



CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION: **Inquest into the death of Steven Richard Angus**

TITLE OF COURT: Coroners Court

JURISDICTION: CAIRNS

FILE NO(s): 2023/1926

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Inquest
19-20 November 2024; 16-17 September 2025

Written submissions following inquest
22 December 2025 – 2 April 2026

FINDINGS OF: Deputy State Coroner S Gallagher

CATCHWORDS: Coroners: inquest, death in custody, police shooting, subject precipitated homicide, veteran, suicidality, mental health

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Introduction

1. Steven Richard Angus was born in Scotland on 26 July 1970.¹ Throughout the Inquest, he was referred to as Steven, in accordance with the wishes of his family.
2. At the time of his death, Steven was a 52-year-old Veteran² as defined by the Australian Institute of Health and Welfare (AIHW) and the Letters Patent of the Royal Commission into Defence and Veteran Suicide (RCDVS).³ As submitted by counsel assisting, I acknowledge the unique nature of military service for Veterans and their families, and the findings of the RCDVS.
3. As an ex-serving member⁴ of the Australian Regular Army (ARA), Steven enlisted on 25 July 2011 as a vehicle mechanic (MECHVEH) in the corps of Royal Australian Electrical and Mechanical Engineers (RAEME). In 2014, Steven injured his back at work while working on Bushmasters. He was recommended for lumbar fusion which was postponed pending treatment for poor bone density.⁵ Despite surgery (spinal fusion on 25 August 2016), the procedure failed to alleviate his ongoing back pain. On 10 November 2016, a medical review board confirmed Steven's Medical Employment category (MEC) as J40. On 22 February 2017, Steven was medically separated from the ARA on a background of lumbar spondylosis, major depressive disorder, alcohol dependence, lumbar spondylolisthesis, and anxiety disorder.
4. Steven was the holder of a Department of Veterans Affairs (DVA) Gold Card and Pension, and received treatment and care in the community, funded by DVA as required.
5. Nicole Angus (Nicci), Steven's former wife, first met Steven in 1992. The pair subsequently married and had three sons, Lachlan, Rory, and William. Steven is remembered by his family as a husband, father, brother, uncle, and son. Steven's family reflected upon his absence through his family statement, portions of which are noted below:

'As a father, Steven was a constant source of support and encouragement for his sons. He may not have been the stereotypical father, some of his lessons may have been unconventional, but no one could question his love for his boys. He instilled in them the values of hard work, kindness, resilience and an infectious sense of humour. They fondly remember his laughter, no one laughs as fully as Steven used to. They miss his ability to tell captivating stories, even when they could tell he was exaggerating. The countless weekends spent outdoors, whether it

¹ Steven emigrated to Australia and obtained citizenship on 11 October 1989.

² PMKeys: 8579275. Exhibit C2 at page 9.

³ AIHW: 'A person who is serving or has served at least one day in the ADF since 1 January 1985 and includes both permanent and reserve members.' RCDVS: '... A person who has served, or is serving, as a member of the permanent forces or reserves as these forces are described in the Defence Act 1903 (Cth).'

⁴ RCDVS: '...Any person who has served in the ADF, whether in the permanent forces or reserves, and who served at least one day and has since discharged from the ADF.'

⁵ Exhibit F2 at [10].

was watching them play league or simply enjoying a barbecue on the beach when visiting his parents. Those moments are cherished memories that they hold close to their hearts.

His sons often reflect on how much he would have loved to witness their milestones, but because he was taken from them, he will miss all the things that are in their future.

Steven's absence is felt profoundly, not just in the lives of his children but also in his extended family and those who knew him. He didn't have a huge group of friends, preferring to keep his circle small, but he was always willing to lend a helping hand or offer a listening ear. His warmth and generosity left a lasting impact on those around him.

For those involved in these proceedings Steven may have been just a name, an inconvenience, a problem that didn't warrant too much time or attention, but to us, he was our dad.

We will continue to remember him not only for the tragic circumstances of his passing but for the joy he brought into our lives and the lives of others. Steven Angus will forever be missed, loved, and remembered.'

6. It is clear that Steven was loved by his family and his passing has caused them enormous pain. I extend my condolences to them.

Coronial investigation

7. Steven's death was a reportable death under section 8(3)(g) of the *Coroners Act 2003* (Qld) (the Act) as a death in custody.⁶
8. The significance of this category lies in the requirement for the death to be reported to, and investigated by, the State Coroner or a Deputy State Coroner. For such deaths, the Act requires that an inquest be held.⁷
9. Detective Sergeant (Det Sgt) Darryl Cox of the QPS Internal Investigations Group (IIG), Ethical Standards Command (ESC) investigated the circumstances of Steven's death. Det Sgt Cox concluded that there was no evidence to support a criminal prosecution against any QPS officer or any other identified person, and there was no evidence to support any breach of discipline or misconduct against any QPS officer regarding Steven's death.⁸
10. Steven's military records (Medical and Personnel file), DVA Records, Medical Records from the Townsville Private Clinic (TPC), Consumer Integrated Mental Health Application (CIMHA) Records, Integrated

⁶ Defined in section 10 of the *Coroners Act 2003* (Qld).

⁷ Section 27(1)(a)(i) of the *Coroners Act 2003* (Qld).

⁸ Exhibit B1 at page 25.

Electronic Medical Record (iEMR), and Pharmaceutical Benefits Scheme (PBS) Records were obtained, in addition to numerous statements and formed part of the brief of evidence, tendered without objection.

Autopsy results

11. On 24 April 2023, Forensic Pathologist, Dr Rebecca Williams performed an autopsy which comprised an external and full internal examination of the body. Postmortem computed tomography (PMCT) scans were obtained. Dr Williams identified two (2) gunshot wounds in the chest. Consultant Radiologist, Dr Trevor Watkins reviewed the PMCT scans and described gunshot wound A and B:

a. Gunshot wound A:

- i. *'Entry wound: Right anterior chest, 107mm to the right of midline at the level of the T8 vertebral body on PMCT.*
- ii. *Trajectory: Anterior to posterior; right to left (11 degrees from the sagittal plane); horizontal plane to angled slightly inferior.*
- iii. *Structures traversed: Skin, subcutaneous soft tissues and musculature of the right anterior chest wall; anterior 4th intercostal space with injury to the adjacent 4th and 5th ribs / costal cartilages; right upper and right middle lobes near the horizontal fissure; right lower lobe; posterior 8th intercostal space and 9th rib; musculature, subcutaneous soft tissues and skin of the right back.*
- iv. *Exit wound: Right back, 55mm to the right of midline at the level of T8 vertebral body on PMCT.*

b. Gunshot wound B:

- i. *Entry wound: Upper left anterior chest, 45mm to the left of the midline at the mid manubrium level on PMCT.*
- ii. *Trajectory: Right to left; superior to inferior (40 degrees from the horizontal plane); anterior to posterior (15 degrees from the coronal plane).*
- iii. *Structures traversed: Skin, subcutaneous soft tissues and musculature of the anterior left chest wall; tangentially along the anterior 3rd intercostal space with injury to the anterior 3rd and 4th ribs; injury to the anterior left upper lobe/lingula lobe; oblique fissure and anterolateral left lower lobe; anterolateral left chest wall musculature, subcutaneous soft tissues and skin.*

- iv. *Exit wound: Left anterolateral chest wall, 180mm to the left of midline at the level of T8/9 on PMCT. The exit wound is incorporated into a left thoracostomy incision.*⁹

12. Dr Williams opined that natural disease was evident:

- a. Fatty liver (a common complication of chronic alcohol abuse). The liver weighed 1900g and had *'fatty capsular and cut surfaces.'*¹⁰ There was *'marked macrovesicular hepatosteatosis, mild chronic portal inflammation and lobular inflammation.'*¹¹
- b. Emphysema (generally due to smoking);
- c. Moderate coronary atherosclerosis;¹² and
- d. The aorta showed *'streak atheroma.'*¹³

13. Given the nature of the traumatic injuries caused by the gunshot wounds, natural disease was not considered to have had any significant contribution to the death.¹⁴ However, noting Steven's problematic alcohol use, I accept that such physical findings confirm the severity of Steven's alcohol use disorder.

