QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of GLT**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Rockhampton
FILE NO(s):	2019/5112
DELIVERED ON:	3 October 2023
DELIVERED AT:	Brisbane
HEARING DATE(s):	31 May 2022, 5 to 7 September 2022, submissions to 24 November 2022.
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, domestic violence, death in custody, restraint, multifactorial cause of death, recognition of rapid deterioration by police officers.

REPRESENTATION:

Counsel Assisting:	Ms J Pietzner-Hagan
Family:	Mr M Murray, and Ms A Carroll, Townsville Community Law Inc.
Commissioner of Police:	Mr M O'Brien, QPS Legal Unit

Senior Constable Martinez, Senior Constable Lally; Senior Constable Traynor; Constable Gibson; Constable Tome; and Constable Ryan:	Ms S Williams, instructed by Ms R Tierney of Gilshenan and Luton

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Introduction

1. GLT[1] was aged 46 when he died in police custody at the Rockhampton Police Station on 8 November 2019. He died after he was arrested by Queensland Police Service (QPS) officers for contravening a domestic violence order. After his arrest, GLT was initially compliant with police. He was escorted without restraints to a police van. However, GLT resisted the arrest and refused to get into the van.

2. GLT was restrained with force on the ground and placed in a cell 'pod' in the back of the police van. He was transported to the Rockhampton Watchhouse, across the road from where he was arrested. When officers attempted to remove GLT from the police van at the watchhouse, he was unresponsive. The incident was recorded on Body Worn Cameras (BWC) and CCTV.

The investigation

3. The investigation into GLT's death was led by Detective Sergeant Neil Parker of the QPS Ethical Standards Command (ESC). ESC investigators conducted interviews with relevant police and civilian witnesses who were involved in the initial attendance at the Leichhardt Hotel in Rockhampton, and subsequent investigations. The police witnesses were subject to directed interviews.

4. The use of force by police officers during the arrest of GLT was examined by Senior Sergeant Tracy Bailey of QPS Operational Training Services.

5. On 8 November 2019, Forensic Officers attended Rockhampton and conducted a 3D photographic scan of the Rockhampton Watchhouse and the carpark area of the Leichhardt Hotel. Forensic Officers also examined the room at the Leichhardt Hotel GLT occupied prior to his arrest, together with the police vehicle GLT was transported in - a Hyundai iLoad van. The van had a window to allow the driver and passenger a view of the prisoner in the cell pod. The cell pod light was functioning. However, there was no monitoring system or image on the dash display panel, and no cameras in the pod or surrounds.

6. Detective Sergeant Parker concluded there was no evidence to support a criminal prosecution against any person or to support any breach of discipline or misconduct against any police officer regarding GLT's death. He noted that GLT was compliant and cooperative with police when he was arrested outside the Leichhardt Hotel, but suddenly and unexpectedly resisted police when asked to enter the police van in the carpark.

[1] A non-publication order was made pursuant to section 41 of the *Coroners Act* and the pseudonym GLT was assigned. Reference was also made to section 159 of the *Domestic and Family Violence Protection Act 2012* (Qld).

7. Detective Sergeant Parker noted that GLT was a large man and was kicking out at the arresting police, who were small in stature. The four police officers managed to pin GLT to the ground and call for assistance. Other police arrived and, with the help of Senior Constable Martinez, GLT appeared to calm down and start communicating with the officers. GLT was then escorted to the police van.

The inquest

8. As GLT died while he was under arrest by police his death was a death in custody as defined in s 10 of the *Coroners Act 2003* (Qld). An inquest was required by s 27(1)(a)(i) of the Act.

9. The main purpose of an inquest is to inform the family and the public about the cause and circumstances of the death, and to answer questions which may have been raised following the death. In appropriate cases, a coroner can also make comments or recommendations about ways to prevent similar deaths, the administration of justice, and public health and safety.

10. A pre-inquest conference was held in Brisbane on 31 May 2022 at the Coroners Court in Brisbane. Oral evidence was heard over three days in Gladstone from 5 to 7 September 2022. Ten witnesses were called to give evidence. Constable Laura Tome was excused from giving evidence at the inquest on medical grounds. However, Constable Tome answered questions from those represented at the inquest via a sworn affidavit, submitted on 16 September 2022.

11. After the conclusion of oral evidence, those granted leave to appear were invited to provide written submissions. The final submissions were received by the Court on 24 November 2022 and were of great assistance in the preparation of my findings.

12. In addition to the findings required by s 45(2) of the *Coroners Act*, the following issues were examined at the inquest:

    a. The circumstances surrounding GLT's arrest and whether officers complied with the relevant policies and procedures.

    b. Whether GLT's physical condition was appropriately monitored, and whether there was a failure to recognise signs of deterioration in his condition, and that he required medical assistance.

    c. Whether any recommendations might be made that could reduce the likelihood of deaths occurring in similar circumstances, or otherwise contribute to public health and safety, or the administration of justice.

The evidence

Personal history

13. In the lead up to his death, GLT was living with his mother at Caboolture. He had been involved in a relationship with Ms ENG for around six years and they had two children together. Ms ENG was living in Rockhampton at the time of the death.

14. GLT's only sister read a family statement at the inquest. She said that GLT was one of four children, and they had a close, strong relationship. She said that her brother was "so much more than the deceased, than just a subject of this inquest".

15. He was described as "an athlete, a comedian, a dad, a mate, a son, an uncle and a brother. He was a hard worker and a world traveller". He was "deeply loved and desperately missed". He started working on oil rigs at age 19, and through hard work and determination became a driller and undertook international FIFO work.

Offending and domestic violence history

16. GLT had a significant criminal history in Queensland. His offences included liquor offences, acts of indecency, obstructing and resisting police, theft, damage, serious assaults, damage to property, drugs and breaching court orders. He had spent some time in prison.

17. There was a domestic violence history between GLT and ENG dating from January 2015. A protection order was made in May 2017 following an application by ENG.

18. On 5 April 2019, a temporary Domestic Violence Protection Order (DVO) was made in the Rockhampton Magistrates Court naming GLT as the Respondent and ENG as the aggrieved. GLT was served a copy of this order on the 10 June 2019 in Perth, Western Australia. The order contained several conditions including:

    (5) The respondent is not to approach the aggrieved.
    (6) The respondent is not to contact either directly or indirectly or ask someone else to contact the aggrieved including by telephone, text and internet.

19. On 10 June 2019 in Perth, GLT was also served with an application to vary the DVO to extend the order for five years, to include a named child, and to have the order nationally recognised.

20. On 26 October 2019, GLT was arrested and charged for contravening this order at Rockhampton. On that occasion he had self-reported the breach at the Rockhampton Police Station. He outlined that he was aware of the DVO but not aware of the specific conditions. He was bailed to appear on 8 November 2019.

21. On 30 October 2019, ENG made an application to vary the DVO, seeking to have both telephone and physical contact with GLT. The application also requested the order be removed on 1 November 2019. This application was set down for hearing at the Caboolture Magistrates Court on 14 November 2019, and was served on GLT on 31 October 2019.

22. The DVO was still in place on the morning of 8 November 2019 when GLT contravened the conditions again by being found in the company of ENG. By this time he was aware the order existed and the conditions of the order as he was on bail for the previous breach.

23. In the early hours of 8 November 2019, GLT came to the attention of the QPS when Constables Traynor and Ryan of the Rockhampton Police Station were detailed to attend the Leichardt Hotel to conduct a welfare check, in response to a 000 call received from GLT.

