QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of William George Grimes**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Maryborough
FILE NO(s):	2020/1054
DELIVERED ON:	5 April 2023
DELIVERED AT:	Hervey Bay
HEARING DATE(s):	9 September 2022, 18-19 October 2022, written submissions - 16 November 2022.
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in the course of police operations, conducted energy weapon, Taser, self-immolation, use of force, mental health response, incident command, police training.

REPRESENTATION:

Counsel Assisting:	Ms Rhiannon Helsen and Ms Alexandra Sanders, Coroners Court
Grimes Family:	Mr Mitch Rawlings, instructed by Caxton Legal Service

Commissioner of Police:	Ms Susan Donkin, QPS Legal Unit
SC Price Constable King Constable Kingsman Constable Gartrell	Mr Troy Schmidt, instructed by Gilshenan and Luton

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Introduction

1. William George Grimes (known as George) was 31 years of age at the time of his death. He suffered from schizophrenia and had a significant history of contact with mental health services.

2. At 11:00pm on 3 March 2020, the Queensland Police Service was contacted in relation to George. His brother, David, reported that he was threatening to commit suicide by dousing himself with fuel and setting himself alight. A suicide note had been located. After speaking to George's family, police established that he had consumed a substantial amount of alcohol and had possession of a red five litre container of fuel.

3. Soon after, QPS officers located George at a park. They attempted to engage with him and followed him to a nearby school ground. Four officers contained him in an area between a shed and a tree at the school. George was highly agitated and yelling at police to stay away as he intended to kill himself. After speaking to police officers briefly, he poured the fuel over his head and torso before moving a cigarette lighter towards himself.

4. At the same time, in an attempt to stop George setting himself alight, Constable Gartrell discharged his Taser. George became engulfed in flames. Steps were taken to put the fire out and immediate first aid was provided by police officers before Queensland Ambulance Service (QAS) paramedics attended.

5. George was transported to the Maryborough Hospital before being airlifted to the Royal Brisbane and Women's Hospital (RBWH) for treatment. He had burns to 70% of his body. On 10 March 2020, life support measures were ceased.

6. George's death was a *'death in police operations'* under the *Coroners Act 2003*. A comprehensive investigation was conducted by Detective Sgt David Perry from the QPS Ethical Standards Command (ESC). He subsequently prepared a coronial report with various annexures, including witness statements, footage, forensic analysis, and various photographic exhibits.

Inquest issues

7. The primary purpose of an inquest is to inform the family and the public about the matters required by s 45 of the *Coroners Act 2003*, including when, where and how the person died and what caused the death. A coroner may also comment on anything connected with the death relating to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future.

8. A coroner is not able to include in the findings or comments any statement that a person is, or may be, guilty of an offence or civilly liable. Where a coroner suspects that a criminal offence has been committed, they can make a referral to the Director of Public Prosecutions or relevant prosecuting authority.

9. Information about a person's conduct in a profession can also be given to the disciplinary body for that profession if the coroner believes the information might cause the body to inquire into or take steps in relation to the conduct.

10. Following a pre-inquest hearing on 9 September 2022, the issues for inquest were settled as:

- Findings required by s.45(2) of the *Coroners Act 2003*; namely the identity of the deceased person, when, where and how he died and the cause of his death.
- Consideration of the circumstances leading up to the decision by police to Taser Mr Grimes on 3 March 2020.
- Consideration of Mr Grimes' mental health care and treatment prior to his death.
- Whether the police officers involved acted in accordance with Queensland Police Service (QPS) policies and procedures then in force and whether their actions were appropriate.
- Whether the training and equipment provided to officers in responding to a similar incident is sufficient.

11. The inquest was held at the Hervey Bay Courthouse on 18-19 October 2022. Ten witnesses were called to give evidence. Family statements from seven of George's family members were read to the court, including his mother, brother, children and former partner.

Personal Circumstances and History

12. George lived with his parents[1] and sister at Odessa Street, Maryborough. He had been living with his partner, Natasha, but that relationship had ended in January 2020, following allegations of violence.[2] George had two children from a previous relationship.

13. George had previous episodes of self-harm including an attempted suicide by dousing himself with fuel and setting himself alight.[3] Further suicide attempts had been made since, for which he was taken to the Maryborough Hospital. Alcohol exacerbated his condition, as did missing doses of medication.[4]

14. Medical records, his family, and former partners confirmed George had a long-standing mental health history. He was diagnosed with schizophrenia in his early teens. He had been prescribed the antipsychotic medication, Seroquel, for some time but had a history of missing doses.

15. George also drank to excess and had done so for some time according to those close to him. Binge drinking largely precipitated thoughts of suicide and self-harm, as well as suicide attempts.

16. Records from Medicare, Consumer Integrated Mental Health and Addiction, and General Practitioner records, as well as those from the RBWH, Maryborough and Hervey Bay Hospitals were obtained as part of the coronial investigation.

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[1] Although Barbara and Neville were George's foster parents, he regarded them as his parents and I will refer to them as such.
[2] Ex B12, [8]
[3] Ex B12, [6]; Ex B14 [49]
[4] Ex B12, [4]

17. The health records obtained by the Coroners Court provide information about past incidents of self-harm or suicide attempts, which include the following:

12.11.11: George was brought to the Hervey Bay Hospital by ambulance after setting himself alight following an argument with his girlfriend.[5] He had surface burns to 30% of his body.[6] He was treated at the RBWH in the ICU for a period of time.[7] The discharge summary indicated that he suffered a partial airway obstruction secondary to 23% thickness burns to his head/face/neck/thorax.[8]

21.12.18: George approached QAS paramedics in the ambulance bay at hospital with a blade and appeared to have self-inflicted wounds on his left forearm. He appeared to be very distressed and was requesting help.[9] A mental health assessment was conducted and he was determined to be at high risk of suicide. He was discharged to the care of his partner with Acute Care Team follow up and possible Alcohol and Other Drugs Service referral.

