concrete walls above platform 3, lining of the pedestrian ramp, the payphone on the platform and in the asphalt surface of platforms 1 and 2.[19]

85. A FARO 3D scan of the incident location and platform was completed. A video presentation was prepared that spliced the BWC footage and 3D imaging of the scene. This depicts the distance between Mr Kermode and the officers at the time he was shot.

86. An ammunition audit was conducted with the three officers. It was found that Constable Rettke and Robertson each had 2 bullets missing, and Sergeant Jude had fired 14 shots.

***Civilian accounts of Mr Kermode's behaviour prior to shooting***

87. Statements were obtained from various civilians who interacted with Mr Kermode during the day leading up to the confrontation with Police at the railway station. These included people at the shopping centres he frequented and on the various trains travelled. Consistently, Mr Kermode was described as behaving in a bizarre manner, approaching persons to ask personal questions, murmuring biblical comments, yelling randomly, kicking cars and speaking gibberish. He appeared to be drug affected and was confrontational with several of the persons he encountered. Most described feeling uncomfortable interacting with Mr Kermode.

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[19] Ex B49

***Search of Mr Kermode's residence***

88. On 17 September 2018, a search was conducted of Mr Kermode's address at Riverview. A forensic examination of his car was also carried out.

89. A laptop and two mobile phones belonging to Mr Kermode were subsequently forensically analysed. While some drug related text messages were found on the mobile telephone, there was nothing of note on the day of the incident, with the last call being made at 9:00 am.

## Findings required by s. 45

**Identity of the deceased** – Jesse Aaron Kermode

**How he died** – Mr Kermode had a history of mental illness and engagement with the criminal justice system. He was on a probation order at the time of his death, but his mental illness was not being treated. He died at the Ipswich Railway Station after he was shot by police officers in the course of their duties. He was under the influence of methylamphetamine when he ran at an armed police officer with a knife in his hands. Police officers had repeatedly directed him to drop the knife.

**Place of death** – Ipswich Railway Station, Bell Street, Ipswich

**Date of death**– 16 September 2018

**Cause of death** – Gunshot wounds to the chest and abdomen

## Conclusions on issues

**The circumstances leading up to the shooting of Mr Kermode by Police on 16 September 2018, including his mental health treatment after his release from custody in March 2017, and his engagement with Queensland Corrective Services after his release from custody.**

90. Mr Kermode's movements and the interaction with police on the day of his death were captured on CCTV and the BWC footage from the officers involved. This is the best evidence of what happened and is set out in these findings and outlined in Detective Sergeant Schmidt's Coronial Report. The events as they transpired were not in dispute.

91. Mr Kermode had a significant mental health history commencing when he was aged 18 years. He also had a substance use disorder since he was a teenager, which involved cannabis and amphetamine. He had experienced drug induced psychosis as a result and had attracted several diagnoses, the most recent being schizophrenia which was largely treatment resistant.[20] In the weeks prior to his death, it was suspected by his family that he had resumed using Ice.

92. Mr Kermode's most recent engagement with mental health services came about after he was released from prison in 2017. He was referred to the drug and alcohol team during this time after he admitted using illicit substances. By April 2018, he was regularly missing appointments and was difficult to contact by any means. His case was closed as he was 'lost to follow up'.

93. Mr Kermode served time in presentence custody between 28 August 2015 and 22 February 2017 for offences including armed robbery. He was sentenced to three years' imprisonment with the sentence suspended after time served for three years. He was also sentenced to a probation order for three years which came into effect after his release. It was noted on sentencing that he was previously diagnosed as being a paranoid schizophrenic.

94. At the time of the commission of the 2015 offences he was living on the street and fending for himself. He was unmedicated and had little or no support within the community. He became known to the other offenders and they prevailed upon him to ensure his participation in the armed robbery offence, including by physical assaults. He had used a pistol during the armed robbery, holding it to a hotel employee's back and pointing it at his head.[21]

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[20] Ex B75
[21] Sentencing remarks, 29 March 2017.

