



CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION: **Inquest into the death of James Michael Watson**

TITLE OF COURT: Coroners Court

JURISDICTION: BRISBANE

FILE NO(s): 2022/5110

DELIVERED ON: 11 August 2026

DELIVERED AT: Brisbane

HEARING DATE(s): 16 – 17 March 2026

FINDINGS OF: Stephanie Gallagher, Deputy State Coroner

CATCHWORDS: Coroners: inquest, police shooting, death in custody, use of weapon, mental health and substance use issues

REPRESENTATION:

Counsel Assisting: Sarah Ford

Family: Mr Mitch Rawlings instructed by Caxton Legal Centre

QPS officers Cowley and North: Ms Anna Waite, Gnech & Associates

Commissioner of Police: Ms Susan Donkin, QPS Legal Unit

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Introduction

1. James Michael Watson, aged 34 years, died in South Brisbane on 11 October 2022 after being shot by police during an altercation. As requested by his family, throughout the inquest he was referred to as 'James'.
2. James, who has been described as a gentle, sensitive and loving person with a clever wit and cheeky sense of humour, was very much loved by his family. He is said to have filled their lives with love and purpose.
3. In addition to being a son, brother, and uncle, James was a committed father to three young children whom he prioritised and adored. His family said that he "beamed with the unquestionable pride of a loving father".
4. When James was 17, he suffered a workplace accident that caused him pain and trauma, leaving a lasting impact on his life and rendering him unable to return to employment.
5. According to James' family, following the accident James was prescribed a "significant" amount of pain medication. Over time, he turned to illicit substances to cope with ongoing physical and emotional pain. This resulted in at least eight overdoses of a polysubstance nature, along with persisting symptoms of anxiety, paranoia, and delusions.
6. Leading up to his death, James was homeless and suffering from mental and behavioural disorders due to drug use. According to his medical records, he had been using Methylamphetamine, Fentanyl, GHB, Heroin, and Cannabis, and he was dependent upon prescription medications including (at various times) Suboxone, Lyrica, Alprazolam, Quetiapine, Diazepam, Amitriptyline, and Pregabalin.
7. On 3 October 2022, eight days before his death, James was taken to an emergency department where he reported daily use of methylamphetamine and GHB (sometimes three millilitres every three hours). He was assessed as experiencing drug dependence, worsening paranoia, and delusions. He left the hospital without being discharged.
8. In the afternoon of 11 October 2022, James was involved in a physical struggle with two Queensland Police Service (QPS) officers outside the Greek Club in South Brisbane. He was armed with a weapon, and following the unsuccessful deployment of a taser, the officers discharged their firearms - lethally shooting James. He was pronounced deceased at the scene.
9. The QPS Internal Investigations Group, Ethical Standards Command (ESC), investigated James' death and concluded that the two officers acted appropriately and in accordance with QPS training, policies and procedures. The investigation was overseen by the Crime and Corruption Commission.

Coronial jurisdiction

10. James' death was a reportable death as it was a death in custody.¹ In these circumstances, an inquest into James' death was mandatory.²
11. An inquest is an inquisitorial fact-finding exercise – one which is intended to provide the public and the family of the deceased with transparency regarding the circumstances of the death, and to answer any questions which may have been raised following the death. The focus of the coronial process is on discovering what happened, not on ascribing guilt, apportioning liability, or attributing blame.
12. The applicable standard of proof is that of “the balance of probabilities”, with reference to the *Briginshaw* standard.³ Accordingly, the more significant the issue for determination, the clearer and more persuasive the evidence must be for me to be sufficiently satisfied, on the balance of probabilities, that the issue has been proven.⁴
13. In adjudicating the evidence and drawing conclusions on the issues, I must be mindful of the impact of hindsight bias – that is, “the tendency after the event to assume that events are more predictable or foreseeable than they really were”. Instead, I must first attempt to understand the circumstances as they appeared at the relevant time to the people who were there. While hindsight is a very useful tool insofar as 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.⁵
14. In accordance with s37(1) of the Act, the Coroners Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate. However, this does not entirely remove the requirement for the Court to have some regard to the rules of evidence⁶ particularly in terms of the receipt and weight to be afforded to evidence during the inquiry.⁷

The inquest

15. A pre-inquest conference was held in Brisbane on 3 November 2025 before the State Coroner. During that conference, submissions were made on behalf of James' family in relation to the addition of further issues, witnesses, and evidence, beyond what had been proposed by counsel assisting.
16. Following the conference, the State Coroner delivered a ruling on the family's submissions. The effect of the ruling was that the witness and issues lists, as originally proposed by counsel assisting, were to remain unchanged.
17. The inquest was subsequently held before me in Brisbane from 16 to 17 May 2026. The issues examined during the inquest were:

- i. the appropriateness of the police actions on 11 October 2022; and

¹ *Coroners Act 2003 (Qld)*, ss8(3)(g) and 10.