27.01.19: George was placed on an Emergency Examination Authority by the QAS when he threatened to commit suicide by setting himself on fire.[10] He was speaking to voices he was hearing and became aggressive, throwing chairs and thrashing out violently. It was determined that he was at immediate risk of self-harm due to his past medical history of suicide attempts and current thoughts of wanting to end his life. He was heavily intoxicated.[11]

8.03.19: George was taken to Hervey Bay Hospital by the QAS as he was suicidal – it was noted that he was not compliant with medication.[12] He was assessed and discharged to the care of his partner, with scripts for Seroquel and Paroxetine. Follow up was to take place in the community.[13]

05.04.19: George's partner reported he was suicidal. He had been drinking and was not taking his medication.[14] He stayed overnight at the Hervey Bay Hospital. On 6 April 2019, a letter was sent to his GP as he was discharged for community follow up.[15]

20.12.19: After an argument with his partner, George poured two containers of petrol over himself. QPS were called and de-escalated the situation. The QPS took him to hospital under an EEA.[16] He presented with rapid speech and auditory/visual hallucinations. His blood alcohol concentration on a breath test was 0.121. When assessed, George claimed that he did not recall what had happened. He admitted having auditory hallucinations. He was ultimately discharged and referred back to his GP in relation to his diagnosis. The Acute Care Team were to provide a support call over the weekend.[17] A letter was sent to his GP on 21

[5] Ex E4, pg. 21
[6] Ex F1, pg. 1
[7] Ex E4, pg. 156
[8] Ex E4, pg. 198
[9] Ex E4, pg. 36
[10] Ex E4, pg. 148 – QAS Report Form
[11] Ex E4, pg. 48 - 58
[12] Ex E4, pg. 61
[13] Ex E4, pg. 64
[14] Ex E4, pg. 75
[15] Ex E4, pg. 145
[16] Ex E4, pg. 96
[17] Ex E4, pg. 107

December 2019, which recommended that George follow up with the GP for further management.[18]

18. It appears that George was originally attending a GP from the Urangan Medical Centre for care, which included his mental health issues. Despite a Mental Health Plan being formulated on 6 December 2019,[19] which included regular follow up and support in the community, George went to another GP in Pialba from this date until his death.

19. George's foster mother, Barbara Ehrich, said that following his passing, life had been heartbreaking and empty. George had been in the care of her family from the age of three. She said that he was a loving son, brother and father. While at times he was quite serious, he was also joking and loving. He had struggled to cope after relationships broke down. Barbara said that George was academically gifted in primary school and had a love of music, becoming a valuable member of the Maryborough Excelsior City Band. On the day of his death he had been happy and relaxed but then his life was suddenly cut short.

20. It was clear from the statements of George's sister and brother that he was a giving person who cared for family members, but particularly his children. He struggled with his mental health and felt at times that he had failed his family. His loss has clearly had a deep impact on all family members.

21. His children reflected on how they miss spending time relaxing with their father, hearing him play music. He is no longer there to protect them or be there for significant events in their lives.

22. I extend my sincere condolences to George's family and friends.

Events leading up to the death

23. On the evening of 3 March 2020, George left his home after giving his sister, Lisa-Maree a note indicating that he intended to suicide.[20] The note said, '*You were my light but I failed and I am sorry'.*[21] His mother said he had been in a 'funny mood all day' and had not taken his antipsychotic medication.[22]

24. Around 11:00pm, George's brother, David, contacted police and spoke to Constable Price, of the Maryborough Police Station, advising that his brother was threatening to commit suicide by dousing himself in fuel and setting himself alight.[23] Constable Price asked that he call triple 000 given the seriousness of the threat.[24] Constable Price told the inquest he had been unable to locate George on QPrime.

25. A short while later a request was made by police communications for any units in Maryborough to attend. A unit consisting of Constable Price and Senior Constable King responded immediately. They went to the family residence and spoke to George's family. Police were told that George had a history of suicide attempts

[18] Ex E4, pg. 135
[19] Ex E8
[20] Ex A5, pg. 3
[21] Ex B17, [6]
[22] Ex B12, [12]
[23] Ex B14 [26]
[24] Ex B6, p. 5

and had walked away from the residence after consuming around 12 cans of beer while discussing domestic violence issues and work-related concerns.[25] He was also upset after a child had nearly been run over by a car in his presence that day.

26. A five-litre container, containing an unknown quantity of fuel, was missing from the residence. Police were shown a letter and text messages written by George, which suggested that he was wanting to harm himself.[26] These messages included comments, such as,

> *'It's too late, I've been upset for too long I'm not scared anymore'.*[27]
>
> *'I have petrol and a lighter so tell everyone to stay away this time I have to go and you all need to understand.'*[28]

27. Attempts to call George by his family went unanswered.[29] His last message stated, '*They won't find me'.*[30]

28. A search was immediately commenced, and George was sighted in Brendan Hansen Park by SC King and Constable Price. Police saw him flicking a cigarette lighter. George went rapidly towards Granville State School and police followed in their vehicle. He was holding the fuel container in his right hand.

29. As George entered the school grounds through an open gate, the officers alighted from the QPS vehicle. They continued to follow him, calling out for him to stop, and attempting to engage with him. Further crews were asked to attend.

30. General duties officers from Maryborough Station, Constable Gartrell and Constable Kingsman responded.[31] Constable Gartrell said they discussed the particulars of the job on the way.[32] Constable Price reported over the radio that George had run from Granville Park in the direction of Granville State School.[33] SC King assisted by providing light from his torch.[34]

31. After arriving at the school, Constable Gartrell and Constable Kingsman entered through a side entrance. Given the lack of lighting, they looked for the flashlights and the sound of voices in order to locate Constable Price, SC King, and George. George continued to move away from them at pace, eventually concealing himself behind the school groundsman's shed, near a cluster of trees.

32. Constable Gartrell recalled seeing George holding the fuel container and attempted to engage with him, mistakenly calling him 'Dave' for a short period.[35] Constable Price was also attempting to engage with George, requesting that he let police help him.[36]

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[25] Ex B6, p. 5 & 6
[26] Ex B6, p. 5 & 6; Ex B14 [29]
[27] Ex B14 [29]
[28] Ex B17, [11]
[29] Ex B14 [33] - [35]
[30] Ex B14 [36]
[31] Ex B4, pg. 6
[32] Ex B4, pg. 6
[33] Ex B4, pg. 6
[34] Ex A5, pg. 16
[35] Ex B4, pg. 7 & 8
[36] Ex B6, p. 28

33. The officers effectively contained George. He appeared agitated at the time and kept repeating, '*stay away, I'm going to kill myself before you do*'. He indicated that he wanted to be alone and was saying, '*they're going to shoot us*' and '*we can do it this time*'.

