

Report by the NSW State Coroner

**into deaths in
custody/police operations
for the year 2018.**

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for the year **2018.****

The Hon. Mark Speakman SC, MP
Attorney General and Minister for the Prevention of Domestic Violence
Level 15, 52 Martin Place
Sydney NSW 2000

12th April 2019

Dear Attorney General,

Section 37(1) of the Coroners Act 2009 ('the Act') requires that I provide to you annually, a summary of all deaths in custody and deaths in a police operation that were reported to a coroner in the previous year. Inquests are mandatory in such cases but many of those deaths that occurred last year have not yet been finalised. I have also included findings of those deaths which were reported in previous years but finalised in 2018.

I attach a hard copy and an electronic copy of the 2018 report.

Section 37(3) requires that you cause a copy of the report to be tabled in each House within 21 days of receipt.

The deaths in question are defined in Section 23 of the Act and include deaths that occur while the deceased person is in the custody of a police officer or in other lawful custody, or while the person is attempting to escape. Also included are deaths that occur as a result of police operations, or while the person is in or temporarily absent from a child detention centre or an adult correctional centre.

As you would appreciate, deaths in prisons have for centuries been recognised as sensitive matters warranting independent scrutiny. Similarly, deaths occurring as a result of police operations which include shootings by police officers, shootings of police officers and deaths occurring as a result of a police pursuit, also attract public and media attention.

The inquest findings referred to are available on the Coroners Court webpage at: <http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx>. Please do not hesitate to contact me if you wish to discuss any of the matters contained in the report or would like further details of any of the matters referred to.

Yours faithfully,

Teresa O'Sullivan
Acting NSW State Coroner

2018- Overall Summary in Brief

- A total of forty one (41) deaths subject to s.23 of the Coroners Act were reported to the State Coroner in the calendar year 2018. This figure represents a reduction of six (6) deaths from the previous annual report for the year 2017.
- Twenty seven (27) deaths in custody were reported in 2018 compared to twenty eight (28) reports in 2017.
- Fourteen (14) deaths from within a Police Operation were reported in 2018 compared to nineteen (19) reports in 2017.
- In 2018, the State Coroner and Deputy State Coroners completed a total of thirty six (36) s.23 inquests. An increase of ten (10) inquests from the year 2017. A further two inquests were suspended following the charging of persons in connection with the deaths.
- Twenty two (22) of the forty one (41) deaths reported in 2018 were as a result of natural causes.
- Deaths as a result of natural causes still remain the highest manner of death (over 50%) followed by hanging of which seven (7) deaths were recorded by this manner in 2018.
- Seven (7) Aboriginal deaths were recorded in 2018, an increase of two (2) deaths from 2017.
- Three (3) Aboriginal deaths occurred in custody and four (4) as a result of police operation. One (1) as a result of hanging, four (4) as a result of natural causes, one (1) as a result of a motor vehicle collision and one (1) as a result of a jump or fall.
- Forty (40) of the forty one (41) of the overall deaths were male.
- Of the twenty seven (27) Deaths in Custody, ten (10) were of inmates who were on remand or bail refused and seventeen (17) were of inmates serving a fulltime custodial sentence.
- Of the ten (10) inmates on remand or bail refused, four (4) died as a result of natural causes and six (6) died from non-natural causes.
- Of the seventeen inmates serving a fulltime sentence, thirteen (13) died as a result of natural causes and four (4) died as a result of non-natural causes.
- Of the forty one (41) deaths in total, thirty five (35) of the persons were over the age of thirty (30) years.
- Of the one (1) female death, this person died in a Police Operation as a result of a fall or jump and was aged under thirty (30).

STATUTORY APPOINTMENTS

Pursuant to *Section 22(2) of the Coroners Act 2009*, only the State Coroner or a Deputy State Coroner can preside at an inquest into a death in custody or a death in the course of police operations. The inquests detailed in this report were conducted before the following Senior Coroners:

NSW State and Deputy Coroners 2018

His Honour Magistrate LES MABBUTT

NSW State Coroner (Resigned State Coroner Appointment, December 2018)

1989	Police Prosecutor, Legal Services NSW Police Force
1997	Courts Co ordinator Chief Magistrate's Office Attorney General's Department
1999-2006	Executive Officer to the Chief Magistrate of NSW
2003	Admitted as Legal Practitioner NSW Supreme Court
2006	Appointed Local Court Magistrate
2013	Appointed Co ordinating Magistrate Central Local Court
2018	Appointed NSW State Coroner
2018	Appointed NSW State Coroner