² *Coroners Act 2003 (Qld)*, s27(1)(a)(i).

³ *Briginshaw v Briginshaw* [1938] HCA 34 and (1938) 60 CLR 336.

⁴ Dixon J (as he then was) in *Briginshaw v Briginshaw* 60 CLR 336.

⁵ The Australasian Coroners Manual. Hugh Dillon and Marie Hadley, Federation Press, 2015 at 10.

⁶ *Rodriguez v Telstra Corporation Pty Ltd* (2002) 66 ALD 579, per Kiefel J at 585 [25].

⁷ *Kostas v HIA Insurance Services Pty Ltd* (2010) 241 CLR 390, per French CJ at 396 [17].

- ii. the findings required by s45(2) of the Act, namely, the identity of the deceased, when, where, and how he died, and what caused his death.
- 18. The brief of evidence was tendered on day one of the inquest and oral evidence was taken from the following witnesses:
 - i. Constable Alistair North;
 - ii. Senior Constable Susan Cowley; and
 - iii. Senior Sergeant Tracy Baily.

The evidence

11 October 2022

- 19. I am satisfied that the evidence obtained by Detective Acting Sergeant Chris Els during his investigation, in addition to the oral evidence heard during the inquest, establishes the below timeline of events for 11 October 2022.
- 20. During the morning of 11 October 2022, James consumed Heroin, Methamphetamine, GHB, Lyrica, and Valium. James's ex-partner, who provided that information to Police, observed James to be acting highly erratically, appearing heavily intoxicated, and paranoid.
- 21. At around 1pm, James climbed onto a balcony at 49 Melbourne Street, South Brisbane, carrying a plastic bag. When confronted by staff at a nearby business, he told them he was looking for a bathroom. He was directed to a public bathroom which he entered.
- 22. Whilst in the bathroom, James removed light fixtures and used a sanitary bin to climb into the ceiling. Once inside, he crawled approximately two metres, before falling through the ceiling into a staff area in Woolworths. This occurred approximately one hour after James had entered the bathroom.
- 23. A Woolworths employee described what occurred next:

"A ceiling tile came loose and a man's legs came down with it. I saw a man holding himself up in an attempt to not fall and we got up to help him. I tried to help him down but he kicked out at me. I got a small stool for him to step down onto and when he got down he aggressively pushed out at me with an open palm."
- 24. Two other Woolworths employees were present. One filmed the incident, and the other contacted 000.
- 25. Police crew SR890, consisting of Senior Constable Susan Cowley and Constable Alistair North from South Bank police station, responded to the job. They attended Woolworths but by the time they had arrived, James had already left and could not be located. Senior Constable Cowley and Constable North continued to patrol the area.
- 26. Approximately one hour later, at 2:59pm, the Police Communications Centre received another 000 call. This time, it was a member of the public who reported (inter alia) an agitated man 'off his absolute nuts' stumbling around and walking in

front of the cars outside the Greek Club and looking like he was about to undo his pants and urinate on the footpath.

27. A code 2 job was created by the Police Communications Centre. The job recorded the following information:

*GREEK CLUB AND CONVENTION CENTRE, 26 EDMONDSTONE ST, SOUTH
BRISBANE, 4101
AIL RE VERY INTOX MALE
INF SAYS THERE IS AN AGITATED MALE PERSON INCREDIBLY INTOX, HAS
PULLED HIS PANTS DOWN NUMEROUS TIMES
INF STATES HE IS ACTING LIKE HE IS GOING TO JUMP IN FRONT OF A CAR
IT IS SCHOOL PICK UP TIME IN THE AREA, AND THE INF IS CONCERNED
FOR THE KIDS
POI DESC AS WHITE MALE, APPROX 6FT, FLITHY GREY-BLUE SHIRT,
DRAGGING A BAG*

28. Senior Constable Cowley and Constable North responded to the job and proceeded to the Greek Club in their Police van.
29. Both officers gave evidence that as James' identity was unknown at the time, they were unable to conduct any QPRIME checks on him. Had such checks been possible, the officers would no doubt have been apprised of James' Police history, warning flags, and known vulnerabilities – thereby allowing them to more fulsomely consider any potential risks and plan accordingly.
30. Notwithstanding the lack of information available to the officers, Constable North gave evidence that, in his mind, they would be responding to a 'drug-affected or mental health-affected person'. Senior Constable Cowley gave similar evidence, and in doing so, said this:

"So, my risk assessment at the time is that I'm not – with jobs, I don't think there's ever a routine job because the complexities of scenes and human behaviour. So, I always tend to approach it as a – more of an unknown risk generally that we're not sure what we're going into, and that forms a threat assessment for me. So, for me at the time – well, we didn't know who that person was. Uh – I assessed that to be an unknown risk because we weren't sure what the background of this person, what the state of the person was..."