34. George engaged in a brief dialogue with police, particularly Constable Gartrell, who attempted to build a rapport with him and deescalate the situation as he was closest in proximity.[37] Constable Gartrell saw George place petrol on the ground around him, apparently to create a barrier.[38]

35. Around three minutes later, George stopped responding to police and appeared to be speaking to himself. He then doused the front of his body with petrol for around 12 seconds. He then moved his left hand, holding the lighter, towards his body, seemingly intending to set himself alight.[39] The lighter was a standard disposable cigarette lighter.[40] At this time, Constable Gartrell discharged his Taser, intending to stop George from completing the act. He was approximately three metres from George at this time. This was captured on body worn camera (BWC) footage.

36. Constable Gartrell was a General Duties officer who was sworn in 2015. He was working a 10:00pm – 6:00 am shift on 3 March 2020. At the commencement of his shift, he tested his Taser, which did not indicate any faults.

37. During the ESC investigation Constable Gartrell described his understanding of Taser training and the Operational Procedures Manual (OPM). He acknowledged that he was aware that a Taser should not be used in connection with a flammable substance. However, he was confident he had a high chance of achieving a successful lock on George due to his clothing and proximity.

38. Constable Gartrell was of the belief that George was going to complete the act of suicide from his behaviour. His assessment of the threat posed was high due to the presence of the lighter and fuel – not only to himself but to the other officers in attendance. Constable Gartrell suffered minor burns while rendering assistance.

39. Constable Gartrell explained that after George created the barrier with fuel, he considered all use of force options available to him, which included tackling, hand to hand, OC spray[41] and baton.[42]

40. Constable Gartrell was concerned about employing OC spray as it is only effective within two metres. He thought it may then be possible for George to rush at him and cause harm, and it may also make him more aggressive.[43] He formed the view that this effectively left him with use of his firearm or Taser as the only options. Constable Gartrell described finding a 'good line of sight' in order to ensure there was a lock-up[44] as this would 'complete the circuit'. He said that this meant there

[37] Ex B4, pg. 13
[38] Ex B4, pg. 13
[39] Ex B4, pg. 14; 38
[40] Ex B4, pg. 33
[41] Oleoresin capsicum spray
[42] Ex B4, pg. 13 & 14
[43] Ex B4, pg. 13 & 14
[44] Neuromuscular incapacitation

would be no spark.[45] His evidence at the inquest was that he was not aware that a spark was formed at the tip of taser barbs immediately after they are fired.

41. When the Taser was discharged, George's hand holding the cigarette lighter was brought into the area of ignition simultaneously. He immediately became engulfed in flames. The attending police officers immediately attempted to put out the fire by rolling him on the ground and covering him with soil. At the inquest, Constable King said that this was effective and the flames were extinguished within around 30 seconds.

42. The QAS were called at 11:10pm and first aid was provided until paramedics arrived and took over treatment at 11:19pm.[46] George was talking coherently to the officers at this time. Members of the Queensland Fire and Emergency Services (QFES) also attended the scene[47] and assisted with treatment of the burns.

43. Advanced Care Paramedics (ACP) Bliesner and Edge were the first to attend the scene.[48] They were advised that George had doused himself in petrol and was alight for approximately 30 seconds. In addition, he had been Tasered and was rolled to extinguish the flames prior to QAS arrival.[49] ACP Bliesner noted that George was alert upon arrival, supine, and maintaining his own airway, although had severe burns to 70% of his body.[50] One Taser barb was found in contact with the groin area of his partially burnt pants.

44. George said that he had been drinking before the incident.[51] He told the paramedics that he had done something stupid and asked if he was going to die. He had a Glasgow Coma Scale score of 15 out of 15 and was complaining of generalised pain to his body.[52] ACP Bliesner noted that he had visible facial hair singeing, as well as partial thickness burns to his head, circumferential burns to his neck and both arms, as well as full thickness burns to his back, abdomen, and upper thighs.[53]

45. While SC King ran to retrieve a fire extinguisher, he was unable to locate one in either of two police vehicles.[54] He then found a large bottle of water, which was used to assist. Twenty minutes of active cooling to George's body was provided by QFES and QPS officers with water bottles.[55]

46. SC King told the inquest that while he thought the police vehicle that he was in had an extinguisher, he did not take it to the incident location as the focus was on George and containing the situation.

47. In addition to pain relief medication, George's burns were covered in cling wrap, and he remained warm while in transit to the Maryborough Hospital. George was subsequently transported by helicopter to the RBWH that evening. Police were

[45] Ex B4, pg. 15
[46] Ex B27, [5]
[47] Ex B21
[48] Ex B27 & B11
[49] Ex B27, [7] & [8]
[50] Ex B27, [9]
[51] Ex B27, [11]
[52] Ex B27, [14]
[53] Ex B27, [15]
[54] Ex A5, pg. 18
[55] Ex B27, [13]; Ex B21, [6]

advised at this time that George had suffered burns to approximately 60%-70% of his body.

48. George was placed on life support and despite receiving extensive treatment at the RBWH in the Intensive Care Unit,[56] on 10 March 2020 a decision was made to remove his life support. He was declared deceased a short time later.

49. Constable Price told the inquest he had not been given any training in the use of fire extinguishers. He said that officers are taught situational containment as part of the use of force model. The risk assessment process during this incident was continuous. The plan to was contain the situation and engage with George. He said this was effectively achieved. It was important to keep eyes on the fuel container. He had not encountered a similar situation before. It was very dark and he could only see Constable Gartrell.

50. Constable Price was aware that George became upset after mistakenly being called 'Dave', and he took over communication with him to try to build rapport, telling him that everyone was worried about him and police were there to help.

51. Constable Price recalled that the training provided at the Police Academy was to the effect that a Taser should not be used near flammable liquids. However, this was not expressed in mandatory terms. After George was engulfed in flames, he rushed to him and used soil to extinguish the flames. He said there is now an Online Learning Product in relation to the use of accelerants and fire extinguishers.

52. Sgt Elder was the Shift Supervisor. He was in the Police Communications Centre and was alerted to the job in relation to George, who he was aware had made threats of suicide by dousing himself with fuel. [57]

53. Sgt Elder contacted SC King, who was the most senior officer on the scene, to ascertain if the crew had fire extinguishers should George carry out his plan.[58] He was told that they did not, and the officers were not near the QPS vehicles. He then made arrangements for a third crew to attend with a fire extinguisher and could hear the negotiations as they were taking place.

54. After hearing that the Taser had been deployed, Sgt Elder attended the scene and authorised Code 1 for all units to attend. He observed George, who had been placed into the recovery position and had significant burns to his body. He directed that bottles of water be retrieved by crews and continued to douse George while paramedics were providing treatment.

