QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

Ruling in relation to issues for inquest and witnesses to give evidence at inquest

CITATION:	**Inquest into the death of Steven Lee Nixon-McKellar**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2021/4607
DELIVERED ON:	2 August 2023
DELIVERED AT:	Brisbane
PIC DATE:	30 May 2023
INQUEST DATE:	Inquest 11-15 September 2023 (Toowoomba)
RULING OF:	Terry Ryan, State Coroner

REPRESENTATION:

Counsel Assisting:	Julie Pietzner-Hagan
Dr Raelene Nixon:	Dana Levitt, Levitt Robinson Solicitors
QPS Officers Smart, Colman, and Giuliano:	Calvin Gnech and Anna Waite, Gnech and Associates

Commissioner of Police:	Michael Nicolson, instructed by Mark O'Brien, QPS Legal Unit
ATSILS:	Angela Taylor (Public Interest Grounds)
QPUE:	Calvin Gnech and Anna Waite, Gnech and Associates (Public Interest Grounds)

1. Steven Nixon-McKellar was a young First Nations man who died at Toowoomba on 7 October 2021 after he was engaged in a prolonged struggle with Queensland Police Service officers who were attempting to arrest him following a call for service about a vehicle acting suspiciously.

2. At autopsy, the Forensic Pathologist concluded the cause of Steven's death was not determined but said "the death represents a cardiac death during restraint".

3. On 30 May 2023, a pre-inquest hearing was held. The inquest was set down for hearing at Toowoomba from 11-15 September 2023. The following issues were identified to be explored at the inquest in relation to Steven's death:

    1. The findings required by s45(2) of the *Coroners Act 2003*, namely the identity of the deceased, when, where and how he died and what caused his death.

    2. The circumstances surrounding the death including:

        a. what, if any arrangements were made to transition Steven's mental health treatment and care from the PMHS to a community mental health service when he was released on parole on 21 July 2021;

        b. what, if any conditions, was Steven subject to under a Treatment Authority, when he was released on parole on 21 July 2021, and whether or not Steven was compliant with those conditions;

        c. what, if any engagement with illicit substance diversion programs Steven was offered when he was released on parole on 21 July 2021; and

        d. what, if any conditions, was Steven subject to under his parole order (including random testing for illicit substances), and whether or not Steven was compliant with those conditions.

    3. Whether the police officers involved, on 7 October 2021, complied with the Queensland Police Service policies and procedures then in force.

    4. Whether the training provided to police officers to respond to the incident was appropriate, including:

        a. the training provided to police officers in respect of the Lateral Vascular Neck Restraint; and

b. what is the current training provided to police officers in respect of the Lateral Vascular Neck Restraint.

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

4. Those granted leave to appear at the inquest were invited to provide submissions by 14 July 2023 in relation to both the issues for inquest and the witnesses who should be called to give evidence. Submissions have been received from Steven's mother, Dr Raelene Nixon, the Commissioner of Police, ATSILS, and Gnech and Associates on behalf of officers Colman, Smart and Giuliano, as well as the Queensland Police Union of Employees. Submissions in reply were provided by Counsel Assisting.

Dr Nixon

5. The submission from Dr Nixon sought leave for Dr Byron Collins, Consultant Forensic Pathologist, to provide an expert opinion on the use of force and the actions of the police and ambulance officers in the aftermath. I agree that relevant materials should be made available to Dr Collins for the purpose of his review.

6. Dr Nixon submitted that the following were appropriate issues for inquest:
   - Whether the actions of the attending QPS officers were appropriate in the circumstances.
   - Whether the actions of the attending QAS officers were appropriate in the circumstances.
   - Whether there are ways to prevent a death from occurring in similar circumstances in the future.

7. Apart from the actions of the QAS officers the issues proposed by Dr Nixon are encompassed by the inquest issues identified at the pre-inquest conference. A statement has been provided by Dr Rashford, Medical Director of the QAS, in relation to the actions of the attending QAS officers. Having regard to that statement, I consider that the actions of the QAS officers can be examined as a specific inquest issue through the examination of Dr Rashford.

8. Dr Nixon also asked that leave be granted for Professor Chelsea Watego to provide an expert opinion on *'structural racism' or 'institutional racism' – the collective failure of an organisation to provide an appropriate service because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist*

stereotyping which disadvantage minority ethnic people" - as a factor which may have contributed to Nixon's death.

9. Dr Nixon submitted that "*Nixon's was the second death in custody following a police operation in Toowoomba in just ten (10) months, with two (2) QPS officers involved in both. As such, Dr Nixon submits that an examination of the culture of Queensland police as an institution, through the lens of 'structural' or 'institutional racism' by Professor Watego, to explain how institutions encode and enact racial prejudice and discrimination in their systems, giving rise to racist outcomes*".

10. Dr Nixon's submission did not ask that the inquest issues be amended to include as an issue whether 'structural racism' or 'institutional racism' was a causative factor in Steven's death.