24. During the first call, ENG was heard in the background telling GLT to hang up. ENG terminated the call. A further call was made, and GLT complained that ENG's friends had followed them and wanted to kill them, and that $5000 was stolen. The LCAD report notes GLT was *'again very vague & terminated call'*. [2]

25. Constables Traynor and Ryan drove into the carpark of the Leichardt Hotel and parked the Hyundai iLoad van. The van was fitted with an internal 'pod' for transporting persons under arrest. The LCAD Report records the Officers were 'on scene' at 3:29am. The officers sat in their vehicle for a short time reviewing the flags and cautions for GLT and ENG on their QLite device.

26. Constables Traynor and Ryan approached GLT and ENG at the front of the Leichardt Hotel. They introduced themselves and the reason they were there. GLT identified that ENG had stolen $5000 from his bank account over a number of months. He said he was staying at the Leichardt Hotel, but was scared and needed somewhere safe to stay until the morning.

27. GLT said a number of ENG's mates were there and he thought they had a crocodile in the room. ENG clarified that she had said, '*imagine if there was a crocodile in our motel room and it started crawling out of the room'*.

[2] Exhibit C5 – LCAD Incident Details.

28. Constable Traynor attempted to understand what GLT and ENG were talking about. GLT appeared distracted throughout the conversation, prompting Constable Traynor to tell him to 'focus'. At one point, GLT asked Constable Traynor if she was '*really a copper*' and if she knew the '*secret handshake*'.

29. Constable Traynor identified the need to serve varied Domestic and Family Violence documentation on GLT. Constable Traynor also identified that GLT was in breach of the DVO by being in the presence of ENG.

30. Constable Traynor decided to arrest GLT for the breach offence and to convey him to the Rockhampton watchhouse. Constable Traynor explained to GLT that he was in breach / contravention of the DVO and that he was under arrest.

31. Although the Rockhampton Police Station was located a short walk away on the opposite side of Bolsover Street, Constables Traynor and Ryan decided to transport GLT to the watchhouse via the Hyundai iLoad van (in the pod). They were with Constable Dale Lally and Constable Laura Tome who had arrived to assist Constables Traynor and Ryan because of the nature of the flags and cautions for GLT and ENG listed on QPRIME. The flags were for violent behaviour, including towards police officers.

32. The officers determined transport in the van was the most operationally sound and safest course of action available. They also considered that due to GLT's compliance there was no need to apply handcuffs at that time.

33. Police asked GLT to walk to the police van with them, and he complied. GLT was accompanied by police to the rear of the Hyundai van, parked in the carpark of the Leichardt Hotel. ENG was told to remain at the Leichardt Hotel. Constable Traynor's evidence was that she had previously had a difficult interaction with ENG.

34. Police informed GLT that they would need to search him before transport. At 03:38:52h[3] GLT complied with the directions of police, placing his hands on the rear of the vehicle to allow Constable Lally to conduct a pat down search of his body. Constable Ryan, Constable Traynor and Constable Tome were also present.

35. Constable Traynor opened the rear door of the iLoad van and pod, and GLT climbed into the pod, sitting on the right side. Although GLT was seated in the pod, his left foot remained outside the pod, preventing the door from closing. At 03:40:03h Constable Traynor told GLT to watch his leg and tried to close the pod door.[4]

[3] Exhibit E22 BWC footage of Constable Traynor.
[4] Exhibit E22 BWC footage of Constable Traynor.

36. GLT asked police why he had to travel in the police vehicle to the Police Station across the street. Constable Traynor told him that it was required because they were going to the watchhouse. Constable Lally informed GLT that it was in case officers required their car to leave urgently. GLT asked to walk but his request was declined. GLT told Police that he did not feel safe. GLT then moved closer to the door of the pod in a crouched position. Constable Lally and Constable Traynor tried to keep GLT in the pod by speaking with him and holding the pod door.

37. GLT again told Police that he did not feel safe travelling in the pod. Constable Traynor and Constable Lally attempted to keep GLT in the pod by speaking with him, telling him it was just across the road. Constable Lally placed his right hand on GLT's left shoulder. GLT again asked why they could not walk. He then proceeded to exit the pod and stood on the step of the Hyundai iLoad van (at 03:40:22h[5]). This placed him in a higher position than the two officers.

38. GLT was then informed that he was obstructing police. He became increasingly agitated, and began yelling that he wanted to walk while standing on the rear step of the van. Constable Lally and Constable Traynor had their hands raised, attempting to hold GLT. They attempted to de-escalate the situation, telling GLT to get in the car, referring to his earlier compliance and that there had previously been no need to handcuff him. Constable Tome and Constable Ryan were also present.

39. Constable Lally produced his handcuffs and further 'closed the gap' between he and GLT, attempting to place the handcuffs on GLT. GLT kicked out at the officers while standing on the rear step and was then taken to the ground by Constable Lally, Constable Traynor and Constable Tome. GLT landed on his feet and verbal commands were given by the officers for GLT to get on the ground. However, he did not comply and was forcibly taken to the ground by police.[6]

40. An intense ground struggle ensued. GLT continued to yell and resist police attempts to restrain him. During the ground struggle, police made multiple observations that GLT was grabbing for items including Constable Lally's firearm. Officers provided a number of verbal commands to GLT, telling him to stop resisting and directing him to roll.

41. At the inquest, each officer provided a description of the perceived intensity of the ground struggle, and the injuries they received during the arrest.

42. During the arrest GLT yelled continually, saying words to the effect of *'You aren't real Police!' 'Help!' 'Murder!' 'I'm fucked!' 'I can't breathe'*. At 03:42:13h[7] a female officer yelled *'we need more crews!'.*

[5] Exhibit E22 BWC footage of Constable Traynor.
[6] Affidavit of Constable Laura Tome dated 30 September 2022, page 7, paragraph 20(a).
[7] Exhibit E22 BWC footage of Constable Traynor.

43. Constable Traynor used both hands to push GLT's head to the ground in an attempt to gain control and allow fellow officers to apply handcuffs.[8] Constable Lally requested: *'Can someone apply some serious pressure to the back of his head. We need to get some control'.*

44. Senior Constable Martinez, who had recently arrived on scene, aided in restraining GLT by momentarily placing a knee on, towards the top of GLT's upper back, near to where the back and shoulder connect to the base of the neck.

45. Constable Lally stated: *'there we go'.* GLT continued to yell for help and was momentarily on his stomach while officers hand cuffed his arms behind his back. Two sets of linked handcuffs were required due to his size and inflexibility. Officers maintained tactical communication between themselves, echoing the command *'cuff into cuff'* (at 03:43:15[9]), and confirmed the physical safety of their colleagues once the handcuffs were applied to GLT.

46. A female officer commented that GLT was on some "serious drugs", and GLT was again told that he was under arrest. Senior Constable Martinez spoke with GLT and at 03:43:33h[10]:

    a. GLT: *'I can't breathe'.*

    b. Senior Constable Martinez: *'yep yep, what's your name?'*

    c. GLT: *'[name]''*

    d. Senior Constable Martinez: *'say again'*

    e. Female Officer: *'watch his hand because he's grabbing at anything he can'.*

    f. Senior Constable Martinez: '*Do you know you're under arrest*?'

    g. GLT: *'yeah yeah'.*

    h. Senior Constable Martinez: *'Are you saying you can't breathe?'*

    i. Female Officer: *'He's fine'.*

    j. Senior Constable Martinez: *'Alright, are you going to play up anymore?'*

    k. GLT: *'No'.*

[8] Exhibit E22 BWC footage of Constable Traynor.
[9] Exhibit E22 BWC footage of Constable Traynor.
[10] Exhibit E22 BWC footage of Constable Traynor.

l. Senior Constable Martinez: *'Because if you play up more, it's going to start hurting even more than it already has'.*

m. GLT: *'Ok bro!'*

n. Senior Constable Martinez: *'Clear as mud?'*

o. GLT: *'yeah yeah'.*

p. Senior Constable Martinez: *'Ok mate'.*

q. Constable Lally: *'He's still resisting'.*

r. Female Officer: *'yeah yeah… watch his hands'.*

s. Female Officer: *'He's grabbing for stuff guys'.*

t. GLT: *'Mate get off me head please'.*

47. The officers confirmed that they would apply a hammer lock, and 'full bend over' to walk GLT to the Hyundai van. The officers continued to talk to GLT who was speaking less, more slowly and quietly, in short bursts.[11]

48. Senior Constable Martinez directed officers to pull GLT's pants up, as they had moved down during the arrest. Senior Constable Martinez continued to speak to GLT, explaining that they were going to sit him up and put him in the back of the van, and that they were going to pull his pants up.