55. Sgt Elder provided a brief to the District Officer, Superintendent Hawkins, Detective Inspector Pettiford and Inspector Clowes. He was directed that there was to be no download of the Taser, but had the involved officers dock their BWCs for download.

56. Forensic testing was conducted of samples of soil (one control and one from the incident location) taken from the scene as well as the fuel container for the purpose

[56] Ex B28 – Statement of Dr Michael Muller, RBWH
[57] Ex A5, pg. 19 onwards
[58] Ex A5, pg. 21

of determining whether ignitable liquid residue was present.[59] Aside from the control sample, ignitable liquid residue was found on the items.[60]

Cause of Ignition

57. In order to determine the source of ignition of the fire that resulted in the fatal injuries to George, advice was sought from the Manager of the State Fire Investigation Unit at QFES, Inspector Mallouk,[61] and Sgt Watene, Forensic Scientist for the Major Crimes Unit, Brisbane Scientific Section.[62]

58. Inspector Mallouk was asked to consider video footage of the incident and provide an opinion as to the ignition source.[63] He was provided with a copy of the BWC footage and the video compilation prepared by QPS. He considered relevant literature in reaching his conclusions.

59. With respect to the ignitability of unleaded petrol, Inspector Mallouk noted the following:[64]

- When an ignitable liquid such as unleaded petrol is poured onto a surface, the liquid's vapours combust, not the liquid itself.
- Unleaded petrol is easy to ignite as it has high vapour pressure, which makes it highly volatile with a very low flashpoint.
- Flammable vapour can only be ignited within specific ranges of vapour concentration, which are expressed as the lower flammable limit (LFL) or Upper Flammable Limit (UFL). The LFL for unleaded petrol is 1.4% in the air, and the UFL is 7.6%.
- Sparks created by a lighter's spark wheel and/or subsequent flame or arcing from electrical equipment and other such devices (such as a Taser) are both competent ignition sources and can ignite petrol vapour.

60. With respect to the two possible sources of the ignition in this case, the electrical energy produced by the Taser and the cigarette lighter (including the spark wheel), Inspector Mallouk found as follows:[65]

- The footage highlights the impact location of both probes, which in effect frames the point of ignition. Based on this evidence, he considered the Taser discharge may be a possible source of ignition.
- The footage also displays that George holding the lighter in his left hand, which is initially in an outstretched position when he douses himself in fuel, prior to discharge of the Taser. Prior to ignition of the fire, George moved his arm down towards his waist. He continued to hold the lighter as he rotated it in an upward direction just below the lower Taser probe. Ignition occurred at this point which

[59] Ex B23
[60] Ex B23, [10] & [11]
[61] Ex B25
[62] Ex B24 (now self-employed)
[63] Ex B25, [1.1]
[64] Ex B25, pg. 5
[65] Ex B25, pg. 5 & 6

was at the same time as the Taser discharge. Based on this, Inspector Mallouk was of the opinion that the cigarette lighter may also have been a possible source of ignition. He told the inquest the lighter's safety mechanism did not stop a spark from being generated.

61. Accordingly, Inspector Mallouk concluded both of the possible sources were competent ignition sources and the cause of fire determination was classified as 'undetermined'.[66]

62. Inspector Mallouk was unable to rule out self-ignition by George as he was unable to ascertain, to a high degree of certainty[67] from the video footage, if the ignited vapour cloud trail closest to the cigarette lighter is from ignition of the cigarette lighter, or a circumstance of the combusting vapour cloud ignited by the Taser probe.[68]

63. Ms Watene was also asked to consider the BWC involved in this incident to see whether a determination could be made as to the ignition source that caused the injuries to George.[69]

64. Ms Watene formed the following opinions based on the material provided and relevant literature:[70]

- The Taser probes are capable of igniting petrol vapour at any point during their deployment. This means that anytime the vapour falls within the flammable range of 1.4%-7.6% the Taser probes will initiate combustion. There are variables that affect whether the vapour reaches its flammable range, including petrol deposition, amount of petrol deposited and environmental conditions, such as temperature and air pressure.

- Either the Taser or the lighter could have ignited the fuel vapours created from the ignitable liquid deposited on George's clothing. It was noted that, *'there is not enough perspective or detail in the video footage to assign more weight for one of the known ignition sources over the other and therefore both must be considered as a potential cause'.*

- From the video frame where the combustion is first observed, both the Taser probe and the lighter held in George's left hand are in close enough proximity to be considered inside the area of flammable range.[71]

- Both the Taser probes and lighter were capable of creating enough energy to ignite petrol, however, it was not known whether the lighter was initiated. This was hard to determine given the nature and quality of the footage.[72] Ms Watene told the inquest that vapour is three dimensional and the footage did not provide that perspective.

65. Ms Watene noted, *'It is possible to say that from the footage, the lighter does not sustain a flaming combustion from the lighter fluid, however, a spark from the*

[66] Ex B25, pg. 6
[67] A likelihood of more than 50%
[68] Ex B25, pg. 6
[69] Ex B23, [6]
[70] Ex B24, [8]
[71] Ex B24, [13]
[72] Ex B24, [15]

rolling flint of the lighter is all that would be required. A flint spark may or may not be capable of being captured in the video recording'.[73]

Use of Taser – Operational Procedures

66. Sgt James Souilijaert, a training officer with QPS Frontline Skills Training was asked to consider the use of force in this incident.[74] Relevantly, he is a qualified Police Operational Skills and Training Instructor, Taser Instructor and Taser Master Instructor.

67. Sgt Souilijaert referred to the use of force provisions outlined in Chapter 14.3 of the OPM. He highlighted that there is no mandated response that requires police to take a certain action in relation to subject behaviours. Rather, officers are taught to make a continual threat assessment to determine the level of risk, both real and potential, that could place the officer and others at risk.[75] Such assessments require a continual re-evaluation of the situation and the use of force necessary. These assessments create situational awareness and are coupled with consideration of the 'Situational Use of Force Model'.

68. The less lethal options available to officers are Conducted Energy Weapons (Tasers), OC spray and a baton.[76] With respect to Tasers, Sgt Souilijaert noted:[77]

- Tasers are intended to be a less lethal force option, used in conjunction with other techniques and tactics that may assist officers to resolve incidents where there is risk of serious injury to a person.

- The use of a Taser is defined as drawing the Taser out of the holster, presentation of the Taser or deployment of the Taser.

- A Taser has two modes of operation – probe mode and drive stun mode. In drive stun mode the Taser is in direct contact with the person and produces localised discomfort.

