



CORONERS COURT OF QUEENSLAND

CITATION: Inquest into the passing of Steven Lee Nixon-McKellar

FILE NO: 2021/4607

JURISDICTION: Brisbane

PROCEEDING: Findings of Inquest

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Inquest
11-14 September 2023 (Toowoomba)

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FINDINGS OF: State Coroner Ryan

CATCHWORDS: Coroners: inquest, death in custody, First Nations man, police powers, use of force, police training, use of baton, prolonged physical altercation, lateral vascular neck restraint, asthma, drug use, multifactorial cause of death, cause of death not determined.

REPRESENTATION:

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	S Robb KC (written submissions 5 September 2024)
Family:	S Levitt and D Levitt, Levitt Robinson
ATSILS (public interest):	A Taylor
Senior Constable Colman, Senior Constable Giuliano & Constable Smart:	J Greggery KC, instructed by Gnech and Associates
Queensland Police Union of Employees: (public interest)	J Greggery KC, instructed by C Gnech and Associated
Queensland Commissioner of Police:	M Nicolson, instructed by QPS Legal Services
Queensland Corrective Services:	J Villanueva, QCS
West Moreton Hospital and Health Service:	P Fairlie

Cultural Warning

Aboriginal and Torres Strait Islander readers are advised that these Findings contain the name of a deceased Aboriginal person. There may be words and descriptions that may be culturally distressing.

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Introduction

- [1] Steven Nixon-McKellar, a proud Gunggari man, was aged 27 years at the time of his passing. He is the son of Dr Raylene Nixon and Larry McKellar, and is remembered by his family as a son, grandson, brother, uncle, nephew, and cousin. In accordance with the wishes of his family, he was referred to as Steven throughout the inquest.
- [2] I acknowledge the immense sorrow that Steven’s passing has caused his family and community. At the commencement of the inquest, Dr Nixon addressed the Court and spoke proudly of the Gunggari people, their connection to country and great courage and resilience. She asked for an honest and open conversation, and a desire to know what led to her son’s final moments. Dr Nixon told the Court that Steven was loved and is missed every single day, and that he was forever in their hearts.¹ I extend my condolences to Steven’s family and community.
- [3] The Gunggari people are the proud Traditional Owners of an expansive area in Queensland’s Maranoa region, centred on the Maranoa River. The Gunggari people achieved formal recognition as Native Title Holders on 22 June 2012 and again on 5 December 2014.²
- [4] As submitted by counsel assisting, with respect to Steven’s cultural links and the use of terminology, I acknowledge that *‘Aboriginal people in Australia are not part of a homogenous mass. Nations, tribes, clans, and language groups make up the fabric of Aboriginal society and each person’s experience can be varied depending on their personal history.’*³
- [5] I also acknowledge the use of terms such as ‘death’ and ‘deceased’ may not accurately reflect the customs and traditions of the Gunggari people, and First Nations people more broadly, and that the term ‘passed’ may be more culturally appropriate. The use of terms such as ‘death’ and ‘deceased’ in these findings is not intended to be culturally insensitive but is required by the wording of the legislation.⁴

Coronial jurisdiction and the role of counsel assisting

- [6] Steven’s passing was reportable under s 8(3)(g) of the *Coroners Act 2003* Qld (the Act) because it happened while he was in custody. Accordingly, an inquest was mandatory.⁵ Chapter Three of the State Coroners Guidelines articulate the importance in the investigation of such deaths:

¹ 11 September 2023, T1-7, L 17-40.

² See [Gunggari Country – Gunggari Native Title Aboriginal Corporation \(gunggaripbc.com.au\)](http://gunggaripbc.com.au)

³ Sorry Business. A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islander people, 5.

⁴ *Coroners Act 2003* (Qld).

⁵ Section 27(1)(a)(i) *Coroners Act 2003* (Qld).

The investigation of deaths in police or prison custody has long been considered an important function of coroners given the vulnerability of people whose liberty is curtailed by the exercise of executive power. The Act recognises and responds to the need for public scrutiny and accountability by requiring all deaths in custody to be investigated by the State Coroner or the Deputy State Coroner and by mandating that an inquest be held into all such deaths. These requirements arose out of the extensive recommendations made in the Royal Commission into Aboriginal Deaths in Custody.⁶

- [7] Section 45(5) of the Act provides that the coroner must not include in their findings any statement that a person is, or may be guilty of an offence, or may be civilly liable. In keeping with the therapeutic nature of the Coronial jurisdiction, the focus of the coronial process is on discovering what happened, not on ascribing guilt, apportioning liability, or attributing blame to any party.
- [8] The relevant standard of proof is the balance of probabilities, with reference to the *Briginshaw*⁷ standard. Accordingly, the more significant the issue for determination, the clearer and more persuasive the evidence must be for the coroner to be sufficiently satisfied on the balance of probabilities that the issue has been proven:

But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the questions whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters “reasonable satisfaction” should not be produced by inexact proofs, indefinite testimony, or indirect inferences.⁸

- [9] In adjudicating the significance of the evidence, the impact of hindsight bias and affected bias must be considered:⁹

Hindsight bias is the tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact...It is an obvious point, but one that nonetheless bears repeating, particularly when coroners are considering assigning blame or making adverse comments that may damage a person’s reputation...

⁶ State Coroners Guidelines, chapter 3.

⁷ *Briginshaw v Briginshaw* [1938] HCA 34 and (1938) 60 CLR 336.

⁸ Dixon J (as he then was) in *Briginshaw v Briginshaw* 60 CLR 336.

⁹ Inquest into the death of Pasquale Giorgio, 2016/1388 at [140] – [142].

Coroners should attempt first to understand the circumstances as they appeared at the relevant time to the people who were there.

Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. This distinction needs to be understood and rigorously applied.¹⁰

- [10] An inquest is not a trial between opposing parties, but rather an inquiry into the death.

An inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest, it should never be forgotten that there are no parties. There is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends... (and) ... the function of an inquest is to seek out and record as many of the facts concerning the death as (the) public interest requires.¹¹

- [11] The jurisdiction of the Coroners Court is prescribed by the Act. The Act prevails over the common law.¹² The Coroners Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate.¹³ In circumstances where the discretion is not otherwise fettered, it falls to be exercised in light of the relevant considerations that arise informed by the subject matter, scope and purpose of the Act.¹⁴

- [12] Family members of the person who has passed are considered to have sufficient interest to appear at, examine witnesses and make submissions at the inquest.¹⁵ The State Coroner's Guidelines¹⁶ note family members' knowledge about the deceased person and concerns about the circumstances of the death should be considered and further, "[e]xperience has shown that families can raise a range of issues that may not be relevant to the circumstances to the death."

¹⁰ *The Australasian Coroners Manual*, H Dillon and M Hadley, Federation Press, 2015, 10.

¹¹ *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625, Lord Lane CJ.

¹² Section 104 *Coroners Act 2003* (Qld).

¹³ Section 37(1) *Coroners Act 2003* (Qld).

¹⁴ *Christensen & Anor v Deputy State Coroner* [2021] QSC 38 at [40] per Rafter AJA; *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* (1986) 162 CLR 24 at 39-40.

¹⁵ Section 36(1)(c) *Coroners Act 2003* (Qld).

¹⁶ At 2.8.

[13] As noted in the *Coronial Findings in the Inquest into the death of Hamid Khazaei*,¹⁷ the common law right of family members to be involved in coronial investigations is extended by the application of the Act. In that matter I concluded that the scope of the role of families in inquests and the rights of family members to make submissions under the Act was as follows:

[45] *Even if the view was taken that limits that may exist, or be imposed by a coroner, on the rights of the family to make submissions at an inquest, I do not consider that those limitations would operate to prevent a coroner from receiving submissions from a person granted leave to appear on the issues raised generally in the inquest, where those submissions might assist the coroner in reaching findings under s 45 or making any comments and recommendations under s 46. Section 37(1) of the Coroners Act 2003 provides that the Coroners Court may inform itself in any way it considers appropriate.*

[46] *Notwithstanding, a number of the submissions from the family asked me to consider matters outside the scope of the inquest, including breaches of common law duties, contract and of Commonwealth legislation. Even if the facts I have found were suggestive of such breaches, as noted above, it is not my role to make findings with respect to civil or criminal liability. It would also be unfair to reach conclusions about such matters when they were not directly in issue in the inquest and witnesses were not asked directly about them. It would also be unfair to make adverse findings against individuals who were not given the opportunity to appear and give evidence at the inquest.*

[14] Whether the family of a deceased person participates in an inquest, and whether the family member is represented at an inquest impacts the role of counsel assisting:

*Although Counsel Assisting clearly plays no representative role in relation to the deceased's family, the role has traditionally ensured the views and concerns of unrepresented families, where relevant to the circumstances of the death, are appropriately ventilated at inquest.*¹⁸

[15] The role of counsel assisting the coroner includes to present the evidence impartially and fairly to the coroner and to explore what findings and comments pursuant to ss 45 and 46 of the *Coroners Act 2003* are open on the evidence.¹⁹ In *R v Doogan*, the ACT Supreme Court explained:

¹⁷ At [29] – [46].

¹⁸ State Coroners Guidelines, 2.11.

¹⁹ State Coroner's Guidelines, 9.5

... the duties of ... counsel assisting coroners ... should be guided by the overriding principle that their goal is the attainment of justice rather than the achievement of a preconceived objective. However, justice is not always, nor even usually, attained by forensically passive approach in which counsel assisting eschew any responsibility to explore particular possibilities actively or to test assertions which may or may not be accurate. On the contrary, coroners are entitled to expect that counsel assisting them will actively pursue the truth and that will almost inevitably involve identifying particular possibilities or tentative conclusions and testing the evidence with a view to determining whether it can be confirmed or discounted.²⁰

[16] Where a person whose interests are engaged by an inquest is legally represented, the responsibility for protecting and advancing their interests lies with their legal representatives, not counsel assisting. Where legally represented, an interested party will have the benefit of the advice of a lawyer who is qualified to carry out the legal work involved and whose paramount duty is to the court and the administration of justice.

[17] Legal representation may assist families to make submissions directed at ss 45 and 46 findings and recommendations within the scope of the issues for consideration, and informed by the purpose and limits of the jurisdiction created by the *Coroners Act 2003*.

Coronial investigation

[18] The coronial investigation was led by Detective Sergeant Parker of the QPS Ethical Standards Command (ESC). Detective Sergeant Parker concluded:

- a. There were no suspicious circumstances associated with the death.
- b. There was no evidence to support a criminal prosecution against any person.
- c. There was no evidence to support any breach of discipline or misconduct against any police officer in respect of the death; and
- d. The application of the use of force by the police officers involved was authorised, justified, reasonable and tactically sound and effective.²¹

[19] The Crime and Corruption Commission (CCC) established under the *Crime and Corruption Act 2001* conducted an overview of the ESC investigation. The CCC did not identify any conduct that constituted a breach of discipline, police misconduct or corrupt conduct. The CCC noted that Senior Constable Colman's use of the Lateral Vascular Neck Restraint (LVNR) complied with Chapter 14 of the QPS Operational Procedures Manual (OPM).²²

²⁰ *R v Doogan* (2005) 193 FLR 239; [2005] ACTSC 74, [162] per Higgins CJ, Crispin and Bennett JJ.

²¹ Exhibit A5, 34.

²² Letter dated 1 March 2022.

Autopsy results

- [20] On 8 October 2021, Forensic Pathologist, Dr Day, conducted an external and full internal examination of Steven's body, including associated testing.²³ Dr Day viewed QPS vehicle dash camera footage of the incident which he described as showing a prolonged restraint/altercation where Steven collapsed '*almost immediately following pressure being applied to his head and neck region.*'²⁴
- [21] Dr Day noted that the footage showed a struggle between Steven and two police officers. All three persons remained standing throughout. A third police officer entered the footage from behind Steven and placed his arm around Steven's neck. Steven collapsed to the ground where he remained unresponsive. The police officers commenced resuscitation efforts.²⁵
- [22] Toxicological analysis of a sample of femoral vein blood confirmed the presence of Amphetamine (0.20mg/L); Methylamphetamine (1.1mg/L); and Paliperidone (<0.01 mg/L). Dr Day considered the presence of Methylamphetamine was within the broadly overlapping non-toxic to potentially lethal range.²⁶
- [23] Dr Day considered the level at which the methylamphetamine was detected was significant and was independently sufficient to cause Steven's passing. He further said that methylamphetamine is a

*'central nervous system stimulant, increasing blood pressure and heart rate and may be directly cardiotoxic (adversely affect the heart), increasing the risk of sudden cardiac arrest via an abnormal heart rhythm (arrhythmia) which may be exacerbated during times of exertion.'*²⁷

- [24] During the examination, Dr Day observed and recorded groups of injuries to the torso, arms, and legs in keeping with being caused by the altercation depicted within the footage. Dr Day considered the injuries were confined to bruising of the skin and underlying soft tissue and were not independently or collectively sufficient to cause death.
- [25] The internal examination revealed evidence of comorbid heart and lung disease in the form of a mild dilatation of the chambers of the heart, moderate coronary atherosclerosis, active chronic asthma, and focal pneumonia. Dr Day considered that individually, the findings were unlikely to be independently fatal. However, in the presence of Steven's stimulant drug use (methylamphetamine), the neck hold applied by police, and significant psychological and physical exertion, the pre-existing disease had the potential to diminish physiological reserve and act in combination to cause sudden death.

²³ Exhibit A3, 1.

²⁴ Exhibit A3, 19.

²⁵ Exhibit A3, 1.

²⁶ Exhibit A3, 18.

²⁷ Exhibit A3, 19.

[26] The cause of death listed in the Autopsy report was 'Not determined'. However,²⁸ Dr Day considered in the body of his report that the cause of Steven's passing was *multifactorial*. The extent to which each factor contributed in terms of Steven's underlying health, the physical altercation with police officers and the use of the LVNR was uncertain. Consequently, the precise mechanism of death was '*not determined*'.²⁹ Dr Day believed that Steven's passing was the result of a combination of all the events, and all the natural diseases, together with methylamphetamine toxicity.

[27] Dr Day ultimately considered that Steven's passing:

*'Represents a sudden cardiac death during restraint, in the setting of a prolonged altercation in which the deceased was physically exerting himself, in my opinion, death has most likely resulted from a combination 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...'*³⁰

*The precise mechanism of death cannot be determined at autopsy examination. Given the close temporal relationship between pressure being applied to the neck and cardiac arrest, it is considered a significant contributory factor. Brief pressure to the neck, in the absence of other contributory factors described is unlikely to cause death independently.*³¹

[28] Dr Collins, Forensic Pathologist, was engaged by Steven's family provided a report.³² He gave evidence at the inquest. To assist Dr Collins in the preparation of his report I agreed Dr Collins and Dr Day could communicate in advance of the inquest.

²⁸ Exhibit A3, 19-20. Under the heading 'Conclusion'.

²⁹ Exhibit A3, 20.

³⁰ Exhibit A3, 19.

³¹ Exhibit A3, 20.

³² Exhibit H1.3.

Inquest

- [29] On 30 May 2023, a Pre-Inquest Conference (PIC) was held in Brisbane. Steven’s family, with the support of their legal representatives and those granted leave to appear were given the opportunity to consider the coronial brief of evidence and provide written submissions in response to the proposed issues for inquest and witness list.
- [30] The Aboriginal and Torres Strait Islander Legal Service (ATSILS) was granted leave to appear in the public interest. Such an appearance means that only submissions about a matter on which a coroner may comment under s 46(1) are permitted, and ATSILS were unable to examine witnesses at the inquest without the Court’s leave.³³
- [31] The Coroners Court informed the Queensland Human Rights Commission (QHRC)³⁴ that an inquest would be held in relation to Steven’s passing. On 5 May 2023, the QHRC advised in writing that it did not intend to seek leave to appear in the inquest.
- [32] On 2 August 2023, I delivered my *Ruling in relation to the issues for inquest and witnesses to give evidence at the inquest* (Annexure A). The QPUE was also granted leave to appear on public interest grounds,³⁵ for its then General President, Mr Leavers, to make a statement and to give evidence and make submissions on matters related to the cessation of training of QPS members in the use of the LVNR. As noted above, no objection was taken by any other party granted leave to appear to the appearance of the QPUE or the inclusion of Mr Leavers on the list of witnesses.
- [33] The inquest was held in Toowoomba from 11 to 14 September 2023. The brief of evidence was tendered at the commencement of the inquest without objection. As noted above, Dr Nixon addressed the Court at the commencement of the inquest. On the final day of the inquest efforts to reach a consensus in respect of the content of a “victim impact statement” provided to the Court on the morning of 14 September 2023 were unsuccessful. Steven’s family, in consultation with their legal representatives, elected to withdraw the statement. Despite this, Dr Nixon was again given an opportunity to address the Court.
- [34] Written submissions were received between 8 November 2023 and 5 September 2024.

³³ Submissions of ATSILS, 1.

³⁴ Correspondence dated 2 May 2023.

³⁵ In the public interest.

Issues for Inquest

[35] The issues for inquest were settled as:

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. The circumstances surrounding the death including:
 - a. what, if any arrangements were made to transition Steven's mental health treatment and care from the Prison Mental Health Service (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 ambulance officers involved, on 7 October 2021, provided appropriate care and/or assessment of Steven.
4. Whether the police officers involved, on 7 October 2021, complied with the Queensland Police Service policies and procedures then in force.
5. 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.
6. 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.