49. At 03:45:06h[12] GLT was laying on his left side, with his hands cuffed to the rear. By this time he was speaking very little, and made what could be described as a sighing or groaning noise.

50. As GLT was transitioned to his feet, four officers (two on each side) supported him. Constable Tome applied a wrist lock/pain compliance hold to GLT's right wrist. GLT was directed to walk to the van, to stand up, walk normally and to use his legs. Officers repeated these commands, raising their voices at times.

51. It appeared GLT was not complying with the directions, and at one point GLT dropped to his knees, before again rising and moving forward with the assistance of Police.[13] Police were unable to see GLT's face as he was walked in a bent over position using a hammer lock hold. Officers interpreted GLT's actions at this time as wilful non-compliance.

[11] Exhibit E17.1 BWC of Constable Lally.
[12] Exhibit E22 BWC footage of Constable Traynor.
[13] Exhibit E21 BWC footage of Constable Tome.

52. Upon reaching the back of the iLoad van, a male officer told GLT that they were going to spin him around. Three of the officers released their hold on GLT and only Constable Traynor (on GLT's right) and Senior Constable Martinez (on GLT's left) were supporting GLT. GLT fell forwards towards the pod and his body hit the back of the pod. At 03:45:49h[14] an audible bang was heard, a male officer stated '*plonk'*.[15] The comment was followed by laughter from police officers.

53. At this time GLT appeared to be experiencing a significantly reduced level of consciousness. It was possible that he was already unconscious.

54. As GLT was assisted by Senior Constable Martinez and Constable Traynor to be seated into the pod, facing towards the officers, Senior Constable Martinez stated: *'don't kick at us alright, I'm gonna push you back into the van'.*

55. GLT was in a semi seated position with his legs outside of the pod, GLT's head dropped to a rearward position and appeared to 'hang' in that position. A groan was heard[16] and a female officer warned: *'watch he's gonna spit, just watch he's getting a brolly ready'.* GLT appeared to be unconscious. Officers accepted at inquest that GLT did not spit on any person at this time.

56. GLT's legs were protruding from the pod and were pushed into the pod by police in order to close and secure the door. At this time, GLT was laying on the floor of the pod on his right side, with his hands cuffed to the rear. Constable Tome used her leg to push GLT into the pod before police closed the door. The officers stated that the door was 'real sticky' and they had some difficulty securing the door.

57. Verbal commands were given to GLT, with which he did not or could not comply:

    a. Senior Constable Martinez*: 'Pull your feet in, sit up on the chair!'. 'Oy! Sit up on the chair!'.*

    b. Constable Traynor*: '[name]!'*

    c. Constable Traynor*: 'He's not going to'.*

    d. Senior Constable Martinez*: 'sit up on the chair!'*

58. 03:46:45h[17] the door of the pod was secured.

[14] Exhibit E22 BWC footage of Constable Traynor.
[15] Exhibit E21 BWC footage of Constable Tome.
[16] Exhibit E21 BWC footage of Constable Tome.
[17] Exhibit E21 BWC footage of Constable Tome.

59. At 03:48:00 GLT was transported to the watchhouse by Constable Traynor (seated in the passenger seat). Constable Ryan was driving. The odometer reading (1764) was the same at the time of 'clocking on and off'.

60. At 03:49:30h the vehicle arrived at the watchhouse. The following brief conversation occurred between Constable Traynor and Constable Ryan:

    a. Constable Traynor: *'I don't even know if he's conscious, I'm not gonna lie'.*

    b. Constable Ryan: *'He's sweating pretty bad, they're not gonna take him'.*[18]

61. The vehicle was driven into the watchhouse airlock and police secured their firearms, as appropriate. Neither Constable Traynor nor Constable Ryan communicated the information contained in the preceding paragraph, which may have reflected concerns for GLT's welfare, to any other member present.

62. At 03:51:30h Constable Christopher Kennedy opened the door of the pod. GLT was laying on his right-hand side. It appears GLT had not moved since he was placed in the pod and his legs were pulled by police into an extended position.

63. Senior Constable Martinez attempted to rouse GLT by performing a sternum rub which was intended to assess GLT's level of consciousness.[19] GLT was unresponsive.[20] Constable Traynor asked if GLT was breathing.[21] Senior Constable Martinez responded that it was hard to tell because of GLT's physical size.

64. Senior Constable Martinez attempted to remove GLT from the pod in order to assess him more closely. He noticed the discolouration of GLT's face which he described as 'bluey-purple'.[22] At 03:51:54h Constable Traynor stated: *'oh my god, he does not look well'.* The decision was then made to call the Queensland Ambulance Service.[23]

65. Up until this point, GLT's clinical decline, and deterioration in level of consciousness, had not been meaningfully identified by police in a way that would cause them to seek the urgent medical assistance he required. A distinction should be drawn between the actions of police before and after this point in time, when police identified the need to transition to the provision of immediate medical care.

[18] Exhibit E22 BWC footage of Constable Traynor.
[19] Transcript – 6 September 2022, Page 2-15, Line 37.
[20] Exhibit E16 BWC footage of Constable Kennedy.
[21] Exhibit E22 BWC footage of Constable Traynor.
[22] Transcript – 6 September 2022, Page 2-16, Line 14.
[23] Exhibit E22 BWC footage of Constable Traynor.

66. At 03:52:29h a direction was given by the Watchhouse Sergeant to commence CPR. Senior Constable Martinez had already transitioned GLT to the ground, behind the Hyundai van and he immediately[24] commenced compressions. The handcuffs were removed while Constable Traynor sourced a resuscitation mask and requested whether they had a 'defib' available.

67. While there was some confusion as to where the defibrillator was located in the watchhouse, Constable Traynor moved with an apparent sense of urgency and purpose until she located the defibrillator and returned to GLT's location.

68. The BWC footage demonstrated that Senior Constable Martinez provided calm and clear instructions to the officers assisting him in providing CPR. Senior Constable Martinez instructed Constable Traynor in how to deploy the defibrillator and coordinated the officers present to rotate through the delivery of compressions and breaths using the resuscitation mask.

69. The request for QAS assistance was received by the QAS Operations Centre at 03:51:58 and at 03:56:42 the Advanced Care Paramedic (ACP) Unit arrived on scene. A second ACP unit arrived at 04:02:01 and at 04:07:16 a critical care Paramedic arrived.[25] A total of 29 minutes of resuscitation was performed (initially by QPS and then with QAS on scene for 24 minutes).

70. The therapies administered to GLT included ongoing, continuous CPR, ventilation via a bag valve mask, an oropharyngeal airway and then a laryngeal mask airway, intravenous (IV) access and a total of four 1mg doses of IV adrenaline. GLT's cardiac rhythm remained in asystole (no electrical activity) despite resuscitation efforts. A life extinct declaration was made at 04:21h.[26]

Autopsy results

71. On 12 November 2019, an external and internal autopsy examination was undertaken by Senior Staff Specialist Forensic Pathologist, Dr Samarasinghe.