31. When the officers approached the Greek Club in their Police van, they observed James walking on the sidewalk and deactivated their van's lights and sirens. James was acting erratically and, in Senior Constable Cowley's opinion, was "quite agitated".
32. The officers drove past James and parked the van ahead of him. Before the officers had the chance to get out of the van though, James disappeared behind it. This is captured by CCTV footage from outside the Greek Club.
33. The CCTV also captured Constable North getting out of the van, at which point, the van's right-side rear door swung open. It is clear, based on the footage, that James had opened that door. This is consistent with Constable North's evidence that prior to exiting the van, he could hear noises coming from the rear of the van.
34. Once Constable North moved to the rear of the van, James very quickly lunged towards Constable North with his left arm outstretched and his right arm raised. This is evident from a review of the CCTV.

35. Constable North, whom I accept did not have an opportunity to activate his body-worn camera, told ESC investigators⁸ that James was holding a 'sharp implement' like a screwdriver or skewer in his right hand.
36. I pause here to observe that the implement, depicted below, consisted of a thin rod with a handle, measuring a total of 30 centimetres in length. The material the implement is made from, and what the implement would ordinarily be used for, remains unknown. In any event, for the purposes of these findings, I will refer to it as 'the weapon'.



37. When James lunged towards Constable North, Constable North tried to move backwards to create distance, but he tripped and fell onto the ground, landing on his left side. By this stage, Senior Constable Cowley had exited the van and activated her body-worn camera. As to what transpired next, I place significant weight on the objective evidence contained in that body-worn camera footage.
38. After Constable North fell to the ground, James ran towards him, pointing and thrusting the weapon, and seemingly trying to stab Constable North while he lay on the ground. He was on his back trying to kick James away. Constable North told investigators and the court that he believed James was trying to stab (and possibly even kill) him with the weapon. Based on what the footage depicts of James at that point, I am satisfied that Constable North's belief was both honest and reasonable.
39. On seeing James' actions towards Constable North (who was still on his back on the ground), Senior Constable Cowley deployed her taser. The top probe made contact with James' left arm, however the lower probe lodged in his shirt. Accordingly, and where only one probe made contact with James' skin, there was an incomplete circuit, rendering the taser ineffective.
40. Following the unsuccessful deployment of the taser, Constable North managed to get James to the ground by kicking him. James fell onto the footpath and landed on his back.
41. As James fell, Senior Constable Cowley used both hands to grab the arm James was holding the weapon in. James managed to use his other arm to take the weapon, and he eventually caused Senior Constable Cowley to lose her grip and stumble backwards. She ended up in what is best described as a crouching position.

⁸ During his walkthrough interview which occurred on the same day as the incident.

42. Once in that position, Senior Constable Cowley drew her firearm and pointed it at James who was still on the ground. She discharged her firearm, firing a total of four shots at James.
43. Constable North, who by that stage was standing, also discharged his firearm, though he fired only one shot.
44. After James had been shot, Constable North, along with two members of the public, rendered first aid. The Queensland Ambulance Service then arrived, and James was pronounced dead at 3:30pm.
45. Approximately 30 seconds passed between Constable North getting out of the police van and James being shot. There is no doubt that this was a highly dynamic and rapidly evolving incident.

Autopsy results

46. Forensic pathologist, Dr Jennifer McCourt, performed an autopsy on James' body on 12 October 2022. She found his cause of death to be:
 - 1(a). Multiple gunshot wounds.
47. Having regard to the gunshot wounds, Dr McCourt observed that:
 - i. there were three entrance wounds to the left torso and two entrance wounds to the back;
 - ii. at least two of the gunshot wounds were independently lethal. One caused air to enter the spinal canal and skull, and the other resulted in three full thickness defects to the heart;
 - iii. one of the wounds was potentially survivable (with appropriate medical intervention); and
 - iv. the remaining two wounds were *potentially* lethal.
48. As to toxicology:

*“...testing showed **high levels of methamphetamine (0.77 mg/L)** and non-toxic levels of its metabolite amphetamine (0.07 mg/L) in post-mortem blood. Diazepam (0.26 mg/L; sedative/anxiolytic medication) and active metabolites nordiazepam (0.20 mg/L), oxazepam (<0.03 mg/L), temazepam (0.02 mg/L); gabapentin (8 mg/L; analgesic medication); amitriptyline (<0.01 mg/L; antidepressant medication) and the active metabolite nortriptyline (0.03 mg/L); and sildenafil (erectile dysfunction medication) were also present at non-toxic levels in post-mortem blood. Alcohol was not detected in blood, urine or vitreous humour. Gamma-hydroxybutyric acid (7 mg/L) was present at a level that is consistent with originating from post-mortem blood that is stored in fluoride-oxalate. Recreational use of gamma-hydroxybutyric acid cannot be ruled out.”*

Ethical Standards Command investigation

49. Detective Acting Sergeant Christian Els of the QPS Internal Investigations Group, ESC, investigated the circumstances surrounding James' death. He produced a detailed coronial report dated 18 February 2024.

50. Ultimately, Detective Acting Sergeant Els concluded that the use of lethal force by both officers was authorised, justified, reasonable, proportionate and appropriate, legally defensible, and tactically sound and effective. There was insufficient evidence to support a criminal prosecution or establish any breach of discipline or misconduct by either Senior Constable Cowley or Constable North.
51. Detective Acting Sergeant Els' investigation and findings were informed by body-worn camera and CCTV footage, civilian and police witness statements, walk-through interviews conducted with Senior Constable Cowley and Constable North, applicable QPS policies and procedures, forensic examination results, and information concerning James' personal circumstances and background (including his medical records). An 'operational skills and training opinion' regarding the use of lethal force by the officers was also obtained and considered. This is discussed below.

Consideration of the inquest issues

Appropriateness of the police actions on 11 October 2022

Use of lethal force

52. Where a Police officer uses their firearm, they must be able to clearly articulate why.⁹ Relevant factors in that regard include whether the officer's life, or the lives of others, were in immediate peril.
53. During their walk-through interviews and also when giving evidence at the inquest, Constable North and Senior Constable Cowley were asked to explain their threat assessments and decision-making with respect to James and their use of lethal force.¹⁰
54. Constable North, who was first advanced upon by James, articulated the following in this regard:
- i. James posed an "extreme" risk. The weapon he was brandishing was an "edged weapon" for the purposes of QPS use of force training. Although not knowing precisely what the weapon was, Constable North considered it could be used to stab him and cause grievous bodily harm or even death.
 - ii. James was directing the weapon towards Constable North's face and torso, leading Constable North to believe James was trying to kill him.
 - iii. Constable North did not have a chance to create sufficient distance between himself and James so as to tactically reposition. James' "persistence" limited any such opportunity.
 - iv. During the struggle between James and Senior Constable Cowley, Constable North was concerned James was going to stab Senior Constable Cowley. Constable North described Senior Constable Cowley as "fighting for her life" and at one point, believed she had in fact been stabbed.

⁹ OPM, chapter 14.7.

¹⁰ As per the QPS Situational Use of Force Model.

- v. OC spray was not an available option because, firstly, James presented as being under the influence and was clearly trying to kill them, and secondly, a taser had already been used and was ineffective. He made the decision to use lethal force after forming the view that James was going to injure or kill Senior Constable Cowley.
 - vi. James was not listening to verbal commands. His motivation was clear. There was nothing that stopped him or altered his behaviour.
55. Senior Constable Cowley articulated her threat assessments and decision-making in this way:
- i. On getting out of the van, she heard Constable North saying words to the effect of “He’s stabbing me” or “He’s trying to stab me”. Constable North sounded very “heightened”. When she gained sight of the struggle between James and Constable North, she observed that Constable North had fallen over and “James was quite aggressive...he had both hands raised over his head.” Her threat assessment at this point was that Constable North was at risk of serious injury and so she drew her taser. She had not yet seen the weapon.
 - ii. Upon seeing the weapon, she observed it to be a “very thin metallic object” that, had it been used with force and directed to the neck or chest area, would likely cause grievous bodily harm or death. This presented a high risk.
 - iii. Although she would have been justified in presenting her firearm at that point, she elected to use her taser to “try and resolve things safely and with a minimum amount of force...” She had hoped the taser would be effective in de-escalating the situation and by giving Constable North an opportunity to get onto his feet.
 - iv. When the taser proved ineffective, she sought to restrain James until Constable North got to his feet. The intention being that they would both then restrain and disarm James.
 - v. OC spray would not have been appropriate because James was agitated and heightened, so it may have been ineffective. There was also a risk of spraying Constable North. Had she used this option and it was ineffective, there was an unacceptable risk that James could escape and harm a member of the public.
 - vi. When she was struggling with James on the floor, she heard Constable North repeatedly commanding James to drop the knife.
 - vii. At the time of discharging her firearm, she believed she was at risk of being stabbed and was in fear for her life.
56. Senior Sergeant Tracy Bailey, former Training Operations Coordinator, of the QPS Operational Training Services, and qualified Police Operational Skills and Tactics instructor, reviewed the use of force use by the officers on 11 October 2022 and provided a comprehensive opinion as part of the ESC investigation. In doing so, she attended the incident scene and reviewed the available body-worn camera footage, dashcam footage, CCTV footage, walk-through interview recordings, and the officers’ service histories.