Witnesses called

[36] During the inquest, oral evidence was heard from the following witnesses:

1. Constable Smart, QPS;
2. Senior Constable Giuliano, QPS;
3. Senior Constable Colman, QPS;
4. Sergeant Donnelly, Operational Skills and Tactics, QPS;
5. Dr Rashford, Medical Director, Queensland Ambulance Service;
6. Mr Cale, Kinetic Fighting Pty Ltd;
7. Acting Inspector Buxton, Manager of Operational Training Services (OTS) and the Chief Operational Skills Instructor, QPS;
8. Detective Sergeant Parker, Internal Investigations Group, Ethical Standards Command, QPS;
9. Mr Leavers, President, Queensland Police Union of Employees;
10. Dr Day, Forensic Pathologist; and
11. Dr Collins, Forensic Pathologist.³⁶

Evidence and findings on inquest issues

[37] I have considered all the available evidence and the submissions of those granted leave to appear, including Steven's family. In examining the issues for inquest, particularly how Steven passed, relevant background events leading up to his interaction with Queensland Police Service (QPS) officers on 7 October 2021 were considered as they provided relevant and probative information.

4 October 2021

[38] On 4 October 2021, at 2:37am Queensland Ambulance Service (QAS) Paramedics were called to attend Schodel Street, Woodridge, in response to reports of a male having an asthma attack. The triple 0 operator asked for the patient's name. The person making the call said: *'It's Steven...ummm...Dylan Connor.'*³⁷ Paramedics Stevens³⁸ and Hutchinson³⁹ attended (Code 1) from the Ipswich Hospital and arrived at 3:10 am.⁴⁰ The delay in attending the address was attributed to heavy fog on the Logan Motorway.⁴¹

[39] Upon arrival an unknown female ran to the ambulance screaming that Steven was dying, and complained of the time it took for the QAS to arrive. Steven walked to the ambulance. Paramedic Hutchinson was the primary treating paramedic and recalled Steven was alert and his airway, breathing and circulation were intact. He was walking and speaking in sentences with an increased respiratory rate. No colour change was noted. Steven was asked to step inside the ambulance for assessment and did so reluctantly.

³⁶ Commissioned by Steven's family.

³⁷ Exhibit E15 at 0:03:51.

³⁸ Exhibit B15.

³⁹ Exhibit B16.

⁴⁰ Exhibit D5.

⁴¹ Exhibit B15, 1.

- [40] Steven yelled at Paramedic Hutchinson that he knew he was having an asthma attack and just needed a *'fucking puffer.'* Paramedic Hutchinson explained that she was unable to administer any medications without at least listening to his lungs and checking his oxygen saturations. Steven agreed to this occurring. On auscultation Paramedic Hutchinson noted that Steven had both inspiratory and expiratory wheezes. She informed Steven that she believed he was having a mild to moderate asthma attack.
- [41] Steven yelled: *'I know I told you I have fucking asthma.'* Paramedic Hutchinson advised Steven that he would need to have a dose of Nebulised (NEB) salbutamol and go to hospital. Steven's tone of voice and frequency of swearing increased. Paramedic Hutchinson described Steven's demeanour as aggressive. She explained to Steven that *the NEB was a bigger, stronger version of the puffer and would work quicker against his symptoms. Steven agreed to start treatment and stated that he had no allergies.*
- [42] Paramedic Hutchinson described Steven as agitated. He did not like being asked questions and would ignore her when she asked for his name. Steven repeatedly said that he knew his *'fucking body'* and did not understand why she could not just give him a *'fucking puffer'* to keep. Paramedic Hutchinson explained to Steven that she did not have puffers she could hand out to patients, that the nebuliser was faster acting, and once they got to hospital, they would organise for him to have a puffer to take home.
- [43] Steven told Paramedic Hutchinson his asthma was triggered by weather changes. She asked Steven why he did not carry a puffer if he knew he had asthma. Steven said that his puffer ran out and he did not have another one. Paramedic Hutchinson advised Steven that next time his puffer ran out he could seek an emergency supply from a pharmacy or see a GP for a script. Steven would not answer further questions about his asthma such as previous hospital or ICU admissions.
- [44] Paramedic Hutchinson formed the view that due to Steven's increasing agitation it was in the interests of her and her partner's safety not to ask too many questions. Paramedic Hutchinson assessed Steven a second time. On auscultation only inspiratory wheezes were noted and Steven's oxygen saturations had increased. She asked Steven if she could give him a second dose to which he agreed. Steven told Paramedic Hutchinson *'you're fucking stupid, the last time I called QAS they gave me a puffer to keep.'* She told Steven that she was unable to do this and assured him that he could get one at the hospital.
- [45] During the second NEB, Steven stood up and said he felt better and no longer wanted to go to hospital. He took off his nebuliser mask, and threw it as he left the ambulance. Paramedic Hutchinson asked Steven if he knew the risks involved in not going to the hospital, which could lead to death. Steven kept walking back into the house and did not acknowledge her.

[46] Paramedic Hutchinson told the female with Steven to call the QAS back if Steven's symptoms worsened. Paramedic Hutchinson determined that due to Steven's aggressive nature and the fact that he was not living alone, it was best not to pursue Steven into the house for safety reasons.⁴² The QAS response was completed at 3:25am.⁴³

[47] Later that same day, Margaret Finlay, a person known to Steven⁴⁴ rang Steven's grandmother and told her she was going to see Steven, who was having trouble breathing and she was going to try to get him to go to hospital. When Ms Finlay saw Steven, she observed him *'hunched over trying to catch his breath.'*

[48] Ms Finlay recalled her conversation with Steven and her pleas for him to go to the hospital. She told Steven his grandfather died of asthma and his mother nearly died a couple of times from asthma and he was going to the hospital. Steven told Ms Finlay: *'I can't, I got a warrant.'* She responded: *'the police don't run the hospital, it's doctors.'*

[49] At 11:00am, Steven⁴⁵ went to the Logan Hospital Emergency Department (ED) under the name "Dylan Conlan", complaining of shortness of breath. Ms Finlay said: *'I think he [Steven] came up with the idea to use Dylan's name.'*⁴⁶ Ms Finlay took Steven to the hospital but only one person was allowed in. Steven was seen immediately. Ms Finlay confirmed that Steven used the name Dylan when he was checked into the hospital.

[50] The ED Registrar, Dr Chowdhury made the following observations of Steven:

- a. *'25-year-old male presents today with shortness of breath and wheeze that has worsened over the course of today, has previously had asthma attack. Nil ICU requirement. Wheeze; ongoing and heard from end of the room. Dylan is agitated - has had some amphetamines IV yesterday - denies any other symptoms of note... Temperature 36.4 (11:34) Systolic Blood Pressure 137 (11:15) Diastolic Blood Pressure 79 (11:15) Pulse 119 (11:34) SpO2 92 (11:34) Respiratory Rate 16 (11:34). Chest; wheeze throughout. HSD tachycardic but nil murmur heard. Abdomen soft non tender, calves soft non tender. Track marks to the whole upper limbs... On review has had a burst of salbutamol and atrovent with hydrocort. Dylan doesn't want to talk to me intermittently has had a sandwich and SOB much improved. Has woken up and has refused to stay in hospital - signed out against medical advice - discussed the risks of death, worsening breathing, Sepsis if he has an infection leading to this.'*⁴⁷

⁴² Exhibit B16, 1 - 2.

⁴³ Exhibit D5, 1.

⁴⁴ Exhibit E9 and E10. Ms Finlay told Police that Steven called her Auntie.

⁴⁵ Exhibit E9.

⁴⁶ Exhibit E9 at 0:06:58.

⁴⁷ Exhibit D4, 2 - 3.

[51] A blood sample obtained from Steven at the Logan Hospital during this admission showed Eosinophils at 0.60H.⁴⁸ A COVID PCR returned a ‘not detected’ result.⁴⁹ At 2:00pm Steven signed a ‘*discharge at your own risk*’ form⁵⁰ and discharged himself against medical advice.

[52] Ms Finlay collected Steven from the Logan Hospital and took him home. Upon collection she described Steven as: ‘*smiling, happy, but he wasn’t fully recovered, I think he discharged himself.*’ Ms Finlay was unsure where Steven stayed that night but believed he rang his mother for money as he was hungry. Ms Finlay told police in relation to Steven’s mental health depot injection, that Stevens ‘*grandmother kept ringing me trying to get me to take him to the hospital to have it.*’⁵¹

5-7 October 2021

[53] On 5 October 2021, about 7:30pm, a grey Subaru Forester bearing registration 411-ZZW was reported stolen from an address in Stafford Street, East Brisbane. The owner of the vehicle had left the vehicle running in the driveway. They did not see who took the vehicle. The Police report said that a neighbour saw the vehicle reverse out of the driveway, clip the footpath and a wheelie bin. They did not see the offenders. Automatic Number Plate Recognition (ANPR) results showed the car travelled southbound on the Gateway Motorway at Belmont at 9:14pm, northbound at 10:39pm and southbound at 11:41pm.

[54] On 6 October 2021, ANPR results showed the vehicle travelled northbound at 2:08am and northbound Gateway Motorway at Nudgee at 2:19am. The images showed two males in the front seats. The driver appeared to be a slim young male. The images were not good enough quality for use in a “be on the lookout” (BOLO) publication. There were no linked occurrences and no occurrences involving the stolen vehicle at that time. Scenes of Crime (SOC) were not tasked to attend the residence from where the vehicle was stolen as the offender/s did not enter the dwelling, nor did they touch anything other than the vehicle. There was no CCTV.⁵² Sometime later, the vehicle was fitted with expired registration plates (596-ZXY) that belonged to a Honda Civic.⁵³

[55] On 7 October 2021, Steven was driving and in possession of the grey Subaru Forester when he was intercepted by QPS officers. The registration plates for the Forester (411-ZZW) were located by QPS forensic examiners, (after Steven’s passing) in the boot of the vehicle, along with other items of property.⁵⁴

⁴⁸ Exhibit A3, at [5]. Exhibit H1.2, question 4.

⁴⁹ Exhibit D4, 10.

⁵⁰ Exhibit D4, 30.

⁵¹ Exhibit E9 at 0:09:45.

⁵² Exhibit C10, 12.

⁵³ Exhibit C10. Exhibit C11, 9.

⁵⁴ Exhibit G4, 101.

Issue one

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.

Events leading up to the death

- [56] On 7 October 2021, about 12:25pm, an anonymous caller reported a suspicious vehicle parked outside a house at Stone Street, Wilsonton, to the Police Communications Centre (PCC).⁵⁵ They said they had gone past and saw *'quite a young Aboriginal man get out of it and it didn't quite look right'...* *'I ran the number plate, and it came back as an expired Honda Civic...596-ZXY.'* The caller requested anonymity.⁵⁶ The identity of the caller was confirmed through the course of the coronial investigation as a member of the public who had used the online Queensland Registration Check App.⁵⁷
- [57] Steven parked the Subaru Forester, fitted with expired registration plates 596-ZXY outside a house on Stone Street occupied by Ms Lawton, who was known to Steven.⁵⁸ Ms Lawton saw Steven get out of the driver's seat of the Forester.⁵⁹ She saw a male in the front passenger seat and one in the rear.⁶⁰ Ms Lawton said that Steven would sometimes come to visit, and she was aware that he had recently been released from custody.
- [58] Steven asked to use the hose. Ms Lawton told Steven the hose would not reach that far, and that she hoped he was not driving a stolen car. Steven said: *'No Aunt, this is legit my car.'* Ms Lawton responded: *'Yeah, whatever.'*⁶¹ Ms Lawton went inside her home to make a cup of coffee. She subsequently heard shouting and walked outside to see the Forester parked in her yard, in a *'strange way'* across the driveway.⁶²
- [59] About 12:29pm, QPS officers from Toowoomba station were tasked to investigate a vehicle of interest (VOI) with false plates (596-ZXY), a Subaru Forester with a *'young male ATSI driver, grabbing a bag out of the car, unknown if they were going into a house on the street.'*⁶³

⁵⁵ Exhibit A5, 25. Exhibit C11, 1. The PCC recorded the call.

⁵⁶ Exhibit A5.

⁵⁷ This issue was explored at the Inquest,⁵⁷ as during his directed interview, Senior Constable Colman said that there had been an earlier broadcast after an off-duty QPS officer (name unknown) had called the station, reporting a suspect vehicle with false plates (not in the same location as that given by the anonymous caller). Exhibit E3.1, answer 159 - 163.

⁵⁸ Exhibit B14.

⁵⁹ Exhibit B14, at [15].

⁶⁰ Exhibit B14, at [23]. A third male was not identified through the police investigation.

⁶¹ Exhibit B14, at [18] – [22].

⁶² Exhibit B14, at [25].

⁶³ Exhibit C11, 1.

- [60] Senior Constable Giuliano and Constable Smart⁶⁴ were rostered on shift together and arrived on scene in a marked QPS Hyundai iLoad van at 12:30pm.⁶⁵ Neither officer had any previous interactions with Steven or the other person in the Forester.⁶⁶
- [61] At the inquest Constable Smart said: *'We were just leaving Park Street when comms called for any unit near Stone Street, Wilsonton area saying that there was an anonymous informant saying that a male was in a car there with false plates on it and he'd just thrown a bag out of the car, and he got back in the car. So, Simon [Giuliano] was driving today. I was in the passenger seat.'*⁶⁷ *...Park Street is directly adjacent to Stone Street. We went out onto Tor Street, straight around to Stone Street. We paused at the entrance of the street, observed what we believed was the suspect vehicle about mid-way down the street on our left.'*⁶⁸ The suspect vehicle was a *'dark grey SUV, Forester.'*⁶⁹
- [62] Senior Constable Giuliano said: *'So we were in Park Street, one street over, receiving those job details, we proceeded around the corner into Stone Street. When we entered Stone Street, I observed a car matching the description of a Subaru Forester parked in front of an address. I drove up to that car, stopped the police car directly behind it, and I exited the police car and proceeded to the driver's door.'*⁷⁰
- [63] Constable Smart said the information provided about the occupants of the VOI was that they were *'male.'*⁷¹ During his directed interview, he said: *'Through experience in Toowoomba dealing with stolen vehicles a common MO is to attach the wrong plate to the vehicle and get around like that, so that's just clicked in my mind as something that's kind of led me to believe oh, this is suspect.'*⁷²
- [64] Constable Smart observed the VOI in the driveway of a house on Stone Street.⁷³ The gate across the driveway was closed⁷⁴ *'... We've parked in behind it with me right next to the rear of the vehicle basically, not even a metre away. At that point going through my head was yep, they're the plates that they've told us that's not the vehicle it belongs to.'*⁷⁵

⁶⁴ 11 September 2023, T1-40, L 12.

⁶⁵ Exhibit C11, 1. Dash Cam footage. Both officers participated in directed interviews with ESC and gave evidence at the Inquest.

⁶⁶ Constable Smart, 11 September 2023, T1-23, L 46 & T1-24, L 1. Senior Constable Giuliano

⁶⁷ Exhibit E1.1, answer 65. 11 September 2023, T1-21, L 27. See also Senior Constable Giuliano's evidence, 11 September 2023, T1-50, L 5. Exhibit E2.1, answer 39.

⁶⁸ 11 September 2023, T1-21, L 38. Exhibit E1.1, answer 67.

⁶⁹ 11 September 2023, T1-21, L 43.

⁷⁰ 11 September 2023, T1-50, L 10.

⁷¹ 11 September 2023, T1-22, L 1.

⁷² Exhibit E1.1, answer 301.

⁷³ 11 September 2023, T1-22, L 19.

⁷⁴ 11 September 2023, T1-45, L 8. Exhibit F9, dash cam footage.

⁷⁵ Exhibit E1.1, answer 69. 11 September 2023, T1-22, L 13.

[65] Constable Smart was concerned that the VOI was going to ram the police van:

*'I'd seen a male in the passenger seat looking around and I've seen the car kind of start nudging backwards and immediate thought was oh, I'm in danger of getting rammed here, we're going to get rammed.'*⁷⁶ ... *Basically immediately after that the car kicked into gear and started moving back and forward. I said to Simon, look out, we're going to be rammed.'*⁷⁷

[66] Constable Smart climbed through the rear of the police van and out of the rear sliding door.⁷⁸ He approached the front passenger window of the VOI and tried to open the door. He observed a male in the front passenger seat and indicated for him to get out of the vehicle: *'The first thing I did was tried the door handle which was locked. The guy inside looked at me, the passenger looked at me and I remember he kind of had like a panicked look on his face and I've basically just motioned him like, you, and I mouthed the words, I'm pretty sure they were something to the effect of get out of the car and I've been making motions with my hand as in pointing at him pointing out. I remember him, I think he nodded.'*⁷⁹ At the inquest, Constable Smart's evidence was that he was yelling: *'Get out of the car!'*⁸⁰ Officer Smart recalled that the VOI continued to move.

[67] Senior Constable Giuliano said:

*'Before I could even get to the driver's door, the car started to move backwards, so I thought it was going to reverse, but then it changed and drove forward and drove through a closed gate into the front yard, and then made a turn to the left inside that front yard. I moved around behind the car to the passenger side. The car was moving forwards and backwards, like, trying to, I guess, turnaround from what it appeared to me.'*⁸¹

[68] Senior Constable Giuliano drew his baton, extended it and: *'Struck the front passenger window once. That door, the front passenger door then opened, and a male person stepped out. I had a brief exchange of words with that person.'*⁸² Senior Constable Giuliano recalled the passenger came out of the VOI with his hands up, which he described as nonconfrontational body language. The passenger said: *'I don't want anything to do with this.'*⁸³

⁷⁶ Exhibit E1.1, answer 69.

⁷⁷ 11 September 2023, T1-22, L 13. Exhibit C4, 3.