14. A prior *'L5/S1 anterior lumbar interbody fusion'* was identified during the PMCT.¹⁵ The trachea and major bronchi contained blood. The lungs were described as:

*'(Left 800g and right 400g) show a heavy amount of black pigment on their pleural surfaces and are emphysematous. The right lung is collapsed. Gunshot wound A passes through the right middle and lower lobes. The left lung is inflated. There are numerous adhesions between the left lung and parietal pleura. On section there is haemorrhage throughout the right lung. Less conspicuous haemorrhage is present within the left lower lung lobe. The right pleural cavity contains 450ml of blood and clot. There is no free fluid in the left pleural cavity.'*¹⁶

15. PMCT of the pleural space identified: *'Right hemopneumothorax. Left pneumothorax. Localised haemorrhage in the left pleural space/ likely tracking along the oblique fissure.'*¹⁷

16. Toxicological analysis of a sample of blood taken from the chest cavity identified:

a. Alcohol	243 mg/100 mL	0.243%
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⁹ Exhibit A2 at page 7.

¹⁰ Exhibit A2 at page 5.

¹¹ Exhibit A2 at page 9.

¹² Exhibit A2 at pages 5 and 11.

¹³ Exhibit A2 at pages 5 and 6.

¹⁴ Supported by histological testing. Exhibit A2 at page 11.

¹⁵ Exhibit A2 at page 8.

¹⁶ Exhibit A2 at pages 4-5.

¹⁷ Exhibit A2 at page 8.

b. Diazepam ¹⁸	Detected (<0.02 mg/L)	Present at low level
c. Nordiazepam ¹⁹	0.03 mg/L	Present at low level
d. Sertraline ²⁰	0.04 mg/L	Present at concentration within usual therapeutic range
e. Desmethyl Sertraline ²¹	1 mg/L	Present at concentration greater than usual therapeutic range, but well below potentially fatal range
f. Quetiapine ²²	0.08 mg/L	Present at low level
g. Zolpidem ²³	0.02 mg/L	Present at low level
h. Meloxicam ²⁴	0.4 mg/L	Present at low level ²⁵

17. No other drugs were detected.²⁶ At the time of his death, Steven was prescribed the following medications:
- a. Escitalopram (anti-depressant);
 - b. Sertraline (anti-depressant);
 - c. Quetiapine (anti-psychotic);
 - d. Diazepam (anti-anxiety);
 - e. Meloxicam (non-steroidal anti-inflammatory); and
 - f. Salbutamol (bronchodilator).²⁷
18. Dr Williams determined the cause of death to be 1(a) Gunshot wound to the chest.²⁸
19. I accept the opinion of Dr Williams.

Inquest

20. The primary purpose of an inquest is to inform the family and the public about the matters required by section 45 of the Act to inform the deceased person's family and the public in a transparent fashion about how the death occurred.

¹⁸ Anti-anxiety agent.

¹⁹ Active metabolite of Diazepam.

²⁰ Anti-depressant.

²¹ Active metabolite of Sertraline.

²² Anti-psychotic.

²³ Hypnotic.

²⁴ Non-steroidal anti-inflammatory.

²⁵ Exhibit A3. Exhibit A2 at page 11.

²⁶ Exhibit A3.

²⁷ Exhibit A2 at page 9.

²⁸ Exhibit A2 at page 11.

In appropriate cases, section 46 of the Act empowers a coroner to comment on anything connected with the death related to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future.

21. However, a coroner is not able to include in the findings or any comments or recommendations any statement that a person is, or may be, guilty of an offence or civilly liable.
22. The focus of the coronial jurisdiction is on determining what happened, not on ascribing guilt, attributing blame to any person or party, or apportioning liability. The relevant standard of proof is that of the balance of probabilities, with reference to the *Briginshaw* standard.²⁹ The more significant the issue for determination, the clearer and more persuasive the evidence must be for a coroner to be sufficiently satisfied, on the balance of probabilities, that an issue has been proven.
23. On 28 February 2024, a Pre-Inquest Conference (PIC) was convened. The Inquest was held over two sittings in Townsville on 19 and 20 November 2024 (“the police evidence”); and Brisbane on 16 and 17 September 2025 (“the medical evidence”).
24. Steven’s family attended the Inquest on both occasions.
25. Written submissions followed the oral evidence.
26. At the commencement of the Inquest, all the statements, records of interview, photographs and videos obtained during the coronial investigation were tendered. Oral evidence was heard as follows—

The police evidence on 19 and 20 November 2024:

- a. Acting Sergeant Louwrens;
- b. Constable Brown;
- c. Detective Senior Sergeant Darryl Cox; and
- d. Inspector Anthony Buxton.

The medical evidence on 16 and 17 September 2025:

- e. Dr Joseph Villaruel;
- f. Dr Syed Mohiuddin;
- g. Dr Anna Lazzari;
- h. Dr Tristan Turner;
- i. Dr Jordan Mulloy;
- j. Dr Babool Raja; and
- k. Associate Professor Wole Akosile.

27. The issues for inquest were settled as:

²⁹ *Briginshaw v Briginshaw* (1938) 60 CLR 336.

1. The findings required by s.45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where, and how he died and what caused his death.
2. Consideration of the circumstances leading up to the death including:

Mental health, treatment and care, suicidality

- a. Steven's mental health condition/s, and the appropriate treatment for him, including whether in all the circumstances there was an appropriate assessment of Steven's suicide risk.
 - b. Whether Steven had access to such treatment and absent Steven's consent, could he be compelled to undergo such treatment?
 - c. What is the role of the Veterans Liaison Officer (VLO) where a Veteran presents to a HHS in the context of a mental health crises, and what, if any interaction did Steven have with the VLO prior to and on 20 April 2023?
 - d. In all the circumstances, was the treatment afforded Steven, for his condition/s appropriate?
 - e. Whether there was any failure to provide appropriate care that caused or hastened the death?
 - f. Whether any aspect of the care actually provided, caused or hastened the death?
 - g. Consideration of 'subject precipitated homicide', including the effect, if any, on first responders.
3. Whether the Queensland Police Service ('QPS') Officers involved acted in accordance with the QPS policies and procedures then in force, and whether said actions were appropriate.
 4. Whether any changes to procedures or policies could reduce the likelihood of death occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.
28. I am satisfied that all information relevant to and necessary for my findings was made available at both tranches of the Inquest.

Evidence and findings on the issues

29. I accept the circumstances surrounding Steven's death as established in the report of Det Sgt Cox³⁰ and detailed in the submissions of counsel assisting.
30. Counsel assisting submitted, and I accept, that a consideration of the events of both 20 and 21 April 2023, where Steven came to interact with the QPS, in the context of welfare checks was appropriate.
31. During the coronial investigation into Steven's death, I have been assisted by evidence pertaining to the severity of Steven's alcohol use disorder.
32. Nicci provided details of Steven's alcohol use:
 - a. She stated that there was only one occasion where she thought the "rehab" was "going to stick";
 - b. That was a two-week period where Steven didn't drink, which was the longest he had gone without drinking since he was 21;
 - c. Steven didn't start to drink until he was 21;
 - d. Steven was a highly functioning alcoholic for the 25 years that he worked in the banking industry;
 - e. It wasn't really till he left the Army that she thought it got to the point where she knew Steven would end up ending his life in one way or the other;
 - f. For five years his mental health has been "really bad;"
 - g. The reason their marriage broke down related to Steven's alcohol use;³¹
 - h. She stated that Steven had lost his job with the bank when he had turned up to work for an appointment drunk; and³²
 - i. When Steven lost his job with the bank, he moved to the Sunshine Coast and subsequently joined the Australian Army at age 42.
33. Prior to the tragic events in 2023, Steven had experienced suicidal behaviour in the context of binge drinking.³³ Psychiatrist, Dr Syed Mushtaq Mohiuddin provided Steven outpatient and inpatient treatment and care from November 2017 to March 2022. During this time, Steven experienced repeated relapses of his alcohol use disorder and was admitted several times for alcohol detoxification rehabilitation.

³⁰ Exhibit B1.

³¹ Exhibit B13 at page 7, L220-222.

³² Exhibit B13 at page 8, L232-235.

³³ Exhibit F5 at [21].