Her Honour Magistrate TERESA O'SULLIVAN (A/State Coroner from December 2017)

Deputy State Coroner

1987	Admitted as solicitor of Supreme Court of QLD
1987-89	Solicitor, Legal Aid QLD
1989-90	Solicitor, Child Protection, Haringey Borough, London
1990	Admitted as solicitor Supreme Court of NSW
1990-97	Solicitor, Marrickville Legal Centre, Children's Legal Service
1998-03	Solicitor, Central Australian Aboriginal Legal Aid Service, Alice Springs
2003-08	Solicitor, Legal Aid NSW, Children's Legal Service
2008-09	Solicitor, Legal Aid NSW, Coronial Inquest Unit
2009	Appointed Magistrate Local Court NSW
2015	Appointed NSW Deputy State Coroner

Her Honour Magistrate PAULA RUSSELL

Deputy State Coroner, Glebe

- 1992 Admitted solicitor ACT Supreme Court
- 1992-3 Legal Aid Office ACT
- 1993-8 ACT Director of Public Prosecutions
- 1998-2000 Private Bar ACT
- 2000 Magistrate Local Court NSW
 - Children's Court 2002-3, 2010-16
 - Deputy State Coroner 2017-18

Her Honour Magistrate ELIZABETH RYAN

Deputy State Coroner

- 1986 Admitted as solicitor of Supreme Court of NSW
- 1986-1987 Solicitor, Bartier Perry & Purcell Solicitors
- 1988-2003 Litigation Lawyer, Commonwealth Director of Public Prosecutions
- 2003-2009 Managing Lawyer, Commonwealth Director of Public Prosecutions.
- 2009 Appointed a Magistrate, NSW Local Court
- 2017 Appointed a NSW Deputy State Coroner.

Her Honour Magistrate HARRIET GRAHAME

Deputy State Coroner

- 1993 Admitted as a solicitor of the Supreme Court of NSW
- 1993-2001 Solicitor at Redfern Legal Centre, Western Aboriginal Legal Centre & NSW Legal Aid Commission
- 2001-2006 Barrister
- 2006-2010 Lectured in Law (Various Universities)
- 2010 Appointed a Magistrate in NSW
- 2015 Appointed NSW Deputy State Coroner

His Honour Magistrate DEREK LEE

Deputy State Coroner

- 1997:** Admitted as a solicitor of the Supreme Court of NSW
- 1998-2002:** Solicitor, Office of the Director of Public Prosecutions (ODPP)
- 2002-2005:** Senior Solicitor, ODPP Special Crime Unit
- 2005-2007:** Solicitor, Legal Aid (Inner City Local Courts)
- 2007-2012:** Barrister
- 2012:** Appointed NSW Local Court Magistrate
- 2016:** Appointed NSW Deputy State Coroner

His Honour Magistrate ROBERT STONE

Deputy State Coroner, Newcastle Local Court

- 1977** Admitted as a solicitor of the Supreme Court of NSW.
- 1977-1979** Solicitor, Greaves Wannan and Williams of Sydney
- 1981** Solicitor, Conway McCallum & Co of Sydney
- 1982-1984** Solicitor, Mortimer Hendriks Griffin & Erratt of Wagga Wagga
- 1984-2012** Partner and from 2006 Chairman of Commins Hendriks Pty Ltd of Wagga Wagga. Accredited Specialist- Criminal Law and Personal Injury Law (from 1983). Accredited mediator. Extensive experience in litigation in a range of jurisdictions.
- 2012.** Appointed a Magistrate, NSW Local Court
- 2016.** Appointed a NSW Deputy State Coroner

CONTENTS

Introduction by the New South Wales State Coroner	7
What is a death in custody?	7
Intensive corrections orders	7
What is a death as a result of or in the course of a police operation?	8
Why is it desirable to hold inquests into deaths of persons in custody or police operations?	8
NSW coronial protocol for deaths in custody/police operations	9
Recommendations	12
Overview of deaths in custody/police operations reported to the New South Wales State Coroner in 2018	13
Deaths in custody/police operations which occurred in 2018	13
Aboriginal deaths in custody/police operations which occurred in 2018	14
Circumstances of deaths which occurred in 2018	15
Summary of individual cases completed in 2018	16
Appendices	
Appendix 1: Summary of deaths in custody/police operations currently before the State Coroner in 2018 for which inquests are not yet completed.	368

Introduction by the New South Wales State Coroner

What is a death in custody?