95. Mr Kermode's probation order was still in place at the time of his death. His response to supervision was good and he reportedly engaged well. He had admitted to a relapse in substance abuse close to the time of his death and there had been some failure to report with difficulty contacting him as he moved between Community Corrections Offices. However, he had reported to Ipswich Community Corrections a month before his death. He then denied any illicit drug use, presenting as well and actively engaging.

96. While the Office of the Chief Inspector commenced an investigation in relation to the assessment and ongoing management of Mr Kermode in the community by QCS, the report was not finalised as the proposed findings and recommendations were found to duplicate those of the Queensland Parole System Review Report, including enhanced case management of people as they move through the correctional system and risk management and elevation of concerns.[22]

97. I accept the submission from counsel assisting and QCS that the evidence does not identify any systems or procedural failures, nor missed opportunities that would have contributed to or prevented the death of Mr Kermode either by any mental health service or QCS.

98. Mr Kermode had been consistently provided with and afforded access to mental health services in a voluntary capacity and had not had a recent episode of psychosis to the knowledge of those who had previously been engaged with him. It is unlikely that the treatment criteria that needs to apply to justify involuntary treatment under the *Mental Health Act 2016* could have been established in the month leading up to his death.

99. His condition was largely treatment resistant and chronic. Mr Kermode appeared to have some insight into his condition but his ongoing use of methylamphetamine, including on the day of his death, meant that he was vulnerable to a rapid decline in his wellbeing.

100. Having regard to his comments in the lead up to his death, including that he was a "Holy Spirit", it is likely that Mr Kermode was suffering a psychotic episode on the day of his death. It is unlikely that police officers would have been able to successfully engage with him given the high level of methylamphetamine in his system and the effect of that drug on his behaviour. His disturbed thinking would have contributed to his behaviour in the lead up to his death.

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[2222] Exhibit B76.

**Whether the police officers involved acted in accordance with the Queensland Police Service (QPS) policies and procedures then in force and whether said actions were appropriate;**

**Whether the training provided to officers in responding to a similar incident is sufficient.**

101. I accept the evidence of Senior Sergeant Hayden and Acting Senior Sergeant Werth that the use of lethal force by each of the officers was justified, proportionate and tactically sound given the actions of Mr Kermode, as there was a reasonable fear of death or grievous bodily harm.

102. The actions of Mr Kermode, while likely drug induced, directly contributed to the escalation of this incident, which included:

- the production of the knife upon police arrival at the train carriage;
- his decision to advance on police while brandishing the knife;
- the threatening way he continued to behave despite being called upon to drop the knife; and
- his unwillingness to negotiate or engage in a dialogue with police at any time during the incident. This was a continuation of his bizarre and threatening behaviour that was consistently exhibited and captured throughout the day.

103. The attending police officers complied with the requirements of QPS Operational Procedures Manual and did not breach the applicable legislation. Officers Robertson and Rettke did their best to deescalate the situation after leaving the train carriage, allowing Mr Kermode to come dangerously close to them as he waived the knife.

104. While it is not possible to discern Mr Kermode's intent from his actions and words, I accept that the QPS officers had no choice but to assess that he would cause the death or grievous bodily harm of an officer when he charged at Sergeant Jude with the knife.

105. I also accept that the training provided to officers in relation to armed offenders and the situational use of force model is sufficient to respond to an incident of this nature.

## Comments and recommendations

106. Section 46 of the *Coroners Act 2003* enables a coroner to 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.

107. Having regard to the ESC investigation and evidence before this inquest I accept that there are no comments or recommendations to be made that would assist in preventing similar deaths in future or in relation to public health or safety or the administration of justice.

108. In particular, I accept that that the issues identified in the draft OCI Report were the subject of recommendations arising from the 2016 Queensland Parole System Review which made 91 recommendations, 89 of which were accepted by the Queensland Government.

109. I close the inquest. I extend my condolences to Mr Kermode's family and friends.

Terry Ryan
State Coroner
BRISBANE