72. The Autopsy Report was provided on 26 February 2021, and included Toxicology and Pathology results. The post-mortem examination showed a moderately obese man with a number of soft tissue injuries in the form of abrasions and bruises to the body. Some of the injuries were consistent with GLT having been restrained. There were injuries of both wrists consistent with having been caused by hand cuffs. There were no significant head or neck injuries.

[24] Transcript – 6 September 2022, Page 2-14, Line 46.
[25] Exhibit G1 – Report of Dr Rashford at page 7.
[26] Exhibit G1 – Report of Dr Rashford at page 8.

73. There was no skeletal trauma other than several bilateral frontal rib fractures. Dr Samarasinghe noted these fractures may be consistent with cardiopulmonary resuscitation. Neuropathology showed only hypertensive cerebrovascular changes. There was no evidence of hypoxic or traumatic brain injury. The only significant natural disease process was significant double vessel coronary artery disease which would have played a role in death.

74. Histology confirmed soft tissue (subcutaneous) haemorrhages observed at autopsy. There was mild enlargement of heart muscle fibres (myocyte hypertrophy) along with interstitial fibrosis (microscopic scarring). There was no evidence of acute ischaemic change ('heart attack'). Smoking related lung changes were demonstrated.

75. The toxicology report referred to the presence of Methylamphetamine ('Ice') and its metabolite Amphetamine. The reported blood level of Methylamphetamine (2.1mg/kg) overlapped the documented non-toxic, toxic and lethal range. No other drugs or alcohol were detected on analysis.

76. Dr Samarasinghe's comments and conclusions were as follows:

> *This moderately obese man had multiple minor soft tissue injuries. Although injuries appeared to be relatively minor the distribution and number of injuries would suggest application of force directly or indirectly during restraint. This man also had significant pre-existing cardiovascular risk factors for sudden unexpected death including double vessel coronary atherosclerosis. It is also well-documented that subjects affected by illicit drugs, such as amphetamines, would be at high risk for sudden arrhythmogenic cardiac death during restraint and often autopsies would not show significant pathologies in such individuals. Amphetamines are central nervous system stimulants and recognised heart toxins and would produce hypertension and increased heart rate. Thus, it is believed that drugs would also have played a major role in his death.*
>
> *In conclusion, the overall findings of this case were considered to be consistent with a sudden unexpected death of an agitated, drug affected psychotic individual with pre-existing coronary atherosclerosis. There was no autopsy evidence of classic signs of asphyxia such as conjunctival haemorrhages and significant congestion.*
>
> *In my opinion, death was due to the combined effects of methylamphetamine toxicity and coronary atherosclerosis. Recent psychological and physical exertion during police interaction would have increased the risk of lethal arrythmia (abnormal heart rhythm). The cause of death was based on the circumstances surrounding death, medical history, and the external and full internal examination including associated testing.*

77. The cause of death was recorded as:

1(a) Methylamphetamine toxicity and coronary atherosclerosis.

Other significant conditions

2. Obesity.

Conclusions on Inquest Issues

Findings required by s. 45 of the Coroners Act

78. I am required to find, as far as 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 –	Anonymised[27]
How he died –	GLT had consumed Methylamphetamine. He suffered from mental health and medical comorbidities, including coronary artery disease. He was arrested for breaching a domestic violence order. His death followed an intense ground struggle with police officers during which he was restrained. The exertion during the restraint would have increased the risk of lethal arrhythmia. It is likely that the failure of officers to recognise his clinical decline and the deterioration in his level of consciousness contributed to the death.
Place of death –	Rockhampton Watchhouse, 161 Bolsover Street, Rockhampton, Qld, 4700.
Date of death–	8 November 2019.
Cause of death –	1. (a) Methylamphetamine toxicity and coronary atherosclerosis. Other significant conditions 2. Obesity.

[27] GLT was identified by way of fingerprint identification.

79. I accept that despite the underlying physical health concerns experienced by GLT, those conditions would not necessarily, in isolation, have caused GLT to die when he did.

80. The cause of death was a result of all the circumstances - the physical and psychological exertion arising from the interaction with police, in addition to GLT's underlying physical health concerns including his Methylamphetamine toxicity. GLT's sudden deterioration could not reasonably have been predicted by police prior to the arrest.[28]

81. Dr Stephen Rashford, Medical Director for the Queensland Ambulance Service (QAS) noted in his report that the:

> *'combination of methylamphetamine toxicity, moderate obesity, the physical exertion of his resistance during the arrest and significant double vessel coronary artery disease created a lethal combination of conditions that contributed to a lethal arrhythmia (abnormal heart rhythm). Central to the development of this arrythmia was the significant physical exertion from the arrest and restraint by the QPS officers, which in the environment of drug toxicity and significant coronary artery disease resulted in this occurrence'.*[29]

82. Dr Rashford acknowledged that the decision to transport GLT in the pod was a matter for the police but considered that if GLT *'been allowed to walk to the police station that was a very short distance away across the car park, as he requested after he complained of feeling unsafe in the secure compartment, it is highly likely that he would not have suffered a cardiac arrest'.*[30]

83. Dr Rashford stated the attending officers did not recognise GLT was losing consciousness as he was placed in the pod of the police van. GLT subsequently had several minutes where his condition was unmonitored. This caused further delay in identifying GLT's deterioration and delayed the provision of medical assistance.[31]

84. Dr Rashford concluded that *'had medical assistance been requested before departing for the QPS station, GLT's chances of survival would have been improved, but not guaranteed'.*[32]

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[28] Exhibit G1 – Report of Dr Rashford at page 6.
[29] Exhibit G1 – Report of Dr Rashford at page 5-6.
[30] Exhibit G1 – Report of Dr Rashford at page 9.
[31] Exhibit G1 – Report of Dr Rashford at page 9.
[32] Exhibit G1 – Report of Dr Rashford at page 9.

The circumstances surrounding GLT's arrest and whether officers complied with the relevant policies and procedures

85. The circumstances surrounding GLT's arrest and death in custody on 8 November 2019 were captured on BWC, CCTV[33], and dash cam footage.

The Arrest

86. The decision to arrest GLT for contravening a DVO was made by Constable Traynor to stop the continuation of the offence. There was no policy in place at the time of the arrest that prevented GLT from being escorted to the watchhouse on foot. The decision to convey GLT to the watchhouse in the Hyundai iLoad pod was made by the attending police, in accordance with their risk assessment of the situation and the relevant policies and procedures.[34]

Use of Force Report

87. Senior Sergeant Bailey provided two statements to the Court and gave oral evidence at the Inquest. Senior Sergeant Bailey's opinion was that all officers acted appropriately and in accordance with the QPS use of force training, policy and procedures, in attempting to use the minimum level of force possible to resolve the incident.

88. Overall, I agree with Senior Sergeant Bailey's assessment of the use of force by the Officers involved in GLT's arrest.

89. However, at the inquest, Senior Constable Martinez was asked a number of questions by the Legal Representative for GLT's family, about allegedly placing a knee on GLT's neck, during the ground struggle.

90. During questioning, Senior Constable Martinez did not accept that he had placed a knee on GLT's neck, but stated: *'from the angle, its near his neck, but it's on his meaty part of his back there…you're creating that from the angle that this is presented from'.*[35]

91. It was submitted for the family that Body Worn Camera Footage of Constable Traynor[36] provides a clear view of Senior Constable Martinez's knee placed on GLT's neck. I have carefully reviewed that footage from 17:42:55 to 17:43:30 which depicts the arrival of Senior Constable Martinez and the application of his knee to GLT.