⁷⁸ 11 September 2023, T1-22, L 32. Exhibit E1.1, answer 69.

⁷⁹ Exhibit E1.1, answer 69. 11 September 2023, T1-22, L 36.

⁸⁰ 11 September 2023, T1-22, L 5.

⁸¹ 11 September 2023, T1-50, L 15.

⁸² 11 September 2023, T1-50, L 21.

⁸³ 11 September 2023, T1-51, L 30. Exhibit E2.1, answer 39. See also Exhibit B13, at [31].

- [69] Senior Constable Giuliano did not give any verbal commands to the persons in the VOI before drawing his baton and striking the vehicle's window. Nor did he try to open the doors at any time.⁸⁴ Senior Constable Giuliano said he activated his body worn camera (BWC) during the struggle with Steven and that he would usually activate it on arrival at an address. On this occasion he believed he had activated it earlier. At the inquest he said: *'I only realised that it wasn't activated when I glanced down during the struggle and saw that the light was green instead of red as it was supposed to be.'*⁸⁵
- [70] Constable Smart said he *'zipped behind the rear of the car,'*⁸⁶ drew his baton and extended it. Upon reaching the driver's side of the VOI, Constable Smart did not try to open the driver's door. He struck the driver's side vehicle window with the baton, yelling *'get out of the car'*⁸⁷ ...
- [71] At the inquest, Constable Smart said: *'I just assumed that the driver's door was locked'*⁸⁸ ... *With the assumption that door would be locked, I begun striking the window with the baton.'*⁸⁹ ... *'My intention was to smash the window to a point where I could safely get my hand in, quickly take the keys and get out. Not to grapple with him through a window.'*⁹⁰
- [72] Constable Smart did not activate his BWC. At the inquest he said: *'Quite frankly, it wasn't on my mind. My first assumption when we pulled up was that we were going to get rammed, so it just didn't cross my mind at that stage.'*⁹¹ Despite this, Officer Smart acknowledged that ordinarily he might activate his BWC *'upon arrival'*, but on this occasion he did not due to: *'the extenuating circumstances. Again, my mind was on my safety, the safety of my partner, and watching for the vehicle acting in a dangerous manner.'*⁹²
- [73] After two to four baton strikes, the driver's side window of the VOI began to shatter. Steven was seated in the driver's seat and moved across to the passenger seat. He then exited the vehicle and was intercepted by Senior Constable Giuliano.
- [74] Senior Constable Giuliano described the interaction with Steven: *'Shortly after, I saw the front driver's window smash, and then a male person then came across out the passenger door, and that male person I now know to be Mr Nixon-McKellar. He came out quite rapidly and we became entangled. We initially went to the ground. Constable Smart came around to assist. We then - we stood back up onto our feet, and then a prolonged struggle ensued.'*⁹³

⁸⁴ 11 September 2023, T1-50, L 31.

⁸⁵ 11 September 2023, T1-50, L 43.

⁸⁶ Exhibit E1.1, answer 69. 11 September 2023, T1-22, L 33.

⁸⁷ 11 September 2023, T1-22, L 37.

⁸⁸ Exhibit E1.1, answer 73.

⁸⁹ 11 September 2023, T1-22, L 12.

⁹⁰ 11 September 2023, T1-38, L 24.

⁹¹ 11 September 2023, T1-23, L 20.

⁹² 11 September 2023, T1-23, L 26.

⁹³ Exhibit C4, 4. 11 September 2023, T1-23, L 43. Exhibit E1.1, answer 73. 11 September 2023, T1-50, L 21.

- [75] At the inquest, Senior Constable Giuliano said: *'He's immediately started trying to get away from me. I, sort of, twisted around I remember. I think he tripped over my left leg, and we tumbled to the ground. I'm trying to get hold of this guy and he's resisting me.'*⁹⁴
- [76] Constable Smart moved back to the passenger side of the VOI to assist Senior Constable Giuliano.⁹⁵ Constable Smart described the passenger as *'an Indigenous fellow as well, they were both Indigenous.'*⁹⁶ The passenger stood a few metres away on the footpath watching the incident unfold.
- [77] Constable Smart attempted to grab Steven and used the baton to strike Steven in the quad several times to *'gain compliance.'* Constable Smart described this as *'ineffective'* and as a result, he *'wrapped'* the baton around Steven *'in a bear-hug-esque fashion'* and tried to *'grapple'* him to the ground. Constable Smart described Steven as being *'significantly larger'* than he was. Constable Smart described his attempt to get Steven onto the ground was also *'ineffective'* and he *'tried to effect compliance with some peroneal strikes'*⁹⁷ but, again, he [Steven] *was too big and I - I couldn't land any [strikes].* A prolonged wrestle ensued.⁹⁸
- [78] Constable Smart considered that Steven was *'motivated to get away, this guy is over here standing behind Simon, we need to try and get this under control straightaway.'* Constable Smart used his baton to strike Steven's right upper leg in the thigh/quad area, several times.
- [79] Steven yelled: *'James you dog!'*⁹⁹ Constable Smart did not know who James was and expressed a concern *'possibly that a James would come out of this address and jump us basically. We did not have this guy under control whatsoever.'*¹⁰⁰ Constable Smart accepted that the passenger may have been James and gave evidence that the passenger did not try to intervene and essentially just walked away.¹⁰¹ The passenger, later identified as Joshua James Lingwoodock, was located by QPS officers on 9 October 2021. He declined to provide a statement and was not called as a witness.¹⁰²
- [80] Constable Smart described Steven grabbing and holding Senior Constable Giuliano's baton during the prolonged struggle. Senior Constable Giuliano attempted to break Steven's hold on the baton.¹⁰³ He yelled at Steven: *'get on the ground!'* ... *'let go of me cunt!'* Senior Constable Giuliano attempted to strike Steven twice on the left thigh with the baton.¹⁰⁴

⁹⁴ 11 September 2023, T1-52, L 15. Exhibit E 2.1, answer 39.

⁹⁵ 11 September 2023, T1-24, L 4.

⁹⁶ 11 September 2023, T1-24, L 8. Exhibit E1.1, answer 79.

⁹⁷ A peroneal strike is a blow to the common fibular (peroneal) nerve on the outside of the leg above the knee

⁹⁸ 11 September 2023, T1-24, L 9. Dash Cam footage.

⁹⁹ Exhibit C4, 5. Exhibit E1.1, answer 79 & 81.

¹⁰⁰ Exhibit E1.1, answer 85.

¹⁰¹ 11 September 2023, T1-25, L 19.

¹⁰² Exhibit A5, 26.

¹⁰³ Exhibit E1.1, answer 85.

¹⁰⁴ Exhibit E 2.1, answer 39, 11 September 2023, T1-52, L 36.

- [81] Constable Smart was behind Steven for the duration of the struggle and was not able to see signs that Steven may have been tiring or entering a state of medical distress.¹⁰⁵ Both officers said they did not have any concerns about potential health issues for Steven, or how that might affect their role in arresting him.¹⁰⁶
- [82] Senior Constable Giuliano thought Steven may be drug affected due to his apparent strength.¹⁰⁷ Constable Smart did not consider Steven displayed any signs of drug use, besides his strength.¹⁰⁸
- [83] At the time of Steven's passing QPS officers were permitted to use the LVNR as a use of force option. Despite being positioned behind Steven, Constable Smart did not apply an LVNR because Steven was taller than him. At the inquest, Constable Smart said: *'I wouldn't be confident that I would have been able to, in my exhausted state, effect an effective LVNR - an effective and safe LVNR.'*¹⁰⁹
- [84] Constable Smart said that after five minutes of grappling with Steven, he was of the view that the police officers were losing the fight. He described being *'completely exhausted. I was out of gas, on my last legs.'*¹¹⁰ Although Constable Smart recalled Steven saying several times *'You've got me'*¹¹¹ Steven did not get on to the ground or let go of the baton.¹¹²
- [85] Senior Constable Giuliano said: *'So I tried to get my right arm, sort of, around into the correct position to use the LVNR correctly but I couldn't manoeuvre into the correct position so I didn't attempt the full manoeuvre.'*¹¹³ He further described concerns for his safety and that of Constable Smart: *'Mr Nixon-McKellar had attempted to grab my baton numerous times and wrestle it away from me so I had the concern that he was potentially trying to arm himself. Brandon's [Constable Smart's] baton was also within easy reach for Mr Nixon-McKellar.'*¹¹⁴
- [86] Senior Constable Giuliano placed an urgent call for assistance using his vest mounted QPS radio.¹¹⁵ Steven was groaning and coughing. Steven said: *'fuck off'... help... you got me'* while continuing to struggle with the officers.¹¹⁶ Both officers told Steven to *'get on the ground' ... 'down'* while holding on to Steven.¹¹⁷ Steven continued to say: *'you got me.'*¹¹⁸

¹⁰⁵ 11 September 2023, T1-25, L 41.

¹⁰⁶ 11 September 2023, T1-27, L 8.

¹⁰⁷ 11 September 2023, T1-53, L 23.

¹⁰⁸ 11 September 2023, T1-27, L 10.

¹⁰⁹ 11 September 2023, T1-26, L 29.

¹¹⁰ 11 September 2023, T1-40, L 23.

¹¹¹ 11 September 2023, T1-41, L 5.

¹¹² 11 September 2023, T1-41, L 2.

¹¹³ 11 September 2023, T1-53, L 11.

¹¹⁴ 11 September 2023, T1-54, L 3.

¹¹⁵ BWC Giuliano 02:32:54.

¹¹⁶ BWC Giuliano 02:33:14.

¹¹⁷ BWC Giuliano 02:33:17.

¹¹⁸ BWC Giuliano 02:33:14, 02:33:17.

- [87] Senior Constable Giuliano said: *'hold him they're nearly here.'* Constable Smart told Steven: *'get on the fucking ground.'*¹¹⁹
- [88] QAS Medical Director, Dr Rashford, reviewed the BWC footage of the arrest, prepared a report and gave evidence at the inquest. He considered that at that stage of the struggle, Steven was speaking between *'exhausted breaths.'*¹²⁰
- [89] Senior Constable Colman responded to the call for urgent assistance and proceeded (code 2 – lights and sirens) to the location.¹²¹ Upon arrival he observed Senior Constable Giuliano, Constable Smart and Steven struggling against a small hatchback on the side of the street.
- [90] At the time Senior Constable Colman did not recognise Steven, but at the inquest he acknowledged that he had dealt with Steven on one previous occasion.¹²²
- [91] Upon Seeing Senior Constable Colman, Constable Smart yelled: *'get over here Tylar!'* At this point, Dr Rashford considered that Steven was *'gasping with mucous coming from his nose'* and making *'incomprehensible noises.'*
- [92] Sergeant Donnelly of the QPS Operational Skills and Tactics Section reviewed the BWC footage of the arrest, prepared a report and gave evidence at the inquest. At this point in the struggle, he considered that Steven: *'appeared to be in a state of distress, either through the pain of being restrained or from overwhelming fatigue due to the prolonged intensive struggle with police.'*¹²³
- [93] Constable Smart yelled: *'he's got a baton.'* Steven said: *'oh no.'*¹²⁴ Senior Constable Giuliano said: *'choke this cunt out, choke him out.'*¹²⁵
- [94] Dr Rashford considered that by this point, Steven had an audible wheeze. It is important to note Dr Rashford's observations of Steven occurred with the benefit of hindsight and the body worn camera footage, on the background of Dr Rashford's considerable medical expertise.

The application of the LVNR

- [95] Senior Constable Colman identified that while Senior Constable Giuliano used the word *'choke'* he took that to mean, apply an LVNR¹²⁶ and he positioned himself behind Steven, placed his left hand on Steven's left shoulder and his right forearm around Steven's anterior neck, positioning himself to apply a LVNR.¹²⁷ Senior Constable Colman pulled Steven backwards towards him.

¹¹⁹ BWC Giuliano 02:33:20.

¹²⁰ Exhibit B18, 3.

¹²¹ 11 September 2023, T1-94, L 25.

¹²² 11 September 2023, T1-94, L 37. *Officer Colman stated it was in relation to a previous arrest many years before, in the Toowoomba region.*

¹²³ Exhibit B17, at [95].

¹²⁴ BWC Giuliano 02:33:43.

¹²⁵ Exhibit F2 at 0:02:20. Exhibit B13, at [33].

¹²⁶ 11 September 2023, T1-95, L 4.

¹²⁷ BWC Giuliano 02:33:45.

- [96] The Court commissioned Mr Cale to review the evidence and provide an expert report. Mr Cale also gave oral evidence at the inquest. He considered that Senior Constable Colman's action in pulling Steven backwards towards him was *'necessary due to the car being in his way'* and that this action was *'not excessive.'*¹²⁸
- [97] Senior Constable Giuliano again said: *'choke him out.'*¹²⁹ Constable Smart was on the ground while Senior Constable Colman applied the LVNR. As he began to *'initiate the LVNR'* Senior Constable Colman *'repositioned'* his arm. This was to ensure Steven's chin was inside Senior Constable Colman's elbow before he applied pressure: *'The adjustment was made as the LVNR is used to apply pressure down the sides of the neck. If his chin wasn't placed in my elbow, then it wouldn't be applying pressure on that location.'*
- [98] Senior Constable Colman acknowledged that this would ensure he did not restrict Steven's airflow, or crush the front of his neck.¹³⁰ Senior Constable Colman recalled: *'As I've gone to apply pressure, he's - basically, at the exact same time I've gone to apply pressure, Simon [Senior Constable Giuliano] has yelled out, he's out or he's unconscious or something to that effect, and that's when we went down to the ground.'*¹³¹ Steven suddenly became unresponsive and limp. Constable Smart was told by his colleagues to get out from underneath Steven so he could be lowered to the ground.
- [99] Senior Constable Colman found the speed with which the LVNR took effect to be *'quite strange.'* He said he had not experienced that before in his QPS training or in Brazilian Jiu Jitsu (BJJ) training. At the inquest, Senior Constable Colman said: *'usually it's a number of seconds prior to them going unconscious, and they might - may try to find the arms, or they may be, like, sort of gasping for air - like, trying to get breaths in.'* However, Senior Constable Colman did not observe these behaviours in Steven.¹³²
- [100] At the inquest, Senior Constable Colman confirmed this was the first time he had applied an LVNR in the context of his operational duties as a police officer.¹³³ His evidence regarding his assessment of the appropriateness of the LVNR was in accordance with his training and threat assessment of the situation. When applying the LVNR, Senior Constable Colman and Senior Constable Giuliano worked together observing the effect of the LVNR.
- [101] When Steven's arms went *'limp'* and Senior Constable Giuliano said: *'he's asleep, he's asleep let him go,'*¹³⁴ Senior Constable Colman started to lower Steven to the ground before the hold on him was released and Steven fell a short way to the ground.¹³⁵

¹²⁸ Exhibit H2.1, 3.

¹²⁹ BWC Giuliano 02:33:47.

¹³⁰ 11 September 2023, T1-95, L 26.

¹³¹ Exhibit E3.1, answer 64. 11 September 2023, T1-98, L 45.

¹³² 11 September 2023, T1-99, L 6.

¹³³ 11 September 2023, T1-105, L 48.

¹³⁴ BWC Giuliano 02:33:56.

¹³⁵ 11 September 2023, T1-96, L 15.

[102] Dr Rashford considered that Steven was unresponsive and likely in cardiac arrest at this time.¹³⁶

[103] Senior Constable Colman placed his left knee on Steven's thoracic back area for approximately two seconds. One of the officers said: *'just watch that pressure, watch that pressure.'*¹³⁷ Steven was handcuffed while the officers engaged in tactical communication: *'get that cuff on, get that cuff on' ... 'roll him on his side, he's out, he's out.'* Steven was rolled into the right lateral position.¹³⁸ Senior Constable Colman conducted a sternum rub which failed to rouse Steven.¹³⁹ Senior Constable Colman recognised that Steven was displaying *'agonal breathing'* which he described as *'not a correct breathing rhythm or a normal breathing rhythm. So, more gasping for air.'*¹⁴⁰

[104] More QPS officers arrived on scene including Constable Ridge¹⁴¹ and Constable Trost.¹⁴² The handcuffs were removed, and Steven was rolled into a supine position. Senior Constable Colman said *'cuffs on cuffs on'* while another Officer said *'no, no, don't. Don't worry about it, just start CPR.'*¹⁴³

[105] Senior Constable Colman checked for a pulse. Using his right hand he applied pressure to the left side of Steven's neck¹⁴⁴ and said: *'start CPR, start CPR!'*¹⁴⁵ Senior Constable Colman commenced chest compressions.¹⁴⁶ QPS officers made several attempts to clear vomitus from Steven's mouth as detailed in the timeline compiled by Dr Rashford.¹⁴⁷ QPS officers called for QAS attendance and continued to provide CPR to Steven. Despite the efforts of the QPS officers and QAS Paramedics, after 32 minutes¹⁴⁸ of resuscitation efforts, Steven could not be revived and was declared deceased at 1:07pm.¹⁴⁹

¹³⁶ Exhibit B18, 4.

¹³⁷ BWC Giuliano 02:34:02.

¹³⁸ BWC Giuliano 02:34:13.

¹³⁹ BWC Giuliano/Colman 02:34:17. 11 September 2023, T1-96, L 46.

¹⁴⁰ 11 September 2023, T1-96, L 26.

¹⁴¹ Exhibit E8, E8.1.

¹⁴² Exhibit E7, E7.1, answer 37.

¹⁴³ BWC Colman 02:34:36. Exhibit E8 and E8.1, answer 75.

¹⁴⁴ BWC Giuliano/Colman 02:34:43. 11 September 2023, T1-96, L 39. No pulse was found.