- Probe mode uses propelled wires and probes to deliver short duration high voltage electrical pulses into the body, which affect the sensory and motor functions of the nervous system, temporarily incapacitating a subject. This is the preferred and standard operation and is deemed the safest and most effective means of using the weapon.

- When deployed in probe mode, the Taser deploys a single 5 second cycle of electrical charge. They are designed to 'spread' after firing. When fired, the top probe impacts at point of aim.

69. Relevantly, section.14.23.3 of the OPM relates to the use of Tasers and specifically states that it <u>should not</u> be used in either mode <u>near explosive materials, flammable liquids or gases</u>.[78]

[73] Ex B24, [15]
[74] Ex B20
[75] Ex B20, [15]
[76] Ex B20, [22]
[77] Ex B20, [24] onwards
[78] Ex B20, [45]

70. Sgt Souilijaert noted that the electrical arc delivered from the Taser can ignite flammable liquids and gases. Tasers can incapacitate in probe mode even if one or both of the probes fail to physically penetrate the body of the subject. The Taser will arc a maximum distance of 5 cm in total, or 2.5cm per probe.[79]

71. A download of the information from Constable Gartrell's Taser indicated that it was armed at 23:08:22, with the trigger pulled one second later at 23:08:23 and the Taser made safe one second after the trigger was pulled at 23:08:24 hrs.[80]

72. Having considered the five conditions that must be satisfied for an application of force to be regarded as appropriate and in accordance with the service's official organisational position as it relates to an application of force per s.14.3.2 of the OPM, Sgt Souilijaert found as follows:

- Constable Gartrell's actions were ***authorised*** as the officers were performing their duties, attempting to detain George under the *Public Health Act 2005*. Constable Gartrell was authorised to carry and use a Taser. He had completed the requisite training and requalification.[81]

- Having considered the BWC footage, walk through with Constable Gartrell and job details, the use of force was ***justified*** as a high and imminent risk was present when the officer tried to stop George from harming himself. While Constable Gartrell was aware of the policy not to discharge a Taser in circumstances where there was possible ignition, he felt he had a high chance of achieving a neuromuscular lock up. Sgt Souilijaert noted, *'admittedly, the split-second decision to deploy the Taser was an extremely high-risk tactic during a critically high-risk situation however there was a sound reason provided for taking such a risk'*[82]

- Having regard to whether the use of force application in this case was ***reasonable, proportionate and appropriate,*** Sgt Souilijaert formed the view that selecting a use of force option with the aim to prevent George from injuring himself was reasonable. However, specific use of the Taser ***was not a reasonable response*** given the risks involved and was not in accordance with training.[83] While selecting a Taser to use on a person who is suicidal to prevent them from harming themselves may be proportionate in some cases, in this case it was foreseeable that deploying the Taser had the potential to ignite a flammable liquid and in turn cause serious injury. Accordingly, deploying the Taser ***was not a proportionate response*** in the circumstances. Furthermore, the decision to deploy the Taser was not in accordance with policy and was ***not an appropriate response*** in the circumstances to prevent serious risk of injury.[84]

- Having considered Constable Gartrell's expressed intention in deploying his Taser was to prevent George from harming himself, with the honest however mistaken belief that no spark would occur if a complete circuit was achieved,

[79] Ex B20, [46]
[80] Ex B20, [69]
[81] Ex B20, [75]
[82] Ex B20, [76]
[83] Ex B20, [77]
[84] Ex B20, [77]

he formed the view that the use of the Taser in this incident may be ***legally defensible***.[85]

- The use of the Taser to resolve this incident was ***not tactically sound*** and effective in the circumstances and was not the correct use of force option due primarily to the risk of ignition.[86]

73. In reviewing this incident, Sgt Souilijaert considered other less lethal use of force options as an alternative to the Taser. He noted that baton strikes, or open or closed hand techniques would have been inappropriate due to the close distance required when using such options and would have placed the officers at significant risk of injury.[87] As to the use of OC spray, while this may have been capable of being deployed at a safer distance, it may not have resulted in the immediate control of George.[88] Tactically repositioning would also not have been appropriate as the risk to George was imminent and would continue to exist.[89]

74. Considering the threats made by George, Sgt Souilijaert formed the view that it would have been prudent for officers to have accessed fire extinguishers from their vehicles and had them available for use.[90]

75. Sgt Souilijaert noted that the dynamic circumstances of this incident, which escalated quickly, were extremely difficult for the involved officers to respond to. They were attempting to isolate and contain George with a view to using communication to build rapport, deescalate and resolve the incident. This process unfortunately broke down and he poured petrol over himself and brought his hand with a lighter closer to his body, presenting an imminent risk to his himself.

76. Essentially, the decisions available to the officers were either to intervene to try and control George, or to stand by and do nothing, hoping he would not complete the act. He recognised that the decision is very difficult to make.[91]

77. In Sgt Souilijaert's opinion, there were no other alternative less lethal use of force options available that would have enabled the officers to immediately incapacitate and control George at that point. He agreed there was a possibility that the use of the Taser may have been effective in incapacitating George without resulting in a fire.

78. Sgt Souilijaert suggested that the QPS investigate the suitability of current fire-fighting equipment in police vehicles and consider alternative use of force options to assist with self-harm situations involving flammable liquids. He also suggested that consideration could be given to less lethal impact munitions or bean bag rounds.[92]

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[85] Ex B20, [78]
[86] Ex B20, [79]
[87] Ex B20, [80]
[88] Ex B20, [82]
[89] Ex B20, [83]
[90] Ex B20, [85]
[91] Ex B20, [87]
[92] Ex B20, [89] & [90]

Investigation findings

79. Police from the Internal Investigation Unit, ESC attended the incident location where the scene was processed, and a forensic examination conducted. The officers involved in the incident were separated and interviewed. Each officer indicated in their interviews that they also spoke to Sgt Elder immediately following the incident to provide a version. Sgt Elder told ESC investigators that he separated the officers before he did the walkthroughs.

80. The Taser used by Constable Gartrell was seized and the information downloaded.

81. Detective Sgt David Perry from the ESC was assigned as the Principal Investigator. A comprehensive coronial report was prepared and provided detailing the findings of the investigation conducted into the circumstances of George's death.[93]

82. The ESC investigation found that there was no evidence to support a criminal prosecution against any person and there is no evidence to support any breach of discipline or misconduct against any police officer regarding George's death.