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[33] Exhibits E23 CCTV - Front of Leichardt Hotel, E24 CCTV - Hotel Carpark, E25 CCTV – First Choice Liquor and E26 – Rockhampton Watchhouse.
[34] Affidavit of Constable Laura Tome, page 6, paragraph 18.
[35] Transcript – 6 September 2022, Page 2-20, Line 15.
[36] Exhibit E22

92. Senior Constable Martinez conceded the manner that he had applied a knee to GLT's back was not considered a traditional three point hold, but that the presence of other officers surrounding GLT, inhibited his ability to apply the traditional hold.[37] Strictly speaking, this is not in keeping with QPS policy, in that it was not the correct application of a *'three point pin'* as outlined in the *Operational Skills Section, Good Practice Guide for Ground Restraint*.[38]

93. Having regard to the *Briginshaw* principles[39], I would need to be satisfied to a very high standard that the serious allegation that Senior Constable Martinez applied his knee to GLT's neck, even for a short period of time, was proven. After considering the BWC footage, the evidence of Senior Constable Martinez and the evidence of the other officers, I am not satisfied to the requisite standard.

94. I also accept that the way in which Senior Constable Martinez's knee was placed on GLT's body did not contribute to GLT's cause of death. There was no medical evidence to support a finding such as asphyxia. There was also no evidence of injury to the cervical spine.[40] GLT's family acknowledged that the evidence supported the conclusion that the placement of Senior Constable Martinez's knee did not directly contribute to GLT's cause of death. However, it was submitted if his knee was placed on GLT's neck during the restraint, it is likely to have contributed to GLT's level of discomfort and distress.

95. While the officers who gave evidence could not recall laughter when GLT fell against the rear of the pod, Detective Sergeant Parker's evidence at Inquest was that police officers involved in the restraint received guidance after the event regarding this issue. Given the evidence on the body worn camera footage and the evidence of Detective Sergeant Parker, I accept that police officers did laugh when GLT fell against the police vehicle.

Hyundai iLoad van

96. There was no camera or electronic monitoring equipment fitted to Hyundai iLoad vans that would allow officers to monitor persons while they are transported in the pod. I agree with the submission of Counsel Assisting that this constitutes a deficiency in equipment and is a significant public safety issue.

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[37] Transcript – 6 September 2022, Page 2-9, Line 40.
[38] Operational Skills Section, Good Practice Guide, Ground Restraint – Version 1.0 July 2014 at page 8.
[39] (1938) 60 CLR 336
[40] Exhibit A4 - Autopsy Report (Autopsy No. SS19J2150) dated 26/02/2021 at page 6.

97. During the inquest, officers were shown photographs of the Hyundai iLoad van and pod[41] used to transport GLT. The officers acknowledged that if a person under arrest was laying on the floor of the pod, that person could not be viewed by officers seated in the front two seats of the vehicle. The officers would need to climb into the back seat to observe a person during transport. GLT was transported in a prone position, laying on his side, handcuffed to the rear. GLT could not be seen by Constable Traynor as the passenger nor Constable Ryan as the driver during transport.

98. Andrew Quinlan, Director QPS Fleet Assets provided a statement indicating:

    a. *'QPS currently operates approximately 152 prisoner transport vans, consisting of Hyundai iLoad vans and Toyota HiAces, and approximately 374 four-wheel drive utility vehicles with dedicated prisoner pods mounted on the rear of the vehicle'.*[42]

    b. *'QPS Fleet Assets has recently completed a six-month trial of a closed circuit audio visual monitoring system fitted to an operational Toyota HiAce prisoner transport van which was conducted in both Brisbane Fortitude Valley and the Gold Coast for three months in each area'.*[43]

    c. *'The trial system was fitted with two-way intercom for communication with the prisoner as well as audio visual monitoring and had onboard storage for the recordings and a monitoring screen fitted between the front seats viewable to both passenger and driver. The trial was found to be successful and believed to increase the safety of prisoners by way of allowing closer monitoring of their health and behaviour during transport to watchhouse or elsewhere'.*[44]

99. A procurement process is underway to fit out CCTV monitoring similar to that used during the trial to the remainder of the fleet. As at September 2022 the QPS had approximately 14 Mercedes Sprinter vehicles, only nine of which had monitoring equipment fitted. These vehicles are generally used for transporting prisoners between watchhouses and prisons.[45]

100. GLT's family submitted that a recommendation be made that the QPS implement, as a result of the trial, the use of electronic monitoring systems fleet-wide for all police vehicles used to transport arrested offenders.

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[41] Exhibit F2 – Photo 11 and 14.
[42] Statement of Andrew Quinlan, Director, QPS Fleet Assets, at para 4.
[43] Statement of Andrew Quinlan, Director, QPS Fleet Assets, at para 5.
[44] Statement of Andrew Quinlan, Director, QPS Fleet Assets, at para 6-7.
[45] Statement of Andrew Quinlan, Director, QPS Fleet Assets, at para 8-10.

101. The Commissioner submitted that the QPS is implementing electronic monitoring systems fleet-wide in respect of police vehicles used to transport arrested offenders and prisoners. The Commissioner submitted no recommendation was required on this topic. I accept that submission.

How GLT was placed in the pod

102. The Operational Skills Section, Good Practice Guide, Restraining Accoutrements[46] states that *'a handcuffed subject should be transported in a seated/upright position or rolled onto their side; and kept under constant visual surveillance'*. This guidance is intended to reduce the likelihood of situations of positional asphyxia.

103. In my view, following his arrest and the subsequent ground struggle, GLT should not have been placed in the pod for transport, as he was likely unconscious. The involved police officers should have urgently sought medical assistance.

104. I accept that QPS officers are unable, due to the current state of equipment available to them (a lack of monitoring equipment in police vehicles), to comply with the above direction unless an officer were to sit in the rear seat of the vehicle during transport and constantly watch a person through the small portal window. The officers view would be further obscured by the centre headrest of the back seat and minimal lighting in the pod itself.

105. Since GLT's death, OPM 14.3.7 Post arrest collapse (medical risk factors)[47] has been amended to read (effective 3 June 2022):

> *a. 'Officers are to closely supervise (constant face-to-face monitoring) persons taken into custody where there is a high risk of excited delirium and positional asphyxia occurring'*…

106. Senior Sergeant Bailey told the inquest that the update occurred in 2020. The wording of this amendment places a positive onus on the officers to monitor a person. However, I agree that this requirement was not reasonable due to the lack of suitable equipment to enable constant monitoring.

Cautions and Flags for Mental Health and Violence

107. A QPRIME printout for GLT tendered at the inquest displayed cautions and flags associated with prior police interactions. On the QPRIME printout, the cautions and flags appear in date order, from newest to oldest. There were three Mental Health and other associated Cautions:

    a. Mental Health – EEA dated 06/05/2018;
    b. Mental Health – EEA dated 06/05/2017;

[46] Operational Skills Section, Good Practice Guide, Restraining Accoutrements at page 5.
[47] Exhibit G2.1.5

c. Mental Health – EEO dated 24/01/2013;
d. Suicidal – 04/01/2014; and
e. Drugs – 24/01/2013.

108. There were also Cautions for:

a. Armed – 16/01/2016
b. Armed – 18/01/2015
c. Armed – 30/03/2011;
d. Violent – 02/05/2008; and
e. Dangerous – 02/05/2008.