¹⁴⁵ BWC Colman 02:35:17.

¹⁴⁶ BWC Colman 02:35:19.

¹⁴⁷ Exhibit B18, 5.

¹⁴⁸ Exhibit B13, at [43] – [45].

¹⁴⁹ Exhibit A1. At that time Steven's identity had not been established and the Life extinct form notes the family name as 'unknown.'

The medical cause of Steven's passing

[106] At the inquest, Dr Day explained that in Queensland, the convention is to provide a singular cause of death, listed as 1(a) on the cause of death certificate.

[107] An alternative may be to provide a narrative cause of death, as seen in some other jurisdictions, and in the opinion given by Dr Collins. Dr Day clarified that in this instance, he was not able to define a singular cause for Steven's death. Consequently, the cause of death was listed as "*not determined*". This was because there were several potentially competing factors that all contributed to the death. Dr Day considered that the death was *multifactorial* [emphasis added]. The last paragraph of his report outlined what may be considered a narrative cause of death.

[108] As noted above, Steven's family commissioned Forensic Pathologist, Dr Byron Collins, to provide an expert opinion. Dr Collins' evidence regarding how the cause of death was defined in an autopsy report was broadly consistent with the evidence of Dr Day:

*'It may be different in - from state to state... various pathologists have different views in how you express a cause of death. Some like the narrative approach, others like the 1A, 1B and 1C. There's no specific requirement by the College of Pathologists to provide a cause of death in a certain form. The only requirement which really goes without saying, is that it is as accurate as possible... The accuracy depends on the post-mortem examination and the reliability of the findings and then the interpretation of those findings by the forensic pathologist. Now, if the forensic pathologist wants to say it's not determined or undetermined, that's his or her prerogative. It doesn't reflect on the accuracy necessarily.'*¹⁵⁰

[109] At the inquest, Dr Collins' evidence confirmed the similarities between his opinion of the cause of death and that given by Dr Day. Dr Collins considered that he and Dr Day were *'both in heated agreement with the cause of death.'* He further clarified his use of the term *'heated'* to mean: *'we weren't at loggerheads; we were with one.'*¹⁵¹

[110] Dr Collins went on to say:

'I think this is an extremely difficult matter because of the pre-existing medical conditions from which the deceased was suffering, and the various emotional and physical events which were occurring at or about the time of the attempted arrest, and that's why it is very hard to pinpoint a silver bullet in this - in all pathological findings to say this was definitely the cause of death and everything else is unrelated or played a lesser role...'

¹⁵⁰ Transcript Day 4, T4-73, L 23 & L 27.

¹⁵¹ Transcript Day 4, T4-52, L 30.

*I understand where Dr Day is coming from and I think it really just reflects that he and I have a slightly different way of - or may have a slightly different way of expressing a certain set of circumstances, particularly in relation to death in custody and as an aside and take it as you like, I would've thought that if you gave Dr Day's pathology report and answers and all the materials in this case to 10 different pathologists, you might come up with a number of different causes of death.'*¹⁵²

*'I agree with Dr Day in as much that he is saying that the cause of death is undetermined and as I understand it, that's because his department prefers the way in expressing a cause of death as 1A, 1B, 1C, two and three and etcetera. And I think in this case, because there are so many interrelated factors it's better to give, I must say, an embarrassingly long narrative, but it does cover everything that I think has been playing a role in the demise.'*¹⁵³

[111] Dr Collins evidence was that the last couple of paragraphs in Dr Day's report were really what he was saying in his narrative, namely that the cause of death was:

*'The sudden unexpected cardiac arrest during intense or prolonged physical activity with the execution of various restraint holds, particularly neck compression in a young adult male suffering from pre-existing active asthma and coronary atherosclerosis in conjunction with the consumption of toxic dosage of methylamphetamine.'*¹⁵⁴

[112] In seeking clarification of what Dr Collins referred to as *'the physical activity with the execution of various restraint holds'*, counsel assisting asked Dr Collins (with reference to the report of Dr Rashford and his opinion of the use of the extendable baton in applying pressure to Steven's abdomen)¹⁵⁵ whether Dr Collins could state that any act played a greater role any others in contributing to death? Dr Collins responded:

'No. I don't think I can because we - we don't really know the exact... mechanism and the exact strength of the force applied which would be generated both by the police officer and by the late Mr Nixon-McKellar during these events. And therefore, I think you just have... to factor... an hypothesis that, if the chest and abdomen are compressed effectively, that does have the potential to cause two problems. One is the redaction of

¹⁵² Transcript Day 4, T4-52, L 46 to T4-53.

¹⁵³ Transcript Day 4, T 4-53, L 5.

¹⁵⁴ Exhibit H1.3, at [6]. Transcript Day 4, T4-53, L 22.

¹⁵⁵ *The so-called chain of causation involves matters that should be dealt with in findings made under s 45(2)(b) How the person died. It is in that section of the findings that the external factors that led to the medical cause of death are also to be described'. See State Coroner's Guidelines Chapter 8, section 8.6. This issue is further outlined above due to the fact that no single mechanism of restraint can be placed any higher than another in potentially contributing to the fatal outcome. That said, it is important to analyse the totality of the use of force.*

*inspiration and expiration'... its efficiency, and secondly, the pooling of blood in the periphery, particularly the lower limbs and lower abdomen and pelvis. And therefore, there is a decreased venous return to the heart... and there will, therefore, be a decreased output from the heart which has the potential to contribute to either loss of consciousness or - and or hypertension. So I think because - if it's accepted by the court that the compression of the chest and abdomen were effective and were forceful, but I think you have to factor that part of the restraint into the whole picture.'*¹⁵⁶

[113] In response to questions regarding the emotional stress¹⁵⁷ that may also be relevant in consideration of the 'whole picture', Dr Collins considered:

*'Emotional stress will precipitate the release of adrenaline and noradrenaline which are the so-called flight and fight hormones and they will, amongst other things, increase the heart rate, increase the blood pressure, increase the physical activity. But having said that, this emotional response or the adrenaline response which is supposed to assist an individual in escaping may be counterproductive in as much that the adrenaline will then have or may have an adverse effect on the various major organs such as the heart.'*¹⁵⁸

*'You can't disregard the presence of at least moderate coronary atherosclerosis, particularly involving the left anterior descending branch with 50 per cent narrowing, and the picture of acute on chronic asthma in association with a small focus of bronchopneumonia, and then there was some aspiration present in the lung slides as well, but that's a terminal event. The outcome of both the cardiac disease and respiratory disease is that it decreases an individual's reserve to respond in relation to maintenance of the vital oxygen levels in the blood during physical and emotional activities, and that's where the interplay is.'*¹⁵⁹

[114] Dr Day said that in respect of the fight/flight response:

*'You get a heightened noradrenaline or sympathomimetic response, so you'd increase your blood pressure, increase in heartrate, so the physical manifestations of that. And in terms of the psychological effects, I suppose people are self-preserving in their actions.'*¹⁶⁰

¹⁵⁶ Transcript Day 4, T4-54, L 5.

¹⁵⁷ Exhibit H1.3, at [3].

¹⁵⁸ Transcript Day 4, T4-55, L 8.

¹⁵⁹ Transcript Day 4, T4-55, L 16.

¹⁶⁰ Transcript Day 4, T4-39, L 23.

[115] Dr Collins was asked whether the timeline of events provided by Dr Rashford in his report (noting that he is an emergency physician) might assist the Court or Dr Collins as a Forensic Pathologist? Dr Collins responded:

*I think that as far as I could see in correlating them with the videos that I saw, that they're pretty good and accurate observations but, unfortunately, they don't provide what his heart rate was doing and what his chest was like; whether he had a wheeze or not. But they're the clinical observations which I'd like to see over and above what Dr Rashford said.*¹⁶¹

[116] When asked how he would propose one were to see or observe those clinical observations in an ideal situation, Dr Collins responded: *it's absurd to suggest but if you had a medico with a stethoscope at hand then that would be optimal. That would be the gold standard. We don't have it. We have Dr Rashford's observations which I think are quite reasonable.*¹⁶²

[117] Dr Collins agreed that this was not something that Police could ever put in place in respect of engaging with a person whom they were seeking to detain and categorised it as a *'pie in the sky hope'*... *'which would never eventuate for obvious reasons.*¹⁶³

[118] At the inquest, Dr Day and Dr Collins¹⁶⁴ were asked by counsel assisting if they agreed with the following information contained in the report of Mr Cale:¹⁶⁵

*I would further contend that the main factor resulting from the tactical shortcomings listed above that likely contributed to Mr Nixon-McKellar's demise if only by exacerbating his then-unknown asthma and drug-induced health problems was exhaustion of his cardiovascular system by two primary means: the sustained release of adrenaline and prolonged physical resistance over the five to 10 minute period of conflict with police and the apparent consistent pressure, albeit of varying levels due to the movements of all three people involved, on Mr Nixon-McKellar's lower diaphragm via the baton use to restrain him.*¹⁶⁶

[119] Dr Day's evidence was that:

*I think we [Paul Cale and Dr Day] are saying essentially the same thing that the cause is multifactorial. It's all worked in combination to cause sudden cardiovascular collapse and death. The precise nature or contribution of each of those is uncertain but they surely have worked in combination.*¹⁶⁷

¹⁶¹ Transcript Day 4, T4-55, L 39.

¹⁶² Transcript Day 4, T4-55, L 48 to T4-56.

¹⁶³ Transcript Day 4, T4-56, L 11.

¹⁶⁴ Dr Collins responded: *'Yes, I think so.'* Transcript Day 4, T4-56, L 20-35.

¹⁶⁵ Transcript Day 4, T4-56, L 20. Exhibit H2, 16.

¹⁶⁶ Transcript Day 4, T4-56, L 35 - *'Yes, I think so.'*

¹⁶⁷ Transcript Day 4, T4-31, L 31.

[120] I accept the submission of counsel assisting that while Mr Cale is not a medical specialist, the quote above was an overall reflection on the use of force¹⁶⁸ which identified issues of public safety that may inform future use of force training, particularly in respect of deaths of this kind.

[121] Dr Day considered that Steven was extremely vulnerable because of the several comorbidities he experienced:

*'I think it makes him extremely vulnerable. The physical exertion and the physical and emotional stresses involved in a prolonged altercation, together with the heart disease, together with the lung disease, and a significant amount of methylamphetamine, decreased his physiological reserve and would make him vulnerable or prone to a sudden cardiac arrest at any moment. It increases his oxygen demand through the stress of the altercation. With heart and lung disease he's unable to supply the heart muscle with the oxygen that is required, which would predispose him to a sudden cardiac arrest.'*¹⁶⁹

Blood sample taken on 4 October 2021 – Eosinophils and asthma

[122] As noted above, blood samples obtained from Steven on 4 October 2021 at the Logan Hospital showed eosinophils at 0.60H.¹⁷⁰ Dr Day noted eosinophils are an inflammatory cell and the peripheral blood count showed eosinophils present at $0.60 \times 10^9/L$. This was at the upper limit of the normal reference range (< 0.60). An increased number of peripheral eosinophils (within the blood stream) is a non-specific finding and has a varied aetiology, including atopic disease such as allergy and asthma, drug hypersensitivities, psoriasis, parasitic infections, haematological neoplasms, and vasculitis. Dr Day considered that in view of Steven's history of acute exacerbation of asthma, and the findings during the post-mortem examination of acute on chronic asthma within the lungs, the increased number of eosinophils within the blood was likely attributable to asthma.

[123] Dr Day further considered that in view of this information, the eosinophils observed around the vessels within the neck would also be in keeping with acute / recent exacerbation of asthma and that recent acute exacerbation of asthma requiring medical attention supported Dr Day's view that asthma was contributory to death:

'Any acute or chronic reduction in the ability of the lungs to oxygenate blood decreases a person's physiologic reserve, and increases a person's vulnerability to death, particularly in circumstances of physiological stress.'

¹⁶⁸ Mr Cale was commissioned to independently review the use of the LVNR.

¹⁶⁹ Day 4, T4-31, L 5-15.

¹⁷⁰ Exhibit A3, at [5].

[124] Dr Day's evidence at the inquest further supported the link between the eosinophils and Steven's asthma:

*'So eosinophils are a type of inflammatory cell that is circulating within the blood. Their elevation is non-specific, there are many causes of those being elevated. But one of those is asthma. And so when we see asthma under the microscope around the airways within the lungs, the predominant cell type that we see is the eosinophils. So their elevation in blood is an expected outcome of someone who suffers from acute asthma. And I do note, going through some of his previous bloodwork from the notes I've been provided, that elevation of eosinophils has been something that's been longstanding, so it would be consistent with asthma.'*¹⁷¹

Toxicology

[125] Dr Day's evidence was that a sample of femoral blood obtained during the autopsy confirmed the presence of the stimulant drug methylamphetamine at 1.1 milligrams per litre. This was *'a significantly high level.'* The level of methylamphetamine found was *'present within a documented potentially lethal level, so at a level where deaths have occurred and methylamphetamine has been the cause of the death.'*¹⁷² Also present was the metabolite amphetamine. The antipsychotic Paliperidone was identified at the *'lowest level of detection.'*¹⁷³

[126] Dr Day accepted that common symptoms of persons who had consumed amphetamine included agitation, irrationality, poor decision-making processes, sometimes aggressive behaviour. He noted that these things were dependant on a person's status and were *'not consistent amongst all users.'*¹⁷⁴ He accepted that irregular heartbeat, arrhythmia, hypertension and high blood pressure were all a *'potential adverse effect of methamphetamine.'*¹⁷⁵ Dr Day considered that tachycardia would be a universal response as opposed to a person-specific response for users of methamphetamine:

*'Those pathophysiological responses such as tachycardia, increase in blood pressure occur at a [indistinct] physiological level. So that would be a more universal response, rather than someone's outward expression of intoxication.'*¹⁷⁶

*'A person's level of tolerance would not impact on that physiological response.'*¹⁷⁷

¹⁷¹ Day 4, T4-29, L 30-40.

¹⁷² Transcript Day 4, page 4-30, line 23.

¹⁷³ Transcript, Day 4, Page 4-30, Line 13.

¹⁷⁴ Transcript Day 4, page 4-44, line 10.

¹⁷⁵ Transcript Day 4, page 4-44, line 26.

¹⁷⁶ Transcript Day 4, page 4-44, line 37.

¹⁷⁷ Transcript Day 4, page 4-44, line 45.

[127] Dr Collins' evidence at the inquest was that:

'The level falls into the category where it may or may not be toxic and even at a fatal level... lethal concentrations of this drug acting by itself have been at a level of .1 milligram per litre which is considerably lower than what is in this case.

But then when you are assessing an individual case, one needs to factor in whether they're naïve users or long-term users because it's well recorded that in long-term users, they can function under normal circumstances without stresses at considerable higher levels than what I've quoted, which would, in a naïve user, be fatal.

*So the toxic range that's given - the lethal range that's given in the textbooks is somewhere between 0.1 milligram per litre to about 69 milligrams per litre. So you can see it's a huge range and the lower level overlaps with the toxic, and the toxic range is not far away from the therapeutic range. And so there is a continuum of levels which may be fatal in various individuals.'*¹⁷⁸

[128] Dr Collins further considered:

*'I agree with Dr Day's comments in relation to the various effects it has on an individual, particularly in relation to cardiotoxicity. But again, that event... can never be predicted.'*¹⁷⁹

[129] At the inquest, Dr Collins considered that the scars observed by Dr Day during autopsy (numerous healing needle puncture wounds in the antecubital fossa)¹⁸⁰, were indicative of scars you *'would typically see in a hard drug user.'* And further there was every indication that Steven was not a naïve drug user. Therefore, he would have a higher tolerance to that drug if that were his drug of choice.¹⁸¹ Dr Collins did not consider that the Paliperidone had any impact at all.¹⁸²

[130] Despite the opinion of Dr Collins that Steven may have not been a *'naïve user'* of methamphetamine, I accept Dr Day's evidence that tachycardia was a universal experience in the use of methamphetamine as opposed to a person-specific response, and that a person's level of tolerance for a drug would not alter the physiological response.¹⁸³

¹⁷⁸ Transcript Day 4, page 4-56, line 39 to page 4-57.

¹⁷⁹ Transcript Day 4, page 4-57, line 13.

¹⁸⁰ Transcript Day 4, page 4-61, line 30. Exhibit A3, page 2.

¹⁸¹ Transcript Day 4, page 4-62, line 11.

¹⁸² Transcript Day 4, page 4-57, line 17.

¹⁸³ Transcript Day 4, page 4-44, line 45.

[131] The relevance of the toxicology results in contributing to Steven's vulnerability to sudden collapse in the setting of restraint was supported by the expert opinion of Dr Rashford, who considered that:

*'The autopsy revealed Mr Nixon-McKellar had consumed methamphetamine metabolites in his plasma. Whilst not overtly toxic, in the presence of a grossly disturbed metabolic environment and compounded by severe cardio-respiratory distress, they were likely to have also contributed to the broader susceptibility of sudden collapse.'*¹⁸⁴

Bruising

[132] At the inquest, Dr Day said the focal haemorrhaging of the posterior laryngeal soft tissue was a non-specific finding that was seen in many autopsies and was principally called an 'artefact'. This means it was seen as an artefact or in the autopsy process. It might also be seen when someone had been intubated or resuscitated. As such, the presence alone was non-specific:

*'It's deep, so there's no haemorrhage to the structures, it's more superficial, so there's no evidence of injury to the more superficial parts of the neck.'*¹⁸⁵

*'There was no injury to the... front of the neck, to the structures of the throat. The absence of injury doesn't mean there hasn't been force applied there. I just don't have any objective evidence of it.'*¹⁸⁶

[133] While there was a physical altercation with QPS officers where a LVNR was applied for a short time, there was no evidence to support the assertion that the LVNR caused damage to the front of Steven's neck, or structures of the throat. I agree that the evidence supports the conclusion that it was more likely that the LVNR was applied in accordance with QPS policy and procedure in place at the time.