34. On initial presentation, Steven had completed an alcohol rehabilitation program at the Caloundra Private Clinic on the Sunshine Coast (in 2017) and a program at Damascus in Brisbane (in 2016).³⁴ Much of the treatment afforded to Steven was aimed at rehabilitation, and psychosocial interventions, including implementing strategies to manage alcohol use.
35. Steven was admitted to the Townsville Private Clinic (TPC) on 8 January 2018 in the context of ongoing alcohol use, non-adherence to medications, and expression of suicidal thoughts under the influence of alcohol. During a three-week admission, Steven underwent detoxification and worked on relapse prevention planning. He was discharged on 23 January 2018.
36. On 14 March 2018, Steven's appointed DVA case worker, an occupational therapist, sought an urgent appointment with General Practitioner (GP) Dr Joseph Villaruel for Steven, as he had been bingeing (alcohol) for three days and was suicidal. Despite the GP being fully booked, the case worker put Steven in a taxi and sent him to the GP clinic. Upon arrival, Steven was intoxicated to the point of being unstable on his feet. Steven purchased beer and sat in the waiting room drinking. The case worker was told that it was not safe for Steven to be sent to the GP practice intoxicated and suicidal, particularly when no appointments were available. The GP practice could not deal with an aggressive client and the case worker was told the protocol was to contact the TPC instead. The TPC had an admission pathway for patients³⁵ in crisis or alternatively, they could be directed to the Acute Care Team (ACT) in the public health system. The DVA case worker considered that Steven's care would be best transferred to another practice equipped to deal with his mental health crisis situations. Steven did not return to that GP practice.³⁶
37. Steven was transported by the Queensland Ambulance Service (QAS) (with assistance from the QPS) to the Townsville Hospital and Health Service (THHS) under an Emergency Examination Authority (EEA). Steven was intoxicated and sent to the short stay unit to sober up so that he could be properly assessed.³⁷ On this occasion the THHS ACT Emergency Department (ED), Clinical Nurse Consultant (CNC), spoke with a representative at the TPC who confirmed that they would be happy to readmit Steven 'tomorrow' if required, however, they would not take patients who were either moderate or high risk under the *Mental Health Act 2016* (Qld). While at the THHS, Steven was breathalysed (BAC 0.123) and the EEA was extended. An admission to the TPC was arranged for Steven.³⁸
38. This pattern of relapse and admission continued for Steven. On 22 October 2018, Steven was admitted to the TPC (six-week admission) following a motor vehicle accident (and possible suicide attempt) under the influence of

³⁴ Exhibit F1 at [11].

³⁵ I acknowledge the term 'consumer' may also be used.

³⁶ Exhibit F5 at [20] – [25].

³⁷ Exhibit E4 at page 5.

³⁸ Exhibit E4 at pages 5 – 15.

alcohol and prescription medications, in the context of psychosocial stressors. Steven was subject to criminal charges and loss of licence.³⁹

39. Between January and February 2019, Steven completed a four-week Alcohol and Substance Use Disorders Day Program, however, he also experienced a decline in his mental state secondary to a relationship breakdown and was again admitted to the TPC in April 2019 (five-week admission).⁴⁰
40. Steven continued to struggle with alcohol and was readmitted to the TPC in November 2019 (discharged December 2019). During this admission Steven identified a “danger time” of 4-7pm for alcohol relapse and planned activities to keep himself engaged during the high-risk period.⁴¹
41. Steven experienced a decline in his mental state after break-ins to his house which worsened his anxiety. On one occasion, Steven had threatened juvenile offenders with a metal bar and had also sat outside with a knife. On 8 September 2020, Steven was taken to the THHS by the QAS (assisted by the QPS) under an EEA. Following assessment he was discharged to the care of a friend and returned home.⁴²
42. Dr Mohiuddin last reviewed Steven on 6 December 2021 as an outpatient.⁴³ Steven had relapsed into heavy alcohol use after experiencing several stressors, particularly one involving an issue with his fence where he had allegedly paid some tradesmen who had then failed to complete the work. His relationship with his partner had also broken down at that stage. Steve reported self-ceasing Quetiapine after running out of tablets, but had continued utilising Sertraline.
43. In view of these stressors, and Steven’s decline, Dr Mohiuddin offered another inpatient admission at TPC, but Steven opted to continue with outpatient follow up with him at the time. Steven expressed the opinion that he had been coping with these stressors better than he had in the past and was keen to continue with outpatient management. Dr Mohiuddin provided another script for Quetiapine to ensure that Steven continued his regular medications. He encouraged Steven to re-engage with his psychologist to help deal with the ongoing stressors, and to seek legal advice with respect to the difficulties he was facing with the tradesmen. Dr Mohiuddin also encouraged Steven to reconsider the option of inpatient admission if he suffered any continuing stressors. Steven denied experiencing any thoughts of suicide or self-harm at the time and was agreeable to seeking help as required.
44. On 21 March 2022, Steven sought a further inpatient admission in the context of alcohol relapse and a fall that resulted in injuries to his hip and knee. Steven failed to attend for the planned admission.⁴⁴

³⁹ Exhibit F1 at [22] – [23].

⁴⁰ Exhibit F1 at [27] – [29].

⁴¹ Exhibit F1 at [31].

⁴² Exhibit E4 at pages 34 – 36. Exhibit F1 at [33].

⁴³ Exhibit F1.

⁴⁴ Exhibit F1 at [38] – [40].

45. From March 2022, Steven's care was transferred to Dr Mohiuddin's colleague, Dr Anna Lazzari.⁴⁵
46. On 30 March 2022, Steven was admitted to the TPC under the care of Dr Lazzari in the context of alcohol relapse secondary to psychosocial stressors (familial stressors and a drink driving charge). Steven was discharged in early May 2022. The admission was reportedly beneficial. Steven had a further admission from 20 February 2023 to 31 March 2023.

Thursday, 20 April 2023

47. On the afternoon of 20 April 2023, the Patient Flow Coordinator at the TPC received a telephone call from Steven who was actively suicidal, with a plan and intent, in the context of acute alcohol intoxication. Steven stated that he had filled all his scripts and was planning to take all his medications with alcohol and then drive or walk in front of a truck. Steven said that he was tired of everything and did not want to keep going. He said he did not care who had to clean up afterwards. The Patient Flow Coordinator called 'Triple 000'⁴⁶ and requested a welfare check. They attempted to contact Steven again; however, he did not answer.⁴⁷
48. The QAS requested QPS assistance. Police communications were informed that Steven had a large knife and several QPS units responded (Code 2) with lights and sirens activated for urgent duty driving.
49. At 12:20pm, Steven was locked inside his home holding a knife to his throat. District Duty Officer (DDO) Senior Sergeant (Snr Sgt) Michelle Faint attended the location to take command and sought the assistance of a mental health co-responder.⁴⁸ Police were advised that the co-responder was not available. Steven expressed his ideation of "suicide by cop" to police. The co-responder model combines policing and health services capability to respond to persons experiencing mental health and suicide crises:

*'The concept is co-response to mental health crisis situations, meaning that police and health services are paired and co-deployed to identified crisis events in order to better assess and respond to community safety and health needs within the situation.'*⁴⁹

50. At 12:45pm, Steven informed police if they attempted entry to his home, he would rush at them with the knife. Police negotiators were requested, and Steven remained contained within the home:

⁴⁵ Dr Mohiuddin was on unplanned leave. Dr Lazzari took over Steven's care. Exhibit F1 at [41] – [43].

⁴⁶ Exhibit C6 to the QPS Coronial report.

⁴⁷ Exhibit F1 at [43].

⁴⁸ Exhibits E33.4 – E33.6.

⁴⁹ Partners in Prevention, Understanding and enhancing first responses to suicide crisis situation, summary report, at page 16.