83. It was noted that Constable Gartrell's intention when deploying the Taser was to prevent George from igniting the flammable liquid, having exhausted all other use of force options and attempts to communicate with him. Constable Gartrell was genuinely attempting to save his life. However, he incorrectly believed that if he discharged his Taser and achieved a secure grounding and complete circuit, no spark would be emitted, and the flammable liquids would not ignite.

84. It was acknowledged that Constable Gartrell's actions were contrary to s.14.23.3 of the OPM. Further training has since been introduced in this regard by way of the Online Learning Product.

85. Detective Sgt Perry acknowledged that this situation was fast moving and difficult to navigate for the officers, particularly given it essentially transpired in complete darkness. Given George's actions by dousing himself in fuel, he concluded that it was reasonable for Constable Gartrell to have formed the view that he intended to harm himself.

86. The following recommendations were made:

- That the QPS ensure that the location of fire extinguishers is well known to officers utilising various police vehicles.

- That QPS provide training to all police officers in the use of fire extinguishers provided by the QPS and utilised by front line police officers.

[93] Ex A5

Autopsy results

87. An external and internal post-mortem examination to the extent necessary to establish the Cause of Death was performed by Dr Bianca Phillips on 16 July 2020.[94] A number of histology and toxicology tests, as well as a CT scan, were also undertaken. Dr Phillips was provided with relevant BWC footage of the incident.

88. The external post-mortem examination revealed extensive surgical treatment of full thickness burns as well as debridement, which were present to approximately 61.5% of his total body surface area (TBSA).[95] There were also partial thickness burns to approximately 3.5% TBSA. The extent of the burns, seven-day period of survival and surgical treatment precluded identification of any Taser injury.

89. Toxicology testing was carried out on blood taken shortly after the incident, which revealed the presence of the antipsychotic, Quetiapine, at a therapeutic level. An alcohol level of 0.140% was detected. Dr Phillips noted that due to fluid resuscitation, the drug levels were likely to have been diluted and it is possible that the levels present were higher than those reported in the ante mortem blood sample.[96]

90. The cause of death was found to be burns.

[94] Ex A3
[95] Ex A3, pg. 7
[96] Ex A3, pg. 7

Conclusions on Inquest Issues

Findings required by s. 45

91. 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 – William George Grimes

How he died – Queensland Police Service officers were called to locate George after he had threatened to take his own life at his home. Despite attempts by the attending Police officers to engage with him, George doused himself with fuel, while holding a cigarette lighter near his torso.

George was Tasered by Police in an attempt to prevent him from completing the act of setting himself alight. George was engulfed in flames which were put out by Police. He was subsequently treated by Queensland Ambulance Service and Queensland Fire and Emergency Services officers before being transported to the Maryborough Hospital and then the Royal Brisbane and Women's Hospital for intensive treatment. It was not clear whether the Taser or the cigarette lighter was the ignition source of the fire. The sequence of events from police arrival at the school took place over less than four minutes.

I am unable to determine whether George had the capacity to form the intention to end his own life at the time, having regard to his lengthy history of schizophrenia.

Place of death – Royal Brisbane and Women's Hospital, Herston, Queensland

Date of death– 10 March 2020

Cause of death – Burns

The circumstances leading up to the decision by police to Taser George on 3 March 2020.

92. The events that transpired commencing on the evening of 3 March 2020 and ultimately resulting in the tragic death of George are detailed above.

93. The engagement between QPS officers and George following their arrival at the Granville State School was largely captured on the BWC footage of the officers involved. This was the best evidence about what happened that evening. The chronology of events was largely not in dispute at the inquest.

94. Central to the inquest was the cause of the ignition of the fuel that George had doused himself with. It was submitted by Mr Rawlings for the family that there was sufficient evidence to determine the Taser probe was the source of ignition.

95. Mr Rawlings accepted that the evidence of the experts, Inspector Mallouk and Ms Watene, was that the Taser probes and the lighter George was holding were both competent and possible ignition sources given their location and capacity to ignite unleaded petrol vapour.

96. Inspector Mallouk's evidence was that the wick effect with clothing increased the rate at which vapours come off petrol. There was also evidence that there was a spark from the Taser moments before ignition. Mr Rawlings also submitted that the BWC footage showed that the lighter was not in close range to the body immediately prior to ignition.

97. However, the expert evidence indicated that unleaded petrol is highly combustible with a relatively low flammable range. Neither expert was able to assign more weight to one source over the other. My viewing of the BWC footage showed that the lighter was in the vicinity of the same point on George' body as the lower Taser probe at the time of ignition. Therefore, contrary to the submissions from the family, I am not able to find on the balance of probabilities that the Taser was the cause of ignition.

George's mental health care and treatment prior to his death

98. The medical records provided to the Court, including those from the WBHHS and the general practitioners engaged with George, disclosed that his condition was longstanding and difficult to manage. His health was exacerbated by failing to comply with medication and excessive alcohol consumption. George was engaged with a GP at the time of his death, and he had been prescribed medication to treat his condition.

99. George was taken to the Wide Bay Hospital ED by police and ambulance on 20 December 2019. The history was that his partner was breaking up with him after he consumed too much alcohol at a Christmas party. While intoxicated, George started to feel suicidal. He poured petrol on himself and threatened to set himself on fire to "prove his love for her".

100. George was assessed by the Mental Health team in the ED after recovering from acute intoxication. When George sobered up, he had no recollection of the events that led him to end up in the ED. He was deemed to have capacity to make his own decisions at that time and was cooperative during the assessment. He denied any ongoing suicidal or self-harm ideas, intent or plan at the time. The Mental

Health team determined George showed no evidence suggestive of psychosis or schizophrenia or any other major mental health illness.

101. George was diagnosed with personality vulnerabilities plus alcohol use disorder. He engaged in a safety plan with the Mental Health team, was happy to go back home and accepted ongoing follow up by the Mental Health Acute Care team. He was followed up on 23 and 31 December 2019 when he reported that he was taking his medication and abstaining from alcohol. He had returned to live with his parents and was planning to go back to work and link in with BRIDGES Alcohol and Drug Services.

102. Wide Bay Mental Health Specialised Services conducted a review after George's death which contained two recommendations. The review team felt that the plan to discharge George from ACT and the MHS, was primarily due to his being assessed as low risk, and his longitudinal risk was not considered. It was also noted that George was assessed as low risk of suicide on discharge but the means that he usually used were lethal, and this was not considered during the safety planning. George did not have a face-to-face assessment or see a psychiatrist during his time with ACT. This practice has since changed and clients are reviewed by a Consultant Psychiatrist during their assessment or follow up process.