[134] Dr Collins told the inquest he had discussed the 6cm x 1cm area of rectangular linear intramuscular haemorrhage of the superficial layer of the proximal left sternocleidomastoid muscle with Dr Day. He agreed with Dr Day that the presence of such bruising was an example of blunt force trauma to that area. However, how that occurred is unknown. There were various possibilities, but there was nothing particularly diagnostic about that bruise to indicate how it was caused.¹⁸⁷

¹⁸⁴ Exhibit B18 at page 8.

¹⁸⁵ Transcript Day 4, page 4-40, line 33. Transcript Day 4, page 4-44, line 1.

¹⁸⁶ Transcript Day 4, page 4-41, line 21.

¹⁸⁷ Transcript Day 4, page 4-57, line 32.

[135] Dr Collins' evidence was that he and Dr Day agreed that if somebody were looking for a carotid pulse, you would have to be pressing pretty firmly to compress that vessel: *'it's not impossible, but I think it would be unusual.'*¹⁸⁸ Dr Collins considered that the other episode where such bruising could have occurred in this event was during the resuscitation where there were attempts to put in a breathing tube and move the neck around and the head around to clear the airway.¹⁸⁹

[136] In respect of the haemorrhage directly subjacent to the overlying supraclavicular lymph nodes and adjacent soft tissue, Dr Collins considered that it was all in the same area and they were just slightly different tissue planes of the neck. Dr Collins evidence was that he was talking as a Forensic Pathologist and that *'an injury that one sees in...autopsy may or may not necessarily be contemporaneous with an alleged event.'*¹⁹⁰

[137] Dr Collins and Dr Day agreed in relation to the fracture of the left third rib that the distribution of the fractures was entirely consistent with having been caused during CPR. However, Dr Collins conceded it was possible it was caused by the application of a baton.¹⁹¹

[138] Counsel assisting submitted that on the evidence it was more likely the rib fracture was consistent with CPR. However, there is insufficient evidence to support that submission.

Dr Rashford, Medical Director, QAS

[139] Dr Rashford is a senior Emergency Medicine Specialist. Given Steven's cause of death, Dr Rashford was uniquely placed to provide an expert opinion in respect of Steven's death due to his understanding and experience in emergency medicine (acute resuscitation), responding to matters involving dynamic police interactions, and assisting in the review and development of police policy.¹⁹²

[140] I have placed considerable weight on the evidence of Dr Rashford, in informing the cause of death, and analysing the interaction with QPS officers, and how the use of force may have contributed to Steven's demise, particularly when read in conjunction with the observations and opinion of Mr Cale.

[141] Dr Rashford provided a report containing a timeline¹⁹³ based on his observations of the BWC and Dash Cam footage. The report listed strenuous exertion, underlying medical comorbidity, physical restraint and impaired ventilation, pathophysiological changes and toxicology as factors contributing to sudden cardiac arrest.¹⁹⁴ Dr Rashford's opinion aligned with the evidence of Dr Day and Dr Collins:

¹⁸⁸ See exhibits H1, H1.1 and H1.2

¹⁸⁹ Transcript Day 4, page 4-58, line 17.

¹⁹⁰ Transcript Day 4, page 4-58, line 6. *Alleged event could include the application of the LVNR, checking for the pulse, or bruising caused during the physical altercation, or during provision of medical care.*

¹⁹¹ Transcript Day 4, page 4-62, line 47.

¹⁹² Transcript Day 2, page 2-52, line 39.

¹⁹³ Exhibit B18, 2 - 6.

¹⁹⁴ Exhibit B18, 7.

*'Mr Nixon-McKellar's death was a result of multiple factors combining in sudden cardiac arrest. The combination of his medical conditions, methylamphetamine toxicity, the marked patho-physiological changes associated with severe exertion, the method of physical restraint with the baton and finally the LVNR have all combined to create a lethal combination.'*¹⁹⁵

Placement of the baton across Steven's abdomen

[142] In respect of the placement of the baton across Steven's abdomen, Dr Rashford's evidence was that the forced placement of the baton across Steven's abdomen impacted his cardiovascular function significantly, decreasing his cardiac output by obstructing venous blood returning to the heart. It also affected his ability to breathe freely, which was essential for him to overcome a grossly disturbed metabolic state. The combination of Steven's underlying medical illness (asthma) and methamphetamine consumption further complicated Steven's condition.¹⁹⁶ This assessment of the placement of the baton was consistent with the opinion of Mr Cale, and was accepted by both Dr Day and Dr Collins at the inquest.

The LVNR

[143] Dr Rashford considered the LVNR application had *'significant potential to transiently affect cerebral blood flow and cause reflex cardiac rhythm disturbance.'* Dr Rashford's evidence was that:

'There was no evidence of significant vascular or airway trauma. The LVNR in itself was not the primary cause of sudden cardiac arrest, but its application at the very point where Mr Nixon-McKellar was clinically extremely vulnerable likely precipitated his sudden deterioration.'

[144] Dr Rashford acknowledged that the QPS officers attempting to restrain Steven were likely unaware of Steven's precarious health status given the mechanics of the struggle and the rapid nature of Steven's decline.¹⁹⁷ Police officers routinely encounter people requiring restraint who have underlying medical conditions. While most people police interact with experience no complications of restraint, a very small percentage are vulnerable.¹⁹⁸

[145] Dr Rashford's evidence was that:

*'There's no way in the world that the police officers could have identified that Mr Nixon-McKellar had underlying asthma or underlying non-obstructive cardiac cardiovascular disease – coronary artery disease.'*¹⁹⁹

¹⁹⁵ Exhibit B18, 9. Submissions on behalf of the QPS Commissioner at [12]-[14].

¹⁹⁶ Exhibit B18, 10. Transcript Day 2, page 2-59, line 11.

¹⁹⁷ Exhibit B18, 10.

¹⁹⁸ Transcript Day 2, page 2-57, line 24.

¹⁹⁹ Transcript Day 2, page 2-57, line 27.

[146] Dr Rashford considered that each of Steven's co-morbidities may not, in isolation, have been expected to cause immediate issues for him. However, for someone such as Steven who becomes: *'profoundly acidotic, who is unable to compensate for that acidosis, who has methamphetamine in their system and then has underlying lower respiratory tract infection, maybe some chronic lung disease with his asthma and non-obstructive coronary artery disease, the whole global picture is primed for catastrophe.'*

[147] It was the *'totality'* of the events that caused cardiac arrest. The LVNR was another *'insult'* that added to the other *'insults'* that were going on. However, Dr Rashford further clarified that it was highly unlikely that it was the only thing that caused the cardiac arrest.²⁰⁰ Instead, it was the final *'insult.'* If Steven did not have the other health issues and only the LVNR was applied, it was unlikely he would have suffered a cardiac arrest.²⁰¹

[148] Dr Rashford explained this was why it was so difficult to resuscitate Steven. If it been a case of *'reduced perfusion of their brain, as we see on the parade field, and we lie the person down, they wake up. If someone has a neck compression and they stimulate a cardiac reflex which drops the heart rate, as soon as that's taken away generally speaking, we'll see them recover, maybe over a slightly longer period of time. If we ever see someone who has a lack of oxygen for a very short period of time, generally speaking they don't have a cardiac arrest and if they do, they resuscitate up very quickly, if that's the only thing that's going on...that's just not the case here.'*²⁰²

[149] I accept the submission on behalf of the QPS officers that a *'temporal connection'* was the highest that the relationship between the LVNR and cardiac arrest can be put. The application of the LVNR is an unquantified and unquantifiable factor.²⁰³

[150] I also accept the submission of counsel assisting that the evidence supports the conclusion that Steven's sudden deterioration could not reasonably have been anticipated or predicted by the QPS officers at the scene. When QPS officers recognised Steven was experiencing a medical emergency they appropriately transitioned to the provision of care.

[151] Efforts to resuscitate Steven were explored at the inquest. Dr Rashford considered that no resuscitation was ever perfect, but he thought the resuscitation was mostly well-run, particularly by the QPS officers. Dr Rashford's evidence was that the QPS officers recognised very early that cardiac arrest occurred and instituted basic life support. Subsequently, the QAS paramedics and the doctor provided advanced life support measures. Unfortunately, Steven was unable to be resuscitated.

²⁰⁰ Transcript Day 2, page 2-56, line 34.

²⁰¹ Transcript Day 2, page 2-67, line 15.

²⁰² Transcript Day 2, page 2-57, line 1. Transcript Day 2, page 2-61, line 3.

²⁰³ Submissions on behalf of Senior Constable Colman, Constable Smart and Senior Constable Giuliano at [18].

[152] QPS officers had face masks available to them²⁰⁴ for the purpose of performing breaths as part of CPR. However, even if police had access to a bag valve mask, it would not have been outcome changing.²⁰⁵ Dr Rashford identified the importance of compressions as opposed to breaths and noted that most people do not want to do direct mouth-to-mouth resuscitation.

[153] Dr Rashford's evidence was that chest compressions ensure that:

*... 'both some form of cerebral, so brain flow and also perfusing those coronary arteries in an attempt to make the heart more salvageable once more advanced therapy occurs...there is also passive ventilation with compressions... the very fact that you're compression up and down on the chest means that air will move passively and whilst and given oxygen wasn't available, no matter what form of ventilation you give it's going to be 21 percent... oxygen, so the air still contains oxygen itself. So on that basis, I don't think that was the issue. The subsequent vomiting and matter in the airway would have made, for someone who doesn't do bag valve resuscitation all the time, really difficult. It's not an easy technique. It's actually a relatively difficult technique to do if you don't do it all the time and on certain individuals it becomes very difficult. So... what I saw with the obstructed airway with vomitus and the like and you see that – apparently police officers clearing the airway a number of times, that would have made bag valve inflation very difficult.'*²⁰⁶

[154] While not ordinarily a matter on which a Forensic Pathologist would comment, at the inquest, Dr Day acknowledged the importance of chest compressions during CPR. He noted that from a basic medical position, his understanding was that chest compressions were the most important timely procedure that you can provide.²⁰⁷

[155] Dr Day considered that it takes a reasonable amount of time for someone to recognise that a person requires CPR²⁰⁸ and in this matter, once the recognition of the need for CPR occurred, the commencement of CPR was a priority.²⁰⁹ While Dr Collins was critical of the time taken to commence CPR, he agreed with Dr Rashford that chest compressions were the more important component of CPR.²¹⁰ Dr Collins understood the reticence of people involved in CPR efforts to issue breaths when there was vomitus present.²¹¹

²⁰⁴ Transcript Day 2, page 2-53, line 27-47.

²⁰⁵ Transcript Day 2, page 2-54, line 5.

²⁰⁶ Transcript Day 2, page 2-54, line 7 and 21.

²⁰⁷ Transcript Day 4, page 4-32, line 37.

²⁰⁸ Transcript Day 4, page 4-33, line 17.

²⁰⁹ Transcript Day 4, page 4-33, line 30.

²¹⁰ Transcript Day 4, page 4-59, line 43.

²¹¹ Transcript Day 4, page 4-60, line 5.

Findings required by s 45 of the Coroners Act 2003

[156] I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. After considering all the evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased: Steven Lee Nixon-McKellar

How the deceased died: Steven died following a physical confrontation with QPS officers who were restraining him during an attempted arrest.

Steven suffered a cardiac arrest, the cause of which was multifactorial. There were several contributing factors. The extent of the contribution of each factor cannot be determined. The contributing factors included physical and psychological exertion, in circumstances where a police baton was held across Steven's abdomen and brief pressure was applied to the neck using a Lateral Vascular Neck Restraint. This occurred on a background of significant underlying natural disease including asthma, bronchopneumonia and coronary atherosclerosis, and the presence of stimulant drug intoxication (methylamphetamine) at a potentially lethal level.

Place of death: Stone Street, Wilsonton, Queensland.

Date of death: 7 October 2021.

Cause of death: Steven died as a result of sudden cardiac arrest in the context of physical and psychological exertion during restraint by police, brief pressure being applied to the neck, stimulant drug intoxication, asthma, bronchopneumonia, and coronary atherosclerosis.

Issue two

The circumstances surrounding the death including 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.

[157] On 21 July 2021, Steven was released on parole from the Borallon Training and Correctional Centre (BTCC). He had been in custody since 10 November 2020.²¹² His full-time discharge date was 28 October 2021.²¹³

[158] At the time of his death, Steven had a diagnosed *mental illness*,²¹⁴ paranoid schizophrenia, and was considered to have a substance use disorder. In those circumstances he met the criteria for mental health consumers considered to have a co-occurring substance use disorder and other mental health disorder.

[159] During his imprisonment at BTCC, Steven was subject to a community category²¹⁵ *Treatment Authority* (TA) under the *Mental Health Act 2016* (Qld) (the MHA). The TA was implemented by the Darling Downs Hospital and Health Service (DDHHS) on 14 August 2018 and remained in place until Steven's death.²¹⁶

[160] While at BTCC, Steven was supported by the Prison Mental Health Service (PMHS). He was treated for a psychotic disorder and anxiety symptoms. Steven was in receipt of monthly Depot injections²¹⁷ for treatment of his paranoid schizophrenia as well as other oral anti-psychotic medication.

[161] He was regularly reviewed by the PMHS during his period of incarceration.²¹⁸ Before his release, Steven was last reviewed by PMHS Psychiatrist, Dr Scott, on 7 July 2021. Dr Scott considered Steven's schizophrenic illness to be in remission in the context of Depot administration and other oral anti-psychotic medication. A further review was scheduled for four weeks' time, but Steven was released on parole before the scheduled review.²¹⁹

[162] Forensic Psychiatrist, Dr Aboud, Clinical Director of the PMHS provided a statement to the Court detailing that a Transition Clinician from the Transition Coordinator Program was allocated to assist Steven's transition into the community (for accommodation, referral to his GP, Alcohol and Other Drugs Service as well as community mental health service).

²¹² Exhibit C13. Exhibit C12.

²¹³ Exhibit J1, paragraph 4. Exhibit J1.1.

²¹⁴ Mental illness is defined in s 10 of the *Mental Health Act 2016* (Qld) as (1) *Mental illness is a condition characterised by a clinically significant disturbance of thought, mood, perception or memory.*

²¹⁵ Section 51 *Mental Health Act 2016* (Qld), if a person is not a classified patient, the authorised doctor must decide whether the category of the TA is inpatient or community. See also *In the matter of SAL* [2019] QMHC 3.

²¹⁶ Exhibit B21, paragraph 10 and 15.

²¹⁷ Exhibit D9, page 24 – 26/06/2021 Patient seen for depot – administered left deltoid.

²¹⁸ Exhibit B21, paragraph 6 to 7.

²¹⁹ Exhibit B21, paragraph 17.

[163] When Steven was paroled, he was referred to the Roma Adult Mental Health Service (under the DDHHS) for ongoing community case management by the DDAMHS community treating mental health team in Roma. Email communication was sent to two email addresses with a follow up phone call to confirm receipt of the email. The psychologist was informed that a case manager would be allocated that day.

[164] Steven was then closed to the PMHS that same day. On 26 July 2021, a provision of service psychologist contact was made to Steven, but he did not participate.²²⁰ Steven was given a discharge handout about the risks of drug overdose/death when released from prison regarding certain medication that had not been taken when in custody. It was standard practice that prisoners were given this information.²²¹ Dr Aboud noted that Steven often refused to engage with the PMHS psychiatrist and would often decline assessment. The records also showed Steven had a history of absconding and was reluctant to engage with mental health services in the community.²²²

[165] Dr Reilly, Chief Psychiatrist, provided a statement and noted that on 26 July 2021, shortly after Steven was released from prison, PMHS contacted Roma Adult Community Mental Health Services (Roma ACMHS) to advise of his release, most recent medical review and his current treatment and care needs. This included advice regarding Steven's current medications, including monthly intramuscular administration of paliperidone, a long-acting injection antipsychotic medication.

[166] From the time Steven was granted parole up until his death, he did not contact Roma ACMHS. Dr Reilly noted that where the PMHS is aware of the pending release from custody of a mental health consumer and the consumer has an established mental health diagnosis, and high psychosocial needs, they may be referred to the PMHS Transition Co-ordination Program. This involves PMHS Transition Co-ordinators supporting the consumer to link with appropriate community support and services before and following release from custody.

[167] I agree with the submission from Counsel assisting and WMHHS that on the available evidence, the PMHS complied with the relevant Chief Psychiatrist policies (as contained in the statement of Dr Reilly) in respect of transitioning Steven's mental health treatment and care from the PMHS to the community.²²³

²²⁰ Exhibit B21, paragraph 18 to 21.

²²¹ Exhibit B21, paragraph 29.

²²² Exhibit B21, paragraph 30 to 31.

²²³ Submissions on behalf of WMHHS at [10].

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.

[168] Dr Gupte, Director of Clinical Services at the Toowoomba Hospital Acute Mental Health Services (DDHHS), the service responsible for the administration of Steven's TA, provided a statement.

[169] Dr Gupte's evidence was that Steven's last TA was made by the Mental Health Review Tribunal (MHRT) on 2 March 2021. The TA was community category, and an authorised doctor could decrease the extent of treatment in the community. No additional conditions are known to have been added.