- a. *‘Police negotiators are highly trained police officers who provide specialised leadership and expertise in the de-escalation and resolution of critical incidents. They are available 24/7 and respond to incidents such as suicide crisis situations, barricade sieges, high risk warrants and other situations where loss of life is imminent.*
 - b. *The police negotiator model is supported by a mental health model of service. The Mental Health Support of Police Negotiator Program – Model of Service sets out overarching principles including scope of practice and respect for organisational expertise and outlines a model of service for the provision of support by mental health services during an incident requiring police negotiation.*
 - c. *Specifically, a dedicated phone line is utilised to make contact with mental health clinicians within the Queensland Forensic Mental Health Service, who provide initial and additional responses toward resolution of the incident.’⁵⁰*
51. Steven was not a current patient in the public mental health system. There was some difficulty in locating Steven on the CIMHA due to the date of birth provided. QAS members continued to engage Steven verbally. Due to his hostility towards police, Tactical Crime Squad (TCS) crews were requested to attend as they had the extra capability and training with ballistic shields that can be used in arrest situations such as the siege involving Steven.
 52. At 1:17pm, QPS Negotiator Snr Sgt Matt Lyons arrived and started speaking to Steven. During the negotiation Steven eventually engaged telling jokes, made demands for written confirmation that he would be taken to a clinic, continued to drink Johnny Walker scotch straight, and moved from inside the house to the patio and back in again multiple times.
 53. At 3:04pm, Steven was arrested by TCS officers on scene, using ballistic shields after he was observed not to be armed with a knife. Police located a kitchen knife nearby on the patio where Steven had placed it down just prior to police moving in on him.
 54. Snr Sgt Matt Lyons explained his involvement with Steven on 20 April 2023.
 55. I have been assisted by the evidence of Snr Sgt Lyons noting his extensive training and experience.⁵¹ Snr Sgt Lyons made relevant observations including the effect that police uniforms, as opposed to plain clothes, can have on a person during a negotiation.⁵² Snr Sgt Lyons made the following powerful observations of Steven’s behaviour:

⁵⁰ Ibid.

⁵¹ Including his involvement with Veterans through his work at Oasis Townsville (Exhibit B8 at page 7, L201 – 206).

⁵² Exhibit B8 at page 14, L487 – 495.

*'Essentially Steven kept saying he wanted to die, suicide by a cop. He had two knives and that all he wanted to do was for Police to shoot him and Peter said, you don't want him to be here because you don't want some young Police officer having to do this and having to live with it and Steven said, yep, that's exactly it and he pointed to me and he said I've got a son that's older than you, I don't want you fucking here, you don't need to fucking see this.'*⁵³

'I continued to talk to Steven who advised me that throughout the duration that he intended to die a suicide by cop and how he wanted to do it was to come out.

He actually motioned, he put two hands above his head, he had two knives, hold them above his head, he said, I'm not going to threaten the Police, all I'm going to do is walk out and cause them to shoot me. They need to shoot me. I asked why and he said, he'd woken up, he didn't really plan it that well, he'd woken up this morning and decided that today was the day.

In front of him on the floor way of the room was a large amount of property and I said, what's all this property? He said these were significant pieces of property within his life that contained letters from his son, information about his ex-wife and property that he wanted to give to his family when he died. He said I've got it all out. He had a – one of the knives he held to his throat, I actually asked him to put the knife down to which he did.

*He was continually drinking out of a bottle of something, gin, whiskey, I wouldn't know what it was, it was brown-y, brown substance in a bottle, I don't drink that, so I wouldn't know what it was called, but he was continually drinking that straight while smoking cigarettes. He was very incoherent, very unstable on his feet when he tried to stand up and at one point couldn't find his phone. Then he found his phone and he was listening to a song and essentially he said it was his goodbye song and he continually listened to that whilst talking to me.'*⁵⁴

'...Continued to talk for a while and he said essentially he's been thinking about it for a while, he was too, he didn't say the word gutless, but he refused to take his own life because he just didn't have the courage to do it. He thought about going out onto University Drive and standing in front of a truck, but he didn't want to put that burden on the truck driver and he would rather have Police officers shoot him.

So I confronted him about this reality and gave him a reality check and said, so you're prepared to have a Police officer shoot you and ruin potentially their lives with subsequent investigations

⁵³ Exhibit B8 at page 7, L221 – 226.

⁵⁴ Exhibit B8 at page 7, L234 to page 8, L250.

and the trauma associated with that, as opposed to a person running you over with a car? And he said, yeah. I said, that's very selfish. He stopped and thought about it for a while and he said, yeah, you're right. You're exactly right, mate. And I said that's – and you don't care? And he said, no, I don't. He was a very matter of fact, he said, no I don't care and he said that openly and honestly.’⁵⁵

56. Snr Sgt Lyons was aware Steven was a Veteran. After extensive verbal negotiations, Snr Sgt Lyons saw an opportunity to peacefully resolve the situation with support from TCS officers carrying plastic shields. Snr Sgt Lyons ran five metres and tackled Steven.
57. Steven was detained and transported from his home to the THHS by QAS with the assistance of QPS, under an EEA.⁵⁶
58. Around 3:54pm, Steven arrived at the THHS ED. Steven was initially taken to the decontamination room for a “decon assessment.” If a patient is brought to the ED under an EEA and they require behaviour management during triage, they are often brought in by the decontamination room (code grey⁵⁷ – potentially aggressive patient). The decontamination room is not a room specifically equipped for mental health crises, but rather a room for decontamination of potentially dangerous materials (such as pesticides, etc).⁵⁸
59. At 5:30pm, Dr Banks handed over to Dr Tristan Turner (Staff Specialist).⁵⁹ Registrar Dr Jordan Mulloy assessed Steven on request by Dr Turner. Dr Mulloy sought assistance from the CNC of the ACT. Dr Mulloy documented his observations⁶⁰ and discussed his plan for Steven with Dr Turner due to Steven’s particularly complex presentation.⁶¹ Both Dr Mulloy and Dr Turner agreed that Steven was not psychotic and was not an acute suicide risk.⁶²
60. While in the ED, Steven engaged cooperatively and appropriately with staff. He was given food and fluids, he slept for periods, and his behaviour settled. He was placed in bed number three in the acute section of the ED (which allowed for high visibility from the write up station and CCTV).⁶³
61. Around 6:45pm, Dr Mulloy conducted a Mental Health Assessment of Steven and determined that he had capacity and did not present an imminent risk to himself, or others and that Steven’s presentation did not warrant a Recommendation for Assessment that would have required Steven to remain in the ED involuntarily awaiting further assessment. It was decided that the

⁵⁵ Exhibit B8 at page 9, L281 – 292.

⁵⁶ Exhibit B1 at [3.24] – [3.30].

⁵⁷ Exhibit E34.1. Exhibit E34.3.

⁵⁸ Exhibit F6 at [8] – [10]. The timing and location distinguish it from all other code greys.

⁵⁹ Exhibit F4 at [7].

⁶⁰ Exhibit F6 at [8] – [12].

⁶¹ Exhibit F6 at [16].

⁶² Exhibit F4 at [12].

⁶³ Appendix F3 to the QPS Coronial Report (Exhibit B1) are stills of Steven in the hospital.

acute alcohol intoxication and suicidal crisis had substantially resolved.⁶⁴ As noted in the Root Cause Analysis:

- a. *'Pre-hospital events were related to alcohol intoxication and a suicidal crisis, both of which had substantially resolved at the time of the review, and the remaining risks were suitable for priority follow up by the ACT in the community.*
- b. *The registrar discussed their assessment with an ED consultant physician, and then with a CNC from ACT.*
- c. *A decision was made to discharge the gentleman home, with priority follow up by ACT.'*⁶⁵

62. Around 7:50pm, Steven was provided with transport to his home and left the ED in a taxi.
63. The following morning, the referral for ACT follow up was received by a senior ACT clinician. The assessment was discussed at the multidisciplinary intake meeting, and a telephone call to Steven was scheduled for the morning. At approximately 11:57am, a call was made to Steven, he did not answer this call. A voicemail was left, and a text message was sent. A plan was established by the ACT clinician to await return contact from Steven and try again on 22 April 2023 if he had not contacted them before then.⁶⁶

Friday, 21 April 2023

64. On Friday 21 April 2023, Steven's son telephoned emergency services⁶⁷ requesting a welfare check of his father in response to text messages expressing further suicidal ideation and intent.
65. Steven had sent a message saying goodbye, with photos of medication.
66. At 4:48pm,⁶⁸ QPS officers attended Steven's home address (priority code 2, lights and sirens). QPS officers Senior Constable (Snr Const) Sarah Smith and First Year Constable (Const) Joel Brown were tasked to respond. On approach, Const Brown checked his QLITE device. QPRIME flags for Steven included a "Be On the Lookout" warning (BOLO) from the day prior (warning that Steven had been involved in a siege with police, likes to carry multiple knives [sic] on person). There was a further BOLO (self-confessed alcoholic).⁶⁹
67. Acting Sergeant (A/Sgt) Carlo Louwrens, whilst at the Kirwan Police station heard the details of the job being given to Snr Const Smith and Const Brown and recognised the address from the siege the day prior. A/Sgt Louwrens

⁶⁴ Exhibit F6 at [22].

⁶⁵ Exhibit E1 at page 2.