57. Having regard to James's aggressive threats, his refusal to comply with directions, and the very little time the officers had to react to the situation, Senior Sergeant Bailey classified James as a high-risk person who posed a real threat to both officers. Overall, she categorised the incident as 'high-risk' with an imminent risk of serious physical harm. She agreed with the officers' threat assessments and determined that those assessments were conducted in accordance with established QPS policy, training, and doctrine.
58. As to the use of force by the officers, she gave evidence that due to a reasonable apprehension of imminent death or grievous bodily harm, the officers were acting in self-defence and their decision to use lethal force was not only appropriate and in accordance with training and policy, but it was the most tactically sound and effective response available. The situation they encountered was an "extremely difficult" one.
59. When asked whether any less than lethal force options were available to the officers having regard to the Situational Use of Force Model, Senior Sergeant Bailey gave the following evidence:
- i. There was no opportunity for the officers to communicate with James and attempt to de-escalate the situation.
 - ii. OC spray would not have been "reliably effective" because it does not immediately stop a person's actions. Furthermore, the presence and levels of drugs in a person's system can allow them to "fight through the pain".
 - iii. Using a baton against an edged weapon puts officers in an "unavoidable risk" and would therefore have been an inappropriate use of force to select.
 - iv. Closed hand tactics, in the context of an edged weapon, would have placed the officers at a very high risk of being injured or killed.
 - v. Once the struggle started, tactical repositioning was "out of the question".
60. I accept the opinions expressed and the evidence given by Senior Sergeant Bailey.
61. I also accept Counsel Assisting's submissions that, when examining the appropriateness of the actions of Constable North and Senior Constable Cowley on 11 October 2022, it is important to bear in mind two critical features associated with this particular incident:
- i. Firstly, the two officers were faced with many unknowns. Where James's identity was unknown, they had no ability to look him up on QPRIME and see his flags and police history. They had also not received any information about him being armed. In these circumstances, their ability to properly assess and plan for the risks they were presented with was somewhat hindered. As explained by Senior Sergeant Bailey during her oral evidence, an unknown person equates to an unknown risk.
 - ii. Secondly, this was a rapidly evolving and highly dynamic situation, the entirety of which occurred over only 30 seconds. Caution must therefore be exercised, and hindsight bias taken into account, when scrutinising

frame by frame every decision made by the officers, and every action taken.

62. There can be no doubt, based on the objective CCTV and body-worn camera footage, that James intentionally advanced towards Constable North and persistently attempted to attack him using the weapon. Then, when Senior Constable Cowley intervened, James sought to attack her. It is clear, from the body-worn camera footage, that James was highly agitated and motivated in this regard.
63. During the inquest, the parties were given the opportunity to inspect the weapon James had in his possession on the day he died. I also inspected it. That inspection confirmed that the weapon measured 30 centimetres in length (including the handle). The weapon was not, however, made of metal, and a manual handling of the weapon revealed that it was, surprisingly, light in weight. It remains unclear as to what the weapon was made of and what function it performed.
64. Counsel for the family did not make any submissions about what the inspection of the weapon revealed and I was not invited to make certain findings in that regard. This was an appropriate position for counsel to take. Irrespective of the weight of the weapon and the material from which it was made, I am satisfied that the officers' perceptions about the risks posed by the weapon were both real and valid. I am also satisfied that if used forcefully enough, the weapon had the potential to cause grievous bodily harm or death.
65. I am satisfied that where the deployment of a taser had proved ineffective, and where James continued to pose a real risk of grievous bodily harm or death to both officers, no less than lethal use of force options were available and so the officers had no choice but to use lethal force. In such circumstances, I am satisfied that the use of lethal force by both Constable North and Senior Constable Cowley on 11 October 2022 was appropriate and no adverse comments or findings are made in this regard.