[170] After Steven's release on parole, he did not present to Roma ACMHS as expected. He did not comply with the requirements of his TA. Dr Prasoon noted that attempts to contact Steven were detailed in the Authority to Transport Absent Persons (ATAP) dated 14 September 2021 and signed by an Authorised Mental Health Practitioner. The date and time of Steven's absence noted on the form was 3 August 2021. The form indicated that the ATAP was issued when Steven failed to attend his appointment as required. The actions taken to locate Steven included telephone contact (multiple unsuccessful attempts due to disconnected telephone numbers), two home visits to his last known address which was his grandmother's house and multiple contact attempts to family.²²⁴

[171] When a person does not voluntarily attend an Authorised Mental Health Service (AMHS) an ATAP may be issued. However, unless there is a risk that the patient may harm themselves or others, reasonable attempts must be made to contact the person and encourage them to return to the AMHS, before completing an ATAP.²²⁵

[172] Dr Reilly noted that a review of Steven's CIMHA record indicated that between July 2021 and September 2021, Roma ACMHS made repeated attempts to contact Steven to check on his general health and mental wellbeing, and to remind him that his long-acting injection medication was overdue. A less restrictive approach was initially adopted. However, when the treating team were unable to establish contact, an ATAP was issued on 14 September 2021. That ATAP was never enforced.²²⁶ The QPS officers who interacted with Steven on 7 October 2021 were not aware that he was subject to an ATAP or suffered from a mental illness. They did not know who he was until after his passing.

[173] I accept the submission of counsel assisting that on the available evidence, treating clinicians complied with the relevant Chief Psychiatrist policies in attempting to encourage Steven to engage with his mental health treatment and care, and to comply with the requirements of his TA.²²⁷

²²⁴ Exhibit B20, paragraph 3.

²²⁵ Exhibit B26, paragraph 16.

²²⁶ Exhibit B26, paragraph 28 to 30.

²²⁷ Submissions on behalf of WMHHS at [11].

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

[174] QCS referred Steven to service providers to help him with the management of his mental health and substance abuse issues, including a referral to AODS in 2020, as well as referrals to psychologists and psychiatrists.

[175] QCS also conducted collateral checks with general practitioners, mental health services and substance abuse services to monitor Steven's engagement with those services, which was often limited.²²⁸ As part of Steven's case management, Community Corrections encouraged Steven to engage with substance abuse intervention and mental health intervention.²²⁹ During Steven's verbal induction to his parole order he told his case manager that he planned to see Dr Hatcher about the suboxone program and he understood the medical and psychological conditions of his parole order.²³⁰

[176] On 6 August 2021, Steven reported to his case manager about the efforts he was making to see Dr Hatcher for the suboxone program. Steven was encouraged to engage in specific substance abuse intervention programs. However, Steven said his priority was to get on the suboxone program and he declined a referral to any other intervention services.²³¹ While QCS has the power to issue a lawful direction for a parolee to attend a treating professional, the preferred method is for the case manager to continue to work with the individual within the community to engage them with appropriate services and treatments.²³²

[177] I accept that QCS was aware of Steven's substance abuse issues and mental health concerns. QCS officers tried to encourage Steven to engage with illicit substance diversion programs.²³³

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.

[178] When Steven was released on parole, he had just over three months of his sentence remaining.²³⁴ Based on previous parole orders, Stevens 'primary criminogenic needs' (the areas where Steven required the most support and oversight) were identified as mental health and substance use.²³⁵

[179] Steven was verbally inducted to his parole order on 22 July 2021 as he had not reported as required upon release to the community.²³⁶ He subsequently reported to his case manager on 30 July 2021, 6 August 2021 and 13 August 2021.²³⁷

²²⁸ Exhibit J1, paragraph 29.

²²⁹ Exhibit J1, paragraph 30.

²³⁰ Exhibit J1, paragraph 32.

²³¹ Exhibit J1, paragraph 33.

²³² Exhibit J1, paragraph 55 and 56.

²³³ Submissions on behalf of QCS at [8]-[9].

²³⁴ Exhibit J1, paragraph 7.

²³⁵ Exhibit J1, paragraph 8.

²³⁶ Exhibit J1, paragraph 31.

²³⁷ Exhibit J1, paragraph 32 to 34.

[180] As a condition of parole, Steven was required to provide a sample for testing if directed by an authorised corrective services officer. A positive result would have caused him to breach his parole order.²³⁸ By mid-August 2021, following inquiries made with the QPS, Steven's case manager determined that Steven's risk could no longer be assessed or managed in the community, due to disengagement with the parole order.²³⁹

[181] Steven was in breach of conditions relating to curfew, his approved place of residence, and alleged further offending.²⁴⁰ As a result, his parole order was suspended on 24 August 2021. The Parole Board of Queensland issued a Return to Prison Warrant on the same day.²⁴¹

[182] The QPS officers who interacted with Steven on 7 October 2021 did not know that he was subject to a Return to Prison Warrant as they did not know his identity until after his passing.

[183] I note Steven's reluctance (as detailed above) to attend the hospital in respect of his asthma in the days preceding his interaction with QPS officers and the conversation recalled by Ms Finlay.

Issue three

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

[184] After Steven's passing the QAS Darling Downs and Southwest Region completed a Significant Incident Review (SIR) which assessed the operational resourcing and response.

[185] The SIR highlighted that the QAS response was both timely and appropriately resourced. *The first QAS unit arrived on scene four minutes after receiving the ICEMS request for service. Within seven minutes of the request, there were several QAS paramedics on scene, including two Critical Care Paramedics (CCPs), a Medical Officer (MO) from LifeFlight (Toowoomba Base) and a Senior Operational Supervisor.*²⁴²

[186] Dr Rashford was not able to find any major fault with the resuscitation efforts provided to Steven.²⁴³ He noted the resuscitation was conducted by two Advanced Care Paramedics (ACP), two CCPs (one of whom was a flight CCP), and a LifeFlight MO. The QPS officers also helped resuscitation efforts, with the provision of external chest compressions under direction from the QAS.

²³⁸ Exhibit J1.1 Condition K.

²³⁹ Exhibit J1, paragraph 15.

²⁴⁰ Exhibit J1, paragraph 16 to 20. See Exhibit J1.2.

²⁴¹ Exhibit J1, paragraph 22 to 24.

²⁴² Exhibit B18, page 6.

²⁴³ Transcript Day 2, page 2-53, line 29.

[187] Steven's airway was suctioned by one of the ACPs, an oropharyngeal airway was inserted, and ventilation was provided with a bag-valve-mask. The primary CCP arrived on scene shortly after, positioned himself at Steven's head and assumed the role of airway clinician and clinical lead. During the management of Steven's airway, the primary CCP had made two attempts at endotracheal intubation, to try to optimise and protect Steven's airway. Both attempts were unsuccessful.

[188] At some stage, one of the ACPs established intravenous access on Steven's left arm. The LifeFlight Retrieval MO and Flight CCP arrived before the primary CCP's second endotracheal intubation attempt. Following the second failed attempt at endotracheal intubation, the MO adjusted in preparation for endotracheal intubation and assumed the position at Steven's head.

[189] The Retrieval MO successfully passed the endotracheal tube into Steven's trachea on the first attempt. During the resuscitation, several drugs were administered, including adrenaline and 0.9% Sodium Chloride, as indicated, for the management of cardiac arrest.

[190] Resuscitation was attempted for a total of 32 minutes. There was no discernible change in Steven's cardiac rhythm and therefore no return of spontaneous circulation at any time. Following the Retrieval MO's discussion with the resuscitating team, a collaborative decision was made to discontinue resuscitation.

[191] Overall, the CPR provided by the QAS and the QPS officers was performed at a high standard. There was a strong effort to achieve minimal interruptions to compressions, with ongoing quantitative analysis and feedback on chest compressions throughout the resuscitation. Fundamental (basic) airway management was also at a good standard.

[192] I accept the expert opinion of Dr Rashford that Steven received appropriate assessment and care from the QAS officers in attendance on 7 October 2021, and further that the CPR attempts of both QAS and QPS members in attendance, were of a high standard.

Issue four

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

[193] When Steven passed, QPS Operational Procedures Manual (OPM) Issue 84 was in place. LVNR was an approved use of force option for QPS officers. In accordance with s 615 of the *Police Powers and Responsibilities Act 2000* (Qld) (PPRA), an officer may use force reasonably necessary to exercise a power under the PPRA.²⁴⁴ However, s 615 does not authorise an officer to use force likely to cause grievous bodily harm or death.²⁴⁵

²⁴⁴ *Police Powers and Responsibilities Act 2000* (Qld) section 615(1).

²⁴⁵ *Police Powers and Responsibilities Act 2000* (Qld) section 615(3).

[194] The use of force by QPS officers was examined by Sergeant Donnelly of QPS Operational Training Services. Sergeant Donnelly's evidence was that there are no officially mandated responses that require QPS officers to take specific actions in relation to certain behaviours by those they encounter. Instead, QPS officers are to be guided as to their use of force by the information and tools contained within Chapter 14.3 of the OPM.²⁴⁶

[195] In assessing the use of force, Sergeant Donnelly concluded that Constable Smart, Senior Constable Giuliano, and Senior Constable Colman were performing a function of the QPS. The officers were identifiable as police in full uniform and a marked police van.

[196] Initially, Constable Smart and Senior Constable Giuliano had responded to a report of a VOI bearing registration plates that did not belong to that vehicle.²⁴⁷ Section 60(1) of the PPRA gave Constable Smart and Senior Constable Giuliano the authority to stop the vehicle.²⁴⁸

[197] Section 754 of the PPRA provides for the offence of evasion.²⁴⁹ Section 365(1) of the PPRA gives a police officer the power to arrest an adult without a warrant where the officer reasonably suspects the person has committed or is committing an offence, if reasonably necessary to:

(a) prevent the continuation or repetition of an offence or the commission of another offence;

(b) to make inquiries to establish a person's identity;

...

(h) to prevent a person fleeing from a police officer or the location of an offence.²⁵⁰

[198] In his evidence Sergeant Donnelly recommended QPS officers activate their BWC on approach to this type of situation.

The baton

[199] As previously noted, Constable Smart held on to either end of the baton and held Steven in a type of 'bear hug.' This action was not consistent with how a baton is typically used by QPS officers. He explained his decision to do so by reasoning he could not re-holster the baton, or throw it away: '*Rather than throw the baton where the other guy could grab it or something what I've done is I've brought it around the front of him and held onto it.*'²⁵¹

²⁴⁶ Exhibit B17, paragraph 14.

²⁴⁷ Section 211 *Transport Operations (Road Use Management – Vehicle Registration) Regulation 2021 (Qld)*.

²⁴⁸ See also s 60(3)(a) and (b).

²⁴⁹ See subsection (1) and (2).

²⁵⁰ Exhibit B17, paragraph 196.

²⁵¹ Exhibit E1.1, answer 81.

[200] Constable Smart said that he would not be confident re-holstering the baton in its extended form as it would be ‘*easily grabbable*’ and ‘*could fall out*.’²⁵² He expressed a difficulty in returning the baton to its pouch when extended, and not having an opportunity to retract it due to the ‘*dynamic situation*’

[201] Senior Constable Giuliano said that he did not attempt to re-holster his baton but if he had, the difficulty would be when the baton is extended: ‘*The holster: it only fits a collapsed baton. To collapse it, you would need to, essentially, strike it on a hard surface to - to make it go back to its collapsed state ... If it’s still extended, it’s potentially going to be hitting my legs or wherever it may be. And furthermore, if - if it’s there, it’s easily - could easily be grabbed and pulled out.*’²⁵³

[202] While Senior Constable Giuliano considered throwing the baton away, he: ‘*was aware that there was at least one other person around. I didn’t know who that person was. I did not want my baton used against me or my partner.*’²⁵⁴

[203] Senior Constable Giuliano and Constable Smart’s evidence was consistent in respect of the difficulties in collapsing an extended baton during a dynamic police interaction.

[204] Sergeant Donnelly considered Constable Smart’s use of the baton, although not taught in that form, was a variation of the ‘harness’ hold. Sergeant Donnelly acknowledged Constable Smart’s height as part of the reason a traditional harness hold may not have been possible, and his concerns about throwing the baton away.

[205] Sergeant Donnelly considered Constable Smart’s actions were consistent with the principle of establishing a position of safety. Officers are instructed to attempt to attain a position or angle of reference on a subject person, minimising the risk of injury to the officer and the greatest tactical advantage. Such a position limits the capacity of the restrained person to harm or assault the officer. It also limits their vision of the officer, further negating assault.²⁵⁵

[206] At inquest, Sergeant Donnelly’s evidence was that the harness hold was a technique used by police, above and below the shoulders, like a seatbelt across the top of the shoulder and underneath the opposite arm. That is a stabilising control point when police cannot control arms and limbs, which have a wide range of motion and movement which can be difficult to control in an escalated situation:

‘He [Constable Smart] is using the concept of stabilisation with regards to the offender or the subject person in this particular circumstance. However, once again the baton isn’t used or taught in that fashion. I would suggest the mere fact that, as mentioned before, that Constable Smart was of the opinion to place the baton

²⁵² Transcript Day 1, page 1-25, line 5.

²⁵³ Transcript Day 1, page 1-55, line 34.

²⁵⁴ Transcript Day 1, page 1-55, line 10.

²⁵⁵ Exhibit B17, paragraph 59 and 60.

back in the scabbard, would be difficult to place the scabbard on the ground, raise the level of threat, secondary or third offenders, so therefore he's kept maintaining control of the baton purely for that reason as opposed to using it as a control point....

I would imagine that due also the height difference that Constable Smart had on Mr Nixon-McKellar the use of the harness technique probably wasn't available to him in that circumstance. The stabilising around the torso is probably his only option really in stabilising, controlling, and maintaining a safe position. We also referenced the fact of staying in close proximity to a subject person prevents them from being counter-assaultive. So there are ... definitely concepts that are taught within frontline skills training applied here, but as to a specific technique using the baton I would say we don't teach that.²⁵⁶

[207] Inspector Buxton's evidence was that steps will be taken by the QPS to address the way in which the baton was used by Constable Smart:

'It will appear in next year's operational skills annual refresh. It's somewhat of an unusual circumstance. In my 30 years of policing and 13 years-odd of doing use of force reviews, I've never seen anything like that before. So the fact that it potentially will impact the diaphragm – and I think there was some commentary about venous blood return via the inferior vena cava. That's something that we've not been exposed to before that I believe. So, you know, in terms of continuous improvement, we'll make some changes and pass some information on through training to inform officers of that particular risk.'

[208] The use of the baton by Constable Smart in an adapted harness hold was not a technique taught by the QPS. However, I accept it was a variation of an approved technique, in circumstances where the baton could not be thrown away or collapsed and returned to its pouch during the confrontation with Steven.

The LVNR

[209] At the time of Steven's passing, the LVNR was distinguished from a choke hold in the OPM:

'The respiratory neck restraint hold (choke hold) which applies pressure directly to the trachea (windpipe) and establishes subject control through the principles of pain and strangulation. A properly applied respiratory neck restraint is likely to cause serious bodily harm or death and therefore is considered a 'lethal force' option'; and

²⁵⁶ Transcript Day 2, page 1-13, line 35.

*Lateral vascular neck restraint hold (carotid neck restraint) which applies pressure to the sides of the neck (i.e. compression of the carotid arteries, jugular veins, and carotid bulb) resulting in a decrease of blood supply to the brain and leading to altered levels of consciousness. The objective of this technique is to establish subject compliance either voluntarily or involuntarily. When properly applied, a lateral vascular neck restraint hold is unlikely to cause death or serious injury, and therefore is considered a 'less than lethal force' option.*²⁵⁷

[210] OPM 14.3.3 specified that:

*'LVNR should not be used unless the incident is "high risk" with imminent operational necessity to apply the hold or if acting or aiding in self-defence. The hold is not to be used on the elderly; children; persons with Down's syndrome; pregnant women; or persons with an obvious or suspected head or neck injury.*²⁵⁸

[211] A further independent, review of the use of force by QPS officers, was commissioned by the Coroners Court. Mr Cale's report detailed his skills and expertise in support of his ability to proffer an expert opinion in the matter, particularly in terms of the LVNR and other training issues. Mr Cale considered in respect of the LVNR:

'The LVNR is a restraint and control technique that involves the bilateral application of pressure to a person's neck, causing compression of the carotid arteries and impeding the flow of blood, and therefore oxygen, to the brain. This action may cause a person to experience an altered level of consciousness or render them completely unconscious. The pressure may be varied by the applicant to achieve either effect (noting that there may be other circumstantial and physiological factors that contribute to these effects, as described in the medical examiner's report, and below). The hold may also be used to simply control the person and induce compliance via exerting the minimal amount of pressure required to do so.'

*'Rear naked choke' is the more common term for the technique known as an LVNR in law-enforcement. However, while both may result in the receiver of the technique being rendered unconscious, they are technically very different. A chokehold, by contrast with the LVNR, applies pressure (and sometimes impact, depending on the speed and force of application) to the throat or windpipe (trachea). The choke is inherently injurious, whereas a stranglehold is not, depending on what is used to effect it.*²⁵⁹

²⁵⁷ OPM Issue 84 (Effective 24 September 2021) Page 1070, Chapter 14, point 14.3.3 Open hand tactics.

²⁵⁸ Exhibit I1, paragraph 7 and 10.

²⁵⁹ Exhibit H2, page 6.