11. The proposal to call Dr Watego to provide an expert report about institutional racism in the QPS would not assist my consideration of whether systemic racism was a relevant consideration in the particular circumstances of Steven's death. As Counsel Assisting's submission noted, the initial QPS response was based on information received about a suspected stolen vehicle which police identified as having false registration plates. It was reported that the car was being driven by a "*young male ATSI driver*." No other information was known about the identity of the driver at the time of the report to police.

12. Consistent with the ruling of the Deputy State Coroner in Victoria in the *Inquest into the Death of Tanya Day*,[1] whether systemic racism played a role in this death is a topic that can be considered by the ordinary process of the examination of witnesses about whether Steven's First Nations status had any effect on their interaction with him.

13. Submissions about whether the Coroners Court should find whether any limitations were placed on Steven's rights and whether those limitations were justified under the *Human Rights Act 2019* can be made at the conclusion of evidence.

14. Dr Nixon also sought a copy of the official policies and procedures in place at the time of the death, including Chapter 14.3 of the QPS' Operational Procedures Manual[2] as well as any other documents, records and/ or other materials relevant to the QPS and QAS officers in attendance, including but not limited to:

    a. *Evidence of professional development and/ or training in the months which followed Washington's death in custody on 13 December 2020 and Nixon's death in custody on 7 October 2021.*
    b. *An overview of the chain of command in Toowoomba, including rank*

[1] COR 2017/6424 – Ruling on Application Regarding the Scope of the Inquest
[2] This has been added to the brief of evidence.

and length of service in Toowoomba and/ or any other location in Queensland.

c. *All complaints, allegations of misconduct, details of investigations, and/ or outcomes in relation to officers involved in either or both of deaths in custody.*
d. *The outcome of any investigation by Ethical Standards Command, Crime and Corruption Commission Queensland, and/ or any other third-party oversight body.*

15. The complaint history of the involved QPS officers may be relevant to my functions under ss45 and 46 of the *Coroners Act 2003*. This was accepted by the Supreme Court in *Doomadgee v Clements*.[3] However, the weight that might be attached to any such material needs to be assessed before it is admitted into evidence, particularly where such complaints have not been proven.

16. Dr Nixon referred to the forensic pathologist's conclusion that the circumstances of the death were multifactorial, "*most likely the combined result of all the above factors, being physical and psychological exertion related to the restraint, brief pressure applied to the neck, stimulant drug intoxication, asthma, bronchopneumonia, and coronary atherosclerosis*." As such, Dr Nixon submitted the appropriate focus of the coronial inquest "*was limited to matters temporally proximate to the primary officers' use of force, including with police batons, and the application of the lateral vascular neck restraint ('L VNR'), to arrest Nixon in connection with a "suspected stolen vehicle"*."

17. Dr Nixon argues that the following matters are inappropriate considerations for the inquest, and the following issues are irrelevant, as none are identified as significant contributory factors in the circumstances of the death:
    a. *criminal and medical antecedents, which remained unknown to QPS officers until after his death.*
    b. *willingness to comply with the conditions of his parole compliance with the conditions of parole, including treatment for schizophrenia and addiction.*
    c. *ill-health in days preceding death, including his presentation at Logan Hospital with asthma.*

18. I do not accept that those matters are irrelevant to my functions under ss 45 and 46 of the Coroners *Act.* As noted in the submissions of Counsel Assisting, the cause of death was multifactorial and the treatment of Steven's health issues, including his asthma, substance use and mental health, is relevant to the circumstances leading up to the death.

19. The provision of support to Steven on his release from prison and his parole

[3] (2006) 2 Qd R 352

compliance are also sufficiently connected to the death to justify the inclusion of those topics in the inquest issues. It is also consistent with the State Coroner's Guidelines relating to the investigation of deaths in custody, which encourage a focus on systemic issues.

20. For the same reasons, I do not accept the submission from Dr Nixon that I should exclude material relating to Steven's *"involvement in the vehicle's theft in Brisbane on or around the 5 October 2021, and/ or driving the vehicle on 7 October 2021".* As the interception of the vehicle was the factor that precipitated the exercise of the police powers by the officers, it is necessary to consider how he came to be in charge of the vehicle on the day of his death.

ATSILS

21. ATSILS did not raise any issues with the proposed inquest issues but submitted that the death of Ashley Washington in Toowoomba 10 months earlier was in similar circumstances. ATSILS had sought that the inquests into the deaths of Mr Washington and Mr Nixon-McKellar be joined. Similarly, ATSILS sought to add an issue for inquest examining the response of the Queensland Police Service and Toowoomba Police Station, and its staff, in the period between Mr Washington and Mr Nixon-McKellar's deaths.

22. ATSILS also submitted Constable Katherine Ridge should be added to the witness list. Constable Ridge was not involved in the confrontation between Mr Nixon-McKellar and police but arrived shortly after and assisted in the CPR efforts. I note that Constable Ridge was present at the incident leading to Mr Washington's death and has been added as a witness in that inquest.