Whether there was a missed opportunity

66. During closing submissions,¹¹ counsel for the family directed me to the moment Senior Constable Cowley discharged her firearm and raised the possibility of a missed opportunity in this regard.
67. Senior Constable Cowley's recollection of the moments immediately preceding her discharging the firearm was, essentially, that following her physical struggle with James, she came to be on her knees with her backside "effectively" on the ground. James was in a position higher to her, with his torso and arm above Senior Constable's neck height, and he had the weapon raised above her head. Senior Constable Cowley also said she thought James had one bent knee – "potential for him to have raised up on that knee and have had sufficient momentum to...continue forward..."
68. When asked about her threat assessment at that point, Senior Constable Cowley gave the following evidence:

¹¹ Both oral and written.

“...his change in position and raising it above his head in a manner that gave me the belief that he was going to stab me – that has prompted me to change my risk assessment and draw my firearm.”

69. Counsel for the family submitted that, contrary to Senior Constable Cowley’s recollection, when she discharged her firearm, James was not in the position she had described. Rather, the body-worn camera footage shows that:

- i. James was “in a supine position on the ground, his shoulders were on the ground, his legs were closest to the officer, and the implement was in his left hand”;
- ii. Senior Constable Cowley had “one foot on the ground with a bent knee, and the other was kneeling on the ground, in a position to stand”;
- iii. James had limited ability to “reach” Senior Constable with the weapon; and
- iv. Senior Constable Cowley fired “the last of the shots” while walking backwards.

70. It is submitted that these circumstances presented an opportunity or “avenue that could have resulted in these fatal shots not being fired” and it was contended by counsel that “there was an opportunity here, when looked at objectively, for tactical repositioning to change the risk profile”. It is said that the “missed opportunity” in this case was Senior Constable Cowley’s “opportunity to move backwards.”

71. In the written submissions made on behalf of the family, counsel points to “two stark lessons” arising from the evidence in this matter – firstly, “in the heat of a moment, tactical repositioning may be as simple as stepping back”, and secondly, “the effects of the adrenaline rush in such a circumstance can lead to substantial interference with situational awareness.”

72. When it was suggested to Senior Constable Cowley, during cross-examination, that it was possible for her to “take a few further steps back”, she disagreed.

73. Senior Sergeant Bailey also gave evidence about any options to tactically reposition. In response to Counsel Assisting’s questions, she said once the struggle started, tactical repositioning was “out of the question”.

74. During cross-examination by counsel for the family, Senior Sergeant Bailey was taken to the footage captured by Senior Constable Cowley’s body-worn camera and asked whether Senior Constable Cowley moving backwards from James was a “tactical repositioning option”. Senior Sergeant Bailey, who had examined the footage for the purposes of her use of force opinion, told the court that it may have been an option if Senior Constable Cowley was standing.

75. Counsel then asked Senior Sergeant Bailey whether “producing the firearm in order to effectively show the use of force without using it to attempt compliance” was an option. Senior Sergeant Bailey explained that to “have any sort of compliance”, time and distance is needed. In Senior Constable Cowley’s case, if she “was on her feet and could make distance very swiftly, that may have been an option, but for this instance, it was not”.

76. I have considered all submissions made on this point, and I have carefully scrutinised the evidence (particularly the body-worn camera footage and opinions of Senior Sergeant Bailey).
77. In terms of factual findings, I accept the family's description of how James was positioned at the time the officers discharged their firearms. Specifically, I find that, contrary to Senior Constable Cowley's recollection (of which I am not critical), James was on the ground on his back and not in a position higher than Constable Cowley. Notwithstanding this, he did have the weapon raised and poised in Senior Constable Cowley's direction,¹². I remain satisfied that he continued to present a risk of death or grievous bodily harm to the officers and that the decision to use lethal force in that moment was appropriate.
78. In relation to Senior Constable Cowley's positioning, I have concluded that the footage corroborates the description given on behalf of the Commissioner, namely:
- "...that all 3 shots fired by SC Cowley occurred while she was still crouched on her haunches and the final projectile can be seen leaving her firearm as she rises from a crouching position to her feet. SC Cowley stands, releases her left arm from the firearm ... which she then uses to radio in, as she steps backwards and continues to hold her firearm in her right hand. The BWC footage highlights none of the shots fired by SC Cowley are fired as she is walking backwards"
79. As to whether there was a missed and potentially outcome-changing opportunity in terms of tactical repositioning by Senior Constable Cowley, I am mindful of the inherent dangers of evaluating Police conduct with the benefit of hindsight and the luxury of unlimited time to do so. The critical issue is one of reasonableness – a Police officer's conduct should be approached in a realistic manner and due consideration needs to be given "to the reality that the officer has to make decisions quickly, often in emergencies and under pressure."¹³
80. Hindsight bias cannot be overlooked in this case - it is necessary to consider the circumstances as they appeared, prospectively, to the two officers directly involved. With this in mind, and having considered the evidence, I do not accept the submissions advanced on behalf of the family. A finding that there was a missed opportunity is not reasonably open on the evidence.