[212] Mr Cale described the correct application of the LVNR in his report.²⁶⁰

[213] I accept Mr Cale's opinion that Senior Constable Colman's use of the LVNR on 7 October 2021, complied with the QPS policies and procedures in force at that time.²⁶¹ I also accept that Senior Constable Colman's application of the LVNR was technically correct, and in line with the mandated procedures for its use. Consequently, it could not be considered a 'variation or adaptation' of the technique that was taught to QPS officers.²⁶²

[214] Sergeant Donnelly's observation of Senior Constable Colman's arm placement was that it was '*off centre*.' However, this occurred after Steven had reportedly lost consciousness, and appeared to have been momentary in the course of lowering Steven to the ground, in circumstances where there were physical obstacles including Constable Smart (on the ground) and the hatchback vehicle. It is also important to note that the medical evidence showed the LVNR did not cause any damage to the structures of the neck.²⁶³

[215] I accept the opinion of Mr Cale in respect of the actions of the officers following the application of the LVNR, including the officers' display of concern after Steven collapsed, and commencement of care.²⁶⁴

[216] Counsel for Senior Constable Colman, Senior Constable Giuliano and Constable Smart submitted that there was no error in the application of the LVNR by Senior Constable Colman and it was not a choke hold. The LVNR did not cause any identifiable injury or bruising to Steven. The relevance of the LVNR was the "temporal relationship between the placement of the neck hold and the cardiovascular collapse and cardiac arrest".

[217] I agree that a temporal connection is the highest the relationship between the LVNR and Steven's cardiac arrest can be put. This was supported by the evidence of Dr Day. The application of the LVNR was therefore an unquantified and unquantifiable factor which had relevance because of its temporal relationship but not otherwise.²⁶⁵

[218] I accept the submission of counsel assisting that Steven's passing occurred after a protracted struggle. While the LVNR was the final use of force option exercised it was not the cause of Steven's passing. The LVNR may have been contributory, but the extent of its contribution cannot be quantified. The cause of Steven's passing is much more complex. Attempting to narrow the cause of the passing to the LVNR alone is simplistic and was not supported by the expert medical evidence available to the Court.

²⁶⁰ Exhibit H2, page 7 to 8.

²⁶¹ Exhibit H2, page 10 to 13.

²⁶² Exhibit H2, page 11.

²⁶³ Exhibit B17, paragraph 137 and 138.

²⁶⁴ Exhibit H2, page 13 to 15.

²⁶⁵ At [17] – [19].

Handcuffs

[219] Dr Collins expressed the view that while handcuffing arises from the QPS policies and procedures in respect of the use of force, he did not consider the handcuffing of an *'unconscious and possibly dead'* person to be appropriate.

[220] Dr Collins would *'presume [that person] is presenting no threat to anybody and that the primary concern would be resuscitation.'*²⁶⁶ Dr Day expressed the view that he *'could not make any contribution'* on this point as he was not a police officer.²⁶⁷

[221] I do not accept the opinion expressed by Dr Collins. It was an opinion given with the benefit of hindsight, with no consideration of the evidence of the QPS officers involved, nor any consideration of the relevant QPS policies and procedures.

[222] The available evidence in respect of this issue supports the conclusion that Steven's manner of driving and manner of exiting the vehicle were contributory factors in the subsequent interaction with the QPS officers. Steven's manner of leaving the VOI can be contrasted with the actions of his passenger and friend, Mr Lingwoodock, who simply walked away from the scene.

[223] Counsel for Senior Constable Giuliano and Constable Smart submitted that the express and unambiguous effect of the evidence of the two officers from the information provided about the vehicle with false plates and the way it was driven after being *'parked in'* by the QPS vehicle was that they *suspected* the vehicle was being used unlawfully and that suspicion was *reasonable* because it was based on objective facts. I accept this submission.²⁶⁸

[224] Counsel for Senior Constable Colman, Senior Constable Giuliano and Constable Smart also submitted that the conduct of Senior Constable Giuliano and Constable Smart in smashing the driver side window in an attempt to grab car keys, and restraining Steven when he got out of the passenger side was lawful because it was within the exercise of powers afforded to the officers under the PPRA:

- a. Section 31(2) PPRA provided a lawful power to stop, detain and search the VOI;
- b. Section 365(1)(a), (b) and (h) PPRA provided a lawful power to arrest Steven without a warrant to prevent the continuation of the suspected unlawful use of the vehicle, establish his identify and prevent him fleeing;
- c. Section 615 PPRA provided a lawful power to use reasonably necessary force to exercise powers under ss 31(2) and 365(1) PPRA; and

²⁶⁶ Transcript Day 4, page 4-60, line 16.

²⁶⁷ Transcript Day 4, page 4-32, line 27.

²⁶⁸ Submissions on behalf of Senior Constable Colman, Constable Smart and Senior Constable Giuliano at [9].

²⁶⁸ Submissions

- d. Section 254 of the *Criminal Code* (Qld) provided a lawful power to use such force and may be reasonably necessary to overcome the force used by Steven in resisting the arrest under s 365 PPRA.²⁶⁹

[225] It was submitted that the use of force by Senior Constable Colman, Senior Constable Giuliano and Constable Smart was neither excessive nor was it likely to cause grievous bodily harm,²⁷⁰ and that the conduct of Senior Constable Colman, in coming to the assistance of Senior Constable Giuliano and Constable Smart was lawful because it was within the exercise of power afforded to him under the PPRA:

- a. Section 615 PPRA provided a lawful power to any person helping Senior Constable Giuliano and Constable Smart to use reasonably necessary force to assist them in exercising their powers; and
- b. Section 254 of the *Criminal Code* (Qld) provided a lawful power to any person lawfully assisting Senior Constable Giuliano and Constable Smart (under s 615 PPRA) to use such force as may be reasonably necessary to overcome the force used by Steven in resisting the arrest of Senior Constable Giuliano and Constable Smart under s 365 PPRA.

[226] I accept these submissions.

Issue five

Whether the training provided to police officers to respond to the incident was appropriate, including the training provided to police officers in respect of the Lateral Vascular Neck Restraint.

[227] I accept the opinion of Mr Cale that the guidelines and protocols supplied for use of the LVNR by the QPS were sensible and clearly conveyed, and the instruction the QPS officers received regarding the application of the LVNR was technically correct and thorough.²⁷¹

[228] However, Mr Cale considered that the time spent on the LVNR within the mandated training sessions was insufficient, such that QPS officers not required to use the LVNR in the course of their work soon after, or who did not receive extra-curricular training in it, would be unlikely to have achieved lasting competency in the technique.

[229] While Mr Cale described the term ‘regular’ as a ‘nebulous term and open to interpretation,’ it was his understanding that QPS officers review and retrain open-hand tactics and techniques annually.

²⁶⁹ Submissions on behalf of Senior Constable Colman, Constable Smart and Senior Constable Giuliano at [10].

²⁷⁰ Submissions on behalf of Senior Constable Colman, Constable Smart and Senior Constable Giuliano at [11] – [13]. Transcript Day 2, T2-67, L 15. Exhibit A3, 20: ‘*brief pressure to the neck, in the absence of other contributory factors described is unlikely to cause death independently.*’

²⁷¹ Exhibit H2, page 21.

[230] Mr Cale's experience instructing soldiers, and military police at the Defence Force School of Policing, had demonstrated to him that training intervals longer than six months were ineffective for recall. He further considered that retention may be improved to some degree if trainees were regularly required to apply trained techniques on the job between training sessions.

[231] However, if they did not have sufficient recall and confidence in the technique when the opportunity arose, they were less likely to use the technique. Consequently, those officers would not benefit from repeat exposure and feedback that such exposure to a technique provided.²⁷²

[232] Counsel assisting submitted that considering the expert opinion of Mr Cale regarding the frequency of training to confirm learning and competency in a technique such as the LVNR, Senior Constable Colman was likely more proficient in the use of the LVNR than his colleagues, given his experience of the technique in his professional employment and extra-curricular BJJ training, despite having utilised the LVNR only once, in a dynamic policing setting.

[233] The submissions of counsel assisting were supported by counsel for the officers, subject to the qualification that refresher training ought to be provided at more frequent intervals.²⁷³

[234] I accept the submission on behalf of the QPS Commissioner that Mr Cale's evidence was only useful in respect of the technical aspects of the LVNR and open hand tactics. However, it was limited by the fact that the QPS Commissioner had directed the LVNR was no longer an approved use of force option for QPS officers, and it was no longer trained by the QPS.²⁷⁴

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

[235] The QPS no longer provides training to officers in respect of the LVNR.

[236] My ruling of 2 August 2023 acknowledged that it was possible that the discontinuation of LVNR training in circumstances where officers may continue to choose to use the LVNR to prevent death or grievous bodily harm was an issue upon which comment could be made under s 46 of the Act.²⁷⁵

[237] On 14 April 2023, former QPS Commissioner Carroll, in accordance with her powers under the *Police Service Administration Act 1990 (Qld)* (the PSAA) announced that the LVNR would no longer be an approved open hand use of force technique for QPS officers. A training advisory note outlining the removal of the LVNR was issued. Reference to the LVNR was removed from the OPM. A detraining strategy was devised for in-service annual requalification and internal communication had occurred via QPS communication channels.

²⁷² Exhibit H2, page 21.

²⁷³ Submissions on behalf of Senior Constable Colman, Constable Smart and Senior Constable Giuliano at [3].

²⁷⁴ Submissions on behalf of the QPS Commissioner at [28].

²⁷⁵ Ruling in relation to issues for inquest and witnesses to give evidence at inquest, paragraph 33.

[238] The QPS Commissioner has responsibility under s 4.8(1) of the PSAA for the *'efficient and proper administration, management and functioning of the police service in accordance with the law.'*

[239] Section 4.8(3) of the PSAA states that the Commissioner is *'authorised to do or cause to be done'* all lawful acts necessary or convenient to carry out her responsibility. Section 4.9 provides the foundation for the Commissioner to give directions. Section 4.9(1) states that: *'In discharging the prescribed responsibility, the commissioner may give, and cause to be issued to officers, staff members or police recruits, such directions, written or oral, general or particular as the commissioner considers necessary or convenient for the efficient and proper functioning of the police service.'*²⁷⁶

[240] On 15 May 2023, Commissioner Carroll issued a revised direction by email. This directed that the use of the LVNR cease immediately:

*'I direct the LVNR is to cease immediately as a use of force option in the course of an officer's ordinary policing duties. To be clear this direction does not affect the application of statutory provisions concerning the force that may lawfully be used to prevent death or grievous bodily harm.'*²⁷⁷

[241] The former President of the QPUE, Mr Leavers, provided a statement and gave evidence at the inquest, in accordance with my ruling.²⁷⁸ The QPUE represents almost 12,500 non-commissioned QPS officers and advocates for those officers in respect of policing resources, *'the prioritisation of use of force training within an environment of competing responsibilities and police training and education in relation to the use of force.'*²⁷⁹

[242] Mr Leavers expressed his support for evidence-based policing practices. In respect of the LVNR he noted:

*'The LVNR is and always has been a very important and useful tool for all police to utilise at various points in a use of force confrontation. The use of the LVNR allows for a swift resolution or a dangerous situation with less risk of harm to the individual than other use of force options. I support the LVNR remaining as a use of force option with police officers receiving expert training in how to perform the restraint correctly. In my opinion there is a real danger for the safety of the public and police officers since the LVNR has been removed from police training and policy.'*²⁸⁰

²⁷⁶ Submissions on behalf of the QPS Commissioner at [40] – [41].

²⁷⁷ Exhibit I2.

²⁷⁸ Ruling in relation to issues for inquest and witnesses to give evidence at inquest.

²⁷⁹ Exhibit B23, paragraph 4 and 7.

²⁸⁰ Exhibit B23, paragraph 13.

[243] Mr Leavers acknowledged the QPUE had not undertaken a survey of its member base in respect of the LVNR. He expressed the QPUE's support for the LVNR Working Group's proposed 12-month review.²⁸¹ He also said there was confusion as to whether the LVNR was banned or not. He said that:

*'Police can do anything to protect themselves or the community from grievous bodily harm or death. That could include hitting someone with a fence paling, throwing rocks at a person, eye gouging or even strangling the person. I would prefer, and I would think the community generally would prefer officers to be trained expertly in the use of the LVNR so that in that extreme situation they can rely on their training before resorting to those more desperate measures to save life.'*²⁸²

[244] To understand efforts made by the QPS to respond to coronial findings and consider an evidenced based approach to the LVNR as a use of force option, information was sought concerning the QPS LVNR Working Group, established in January 2022 in response to my findings and recommendations in the *Inquest into the death of Noombah*.²⁸³

[245] Inspector Buxton provided a statement and gave evidence at the inquest to assist the Court in this matter. In his role, he develops strategies, plans and policies to support educational activities, development of curriculum, delivery, and assessment of frontline skills training for recruits.

[246] I accept the evidence of Inspector Buxton noting his extensive policing experience and detailed understanding of the complexity of developing and delivery training to support an operational police force.

[247] The LVNR Working Group Report noted:

'The LVNR is not the neck hold known as the "choke hold" which applies pressure to the front of the neck and has been linked to deaths and serious injuries in other jurisdictions across the world. The LVNR forms part of an approved technique to use within the QPS Situational Use of Force model (2016), specifically within the category of Open Hand Tactics.'

[248] The history of the LVNR and its temporary classification as a *lethal force* option was outlined in the LVNR Working Group Report.²⁸⁴ The term *lethal force* [emphasis added] is defined in the Service Manual Definitions ('SMD') as:

'A force that is likely to cause death or serious injury or which creates a degree of risk that a reasonable person would consider likely to cause death or serious injury.'

²⁸¹ Exhibit B23, paragraph 16.

²⁸² Exhibit B23, paragraph 23 and 25.

²⁸³ Findings delivered 11 January 2022. Exhibit I1, paragraph 1.

²⁸⁴ At [11] – [14].

[249] *Less than lethal force* [emphasis added] is defined in the SMD as:

‘A force option that is less likely to cause death or serious injury to a person when properly applied by a police officer. The goals associated with the use of less lethal force are to bring the person under the control of the police officer, expose the police officer to the minimum possible risk of injury by the person and minimise the likelihood of injury to police, the public or the offender.’

[250] Less lethal options available to QPS officers include the Conducted Energy Weapon (CEW) or “Taser”, Oleoresin Capsicum (OC) spray and the Baton.²⁸⁵

[251] The outcome of the Working Group was that:

‘The majority recommended LVNR remain as part of the OST curriculum with the same threshold as per OPM 14.3.3 (self-defence/high risk and immediate need to apply the restraint) with no change to the OPM for situations when the LVNR is not to be used. A 12-month ongoing review of LVNR was recommended with an inclusion to undertake annual OST training revision, survey of officer/community attitudes, mandatory QPRIME use of force reporting and continuous review of LVNR applications by the working group. The working group endorse research engagement with a university.’²⁸⁶

[252] The LVNR Working Group noted:

‘The case for the LVNR remaining is that it is effective in a variety of situations where other tactics would be less so, including with officer-offender parity and disparity, single officers, close quarters and limited space applications. There is no technique which directly replaces the LVNR. All use of force options carry levels of risk in their lawful application including TASER. The working group noted TASER use has also been linked to deaths during restraint.’

‘Advice from QAS medical director, Dr Stephen Rashford, supported from a medical position the LVNR was a relatively safe technique to use, and deaths tended to occur from a protracted struggle with LVNR being one of the last use of force options used in a lengthy struggle. It was also noted there was a lack of Australian use of force data to justify any data based and evidential decisions on the continued use of the LVNR. It should be noted Dr Rashford voted to continue use of the LVNR but raise the threshold for use to equivalent to lethal use of force.’²⁸⁷

²⁸⁵ Exhibit B17.

²⁸⁶ Exhibit I1, paragraph 4.

²⁸⁷ Exhibit I1, paragraph 52 and 54.

[253] As noted above, I accept that Steven’s passing was one that occurred after a protracted struggle. The LVNR was the last use of force option exercised and was not the cause of his passing. While it may have been contributory (and its contribution cannot be quantified), the cause of his passing is more complex.

[254] Counsel for the QPS Commissioner submitted that the LVNR Working Group did not make any recommendations to the Commissioner. The report provided the Commissioner with four options in respect of the use of the LVNR by the QPS and noted the voting of the members of the working group.

[255] The “recommendation” made by the Working Group was that their review (report) be referred to the QPS Commissioner for her determination.²⁸⁸ The four options were:

- a. The LVNR be removed from the OST curriculum with amendments made to the police OPM;
- b. The LVNR remain in the OST curriculum with an ongoing 12-month review, with OST training revisions, a survey of officer and community attitudes, and a reporting requirement for use of the LVNR;
- c. The LVNR remain with no change; and
- d. The LVNR remain and be reverted back to the lethal use of force option.

[256] The Working Group provided background to the approach taken by other law enforcement agencies in Australia and overseas. Most policing agencies no longer use or train the LVNR as a use of force option. Community sentiment was acknowledged as the reason some jurisdictions had removed the use of the LVNR.

[257] Inspector Buxton explained the importance of the Peelian Principles of Policing and acknowledged its cultural relevance and consideration of First Nations people:

‘It’s that idea that police are civilians in uniform, but key to this and linked to it are a couple of different concepts that are still very relevant today, and that’s police legitimacy and the need for us to have community consent to police the community. And there’s the nine principles, the three core ideas, but they revolve very much around the community policing model and ... enshrine many things that have later been adopted into such things as, like, the Human Rights Act.’

[258] Inspector Buxton’s evidence was that the LVNR is no longer trained in accordance with the QPS Commissioner’s direction, and the OST team had developed further training – the Intercept, Stabilise and Resolve Matrix (ISR).

²⁸⁸ At [77] of the Working group final report. Submissions on behalf of the QPS Commissioner at [37].