109. A copy of the QPRIME flags for GLT was shown to officers during the inquest. Constable Lally's evidence was that while he will review flags before approaching a job, every job is taken on its merits. All information officers have before proceeding to a job will form part of the risk assessment for that job.[48] Constable Lally accepted, with the benefit of hindsight, that with respect to GLT and the initial job to which the Police were required to respond, there were *'some elements in terms of some disturbance there of the mind'.*

110. Constable Traynor did not recall seeing any mental health EEA flags, but did recall the armed, violent and dangerous flags.[49] Constable Traynor explained that on a QLite device, the flags for violent, armed and dangerous will appear as red – meaning the most serious. These flags would come above the mental health flags that would have been yellow and below.[50]

111. Constable Traynor's evidence was that while she would take into consideration the date a flag was placed, the flags are usually put on by police, meaning there has been a violent interaction with police previously. Where there is a violent flag in place, they would take more police to respond to a job. Constable Traynor's evidence was that if she had seen the flags for EEA on the night, those flags would not have influenced the way she approached the situation.[51]

112. Constable Traynor accepted, with the benefit of hindsight, reflecting upon GLT not wanting to be transported in the vehicle, and the totality of the situation, including the mental health flags, she would probably agree GLT had mental health issues. This would not have changed what she did on the evening.[52]

[48] Transcript – 5 September 2022, Page 1-9, Line 4.
[49] Transcript – 5 September 2022, Page 1-34, Line 5.
[50] Transcript – 5 September 2022, Page 1-34, Line 10.
[51] Transcript – 5 September 2022, Page 1-34, Line 30.
[52] Transcript – 5 September 2022, Page 1-40, Line 10.

113. Constable Ryan's evidence was that she recalled seeing several violent flags for GLT when she reviewed the QLite device before approaching him.[53] Constable Ryan recalled watching her BWC footage later and seeing flags for mental health.[54] Constable Ryan did not recall anything about GLT's presentation on the evening that would have placed him in the category of requiring an EEA.[55] Constable Ryan had attributed GLT's comments about a crocodile to possible drug related behaviour.[56]

GLT's Mental Health history

114. GLT had a mental health presentation on 6 May 2018, where he was subject to an EEA. On that occasion, GLT was brought to DEM by the QPS on an EEA, reporting paranoia after three days of binge drinking and using drugs (methamphetamine and marijuana).

115. The EEA was extended to 10:00am and then to 1:00pm. The Social Worker assessing GLT noted that he was erratic and delusional. He stated people were out to get him and his family and did not believe the QPS were the "real police".[57] The EEA was revoked after GLT had slept and presented as calm and coherent.

116. Further examination of GLT's Mental Health records revealed the following history:

- *January 2013 – RCACT – brought in by QPS on an EEO due to paranoia/delusional ideation secondary to amphetamine use.*
- *History of a suicide attempt in 2013 – concerned that police were not really the police.*
- *Diagnosis – Mental and behavioural disorders due to use of other stimulants, including caffeine, harmful use, methamphetamine*.[58]

117. In circumstances analogous to those leading up to his death, on 6 May 2017, Caboolture Police arrested GLT and after a short conversation he was handcuffed and taken into custody. GLT initially complied with all police directions. When police attempted to secure GLT in the rear of the prisoner compartment of a marked sedan, GLT sat on the seat, but refused to move is legs to allow the door to close.

[53] Transcript – 5 September 2022, Page 1-58, Line 41.
[54] Transcript – 5 September 2022, Page 1-59, Line 1.
[55] Transcript – 5 September 2022, Page 1-59, Line 25.
[56] Transcript – 5 September 2022, Page 1-60, Line 21.
[57] Exhibit D2 – Mental Health Services Triage and Rapid Assessment, 06/05/2018, page 1 of 10.
[58] Exhibit D2 – page 2 & 3 of 10.

118. GLT became aggressive and subsequently lunged at police. Multiple police were required to secure GLT and police attempted to move him to a prisoner van. Upon approaching the pod, GLT braced his legs against the door preventing Officers from securing him in the pod. Four officers used force to secure GLT prior to transport. GLT identified to police that he had been under the influence of alcohol.[59]

119. Dr Rashford noted in his report that when GLT used the words: *"You are not real police,"* the behaviour appeared to be consistent with GLT's known mental health illnesses and drug use, particularly paranoia when intoxicated with methylamphetamines.[60]

120. When asked how police may be taught to treat flags for mental health in approaching future matters, Dr Rashford said that occupational violence and occupational safety for staff had to have primacy for any organisation. For example, the QAS deals with many people with a history of violence. While not all people with mental illness are violent, and not all people with a history of violence are violent all the time, first responders have to work through those issues and have to make decisions.[61] Dr Rashford noted that flags are important, but education behind the flags is more important.

121. Having regard to Dr Rashford's evidence, Counsel Assisting submitted that the system of prioritising flags on QLite devices should be reviewed and consideration given to the ordering/colour coding of flags.

122. The Commissioner did not support this recommendation. The submission from the Commissioner noted that there was insufficient evidence before the inquest to justify such a recommendation, and Dr Rashford did not have sufficient expertise in the way information is recorded in QPS systems and how this might impact on officers' decision making when attending at an incident.

123. Counsel Assisting submitted that while occupational safety for police must have some priority, the safety of officers is put in question when they are provided information in such a way that may lead to unconscious bias, in how they approach a matter. The Commissioner submitted there was insufficient evidence arising from this inquest for me to find that police officers may be subject to "unconscious bias" as a product of the way that flags/cautions are recorded. While it is possible that flags for matters such as mental health and violence in QPS systems may affect officers' approaches to incidents, I agree that there was not enough evidence to support a review of those matters.

[59] Exhibit A5 Statement of Detective Sergeant Parker at page 37 to 38.
[60] Exhibit G1 – Report of Dr Rashford at page 6.
[61] Transcript – 7 September , Page 3-24, Line 1.

124. Drug use and associated drug induced mental illness and anti-social behaviour are very common issues confronted by operational police. It is likely the expectation and not the exception. Constable Tome gave evidence that the type of flags and warnings for GLT are common with most people that police interact with, and their main concern was for the safety of the two female officers in attendance.[62] She noted that the way flags and warnings are displayed on the QLite device had changed since GLT's death.

125. I do not consider that GLT's presentation would have obviously warranted an EEA under the *Public Health Act.* However, with the benefit of hindsight, officers were able to identify some features of GLT's behaviour that may have been attributable to underlying mental health issues, in the context of a known history of substance misuse.[63]

Whether GLT's physical condition was appropriately monitored, and whether there was a failure to recognise signs of deterioration in his condition, and that he required medical assistance

126. I accept the submission of Counsel Assisting that officers acted in accordance with their training and policy and there were no indicators of unnecessary violence, or wilful disregard for GLT's welfare.

127. However, the evidence indicates that officers failed to recognise the signs of GLT's deterioration and his condition was not monitored at any time before efforts were made to extract him from the van at the watchhouse.

128. The closest officers came to recognising GLT's urgent need for medical assistance (prior to when the pod door was opened in the watchhouse) was when Constable Traynor and Constable Ryan shared their concerns about his observations in the vehicle on the way to the watchhouse.

129. This is not a new issue and a number of previous inquests have touched on this issue.

130. The problem appears to be two-fold. Officers are not capable of recognising the signs of rapid deterioration (which is a broader training issue). They also have sub-standard equipment available to them to enable them to comply with policy. In these circumstances the officers resorted to their level and quality of training and equipment.

[62] Affidavit of Constable Laura Tome, page 7, paragraph 14(b).
[63] OPM 6.6.2 Emergency Examination Authority (EEA). Section 157B *Public Health Act* 2005 (Qld).

131. Senior Sergeant Bailey noted in her first statement[64]:

> *'I am aware of common causes of fatalities due to prolonged struggles combined with severe underlying health conditions, especially heart related ones. This however, is very difficult for police to readily recognise without in-depth background knowledge of the subject.* (emphasis added)

132. As was borne out at inquest through the evidence of Dr Rashford and the joint QAS / QPS training package, police are not expert medical practitioners and they operate in a highly complex, fast-moving environment. However, I do not agree that it is difficult for police to recognise when a person is rapidly declining.