Kicking of James' body

81. After James had been shot, he fell onto the pavement on his right-hand side with the weapon still in his left hand. Body-worn camera footage depicts Constable North kicking James shortly thereafter.
82. During Constable North's ESC interview, which occurred on the same day as the shooting, he said that prior to kicking James, Senior Constable Cowley had said words to the effect of "He's dead". Constable North also mentioned that James was not moving at that point.
83. Later, during that same interview, Constable North said this:

¹² Corroborated by Senior Constable Cowley's body-worn camera footage.

¹³ *Walker v Hamm* [2008] VSC 596.

“...he was still holding it um he was still gripping it um he was incapacitated like he wasn't uh, there was no kind of noise coming out of his ... uh mouth um there was no movement uh but he still had the knife in his hand kind of um resting on the kind of the gutter there, like that over the top. Uh Sue's, I can't remember what happened but um I've, I basically looked at him um gone well C-P-R time, we should do some first aid uh I've gone over um realised that he's still motivated from before, I don't think he's changed his opinion um I gave, gave him a kick um he didn't move so then I've um realised that the knife is kind of let loosely in his hands at that point and I've dragged him that way um like uh to the point where he's out of the gutter a bit uh and the knife is dislodged from his hand and fallen into the gutter. So he's no longer a threat at that point to me and my partner.”

84. During oral evidence and under cross-examination at the inquest however, Constable North said this about the kick:

“At that point – um – he was still armed. Um – the kick was to see whether he was still – uh – wanting to engage in – uh – in a fight – um – or try to attack us further. Um – and it was to assess a level of – uh – sort of consciousness. Um – and that's why I've – uh – given him a kick on the side, and then to dislodge the weapon.”

85. When it was put to Constable North during cross-examination at the inquest that the kick was unnecessary, he stated:

“Uh – no. Um – the – to get – to get care to the person, we need to make sure they're unarmed. We need to get – get the weapon out of them as quickly as possible as swiftly as possible, to then get into –um – first aid. And it wasn't a hard kick. It was a – it was a – it was a decent – um – uh – it was – it was – it was – there was force, but it wasn't – um – uh – done with any malice to cause injury. It was a – um – a check and a – um – of – of – to see, you know, his responsiveness – um – and also to potentially dislodge that – um – implement out of his hand. Um – which I needed to do – um – by dragging him away anyway.”

86. The versions provided by Constable North are clearly inconsistent. His contemporaneous version at the scene implies that he thought James was already dead when he kicked him. His explanation during the inquest, however, was that he kicked James to ascertain whether he still posed a threat – the inference being that James might still have been alive.

87. It was submitted by counsel for the family that Constable North's conduct in kicking James was inappropriate and, contrary to what Constable North said in his oral evidence, was more likely done out of frustration or adrenaline.

88. I have re-watched the footage of the kick. I have determined that the accurate sequence of events is this:

- After James is shot, Constable North uses his radio to request assistance, stating “We just shot someone. He just pulled a knife and tried to stab me and my partner...” At this point, James is lying on the ground motionless but still holding the weapon.
- Senior Constable Cowley, who still has her firearm pointed at James, then says “If you can hear me, do not move!” James continues to lie motionless.
- Constable North moves to James, kicks him and says “Drop the weapon!”
- Senior Constable Cowley also directs James to drop the weapon, at which point Constable North appears to roll James onto his back. It is not until

after this has occurred, that Senior Constable Cowley says “He’s dead, he’s dead”.

89. I accept what is objectively seen and heard on Senior Constable Cowley’s body-worn camera footage. On that basis, I have determined that Constable North’s evidence, as given during the inquest, is credible and reliable. I have reached the conclusion that Constable North was not certain James was dead. While the kick was more forceful than it likely needed to be, I accept the intention behind it, that is, that it was done to ensure James no longer posed a threat – particularly when the weapon was still in his hand.

Failure to separate

90. For completeness, I note that there was much discussion during the inquest concerning the failure of Constable North and Senior Constable Cowley to separate after the incident as recommended by QPS policy.
91. While I acknowledge that separation of Police officers involved in a critical incident (as this was) is certainly optimal and best practice, I make no adverse comments or findings on the failure to do so in this case.
92. This was Constable North’s first critical incident. A review of the body-worn camera footage clearly demonstrates that after the shooting, he was in a very heightened and adrenaline-fuelled state. He was panicked and distressed about the fact he had not activated his body-worn camera, and Senior Constable Cowley, as the senior officer, was trying to placate him.