103. It was also identified that no family member was included in the discharge safety planning for George despite his partner advising the ACT clinician that he would have blackouts and consume alcohol secretly. It was considered that George should have remained under the care of ACT until it was certain he had linked in with the GP and BRIDGES, or at least had a safety plan that involved his community supports around his use of alcohol and access to petrol.

104. The review recommendation relevant to this inquest was:

> *A client's family or significant other, will be involved in the planning of a client's discharge from the Mental Health Service. This will ensure Collateral will be gained from a client's family members and support persons, if a client is unreliable with the information required for a safe discharge.*

105. Information was provided by Ms Mays about the implementation of the recommendation relating to ACT follow up in the community and the actions taken post discharge.[97] I am satisfied that these have since been actioned and are now reflected in the updated policies in place.

106. I accept that there was no evidence, at the time of assessment, to support any major mental illness requiring further intervention or ongoing follow up. George was satisfied with the supports available to him after discharge from the Mental Health service and was aware of the emergency and crisis contacts.

107. I agree with the review conclusions that despite the issues identified by the analysing team regarding the risk assessment and the safety planning on discharge, there was a significant likelihood that George would have engaged in similar high-risk behaviour in the future. This was due to his ongoing lack of engagement in managing his alcohol misuse which would affect his ability to manage his high-risk behaviours.

[97] Ex B33

Whether the police officers involved acted in accordance with Queensland Police Service policies and procedures then in force and whether their actions were appropriate.

108. Constable Gartrell presented as a reliable and honest witness. His explanation at the inquest in relation to why he deployed his Taser was consistent with what he told investigators soon after the incident.

109. Constable Gartrell explained that George appeared to have had formed the intention to complete the act of igniting himself after he had created a barrier around himself with fuel and disengaged from police.

110. Constable Gartrell considered all of the use of force options available to him, which included open or closed hand techniques, OC spray and use of his baton. He was concerned about employing OC spray as it is only effective within two metres, and it may then be possible for George to rush at him and cause harm and also may make him more aggressive.

111. Constable Gartrell formed the view that this effectively left him with use of his firearm or Taser. Constable Gartrell described finding a 'good line of sight' in order to ensure there was a lock as he believed this would 'complete the circuit' and there would be no spark created in deploying his Taser.

112. Chapter 14.23.3 of the OPM stipulates that the circumstances in which a Taser should not be used including around flammable liquids. The provision is not intended to be prescriptive and training with respect to the use of a Taser and flammable liquids has evolved to ensure recruits and officers are more aware of the associated risks in a similar scenario and those involving self-immolation, which is specifically included and canvassed in the training now provided.

113. Mr Rawlings submitted that the OPM was sufficient and that officers should follow the guidance not to deploy the Taser in circumstances where the use of the Taser may cause more harm to the person who is intending to self-harm. That is, an officer should not undertake a high-risk activity to prevent harm where there is an appreciable risk that their actions will cause harm. Where an officer finds themselves facing this quandary, they should not act.

114. Sgt Souilijaert highlighted that there is no mandated response that requires police to take a certain action in relation to subject behaviours. Rather, officers are taught to make a continual threat assessment to determine the level of risk both real and potential that could place the officer and others at risk. Such assessments require a continual re-evaluation of the situation and the use of force necessary.

115. Sgt Souilijaert accepted that Constable Gartrell's reasoning, while mistaken and therefore not tactically sound, was understandable given the imminent risk that George would cause serious harm to himself.

116. Sgt Souilijaert noted that the dynamic circumstances of this incident, which escalated quickly, were extremely difficult for the officers to respond to. They were attempting to isolate and contain George with a view to using communication to build rapport, deescalate and resolve the incident.

117. However, this process broke down and George poured petrol over himself bringing his hand with the lighter closer to his body. Essentially, the options were to intervene to try and control George or to stand by and do nothing, hoping he would not complete the act.

118. Constable Gartrell's choice was to either let George set himself on fire or do something to try save his life. I accept that decision was very difficult to make in exceptionally challenging circumstances, and that Constable Gartrell's intention in deploying the Taser was to render George incapable of carrying out his plan.

119. I am satisfied the other officers at the scene complied with the relevant QPS operational policies and procedures and did their best to preserve George's life. Attempts were made to isolate and contain George, limiting the risk of harm and threat presented. Communication in order to deescalate the situation was attempted albeit unsuccessfully. Other emergency services were called to assist, but the incident escalated before they were able to do so.

120. With respect to the first aid provided by officers on the scene, I accept the evidence of Inspector Mallouk who indicated that using soil to extinguish the flames when a fire blanket or extinguishers were unavailable was an effective approach, referring to the "stop, drop and roll" technique to minimise injury when clothing catches fire.[98]

121. Submissions from the family were not critical of the actions of the involved police officers in any way. They agreed that the involved officers were both compassionate and professional in their approach to George and in their evidence. I agree with that submission.

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

122. Following George' death, the QPS implemented an Online Learning Product with respect to self-immolation, which is now mandatory for all officers. The QPS has also modified the Taser component of Operational Skills and Tactics Training to specifically address flammable liquids and the risks associated with deploying a Taser in those circumstances.

123. The training covers planning for such an incident and the need to continually reassess those plans. It also covers the options available to police if faced with a similar incident, and consideration of other resources in conjunction with situational containment. I am satisfied that these steps are sufficient to address concerns as to the sufficiency of training.

124. During the inquest questions were also raised about the use of a fire extinguishers in responding to an incident of this nature. Each police vehicle is equipped with a fire extinguisher and further information is provided to officers via online training.

125. A suggestion was made and endorsed by the officers who provided evidence about the possibility of a sticker being placed on the dashboard of each police vehicle to indicate the location of the fire extinguisher. As to resources that may have assisted the officers in responding to a like incident, the availability of a fire blanket was also suggested.

[98]Snr Sgt Bailey's statement also refers to this technique the use of water to cool burns.

126. Counsel Assisting said that it was apparent from the evidence provided by the officers during the hearing, that there was little overarching direction and holistic guidance provided by a senior officer in coordinating a response to this incident.

127. While Sgt Elder as the Shift Supervisor was providing direct guidance and support to the crews at the scene, it was suggested by a number of the officers that a District Duty Officer (DDO) for the Wide Bay District would be beneficial to provide this senior level support to crews on the ground.