⁶⁶ Ibid.

⁶⁷ Via Triple 000. Appendix G1 to the QPS Coronial Report (Exhibit B1).

⁶⁸ CAD data shows the crew booked off at the scene at this time – tasked at 4:43pm.

⁶⁹ Appendix C9 to the QPS Coronial Report (Exhibit B1) at [95].

immediately proceeded alone to the address (arrived at 4:49pm) to assist and share knowledge of the incident that occurred the previous day.

68. A/Sgt Louwrens should be commended for his diligence.
69. A/Sgt Louwrens, Snr Const Smith, and Const Brown⁷⁰ were met by Nicci who was aware of the messages Steven had sent to their son and had keys to the house. Nicci was concerned for Steven’s welfare and tried to assist the QPS officers to speak with Steven. Nicci moved to the backyard through an open side gate and the QPS officers moved with her. A further QPS crew arrived and two officers stayed in the front yard of the address.
70. As Snr Const Smith and A/Sgt Louwrens approached the back patio, they observed the back door of the house was open. A/Sgt Louwrens sighted Steven inside the house in the kitchen armed with two large steel bladed kitchen knives (a Klevacut brand 20cm steel bladed chef knife and a Wusthof brand 15cm steel bladed knife).
71. Nicci started speaking with Steven and was told to move away by A/Sgt Louwrens and Snr Const Smith (for her safety). The two officers moved onto the patio and attempted to speak with Steven. Nicci moved to the front yard and started speaking with the other QPS officers.
72. Snr Const Smith attempted to negotiate with Steven who was inside the back door of his home. Police remained at the edges of the patio area. The QPS officers considered all options available to them, including the use of a Taser. Steven yelled at the QPS officers telling them to get their guns out and expressed a view that he had been talking to a “nice man” the day prior and that he had been “tricked” by the QPS on that occasion. I accept this remark was in reference to Steven speaking with the police negotiator (Snr Sgt Lyons) the day prior, who was wearing plain clothes as opposed to a police uniform.
73. Relevantly, the following exchange and attempts by Snr Const Smith to de-escalate the high-risk situation was captured by her BWC:

BWC of Snr Const Smith	
SC Smith	<i>My name is Sarah I am just here to talk to you.</i>
Steven	<i>You did this fucking last night you distracted me – it’s not happening this time!</i>
SC Smith	<i>It wasn’t me mate I’ve only met you now.</i>
Steven	<i>What’s gonna happen?</i>
SC Smith	<i>I just want to talk to you Steven. I just want to have a conversation with you ok. Steven please don’t do that.</i>
Steven	<i>I don’t want to hurt anyone but myself right!</i>

⁷⁰ The QPS officers had their BWC activated.

SC Smith	<i>Your ex-partner is here she doesn't want to see you like that.</i>
Steven	<i>You's need to back off cause I am going to charge out there and you're gonna have to fucking shoot me!</i>
SC Smith	<i>Please don't do that you just said you don't want to hurt anyone.</i>
Steven	<i>I'm coming out with two knives, I want you to put me to sleep!</i>
SC Smith	<i>Please don't do that to us, we don't want to do that to you, please that is something I will remember for the rest of my life, please don't do that.</i>
Steven	<i>You fuckers threw me last night!</i>
SC Smith	<i>I've only just met you now and I just want to help you right now. Can you please just give me the chance to help you and talk to you.</i>
Steven	<i>I'm dangerous and armed, I'm threatening ya's!</i>
SC Smith	<i>I think you're just hurting right now tell me what's got you to this point.</i>
Steven	<i>Get your guns out the holster!</i>
SC Smith	<i>No Steven please don't do that to me I don't want to do that.</i>
Steven	<i>Bring them out your fucking holster so you're ready!</i>
SC Smith	<i>Steven please don't do that, please don't, I'm really asking you, please don't do that to me. You don't know me ok and I don't know you and I can see you're hurting and I just want to help you right now can you please let me help you and talk to you.</i>
Steven	<i>I don't want to hurt anyone but myself!</i>
SC Smith	<i>Ok why do you want to hurt yourself?</i>
Steven	<i>STOP! FUCKING STOP IT!</i>
Steven	<i>Delaying – you fucking snuck up on me last night because I was talking to a nice guy!</i>
SC Smith	<i>Ok alright. Nothing's happening right now ok...Just tell me...</i>
Steven	<i>Put your hands on the gun!</i>
SC Smith	<i>Please don't do that to me, I don't want to do that.</i>

74. Steven ran from the back door of his home towards the QPS officers with the two large kitchen knives raised at shoulder height, pointing towards the QPS officers who shouted several commands for Steven to drop the knives. Snr Const Smith immediately retreated off the patio, and then quickly turned to face Steven as she drew her firearm. Simultaneously A/Sgt Louwrens moved rearward away from Steven to create space whilst bringing his firearm up to a firing position. Steven did not comply with the commands and was shot by the QPS officers who then immediately provided tactical first aid to Steven and called for the QAS to attend.

75. At 5:01pm, QAS paramedics arrived on scene and found Steven unresponsive with a weak pulse and irregular respirations. QAS paramedics took over the care and continued resuscitation efforts which included CPR, reapplication of chest seals, oropharyngeal airway, bag-valve mask ventilation, bilateral needle chest decompression with Pneumodarts, endotracheal intubation, intraosseous access, intravenous access, administration of fluid, blood, and tranexamic acid; and bilateral finger thoracostomies.⁷¹ Steven could not be revived and was declared deceased at 5:26pm.

Conclusions on Inquest Issues

Issue 1 – Findings required by s. 45 of the Coroners Act

76. The *Coroners Act 2003* requires me to find, if possible, the cause of a person's death, who the deceased person was and when, where, and how they came to die. As a result of considering all the evidence pertaining to this death, including the material contained within the brief of evidence, I make the following findings.

Identity of the deceased – Steven Richard Angus

How he died – On 21 April 2023, QPS officers responded to a welfare check at Steven's home. Steven was intoxicated with alcohol and had armed himself with two large knives and did not comply with directions from the QPS officers to drop the knives. Steven ran towards QPS officers with the knives raised at shoulder height and was consequently shot by QPS officers in the performance of their duties.

Steven had been involved in a siege the day prior (20 April 2023) where he was intoxicated and had expressed suicidal ideation, consistent with subject precipitated homicide. On that occasion, Steven was subdued by QPS officers and taken to the THHS under an EEA. He was subsequently released and returned home that same day.

Place of death – 17 Bel Air Avenue
Kirwan, Townsville, Queensland, 4817

Date of death– 21 April 2023

Cause of death – 1(a) Gunshot wound to the chest.

⁷¹ Exhibit A2 at page 10.

Issue 2 – Consideration of the circumstances leading up to the death including mental health, treatment and care, suicidality

77. Counsel assisting submitted, and I accept that while the *Coroners Act 2003* does not contain a prescribed definition of suicide, it would be appropriate for me to consider the definition of the term “suicidality” contained in the Queensland Centre for Mental Health Research (QCMHR) Report:

‘Suicidality (suicide ideation, plans and attempts) is a source of morbidity and often precedes suicide death. It therefore presents an important opportunity for proactive suicide prevention interactions to alleviate suffering for veterans, their families, and communities.’⁷²

78. As submitted by counsel assisting, I acknowledge the findings contained in the QCMHR Report. Namely, that in Queensland, police and paramedics will engage with at least one new veteran in suicide crisis every 16 hours, on average. This rate does not account for contacts due to re-presentations by veterans. The rates are based on estimated counts and have been adjusted to account for missing PMKEYS⁷³ data related to service status at the time of an index paramedic or police contact.⁷⁴ This research has been accepted by the RCDVS.
79. To make a finding of suicide with respect to the circumstances of Steven’s death, I must be satisfied that he acted intentionally, knowing the probable consequence.⁷⁵ The capacity to form such intent is a threshold requirement for a finding of suicide.⁷⁶ Recognised circumstances which may deprive a person from having such capacity include mental disease, intellectual impairment, psychosis, extreme distress, intoxication under the influence of alcohol or drugs or infant immaturity.⁷⁷ In some circumstances, a death can have been an accident even though it appears to be intentional and in other rarer cases, there can be a suspicion of foul play. Accordingly, before a finding of suicide is made, the evidence supporting such a finding cannot be equivocal. A finding of suicide must be determined on the balance of probabilities, but its seriousness warrants the application of the upper spectrum of the Briginshaw scale, meaning that there must be clear evidence to support such a finding. Usually, the evidence supporting such a finding is circumstantial requiring inferences of fact to be drawn from those circumstances.
80. While Steven was affected by alcohol at the time of his death, it is more likely than not, given his prior interactions with members of the QPS and his documented history of suicidal ideation, that Steven was acting intentionally to cause police to shoot him.