133. I acknowledge that the inquest is able to consider events with the benefit of hindsight. However, it is not unreasonable to expect that professional police officers should be actively monitoring persons under arrest for signs of distress and reduced levels of consciousness after a physical altercation, particularly before the person is placed in a secure pod for transport.

134. When Constable Ryan was questioned at inquest about her statement *'he's sweating pretty bad, they're not going to take him'* she clarified this was a reference to watchhouse procedures for a medical clearance.

135. Constable Ryan acknowledged that GLT's sweating was a symptom listed on the CARE guide that may have suggested he was physically unwell.[65]

136. Constable Ryan confirmed at the Inquest that when Constable Traynor said to her: *'I don't even know if he's conscious, I'm not going to lie',* a concern was raised for her that GLT may not be conscious. However, at that point they were about to reverse into the watchhouse bay and she believed it was for everyone's safety, after what had happened, to reverse the vehicle into the bay and have it in a contained space for when the doors of the vehicle were opened to extract GLT. Constable Ryan accepted that with the benefit of hindsight, she would possibly have sought medical attention at the scene of the arrest rather than transporting GLT.[66]

Dr Rashford's evidence

137. Dr Rashford acknowledged the difficult role police officers have in operating in a dynamic and fast-moving environment, where they will often be required to move quickly from the traditional role of 'policing' to the role of 'caregiver'.

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[64] At paragraph 140.
[65] Transcript – 5 September 2022, Page 1-68, Line 5.
[66] Transcript – 5 September 2022, Page 1-69, Line 3.

138. GLT's behaviour during the arrest process *'escalated in an unpredictable and confronting manner'*.[67] Nonetheless, it was Dr Rashford's evidence that there was *'a delay in the recognition of GLT's deterioration'*[68] by the police officers in attendance.

GLT becomes unconscious.

139. Dr Rashford's opinion was that at the point GLT was *'placed into the secure compartment of the Police vehicle'* (pod), he was not speaking. Dr Rashford believed that he was "*incredibly fatigued and, at worst, was in the process of becoming unconscious at that point*".[69]

140. Dr Rashford said that GLT had "semi-assisted" to get into the back of the police van, but at that point, he makes no further physical efforts and was "*basically pushed into the back of the paddy wagon*". He was in the same position when he arrived at the Rockhampton watchhouse.

141. Dr Rashford's opinion was that his condition has significantly changed from a couple of minutes earlier, and it was likely that he suffered a cardiac arrest near that point. Dr Rashford was confident that GLT was "*almost certainly unconscious at that point and the cardiac arrest certainly occurred before the arrival at the police station*". The footage he reviewed showed GLT had hypostasis in the skin of his abdomen and his face. He said that does not occur immediately after cardiac arrest but takes several minutes.[70]

142. At inquest, the BWC footage of Constable Laura Tome[71] was shown to the police witnesses and an aide memoir was referred to in order to assist the parties in reviewing the evidence in conjunction with the BWC footage.

143. At T17:45:52Z / 03:45:52h, GLT can be seen at the entrance of the pod, in a semi seated position, facing towards officers. His head drops to the rear and appears to 'hang' in a rearward position.

144. Consistent with the expert evidence of Dr Rashford, I am satisfied GLT was likely unconscious at this point. None of the Police Officers involved in the arrest recognised that GLT had become unconscious. Dr Rashford's evidence at inquest was that: *'In the setting of what had led up to the event, I don't think they recognised that this person was… exhibiting signs which were very concerning for his physical health'*.[72]

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[67] Exhibit G1 – Report of Dr Rashford at page 8.
[68] Exhibit G1 – Report of Dr Rashford at page 8.
[69] Exhibit G1 – Report of Dr Rashford at page 4, Transcript – 7 September 2022, Page 5-5, Line 20. See also Exhibit E18 BWC – Senior Constable Martinez at T17:45:58Z
[70] Transcript – 7 September , Page 3-3, Line 35.
[71] Exhibit E21.
[72] Transcript – 7 September , Page 3-10, Line 46.

145. The failure by police officers to recognise GLT was likely unconscious, is further supported by the words and actions of the officers and their failure to provide medical assistance at that point in time.

146. I agree with the submission from Counsel Assisting that in the 'heightened state of the moment', the officers unwittingly assigned malice or recalcitrance to GLT's actions. I also accept that after the ground struggle, the officers' paramount concern was their own safety and that of their colleagues. Their fatigue, and level of injury, was evident from the body worn camera footage which was recorded after GLT was secured in the police van.

147. I also acknowledge the submission from the involved officers that Dr Rashford's assessment was made with the benefit of hindsight, and the review of footage. I accept that the evidence, at its highest, does not enable a finding that it was certain that GLT was unconscious when he was placed in the pod.

148. When asked what 'visual cues' may be evidence of GLT being unconscious, Dr Rashford responded:

- *'It's actually a culmination of things and there are a lot of human factors involved in this … I've been to a lot of inquests now where the same factors are at play, and after a physical exertion, the police are glad that the physical efforts are over. But the person – a person who exerts themselves significantly just doesn't suddenly stop and their breathing slow down and their ability to pronate change. If you think of yourself, if you do an immense of exercise in a short period of time, you're breathing heavily and stimulated for a period of time until you repay your oxygen debt that you've built up during that period of exertion'.*

- *'So the thing for me is that you've got a fellow who's completely – well, significantly resisted attempts at restraint… he does utter a number of utterances of, you know, I'm fucked. I can't breathe, and a number of other things which I've notated in my report. And then he gets to a point where he's basically not uttering coherent words at all… and his physical efforts are not there anymore. He's not resisting anything'.*

149. Dr Rashford said the footage showed GLT did not make any significant purposeful movement whatsoever after being placed in the van. He said that it was necessary to understand triggers and consider whether something has happened to this individual and have they suffered a medical event.

150. Dr Rashford highlighted the "*hundred miles an hour to zero syndrome*". He said that this was seen recurrently in this group of individuals and in this setting, and was a combination of factors which lead to cardiac arrest. There was generally no one single factor. He described the scenario '*of a person who has significant change and now they're not actually making purposeful movements whatsoever… And I think that that required further analysis of the person's condition'…*[73]

151. When Dr Rashford was asked about an 'audible bang' as GLT reached the back of the pod, in company of the Police officers, he responded that his interpretation was that GLT *"did not have control of his movements at that point. I think he was, at best, incredibly fatigued and, at worst, was in the process of becoming unconscious at that point. But he certainly – his condition had significantly changed".*[74]

152. Dr Rashford was also asked about a theoretical 'gold standard' of care for someone presenting in the way GLT was on the evening of his death. Dr Rashford responded that, in hindsight, GLT needed a period of observation before being placed into the police van to make sure he was okay, because he was exhibiting signs that his physical status had changed dramatically. He said that "*he may well have been changed from a primary law enforcement to a primary medical issue at that point*".[75]

153. The following statements of Constable Traynor and Constable Ryan were also put to Dr Rashford at the Inquest.

    - Constable Traynor: '*I don't even know if he's conscious, I'm not gonna lie'.*

    - Constable Ryan: *'He's sweating pretty bad, they're not gonna take him'*.

154. Dr Rashford said that those statements indicated that the officers immediately needed to reassess GLT*, "and if they thought that person was unconscious in the back of the paddy wagon in that secure cell, they need to remove them. They need to get 360 degree access".* He said that those comments indicated that there was a need to reassess GLTs' current condition and "that was the learning problem"*.*[76]

155. Neither Constable Traynor or Constable Ryan communicated the information above, which indicated they held some concerns for the physical welfare of GLT, to any other person upon arrival at the watchhouse.