Findings required by s45(2) of the Coroners Act 2003

93. I am required to find, as far as possible, the medical cause of the death, who the deceased person was, when, where, and how they died. As a result of considering all the evidence, including the material contained in the exhibits and the oral evidence heard during the inquest, I make the following findings:

Identity of the deceased –	James Michael Watson.
How he died –	James had long-standing substance abuse and mental health issues. In the 24 hours preceding his death, he had consumed Methylamphetamine, GHB, and prescription medications. Concerned by his erratic behaviour, members of the public contacted police. Upon the arrival of two police officers, James tried to attack them with a weapon. Taser deployment was ineffective and when James continued to attack the officers and disobey police directions, both officers shot him.
Place of death –	29 Edmondstone Street, South Brisbane, Queensland, 4101.
Date of death–	11 October 2022.
Cause of death –	Multiple gunshot wounds.

Comments and recommendations

94. In accordance with s46 of the Act, a coroner may, whenever appropriate, comment on anything connected with a death investigated at an Inquest that relates to the administration of justice, public health or safety or ways to prevent deaths from happening in similar circumstances in the future.¹⁴
95. In making such recommendations, I am not limited to recommendations to prevent an identical death, being those with identical injuries, but rather those deaths that occur in similar circumstances or like situations.
96. During oral submissions, counsel for the family ultimately submitted that I make a comment (not a recommendation) to the effect that the circumstances of James' death be used by the QPS for training purposes.
97. In response, and at the conclusion of the inquest, I foreshadowed making a recommendation along the following lines:

"The QPS consider using body-worn camera footage from police shooting incidents in the operational skills and tactics (OST) training and refresher training provided to officers. Additionally, QPS consider extracting still images from the footage to facilitate training on use of force options."

98. Conscious of the fact this may already be occurring, I invited written submissions on the topic. All parties accepted that invitation.
99. On behalf of the Commissioner, an addendum statement from Senior Sergeant Bailey was provided. That statement confirms that the QPS has been using body-worn camera footage from Police shootings in operational skills and tactics training since 2020. It was submitted that in those circumstances, the first component of the proposed recommendation is unnecessary. This does not seem to be in dispute, and I accept the submissions advanced by the legal representatives for the Commissioner and the individual officers in this regard.
100. As to the second component of the proposed recommendation, that is, the use of still images in training, I accept Senior Sergeant Bailey's evidence on this topic. She warns against the use of still images in a vacuum and highlights the limitations and dangers associated with doing so:

"...The still image represents a fraction of a second and does not account for the rapidly changing circumstances, the officer's perspective, or the potential threats perceived in real-time. As such, while stills can be a useful supplement to training, they should not be relied upon in isolation to assess decision-making in dynamic situations."

The dynamic and complex nature of police interactions, particularly in high-stress situations, requires training methods that reflect the reality of operational duties. Still images, while useful as supplementary tools, are inherently limited in their ability to convey the full context of rapidly evolving incidents. Relying on still images in isolation risks oversimplifying the nuanced decision-making processes that officers must engage in during critical incidents."

¹⁴ The power to make recommendations should be construed liberally. As Muir J confirmed in *Doomadgee v Clements* [2006] 2 Qd R 352.

101. In any event, counsel for the family has since clarified that the family is not in fact proposing that “the training rely on a single freeze frame or screenshot.” Rather, what the family seek is that the circumstances of James’ death “be used as a training tool to prevent the need to resort to lethal force in the future”. It is submitted that the circumstances be “viewed as a whole to explore the missed opportunities in the midst of dynamic and adrenaline-impacted interactions.” As I understand it, the suggestion that Senior Constable Cowley could have tactically repositioned is the “missed opportunity” being referred.
102. I agree with the submissions made on behalf of the Commissioner and the individual officers in response to the clarified submission advanced by the family. Put simply, the family’s proposed recommendation is predicated upon findings that: (1) Senior Constable Cowley missed an available tactical opportunity to avoid the use of lethal force and (2) had that not occurred, the outcome may have been different. As dealt with earlier in these findings, I have rejected the family’s submissions on this point.
103. I am satisfied that the QPS already use body-worn camera footage of critical incidents for the purposes of training. The specific incidents and footage selected for that training is a matter for the QPS. There is no evidence before me that this training method is inadequate and, in any event, the question of training was not an issue examined during this inquest.
104. I decline to make the comments and recommendations sought by the family.

Closing remarks

105. I extend my condolences to James’ family and friends.
106. I also acknowledge the toll that this incident has undoubtedly had on the Police officers and first responders involved.
107. I close the inquest.

Stephanie Gallagher
Deputy State Coroner
BRISBANE