It was agreed by all Mainland State and Territory governments in their responses to recommendations of the Royal Commission into Aboriginal Deaths in Custody that a definition of a 'death in custody' should, at the least, include:¹

- the death, wherever occurring, of a person who is in prison custody, police custody, detention as a juvenile or detention pursuant to the *Migration Act 1958* (Cth);
- the death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper *care* whilst in such custody or detention;
- the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and
- the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

Section 23 of the *Coroners Act 2009* (NSW) expands this definition to include circumstances where the death occurred:

- while temporarily absent from a detention centre, a prison or a lock-up; and
- while proceeding to a detention centre, a prison or a lock-up when in the company of a police officer or other official charged with the person's care or custody.

It is important to note that in relation to those cases where an inquest has yet to be heard and completed, no conclusion can be drawn that the death necessarily occurred in custody or during the course of police operations.

This is a matter for determination by the Coroner after all the evidence and submissions have been presented at the inquest hearing.

Intensive Correction Orders

Where the death of a person occurs whilst that person is serving an Intensive Correction Order, such death will be regarded as a death in custody pursuant Section 23 of the *Coroners Act 2009* (NSW).

Corrective Services NSW has a policy of releasing prisoners from custody prior to death, in certain circumstances. This generally occurs where such prisoners are hospitalised and will remain hospitalised for the rest of their lives.

¹ *Recommendation 41, Aboriginal Deaths in Custody: Responses by Government to the Royal Commission 1992 pp 135-9*

Whilst that is not a matter of criticism it does result in a “technical” reduction of the actual statistics in relation to deaths in custody. In terms of Section 23, such prisoners are simply not “in custody” at the time of death.

Standing protocols provide that such cases are to be investigated as though the prisoners are still in custody.

What is a death as a result of or in the course of a police operation?

A death which occurs ‘as a result of or in the course of a police operation’ is not defined in the *Coroner’s Act 2009*. Following the commencement of the 1993 amendments to the *Coroners Act 1980*, New South Wales *State Coroner’s Circular No. 24* sought to describe potential scenarios that are likely deaths ‘as a result of, or in the course of, a police operation’ as referred to in Section 23 of the *Coroners Act 2009*, as follows:

- any police operation calculated to apprehend a person(s)
- a police siege or a police shooting
- a high speed police motor vehicle pursuit
- an operation to contain or restrain persons
- an evacuation
- a traffic control/enforcement
- a road block
- execution of a writ/service of process
- any other circumstance considered applicable by the State Coroner or a Deputy State Coroner.

After more than twenty years of operation, most of the scenarios have been the subject of inquests. The Senior Coroners have tended to interpret the subsection broadly. This is so that the adequacy and appropriateness of police response and police behaviour generally will be investigated where we believe this to be necessary. It is critical that all aspects of police conduct be reviewed notwithstanding the fact that for a particular case it is unlikely that there will be grounds for criticism of police.

It is important that the relatives of the deceased, the New South Wales Police Force and the public generally have the opportunity to be made aware, as far as possible, of the circumstances surrounding the death. In most cases where a death has occurred as a result of or in the course of a police operation, the behaviour and conduct of police is found not to warrant criticism by the Coroner’s.

We will continue to remind both the NSW Police Force and the public of the high standard of investigation expected in all Coronial cases.

Why is it desirable to hold inquests into deaths of persons in custody/police operations?

In this regard, I agree with the answer given to that question by former New South Wales Coroner, Mr Kevin Waller, as follows:

The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty,

and it is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion, and satisfies the community that deaths in such places are properly investigated².

I also agree with Mr Waller that:

In the public mind, a death in custody differs from other deaths in a number of significant ways. The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution.

When the death is by deliberate self-harm, the responsibility is seen to rest largely with the institution. By contrast, a civilian death or even a suicide is largely viewed as an event pertaining to an individual. The focus there is far more upon the individual and that individual's pre-morbid state.

It is entirely proper that any death in custody, from whatever cause, must be meticulously examined³.

Coronial investigations into deaths in custody are an important tool for monitoring standards of custodial care and provide a window for the making and implementation of carefully considered recommendations.