[73] Transcript – 7 September , Page 3-4, Line 20.
[74] Transcript – 7 September , Page 3-5, Line 17.
[75] Transcript – 7 September , Page 3-8, Line 13.
[76] Transcript – 7 September , Page 3-10, Line 10.

156. Independent of the 'human factors' at play, if Constable Traynor was unsure whether GLT was conscious, swift action should have been taken, such as verbalising this concern to her colleagues and ensuring that the pod door was opened quickly, and confirmation of GLT's welfare was obtained.

157. Dr Rashford further said that if any one of the officers "*feels uncomfortable, they should feel empowered to actually say, "Look, I know we're all okay, but I'm worried…. There's something not right here."*[77]

Resuscitation efforts once Police identified GLT's need for medical assistance.

158. Dr Rashford's evidence was that GLT was in cardiac arrest upon arrival at the Rockhampton watchhouse.[78] Once Officers recognised that GLT was in a critical condition, Dr Rashford described the response of Police as *'prompt and of a very high standard for non-clinicians'*.[79]

159. Dr Rashford said the "*resuscitation efforts were more than adequate and they did everything possible to try and save his life'.*[80]

Whether any recommendations might be made that could reduce the likelihood of deaths occurring in similar circumstances, or otherwise contribute to public health and safety, or the administration of justice

Lessons Learnt

160. Dr Rashford was asked at inquest what learnings he believed may flow from this situation. He noted that after the QPS and QAS had encountered a number of these situations occurring over the last few years and the QAS and QPS had been working separately. There are now combined education initiatives being rolled out. He noted that by the nature of their work, QPS officers will often be the first responders, or first on scene of people suffering primary medical events, particularly in the setting of restraints and other presentations. As a consequence, the education has shifted to "*concepts of changes in behaviour, changes in physical characteristics, to trigger a review of what could be now an evolving medical issue*".[81]

[77] Transcript – 7 September , Page 3-13, Line 18.
[78] Transcript – 7 September , Page 3-3, Line 25.
[79] Exhibit G1 – Report of Dr Rashford at page 7.
[80] Transcript – 7 September , Page 3-8, Line 30.
[81] Transcript – 7 September , Page 3-8, Line 40.

161. Dr Rashford also considered there needs to be a *'cultural change'* to recognise that a restrained patient with "these particular characteristics is a very high level clinical presentation and a very high risk presentation and we need to treat it as such".[82]

162. Dr Rashford was asked about the use of terms in the Operational Procedures Manual such as 'excited delirium' and 'positional asphyxia', and whether those terms were as relevant as they were in the past or whether there are additional syndromes or issues for police to look at as well as these multifactorial types of situations. Dr Rashford responded:

    - *'I think they're a gross oversimplification of what the presentation is. Look, excited delirium does occur, but it's only a very small subset of all the people who present with acutely disturbed behaviour, and it is a syndrome, but most of those other people who present who may not meet the definition of excited delirium still are a risk, and so I actually think we should be looking at it in terms of acutely disturbed behaviour in the setting – or aberrant behaviour in the setting of – whether it's intoxication or perhaps mental illness or other – other forms of presentation'.*[83]

163. Dr Rashford was asked what he believed was the best way to train people to recognise signs and symptoms (as exhibited by GLT and persons in similar situations) and to take action – whether that required a facilitated learning approach, an online learning package or both. He said it has to be a combination but lived experience was powerful including exposure to BWC footage of critical incidents.[84]

164. Dr Rashford was asked whether following an internal investigative process, something like a debrief in the workplace, with real time and lived experience of officers would be beneficial. Dr Rashford replied:

    - *'I think every one of the officers involved in this case, I'm sure, was horrified at the final outcome and – and would not have seen it coming. And one of the questions you asked me is did they pick up on it. I think if any of them had picked up that he was really unwell, GLT was unwell, they would have intervened. I really do believe that. And I think we have to ask ourselves why didn't they, and that's part of the debriefing process. So we learned for our education, for other people, but also for the officers involved'*.[85]

[82] Transcript – 7 September , Page 3-9, Line 19.
[83] Transcript – 7 September , Page 3-13, Line 37.
[84] Transcript – 7 September , Page 3-11, Line 8.
[85] Transcript – 7 September , Page 3-11, Line 33.

Joint QPS / QAS Training package

165. Inspector Anthony Buxton, Manager, Operational Training Services gave evidence about specific training under development by the QAS and QPS in response to a number of earlier coronial recommendations. A draft version of the training was shown to the Court and Inspector Buxton noted that the training would have theoretical and practical elements.

166. Officers will be required to display a minimum standard of skill. I acknowledge that the training that has been developed is consistent with the recommendations of Dr Rashford, and will hopefully address the current short fall in training for QPS.[86]

167. The Commissioner's submission noted that the training package developed in partnership with the QAS has been finalised and released. Completion of the training is compulsory for all police officers up to the rank of Superintendent.

168. All police recruits, as part of their training are required to complete Operational Skills Training ("OST"), which includes components on "Post Arrest Collapse". This training encompasses identifying medical risk factors and the application of the "Custody and Arrest Risk Evaluation (CARE) Guide". After recruits are sworn as police officers, it is compulsory for those officers to complete the QPS/QAS joint training package.

169. Post Arrest Care and rapid medical decline themes from the QPS-QAS OLP were earmarked as themes for compulsory annual OST training in the 2023/2024 calendar year. On 14 November 2022, Assistant Commissioner Mark Kelly released a memorandum state-wide, stating that the proposed themes for OST training included:

> *"Post Arrest Care (Inquests of Mitchell, Noombah, Giorgio and Coolwell)"*

170. The Commissioner's submission noted that the QPS is aware that the use of BWC footage, officer accounts and operational case studies have strong links to adult and immersive learning principles. The QPS will seek to include these sources of information into its training where it is appropriate and affords a desired learning outcome for officers. However, the use of these sources is dependent upon the consent for use by third parties such as the family of the deceased.

[86] Statement of Inspector Anthony James Buxton. Transcript – 6 September 2022, Page 2-52 onwards.

171. The Commissioner's submission noted that the QPS continues to internally review its training packages and delivery, with the expectation training will evolve where deficiencies and emerging issues within the community which need to be addressed through updated training are identified. The development of the training has been in accordance with previous coronial recommendations.

172. The Commissioner submitted that no further recommendation is required in respect of the training which has been developed in conjunction with the QAS and is now being delivered to police officers. I accept that submission.

Terminology

173. I agree with the submission of Counsel Assisting that the use of terms such as 'excited delirium' and 'positional asphyxia' within QPS policies should be reviewed, in consultation with the QAS, to ensure terminology is accurate and reflects of 'best medical practice'.

174. There is a risk that the use of terms that are either unclear or dated will detract from a QPS officer's ability to actively recognise signs of deterioration.

Requirement for mandatory confirmation of health status of person under arrest, prior to transport

175. I also agree with the submission of Counsel Assisting that the QPS should introduce a mandatory requirement for its officers to provide radio confirmation of the health status of a person under arrest before transport in a secure pod.

176. Verbal confirmation that the person is conscious and responding when placed in the pod, in combination with the anticipated monitoring equipment for the vehicles would sensibly assist in increasing public safety.

Recommendations:

1. ***I recommend that the QPS review the use of terms such as 'excited delirium' and 'positional asphyxia' within its policies and procedures, in consultation with the QAS, to ensure that the terminology used is accurate and reflects 'best medical practice'.***

2. ***I recommend that the QPS introduce a mandatory requirement for police officers to provide radio confirmation of the health status of a person under arrest before they are transported in a secure pod.***

177. I extend my sincere condolences to GLT's family and friends. I close the inquest.

Terry Ryan
State Coroner