Comments and recommendations

128. Section 46 of the *Coroners Act 2003* provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

129. Counsel Assisting submitted that the following recommendations could be directed to the QPS in relation to the training and equipment provided to police, and in relation to operational command:

- first aid training provided to officers specifically should include an effective response to burns as a result of self-immolation or ignition;

- the QPS consider whether the implementation of a sticker identifying the location of the fire extinguisher in a particular police vehicle may be operationally viable to assist crews in order to access it as expeditiously as possible;

- the QPS consider whether the implementation of a Duty District Officer in the Wide Bay District would be beneficial to provide senior level support and command to staff in the region;

- the QPS consider whether kitting vehicles with a fire blanket would be operationally viable and assist in situations where they are required to respond to threats to self-immolation or the like;

- the QPS continue and expedite the development of the package of less lethal bean bag munitions for front line officers.

130. The Commissioner submitted that on consideration by the Coroner of the evidence given at Inquest, any coronial recommendations made pursuant to s 46 "*should not be impracticable or uninformed or even utopian*". It was submitted the Coroner should be "*cautious when making broad scale recommendations, based on subject matters, when there is little or insufficient information provided to the Coroner to appreciate the full implications and possible unintended consequences of such recommendations*".

131. The Commissioner ultimately submitted that no recommendations or comments are required or ought to be made in relation to the training and equipment provided by the QPS to officers, or the position of DDO.

132. With respect to the treatment of burns by operational police, the QPS provided a statement from Snr Sgt Bailey regarding the issue of the first aid training received by officers and the inclusion of burns treatment in compulsory Tactical First Aid Training (TFAT).

133. Snr Sgt Bailey stated that all police recruits require a current first aid and CPR certificate with a validity date of at least three months post-graduation when they are sworn into service. All four officers involved in this incident (Senior Constable King, and Constables Gartrell, Price and Kingsman) held current First Aid and CPR certificates at the time of their graduation from the Police Academy.

134. To supplement general first aid training, the QPS provides TFAT which is specifically designed to equip officers with the knowledge and understanding of the severity and types of traumas they are likely to encounter in the course of their duties, to respond and preserve life until paramedics arrive at the scene. This training is compulsory for all sworn officers and must be completed annually. Following George' death this includes revision about the effects of burns and their treatment, as well as the use of fire extinguishers.

135. It was clear from the evidence that the first aid provided by the four officers at the scene was consistent with current first aid training and the response of the paramedics who took over George's care. Having regard to the changes implemented following George's death, I am not persuaded that a further recommendation on first aid training for burns treatment is required.

136. With respect to whether the placement of stickers identifying the location of the fire extinguisher in police vehicles may be operationally viable, the Commissioner noted that fire extinguishers are fitted to all service vehicles. The 'standard' location of fire extinguishers within services vehicles is in the boot attached to the shelf. There are some variations depending on the make and model of the vehicle.

137. The Commissioner submitted that the provision of fire extinguishers in service vehicles is primarily for the containment of fire and the use of a dry chemical fire extinguisher on a person is a last resort as propellant and gases may be harmful. This ought to be weighed against the fact the person is already on fire and has at that time suffered severe injuries if completely alight. This is consistent with the expert evidence of Inspector Mallouk that fire-extinguishers "*have an asphyxiant effect but it's better than no option at all*."

138. The Use of Accelerants and Self-Immolation OLP includes photos of where fire extinguishers are located within QPS vehicles, depending on the make and model. The OLP also includes guidance that officers should, as part of their pre-deployment check, ensure they know location the location of the fire-extinguisher and check the unit is securely held in the correct harness, the safety pin is fitted correctly, it is serviceable, in date and that the pressure gauge is reading green.

139. Additionally, the OLP contains guidance in situations where accelerant use is known, to carry the fire extinguisher from the vehicle to the scene so it is accessible.

140. In those circumstances I agree with the submission from the Commissioner that the addition of a sticker in service vehicles is not a substitute for officers having visually located the fire extinguisher as part of the pre-deployment and would be unlikely to assist any further in such an event.

141. The Commissioner submitted there was no evidence before the Court as to whether a fire blanket kitted in a service vehicle would have assisted in this incident or altered the outcome. I agree that it was also not clear that a fire blanket could have been safely deployed by officers in circumstances involving an accelerant which resulted in intense heat, and may not provide any assistance in this situation.

142. The Commissioner's submission noted that in July 2022, the Operational Equipment Committee gave approval for the Less Lethal Impact Munition (LLIM), colloquially known as "bean bag rounds", to progress to a trial stage. Operational Training Services are waiting on developments with the trial, including the completion of evidence-based research to enable presentation to the Executive Leadership Team. It is anticipated this will occur in the first half of 2023.

143. To ensure the quality of this trial is not compromised, the Commissioner submitted that a recommendation regarding its expedition ought not be made as the efficacy of the trial is paramount. I accept that submission.

144. Finally, with respect to the placement of a DDO in the Wide Bay District the Commissioner submitted that the current model in the Wide Bay District of Shift-Supervisor and On-Call-Commissioned-Officer (OCCO) was adequate to ensure support and command to junior officers.

145. It was submitted that the adequacy of the current staffing model was demonstrated by the level of senior support and command provided to the involved officers throughout the incident by the Shift Supervisor, Sgt Elder, who at the time of the incident had over 20 years of dedicated policing experience. Sgt Elder supported the officers by deploying a third crew to bring extinguishers to the scene, and asked the Police Communications Centre to request QAS and QFRS to attend. He also personally attended the incident.

146. The Commissioner submitted there was no evidence before the Court to suggest the level of supervision or incident oversight provided to the involved officers was inadequate. Further, there is also no evidence before the Court that a DDO would have provided any additional support than that provided by Sgt Elder.

147. The Commissioner also submitted there was no evidence before the Court regarding the high-level strategic decisions of the QPS which are invariably involved in the allocation of a DDO to a district, including the funding allocation required for such a decision. In the vacuum of such evidence, the Commissioner submitted a recommendation regarding the implementation of a DDO in the Wide Bay Area was inappropriate.

148. I appreciate that the allocation of specific positions within the QPS is a matter for the QPS executive, as would be the consideration of any recommendation I make in this regard. I also agree that Sgt Elder provided effective leadership and guidance to the crews under his command on the night of 3 March 2020.

149. However, each of those officers indicated in their evidence that a DDO at the level of Senior Sergeant for the Wide Bay District would be beneficial in providing senior level support in high-risk jobs to officers on the ground.

Recommendation

I recommend that the Queensland Police Service establish a District Duty Officer at the level of Senior Sergeant in the Wide Bay District.

150. I close the inquest.

Terry Ryan
State Coroner
HERVEY BAY