⁷² Exhibit G1 at page 10. The RCDVS defined “suicidality” as suicidal ideation, suicide plans and suicide attempts.

⁷³ PMKEYS – a unique identifying number assigned to a Veteran. They may also have a “service number.”

⁷⁴ Exhibit G1 at page 28, [5.1.2].

⁷⁵ *Clark v NZI Life Ltd* [1991] 2 Qd R 11.

⁷⁶ *Inquest into the death of Tyler Jordan Cassidy* [2011] Coroners Court of Victoria.

⁷⁷ Suicide Reporting in the Coronial Jurisdiction, Coronial Council of Victoria Consultation Paper, 23 April 2014.

Issue 2a – Steven’s mental health condition/s, and the appropriate treatment for him, including whether in all the circumstances there was an appropriate assessment of Steven’s suicide risk

81. Counsel assisting submitted, and I accept that the term “mental health” is a term used to describe both the positive and negative mental states of an individual, sometimes referred to as “mental well-being” or “mental illness.” The World Health Organization defines “mental wellbeing” as:

‘A state that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It has intrinsic and instrumental value and is a basic human right.’⁷⁸

82. In Queensland, the term “mental illness” is defined in section 10 of the *Mental Health Act 2016* (Qld) as ‘a condition characterised by a clinically significant disturbance of thought, mood, perception or memory.’ As submitted by counsel assisting, wherever possible, there must be commonality in definitions used in respect of patients such as Steven to avoid confusion and to ensure opportunities for systems improvement are not missed.

Diagnosis

83. Counsel assisting submitted, and I accept that as of 31 March 2023, Steven had a ***co-occurring substance use disorder and other mental health disorder***⁷⁹ having been diagnosed with major depressive disorder with anxious distress, generalised anxiety disorder, and severe alcohol use disorder. Steven had a “mental illness” as defined in the *Mental Health Act 2016* (Qld). Earlier diagnoses also included alcohol induced mood disorder and social anxiety.
84. As part of the coronial investigation, I have had regard to the publicly available Queensland Health Guideline for such conditions:

‘Consumers with co-occurring substance use disorders and other mental health disorders and their families have multiple, complex needs that require a high level of responsiveness across all services, levels of care and throughout all phases of recovery including engagement, screening, assessment, treatment, rehabilitation, and transitions of care, including illness self-management with relapse prevention.

Comprehensive treatment and care for consumers with co-occurring substance use disorders and other mental health disorders is fundamental to Queensland Health Mental Health Alcohol and Other Drugs (MHAOD) Services.’⁸⁰

⁷⁸ See <https://who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>.

⁷⁹ “Mental Disorder” as referred to in the Diagnostic and Statistic Manual of Mental Disorders (DSM-5).

⁸⁰ See https://www.health.qld.gov.au/_data/assets/pdf_file/0023/1118246/qh-gdl-964.pdf.

85. Counsel assisting submitted that I accept that in addition to the complexity of Steven's needs as a patient with a co-occurring substance use disorder (alcohol) and other mental health disorders, as a Veteran, this further complicated the need for effective treatment and care in the community given the known risks and vulnerability of this cohort, as identified by the RCDVS and the QCMHR Report.⁸¹ I accept that submission.

Treatment

86. As submitted by counsel assisting, I accept that, on the evidence available, Steven was receiving appropriate treatment and care in the community from psychiatrists in particular, noting his reluctance to engage with psychologists.
87. Evidence before the court, in support of this finding includes that:
- Steven had a longitudinal pattern of alcohol related issues, including prior contacts with public mental health services.
 - Steven received suitable treatment through (primarily) the private healthcare system, funded by DVA once he separated from the ADF. Prior to that, Steven had been supported by the ADF to receive treatment and care for his alcohol use disorder, other mental health, and physical conditions.
 - In respect of Steven's mental illness/disorders of major depressive disorder with anxious distress, generalised anxiety disorder, Steven was appropriately prescribed an antidepressant (Sertraline 200mg daily), a mood stabiliser (Quetiapine 75mg nocte), a hypnotic (Zolpidem 10 mg daily); and an anti-inflammatory agent (Meloxicam 15 mg daily) in the context of his back pain.⁸²

Last inpatient admission prior to death

88. Prior to his death, Steven's last inpatient admission to the TPC⁸³ was from 20 February to 31 March 2023 under the care of Dr Lazzari, for alcohol withdrawal, recovery treatment, and management of his mood.⁸⁴ Steven had commenced an alcohol withdrawal program prior to that admission.
89. Steven told Dr Lazzari that prior to the admission he had not been taking his medications (except for Meloxicam and paracetamol) and that after he recommenced taking his prescribed medication his mood improved, he was eating well and exercising daily. Steven remained anxious about the possibility of relapsing and disappointing his family again.

⁸¹ Exhibit G1.

⁸² 16 September 2025, T1-36, L4 – 5.

⁸³ The TPC is a voluntary facility – it only admits voluntary patients.

⁸⁴ Exhibit F3 at [9] – [10].

90. Counsel assisting submitted that such concern is commensurate with the known concerns and vulnerabilities that patients (including Steven) have when diagnosed with a co-occurring substance use disorder and other mental health disorder, and further supports the need for health practitioners in all areas to be educated to support such patients to engage with treatment wherever possible, and to overcome stigma in accessing services.⁸⁵ I accept that submission.
91. As submitted by counsel assisting, I accept that on the evidence of Dr Lazzari, Steven’s engagement with treatment was superficial, he was reluctant to be referred to support services, his social anxiety remained significant, and he maintained a tendency to self-cease medications.⁸⁶ Dr Lazzari last reviewed Steven on 29 March 2023⁸⁷ and described Steven as bright, reactive, and preparing for discharge on Friday. Steven was fearful of relapsing into alcohol use and disappointing his family again. However, Dr Lazzari’s evidence was that Steven was future focussed and agreed to see his GP for a new referral to Dr Mushtaq Mohuiddin (psychiatrist) whom had previously treated Steven. Dr Lazzari was closing her inpatient practice and felt it would be better for Steven to see a psychiatrist that had “admitting rights” to the hospital.⁸⁸ Dr Lazzari believed the hospital administration staff sent Dr Monteagudo, Steven’s GP, a copy of his discharge summary requesting re-referral to Dr Mohuiddin. Dr Mohuiddin never received any such referral.⁸⁹
92. Steven was discharged home on 31 March 2023 and was prescribed the following medications:
- a. Meloxicam 15mg, 1 tablet morn (for joint pain);
 - b. Quetiapine 75mg, nocte (for anxiety, depression, insomnia);
 - c. Sertraline 100mg, 2 tablets morn (for depression);
 - d. Thiamine hydrochloride (B1) 100mg, one in the morn (due to alcohol use);
 - e. Zolpidem, 10mg nocte, 1 tablet (if required for insomnia);
 - f. Nicotine patch, 25mg per hour, 16 hours per day; and
 - g. Multivitamins (for general health considering alcohol use).⁹⁰
93. Steven declined referral to Open Arms for review by a psychologist and referral to the Alcohol Substance Use Disorders Day Program at the Townsville Clinic, the Currumbin Drug and Alcohol program, or referral to any residential drug and alcohol rehabilitation facility.⁹¹

Suicide Risk

⁸⁵ Queensland Health Guideline (QH-GDL-964:2021) *Co-occurring substance use disorders and other mental health disorders: policy position statement for Mental Health Alcohol and Other Drugs Services 2021*.

⁸⁶ 16 September 2025, T1-35, L12 – 45. Exhibit F3 at [12] and [16].

⁸⁷ Exhibit F3 at [13]. 16 September 2025, T1-36, L7.

⁸⁸ Exhibit F3 at [13].

⁸⁹ Exhibit F1 at [44].

⁹⁰ Exhibit F3 at [14].

⁹¹ Exhibit F3 at [15] – [16].