[259] OST instructors had been trained in the ISR Matrix Instructors Course which demonstrated the QPS was proactively engaging in future training needs of the service in respect of open hand use of force options. Inspector Buxton's evidence was that the trained substitute for the LVNR, in respect of close-quarters restraint was the harness stabilising technique. However, he acknowledged that it did not do exactly what the LVNR did.²⁸⁹

[260] The QPUE submitted that I should make the following comments under s 46:

- a. *That the Commissioner of Police reconsider the recommendation of the LVNR Working Group;*
- b. *That the Commissioner of Police urgently develop and provide an online training module for QPS officers which addresses:*
 - (i) *The LVNR Working Group's recommendation and the Commissioner's reconsidered decision; and*
(Assuming the Commissioner does not change [the] decision)
 - (ii) *The legislative framework for the use of force by QPS officers;*
 - (iii) *The Commissioner's position on the disciplinary consequences for the use of LVNR by QPS officers; and*
 - (iv) *The restructured approach to OST training and situational use of force model in the absence of the training about LVNR.*

[261] The Commissioner submitted that the training resources available to the QPS are finite, and there is no benefit to police officers or to the community in training police officers in the LVNR when it is not an approved use of force.

[262] It was also submitted that the directions given by the Commissioner, the policy changes and the revised training offered to officers were sufficient for police officers to understand the current position with respect to the use of the LVNR and other use of force options. I accept those submissions.

Issue six

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.

[263] Section 46 of the *Coroners Act* provides that a Coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to public health or safety; the administration of justice; or ways to prevent deaths from happening in similar circumstances in the future.

[264] I have considered the use of the LVNR above. Submissions on other possible comments were received from counsel assisting and ATSILS. I have considered those submissions together with the response of the Commissioner.

²⁸⁹ Transcript Day 3, T3-14, L 40-50. Submissions on behalf of the QPS Commissioner at [52] – [54].

Body alarm response / cognitive overload

[265] Counsel assisting's submissions referred to the need to consider the 'totality of a situation' and the body alarm response and the effect it has on officers during high-risk situations. Sergeant Donnelly gave evidence of this phenomenon and its effect on officers.²⁹⁰

[266] Mr Cale's evidence was that the optimal way to implement training to minimise the impact of the 'body alarm response' in these types of situations: *'Would be to understand the effects of somebody in confrontation, a clear understanding, and recognise that what's happening is a normal process of combative situation. And then to apply things such as box breathing and so on to lower the breath rate to allow for the ability to start thinking through problem-solving. But in - also in saying that, as I mentioned before, if they don't have the techniques and information to recall that's been trained correctly under stress.'*²⁹¹

[267] In respect of online training to refresh this type of technique, Mr Cale considered: *'So relying on online training, written words, and so forth, will not be recalled when you're under stress. You have to actually be involved in a training that's safely conducted but does include stresses that are similar to those found during operational duty. In person training is the optimal way.'*²⁹²

[268] I accept that current QPS training is aimed at addressing the body alarm response and cognitive overload to assist officers to function effectively under pressure.

Excited delirium

[269] Counsel assisting submitted that use of terms such as excited delirium in respect of multifactorial deaths such as Steven's, should be discouraged due to the medical inaccuracy of the terminology. I accept this submission.

[270] In the *Inquest into the death of GLT*, I recommended that the QPS review the use of terms such as 'excited delirium' and 'positional asphyxia' within policies and procedures, in consultation with the QAS, to ensure that the terminology used is accurate and reflects best medical practice. Considerable work has been done in this area since Steven's death.

[271] I accept there is ongoing work between the QPS and QAS in respect of OPM ss 14.3.6 and 14.3.7 which refer to positional asphyxia, excited delirium, acute behavioural disturbances and recognising when somebody is entering into medical distress.²⁹³

[272] On that basis, I do not consider that any further recommendation is required.

²⁹⁰ Exhibit B17, paragraph 38 to 39.

²⁹¹ Transcript Day 2, page 2-94, line 43.

²⁹² Transcript Day 2, page 2-95, line 4.

²⁹³ At [86]-[88].

Consideration of premature onset of chronic underlying disease in use of force training and policy development

[273] Counsel assisting submitted that consistent with the evidence of Dr Day, post arrest collapse and multifactorial deaths of this kind are a broad public safety issue: *'anybody, regardless of their Indigenous status, who have these underlying conditions is predisposed to death in this manner in these circumstances.'*²⁹⁴

[274] However, in respect of Steven as a First Nations man, counsel assisting referred to the evidence of Dr Rashford: *'Very sadly as we all attempt to close the gap on health care equity and outcomes, we recognise that people with First Nations heritage unfortunately have... from my experience perhaps more premature onset of underlying chronic disease, particularly cardiovascular, and we need to bear that in mind.'*²⁹⁵

[275] ATSILS submitted that unfortunately, First Nations people are more at risk of developing chronic diseases which can have a premature onset or go undiagnosed. Additionally the use of illicit drugs can lead to cardiac malfunction, causing enlargement of the heart, impact arteries or scarring on the heart. ATSILS submitted that it was crucial to consider these factors in the development of policies and procedures, and training and education resources.²⁹⁶

[276] Counsel assisting submitted that I should consider a recommendation that the QPS and QAS review their policies to ensure acknowledgement of the likelihood of premature onset of chronic disease, particularly cardiovascular disease for First Nations persons, as a potential risk factor for sudden collapse during interactions with Police.

[277] However, Counsel for the QPS Commissioner submitted that the QPS was working in partnership with the QAS in the review of policies, consistent with the evidence of Inspector Buxton given at the inquest. Both Inspector Buxton and Dr Rashford gave evidence about the approach taken by the QPS and QAS to amend the wording of the OPM and as such no recommendation was required.²⁹⁷ I accept this submission.

²⁹⁴ Transcript Day 4, page 4-46, line 47 to page 4-47. See Findings in the inquest into the death of GLT 2019/5112, Findings in the inquest into the death of Noombah 2018/686, Findings in the inquest into the death of Pasquale Giorgio 2016/1388.

²⁹⁵ Transcript Day 2, page 1-58, line 28.

²⁹⁶ Submissions of ATSILS, 8.

²⁹⁷ Submissions on behalf of the QPS Commissioner at [61].

Section 48 referral

[278] The family’s legal representative, Ms Levitt, submitted on behalf of Steven’s family²⁹⁸ that two named QPS officers be “*held to account for manslaughter*” as a primary or as an accessory.

[279] Mr Greggery KC, submitted on behalf of his clients that such a submission was an “*inflammatory and unsustainable proposition in fact and law*.”²⁹⁹

[280] I do not accept the submission of Ms Levitt. It is outside the scope of the inquest as corralled by the issues for consideration and outside the scope of the coronial jurisdiction. A coroner must not express any statement in findings that a person is, or may be guilty of an offence, or civilly liable for something.³⁰⁰

[281] However, s 48(2) of the *Coroners Act* requires that if, from information obtained while investigating a death, a coroner reasonably suspects a person has committed an indictable offence, the coroner must give the information to the Director of Public Prosecutions. Information that has been obtained under s 39 (incriminating evidence) cannot be used for a s 48 referral.

[282] Under the State Coroner’s Guidelines the right to make submissions with respect to a s 48 referral is confined to counsel assisting and counsel for a person subject to possible referral.

[283] Consistent with common law principles, there must be a factual basis to reasonably ground such a suspicion.³⁰¹

[284] The cause of Steven’s death was not determined. The expert evidence of the forensic pathologists and Dr Rashford was not able to quantify the actions on the part of any of the police officers in causing Steven’s death in terms of the legal requirements for the test of ‘substantial or significant’ cause of the death as set out in *Royall v The Queen*.³⁰²

[285] While the force used to restrain Steven has likely contributed to his death, it is less apparent that the police officers’ conduct was ‘a substantial or significant cause of his death’.

[286] Appropriately, no submission was made by counsel assisting in respect of any referral to the DPP or any other relevant disciplinary body.

²⁹⁸ Submissions on behalf of the family at [4] - [14].

²⁹⁹ Submissions on behalf of Senior Constable Colman, Constable Smart and Senior Constable Giuliano at [22b].

³⁰⁰ Sections 36(2), 36(3) and 45(5) of the *Coroners Act 2003* (Qld). Submissions of counsel assisting dated 5 September 2024 at [27] – [28].

³⁰¹ *George v Rockett* (1990) CLR 104.

³⁰² (1991) 172 CLR 378 at 423. See also *R v James, Tappin & Thomas* [2009] QSC 93 and *R v Legradi & Lombaard* [2010] QCA 364

Submissions implying bias

[287] Steven’s family were legally represented at the inquest. The submissions made on behalf of the family were not directed towards the findings that may be made under s 45 of the *Coroners Act 2003*, the comments or recommendations that may be made under s 46, or counsel assisting’s appraisal of same.

[288] The legal representatives for the family conveyed instructions that the family felt alienated from the coronial process and found it to be a “profoundly traumatising” rather than “therapeutic” experience.

[289] I acknowledge that some of the matters of concern to the family arose from a lack of clarity on the part of the Court in relation to matters such as the permissible content of family statements, and the display of photographs in the court room. The Court has endeavoured to provide more certainty to inquest participants in this regard, as set out below under the heading “Practice Directions and Cultural Capability”.

[290] I also recognise that the nature of inquest proceedings involving the passing of a First Nations person following a violent confrontation with police officers will be traumatising for family members. In this matter, the footage of the restraint leading up to Steven’s death was distressing. The language used by Senior Constable Giuliano in urging Senior Constable Colman to “choke” Steven was highly offensive and unprofessional. The use of this language and the proximity of the LVNR to his collapse understandably caused family members to believe that Steven’s death was directly related to that action.

[291] However, as noted above the Court operates in a prescribed legal framework. Legal representatives for participants in an inquest are required to avoid being guided by their client’s wishes alone. As officers of the court, legal representatives have a paramount duty to the court and the administration of justice. This duty prevails to the extent of inconsistency with any other duty, including the duty to the client.³⁰³

[292] During the inquest hearing, legal representatives for Steven’s family expressly resiled from the suggestion that they had made an allegation of bias against counsel assisting.³⁰⁴

[293] Despite that, the family’s written submissions impugn the coronial process and personally impugn counsel assisting based on the family’s perception of counsel assisting’s personal mannerisms (nodding while listening to evidence given by a witness being examined) and words used in acknowledging the answers of witnesses. Both criticisms related to the advocacy style of junior counsel assisting, rather than substantive content.

³⁰³ *Rondel v Worsley* [1969] 1 AC 191 at 227

³⁰⁴ T3-27, lines 8 to 10; T3-28, lines 22 to 28; line 34; lines 42 to 46.

[294] The legal representatives for the family asserted that the empathy between counsel assisting and the police witnesses was obvious to them. The legal representatives also criticised the role of ESC in investigating police:

The frequency with which reports to the coroner are stacked in favour of the police, not least in this matter, cause the public to question the independence of coronial inquest process, particularly when Counsel Assisting is propounding the conclusions of the ESC and also making recommendations to the Coroner. For a NSW practitioner this level of bias in the process is confronting, as is the evident empathy between Counsel Assisting and the police witnesses as outlined in paragraph 1 (c) above, as the subject of complaint by family members to their legal representatives. It was also obvious to their lawyers. (emphasis added)

[295] These submissions were not made by reference to evidence, but were expressed as the personal opinions of the legal representative on instructions imparted by the family.

[296] The legal representative for the family also made submissions about the nature of and way the evidence of the former President of the Queensland Police Union of Employees (QPUE) was given.

[297] The QPUE was given leave to appear at the inquest on a limited, public interest basis. The family had the opportunity to be heard before this decision was made.³⁰⁵ My ruling in relation to issues for inquest and witnesses to give evidence at inquest expressly noted:

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.

[298] As recognised by the legal representative for the family, no objection was taken to the evidence given by the President of the QPUE in a statement prior to the commencement of the inquest hearing. During the inquest hearing, legal representatives for the family confirmed that no objection was taken to the fact that the QPUE was granted leave to appear, or to the tendering of material provided by the QPUE into evidence.³⁰⁶

[299] However, the written submissions from the family complained “that the use of the coronial inquest as a lobbying platform for advocates of the impugned LVNR, particularly by the President of the QPUE is inappropriate” and that it was inappropriate “that Mr Leavers be afforded the opportunity to advocate for the LVNR’s reintroduction as an approved use of force technique”.

³⁰⁵ Ruling in relation to issues for inquest and witnesses to give evidence at inquest, 2 August 2023 at [26].

³⁰⁶ T3-30 lines 34-47.

[300] No application was made that I, or counsel assisting, should recuse ourselves on grounds of actual or apprehended bias. No application has been brought under the *Judicial Review Act 1991*.

[301] No submissions were made by the legal representatives for the family with respect to the relevant legal principles regarding actual or apprehended bias in inquisitorial settings, in such settings where a party is represented, or at all.³⁰⁷ It follows there has been no application of those principles to the facts and circumstances of this matter. No relevant nexus arises.

[302] I agree that the use of the word “bias” by the legal representatives for Steven’s family in written submissions was, in context, sensational. No substantive allegation of partiality or bias was made.³⁰⁸

Practice Directions and Cultural Capability

[303] Subsequent to the conclusion of the evidence in this Inquest, two practice directions have been issued to address procedural matters in the coronial jurisdiction. These practice directions provide greater certainty in relation to some of the matters that were a source of distress for the family in this matter:

- i) Practice Direction No. 1 of 2024, *Procedures for Pre-Inquest Conferences and Inquests*, provides guidance in relation to pre-inquest conferences and inquests in Queensland. It confirms that inquest proceedings are investigative rather than adversarial in nature. The practice direction acknowledges that inquests are stressful for families and the principal witnesses. It also deals with the display of photographs and cultural ceremonies at pre-inquest conferences and inquests.
- ii) Practice Direction No. 2 of 2024, *Family Statements*, was introduced to provide clarity about family statements in coronial proceedings and the type of information that should be contained within the statement in circumstances where the concept is not defined within the *Coroners Act*.

[304] In late 2023, the Coroners Court established the position of Cultural Capability Manager. The role of this identified position is to support the enhancement of the Court’s capacity to effectively support families, as well as coroners and relevant agencies in the investigation and review of the deaths of First Nations people. The Cultural Capability Manager delivers training to registry staff and coroners, and provides direct personal support to First Nations families in the coronial system.

[305] The Cultural Capability Manager has also assisted with engagement with ATSILS in relation to the development of protocols for the investigation of passings of First Nations people in custody and in the course of police operations.

[306] The QPS has also recently created an identified position of Principal Coronial Cultural Advisor in the Coronial Support Unit to promote culturally sensitive coronial investigations.

³⁰⁷ *Keating v Morris* [2005] QSC 243, [47] per Moynihan J, *Firman v Lasry* [2000] VSC 240

³⁰⁸ *Ebner v Official Trustee in Bankruptcy* (2000) 205 CLR 337

Release of body worn camera footage

- [307] Section 54 of the *Coroners Act* deals with access to investigation documents. A person may access the document only with the consent of the investigating coroner. The coroner may consent to access if the coroner considers the person has a “sufficient interest” in the document, or that access is in the “public interest” and has consulted with a family member of the person who has passed.
- [308] The investigation documents forming part of the coronial brief have been released to the inquest parties on the condition that the documents are only to be used for the purpose of the inquest.³⁰⁹
- [309] On 12 September 2023, the inquest parties were informed of a media request for publication of exhibit F2 which contained footage of the application of the LVNR.
- [310] The relevant footage was played in court during the inquest, consistent with the principles of open justice.
- [311] Steven’s family indicated they supported the release of the exhibit to the media. The Commissioner of Police and the involved officers did not oppose the release, but submitted that the release should be deferred until the findings were published.
- [312] On 13 September 2023, I accepted the submission on behalf of the Commissioner and the involved officers that release of the footage at that time would be premature and could result in unhelpful inferences being drawn about the context of the death, particularly when there was still significant evidence to be heard from forensic pathologists about the cause of Steven’s death.
- [313] On 13 September 2023, before the evidence was heard from the forensic pathologists, I decided that access to that exhibit should be deferred until the inquest findings were handed down, up to the point of two minutes and 53 seconds.
- [314] In written closing submissions, Senior Constables Colman, Smart and Giuliano sought leave to make further submissions regarding the publication of exhibit F2. I agree that leave should be granted for this purpose and that the relevant footage should not be released to the media in the absence of further submissions.
- [315] As noted above, the evidence of Dr Day was that the cause of Steven’s passing “is considered multifactorial and the precise mechanism for his death not determined”. There is no certainty that the physical altercation with police officers and the use of the LVNR specifically caused his passing. Dr Day (with whom Dr Collins and Dr Rashford agreed) believed that Steven’s passing was the result of a combination of all the events, and all the natural diseases, together with methylamphetamine toxicity.

³⁰⁹ Under s 55 of the *Coroners Act*

[316] Notwithstanding the expert evidence, the submissions of the family have continued to attribute a direct causal link between Steven's passing and the use of force by the QPS officers. The family have pressed that the officers should be prosecuted for manslaughter.

[317] I accept that the circumstances and context in which the exhibit would be received if released have changed because of the evidence and propositions received at the inquest, as well as the submissions following my ruling of 13 September 2023. I also accept that the principles of open justice may now be engaged in a different way because the context in which the information would be received has changed.

[318] I invite further submissions on the question of whether Exhibit F2 should be released to the media by 9 March 2026. There should be no publication of that exhibit until further order.

[319] I close the inquest.

ANNEXURE A



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 Manual² 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 be 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