23. ATSILS also requested the training and discipline records of Officers Colman, Giuliano and Smart be included in the brief, together with any training programs, supports, regional directives and procedural changes that occurred within the Toowoomba Police District in the period between the deaths of Mr Washington and Mr Nixon-McKellar. I accept that any changes made to local policies and procedures relating to arrest in the Toowoomba District would be relevant to the consideration of the circumstances of Steven's death.

24. I have previously advised ATSILS that I am not satisfied that the circumstances of the deaths are sufficiently similar to warrant the joinder of the two inquests. The fact that the same officers attended at both deaths is not surprising given the size of Toowoomba and the pool of available police officers. The relevant officers also played different roles at each event.

25. I do not agree with the submission from ATSILS that Constable Ridge should be added to the witness list. Constable Ridge only responded after

Steven collapsed. Her oral testimony would add little to the information already contained in her directed interview.

QPUE

26. The QPUE sought leave on public interest grounds pursuant to section 36(1)(c) *Coroners Act 2003*. I accept that the QPUE should be granted leave to appear under s 36, noting that submissions on its behalf are to be limited to matters on which comments can be made under s 46 of the Act. I also accept that the QPUE President may be able to provide relevant evidence under s 46 of the *Coroners Act* in this matter.

27. The QPUE also proposed an expansion of the proposed issues at inquest to include the change in policy in regard to training and use of the lateral vascular neck restraint (LVNR), in which the Commissioner of Police announced that the LVNR would be removed from the Queensland Police Service approved open hand use of force techniques in April 2023.

Commissioner of Police

28. The Commissioner submitted that the proposed extension of the scope of the inquest sought by the QPUE is outside the scope of the inquest, noting the QPUE has other avenues available to explore the Commissioner's decision. The Commissioner's submission set out the QPS' review of the inclusion and training of the LVNR in the situational use of force model following the Noombah inquest recommendation of January 2022.

29. The Commissioner's submission noted that a 17 member Working Group was established and it presented options to the Commissioner in March 2023. On 14 April 2023, the Commissioner announced the LVNR would be removed from approved open hand use of force techniques used by the QPS. A training advisory note was issued to the Queensland Police Service outlining the removal of the LVNR, including links to training material on use of the technique. The Operational Procedures Manual was also amended to delete any reference to the LVNR.

30. The Commissioner submitted that the decision of the Commissioner to remove the use of the LVNR by the Queensland Police Service as an approved open hand use of force technique after the death of Mr Nixon-McKellar has no bearing on the findings required for this inquest, as it is outside the scope of the inquest and not connected with the death of Mr Nixon-McKellar, who died before the Commissioner made her decision and issued her direction.

31. I accept the submission from the Commissioner that the scope of the inquest should not be widened to examine the Commissioner's decision in relation to the use of the LVNR. The inquest issues already encompass the use of

force policies in force at the time of the death, the training provided to police including that relating to LVNR and current training in respect of LVNR.

32. The Coroners Court is obtaining an independent opinion about the training provided and its application in this case. The Court has also obtained a statement from Inspector Anthony Buxton about the review of the inclusion and training of LVNR in the situational use of force model. I agree that the materials referred to by the working group should be obtained.

33. It is possible that the discontinuation of training in circumstances where officers may elect to use LVNR in some circumstances to prevent death or grievous bodily harm may be an issue upon which comment can be made under s 46.

Ruling

1. The following be added as an inquest issue:

   Whether the Ambulance Officers involved, on 7 October 2021, provided appropriate care and/or assessment of Steven.

2. The complaint and disciplinary histories of QPS officers Colman, Giuliano and Smart are to obtained for my review and consideration as to whether they should be added to the brief of evidence.

3. A statement is to be provided from an appropriate senior officer in the Toowoomba Police District outlining any local training programs, directives or procedural changes relating to exercise of police powers and responsibilities during arrests implemented since the start of 2021.

4. That the QPS LVNR working group materials be obtained.

5. That a statement relevant to s 46 matters be provided by Mr Ian Leavers, President, QPUE.

6. The following witnesses should be called to give oral evidence

   a. Constable Brandon Smart – QPS
   a. Senior Constable Simon Giuliano – QPS
   b. Senior Constable Tylarr Colman – QPS
   c. Detective Sergeant Parker – QPS – ESC Investigating Officer
   d. Sergeant James Donnelly – QPS – Use of Force Reviewer
   e. Acting Inspector Anthony Buxton – QPS – LVNR working group
   f. Dr Stephen Rashford – QAS Medical Director
   g. Dr Christopher Day – Forensic Pathologist
   h. Mr Paul Cale – Expert report writer
   i. Dr Byron Collins – Forensic Pathologist engaged by legal representatives for the family.

j. Mr Ian Leavers – QPUE President.

Terry Ryan
State Coroner
2 August 2023