94. Dr Lazzari gave evidence at the Inquest, that in terms of any risk to himself, Steven being future focussed upon discharge was a protective factor.⁹² Further protective factors included his good engagement with the TPC and Steven's knowledge of the 1800 admissions intake line, and his rapport with Dr Mohiuddin (given prior treatment).

Emergency Department presentation on 20 April 2023

95. In relation to Steven's presentation to the THHS ED on 20 April 2023, counsel assisting made the following submissions:⁹³

'Outside of presentations in the context of psychosocial crisis and intoxication (as seen during the execution of EEA's), Steven experienced significant difficulty in engaging in treatment, particularly for his severe alcohol use disorder. It is respectfully submitted that is not a failing of Steven, nor necessarily the health system, but rather, reflective of the insidious and complicated nature of addiction.

The unfortunate fact is that EDs are not equipped to deal with such patients, outside of providing care for immediate trauma.

Steven needed longitudinal engagement and support in the community to address addiction (possibly, "warm referrals" / handovers to support services, may have assisted, but it cannot be said on the evidence that they would have been outcome changing).

Seven's pattern of crisis resolution in the ED (when not intoxicated) meant that he was a poor historian and could not be relied upon to engage in treatment follow up in the community. In that sense, collateral information (from police, friends, family, and the TPC) may have assisted, but would not necessarily have been outcome changing. Nonetheless, it begs the question of the information sharing pathways available.'

96. I consider the assessment note made by Dr Mulloy to be exhaustive and appropriate in circumstances where Steven did not satisfy the criteria to be held under the EEA any longer or the *Mental Health Act 2016* (Qld).
97. On the evidence available, there was no failure by the THHS to provide appropriate healthcare.

ED Risk assessment

98. Counsel assisting has submitted that I should accept the expert opinion of Associate Professor Akosile that the risk assessment performed in the ED relied heavily on Steven's immediate statements, potentially missing

⁹² 16 September 2025, T1-36, L18 – 45.

⁹³ Submissions of Counsel Assisting at [77].

contextual information that may have significantly altered the management approach.⁹⁴

99. Counsel for the THHS contends that the evidentiary basis for counsel assisting's submission is not supported by the evidence available and that the assertions made by counsel assisting fail to recognise the practical and contextual limitations faced by the clinicians.⁹⁵ Counsel for the THHS submits that the conducted risk assessment on 20 April 2023 was both appropriate and adequate.⁹⁶
100. I accept the submissions of counsel assisting that while it cannot be definitively said that the clinical response caused or hastened the death, from a psychiatric point of view, they *may* be missed opportunities for intervention, support and potential further engagement in treatment and care for complex presentations such as Steven.⁹⁷ In this regard, however, I am cognisant of privacy issues and practical restraints with respect to information sharing.
101. I have been assisted by the evidence of Dr Turner and Dr Mulloy as the ED Doctors that reviewed Steven in understanding the unique pressures they faced on 20 April 2023 including the volume and complexity of patients subject to EEA's, the physical resources (such as space, quiet rooms, and beds available in the ED).⁹⁸ As noted in the submissions of Counsel for THHS,⁹⁹ between January and August 2025 there were 1900 EEA's presentation to THHS, of those 1100 were not admitted. This averages 8 per day and does not include other presentations which have a mental health component.
102. On the evidence, outside of extending the EEA,¹⁰⁰ I find that the ED medical practitioners had limited options available to them.

Issue 2b – Whether Steven had access to such treatment and absent Steven's consent, could he be compelled to undergo such treatment?

103. On 20 April 2023, Steven was assessed in the ED of the THHS under an EEA made pursuant to Chapter 4A of the *Public Health Act 2005* (Qld).¹⁰¹
104. A discussion occurred between the ED Registrar and the ACT clinician. The options were for an ACT clinician to conduct an in-person review of Steven or for the ED doctor to discontinue the EEA and discharge Steven from the ED for community follow up. Steven told the ED doctor that he was no longer suicidal, and that he wished to go home. A family may not be informed of a decision to discharge a patient absent of the consent of the patient.

⁹⁴ Submissions of Counsel Assisting at [78].

⁹⁵ Submissions of Counsel for THHS at [6] – [15].

⁹⁶ *Ibid* at [16].

⁹⁷ Exhibit H2 at page 18.

⁹⁸ Exhibit F6 at [23] – [46].

⁹⁹ Submissions of Counsel for THHS at [11].

¹⁰⁰ Which they deemed was not required.

¹⁰¹ Section 157D.

105. A voluntary admission *might* have mitigated against Steven becoming intoxicated the following morning, as his access to alcohol could have been curtailed, however, it would not have altered the trajectory of his discharge.
106. The records do not indicate whether a voluntary admission was considered.¹⁰²
107. In accordance with the *Mental Health Act 2016* (Qld) a person can receive treatment and care for their mental illness¹⁰³ under a Treatment Authority (TA) when they do not have capacity to consent.¹⁰⁴ An authorised doctor¹⁰⁵ may make a TA where they are satisfied the treatment criteria¹⁰⁶ apply and there is no less restrictive way¹⁰⁷ for the person to receive treatment and care for their mental illness.¹⁰⁸ I accept counsel assisting's submission that on the evidence available, there was no basis on which an authorised doctor could have made a TA for Steven.

Issue 2c – What is the role of the Veterans Liaison Officer (VLO) where a Veteran presents to a HHS in the context of a mental health crises, and what, if any interaction did Steven have with the VLO prior to and on 20 April 2023?

108. The Veteran's Liaison Officer (VLO) is a specialist clinical nurse, qualified to assess the support needs of a patient identified as a Veteran and to assist in transitioning a Veteran from hospital to home by coordinating clinical and community-based services as per DVA entitlements.¹⁰⁹ The current role provides support to inpatients only (within business hours).
109. The VLO was not available to Steven during his presentation at the ED on 20 April 2023.¹¹⁰

Issue 2d – In all the circumstances, was the treatment afforded Steven, for his condition/s appropriate?

110. Counsel assisting submitted, and I accept that in all the circumstances, the treatment afforded Steven, for his diagnosed conditions was appropriate, both in terms of the treatment and care he received in the community and the treatment and care received in the ED, however, there are opportunities for improvement in care for persons such as Steven who are in crisis.

¹⁰² Exhibit F9 at [37].

¹⁰³ Section 10 *Mental Health Act 2016* (Qld).

¹⁰⁴ Section 14(1) *Mental Health Act 2016* (Qld).

¹⁰⁵ Schedule 3 *Mental Health Act 2016* (Qld).

¹⁰⁶ Section 12(1) *Mental Health Act 2016* (Qld).

¹⁰⁷ Section 13 *Mental Health Act 2016* (Qld).

¹⁰⁸ Involuntary Patient is defined in section 11(a)(iii) of the *Mental Health Act 2016* (Qld).

¹⁰⁹ Exhibit E32.1 – E32.3.

¹¹⁰ Exhibit F9 at [52].

Issue 2e – Whether there was any failure to provide appropriate care that caused or hastened the death?

111. Counsel assisting submitted, and I accept that, on the available evidence there was no failure to provide appropriate care that caused or hastened the death.

Issue 2f – Whether any aspect of the care actually provided, caused or hastened the death?

112. Counsel assisting submitted, and I accept that, no aspect of the care actually provided, caused or hastened the death.

Issue 2g – Consideration of ‘subject precipitated homicide’, including the effect, if any, on first responders

113. Counsel assisting submitted that this court should accept the expert opinion of Associate Professor Amber McKinley and that the incident involving Steven on the day of his death is one that may be appropriately categorised as meeting the definition of SPH.¹¹¹
114. I accept the opinion of Associate Professor McKinley and note that, as submitted by counsel assisting,¹¹² the literature on SPH in fatal police shootings in Australia consistently emphasises the complex interplay of mental illness, substance abuse, and situational factors. This highlights the need for continued research and development of evidence-based strategies to better equip law enforcement in handling such encounters.
115. In this regard, as submitted by counsel assisting, I have been assisted by the consideration of SPH as outlined in the *Findings of the Inquests into the deaths of Mark Andrew Sheppard, Luke Brian Gilbert, and Peter Owen Pilkington* respectively.

Issue 3 – Whether the Queensland Police Service (QPS) Officers involved acted in accordance with the QPS policies and procedures then in force, and whether said actions were appropriate

116. On 20 November 2024, I determined that in respect of this issue for inquest, the QPS Officers involved acted in accordance with the QPS policies and procedures then in force, and their actions were consistent with those policies and procedures.¹¹³

¹¹¹ Exhibit H1 at page 23.

¹¹² Submissions of Counsel Assisting at [91].

¹¹³ 20 November 2024, T2-58, L31 – T2-59, L3.

Issue 4 – Whether any changes to procedures or policies could reduce the likelihood of death occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice

117. As submitted by counsel assisting, I have been assisted by QCMHR’s report, – Partners in Prevention and the commentary therein regarding information sharing:

‘Information sharing should be accessible for the duration of the crisis. There is a need to consider whether the current Memorandum of Understanding should be broadened to include sharing of relevant information back to QAS/QPS post-incident, in order to improve care.

Deficiencies exist in feedback of information to (and from) family, next of kin, and General Practitioners. Better coordination and information sharing is required between the regular service provider and first responders, and others who are actively involved in the individual’s care.’¹¹⁴

118. Counsel assisting submitted, and I accept, that such deficiencies are seen in Steven’s case and represent important opportunities for systems improvement that could reduce the likelihood of death occurring in similar circumstances or otherwise contribute to public health and safety, particularly for Veterans such as Steven.

‘Ongoing initiatives that foster collaboration, knowledge exchange, and mutual support between police, health services and paramedics, are important to improving knowledge and confidence among police staff, and ensuring effective management of risk while minimising use of legislative powers. Maintaining oversight of Queensland’s evolving crisis care system will assist police in confidently facilitating appropriate care pathways for individuals in crisis.’¹¹⁵

119. I have also been assisted by the findings of the RCDVS (specifically Volume 4 of the Final Report) and the following Recommendations referred to during the Inquest:

- a. Recommendation 72: Expand and strengthen healthcare services for veterans.
- b. Recommendation 73: Improve military cultural competency in health professions working with veterans.

¹¹⁴ Partners in Prevention, Understanding and enhancing first responses to suicide crisis situation, summary report, at page 35.

¹¹⁵ Partners in Prevention, Understanding and enhancing first responses to suicide crisis situation, summary report, at page 26.

120. On the evidence available, there appears to be a deficiency in the ability of those that treat veterans to be properly cognisant of clinical history and treatment programs.
121. Counsel assisting submitted that this court should accept the expert opinion of Associate Professor Akosile that Steven’s case is a powerful reminder of the importance of thorough evaluation of collateral information gathering and the need to better understand the complex interplay between mental health, alcohol use, and psychosocial factors in emergency psychiatric care.¹¹⁶
122. I accept Associate Professor Akosile’s conclusions.
123. Counsel assisting has referred to the systemic improvements and additional resources that have transpired since Steven’s passing, in addition to the changes to policy and process, as outlined in the statement of Dr Jacqueline Montwill, Clinical Director Adult Mental Health Services (AMHS), Mental Health Service Group (MHSG), THHS.¹¹⁷ With the benefit of hindsight, Dr Montwill¹¹⁸ identified further opportunity for improvements:
- a. There is no mechanism for afterhours presentations to the ED to loop in the private clinic (when planning follow-up for a patient that is also under the care of the private clinic).
 - b. Communication with the private sector could be improved for both accessing recent information about diagnoses and treatment for a patient presenting to the public system, and also in order to lodge a request for an inpatient bed in the private system contemporaneously, noting availability would likely be confirmed the next working day (during standard business hours).
 - c. An alert in respect to approaching Anzac Day may be helpful in addressing the large serving and Veteran population.
 - d. The input of the VLO to support Veterans in presentations in ED may be helpful. The current role is to provide support to inpatients only – limiting their access to Veterans in crisis. Fuller access would be beneficial.
 - e. Given the current legal framework, where a person cannot be held subject to the *Mental Health Act 2016*, a community based, staffed respite space for people in crisis that could accommodate an admission for up to three days might be helpful (to cover times such as weekends, where private clinics are closed, or to allow for more robust screening of patients and discharge planning).
124. Since the introduction of the *Mental Health Act 2016* (Qld) there has been an increase in the need for police involvement in the treatment of those in the community dealing with mental illness.

¹¹⁶ Exhibit H2 at page 17.

¹¹⁷ Exhibit F9 at [42] – [48].

¹¹⁸ Exhibit F9 at [49] – [55].

125. Counsel assisting submitted that this court should accept the evidence of QPS Inspector Bernie Quinlan who noted that mental health crises responded to by the QPS are varied and multifaceted. They often require collaborative and integrated response to address the needs of persons in crisis in the community.
126. In particular, Inspector Quinlan refers to Safe Spaces as an alternative to a police watchhouse or emergency department – A Safe Space is an accredited Suicide Safe Building/Service. The Safe Space is participant driven where participants have choice and control over the supports they would like to engage in, including guided sensory and calming activities to self-manage emotions, psycho-social support, and Dialectical Behaviour Therapy (DBT).¹¹⁹
127. I accept the evidence of Inspector Quinlan.

Comments and recommendations

128. In accordance with section 46 of the Act, a coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to the administration of justice, public health or safety or ways to prevent deaths from happening in similar circumstances in the future.¹²⁰
129. In making such recommendations, I am not limited to recommendations to prevent an identical death, being those with identical injuries, but rather those deaths that occur in similar circumstances or like situations.
130. In the interests of public safety and in an effort to reduce the likelihood of deaths occurring in similar circumstances in the future, I make the following recommendations:

Recommendation One

I recommend that relevant stakeholders from Queensland Health (including the Chief Psychiatrist and Forensic Mental Health Services), the QAS, and relevant specialists consider the formulation of a working group under the Minister of Health and Ambulance Services to consider:

- a. A mechanism for afterhours presentations to the ED to ‘loop in’ private clinics to support follow up care and referrals for patients such as Steven.
- b. That access to the VLO be extended to capture Veterans in crisis that present to the ED, as Steven did.

¹¹⁹ Exhibit F8 at [20-g].

¹²⁰ The power to make recommendations should be construed liberally. As Muir J confirmed in *Doomadgee v Clements* [2006] 2 Qd R 352.

- c. That the capability of the Mental Health Liaison Service to support QPS and QAS staff in the community responding to Veterans in crisis be further explored, noting the findings of the QCMHR Report.

Recommendation Two

That the Commissioner of Police consider the application of modern technology to implement an alert screen, or pre-populated summary of incident details, for interactions with the QPS in a preceding period of 30 days to allow QPS officers to profile a vulnerable individual more accurately and efficiently and support an effective and consistent response to responding to mental health incidents and/or individuals suffering a mental health crisis.

Closing remarks

I acknowledge the toll that Steven's death has had on the officers of the QPS and the First Responders involved.

I extend my condolences to Steven's family and friends.

I close the Inquest.

Stephanie Gallagher
Deputy State Coroner

Schedule of abbreviations

ACT	Acute Care Team
ADF	Australian Defence Force
AIHW	Australian Institute of Health and Welfare
AMHS	Adult Mental Health Service
ARA	Australian Regular Army
BOLO	Be On the Lookout
CCTV	Close Circuit Television
CIMHA	Consumer Integrated Mental Health Application
Const	Rank: Constable (including first year)
CNC	Clinical Nurse Consultant
DDO	District Duty Officer
Det Sgt	Rank: Detective Sergeant
DVA	Department of Veterans Affairs
ED	Emergency Department
EEA	Emergency Examination Authority
ESC	Ethical Standards Command
IEMR	Integrated Electronic Medical Record
IIG	Internal Investigations Group
MECHVEH	Vehicle Mechanic
MHA	Mental Health Assessment
MHLS	Mental Health Liaison Service
MHSG	Mental Health Service Group
PBS	Pharmaceutical Benefits Scheme
PIC	Pre-inquest Conference
PMCT	Postmortem Computed Tomography
PTE	Rank: Private
QAS	Queensland Ambulance Service
QCMHR	Queensland Centre for Mental Health Research
QPS	Queensland Police Service
RAEME	Royal Australian Electrical and Mechanical Engineers
RCA	Root Cause Analysis
RCDVS	Royal Commission into Defence and Veteran Suicide
Snr Const	Rank: Senior Constable
A/Sgt	Rank: Acting Sergeant
Snr Sgt	Rank: Senior Sergeant
TCS	Tactical Crime Squad
THHS	Townsville Hospital and Health Service
TPC	Townsville Private Clinic
VLO	Veterans Liaison Officer