New South Wales coronial protocol for deaths in custody/police operations

As soon as a death in custody/police operation occurs in New South Wales, the local police are to promptly contact and inform the Duty Operations Inspector (DOI) who is situated at VKG, the police communications centre in Sydney.

The DOI is required to notify immediately the State Coroner or a Deputy State Coroner, who are on call twenty-four hours a day, seven days a week. The Coroner so informed, and with jurisdiction, will assume responsibility for the initial investigation into that death, although another Coroner may ultimately finalise the matter. The Coroner's supervisory role of the investigations is a critical part of any coronial inquiry.

Upon notification by the DOI, the State Coroner or a Deputy State Coroner will give directions for experienced detectives from the Crime Scene Unit (officers of the Physical Evidence Section), other relevant police and a coronial medical officer or a forensic pathologist to attend the scene of the death.

The Coroner will check to ensure that arrangements have been made to notify the relatives and, if necessary, the deceased's legal representatives. Where aboriginality is identified, the Aboriginal Legal Service is contacted.

Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit and the Forensic Pathologist. The Coroner, if warranted, should inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during the inquest.

If the State Coroner or one of the Deputy State Coroner's is unable to attend a death in custody/police operations occurring in a country area, the State Coroner may request the local Magistrate Coroner to attend the scene.

²Kevin Waller AM. *Coronial Law and Practice in New South Wales, Third Edition, Butterworth's*, page 28

³Kevin Waller AM, *Waller Report (1993) into Suicide and other Self-harm in Correctional Centres*, page 2.

A high standard of investigation is expected in all coronial cases. All investigations into a death in custody/police operation are approached on the basis that the death may be a homicide. Suicide is never presumed.

In cases involving the NSW Police

When informed of a death involving the NSW Police, as in the case of a death in police custody or a death in the course of police operations, the State Coroner or the Deputy State Coroner's may request the Crown Solicitor of New South Wales to instruct independent Counsel to assist the Coroner with the investigation into the death.

This course of action is considered necessary to ensure that justice is done and seen to be done. In these situations Counsel (in consultation with the Coroner having jurisdiction) will give attention to the investigation being carried out, oversee the preparation of the brief of evidence, review the conduct of the investigation, confer with relatives of the deceased and witnesses and, in due course, appear at the mandatory inquest as Counsel assisting the Coroner.

Counsel will ensure that all relevant evidence is brought to the attention of the Coroner and is appropriately tested so as to enable the Coroner to make a proper finding and appropriate recommendations.

Prior to the inquest hearing, conferences and direction hearings will often take place between the Coroners, Counsel assisting, legal representatives for any interested party and relatives so as to ensure that all relevant issues have been identified and addressed.

In respect of all identified Section 23 deaths, post mortem experienced Forensic Pathologists at Lidcombe, Newcastle or Wollongong conduct the examinations.

Responsibility of the Coroner

Section 81 of the *Coroners Act 2009* (NSW) provides:

81 Findings of Coroner or jury verdict to be recorded

- (1) The coroner holding an inquest concerning the death or suspected death of a person must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so:
 - (a) the person's identity, and
 - (b) the date and place of the person's death, and
 - (c) in the case of an inquest that is being concluded—the manner and cause of the person's death.
- (3) Any record made under subsection (1) or (2) must not indicate or in any way suggest that an offence has been committed by any person.

Section 78 of the *Coroners Act 2009* (NSW) provides:

78 Procedure at inquest or inquiry involving indictable offence

This section applies in relation to any of the following inquests:

- (a) an inquest or inquiry held by a Coroner to whom it appears (whether before the commencement or during the course of the inquest or inquiry) that:

- (i) a person has been charged with an indictable offence, and
 - (ii) the indictable offence raises the issue of whether the person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.
- (b) an inquest or inquiry if, at any time during the course of the inquest or inquiry, the Coroner forms the opinion (having regard to all of the evidence given up to that time) that:
- (i) evidence is capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence, and
 - (ii) there is a reasonable prospect that a jury would convict the known person of the indictable offence, and
 - (iii) the indictable offence would raise the issue of whether the known person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.
- (2) If this section applies to an inquest or inquiry as provided by subsection (1)(a) the Coroner:
- (a) may commence the inquest or inquiry, or continue it if it has commenced, but only for the purpose of taking evidence to establish:
 - (i) in the case of an inquest—the death, the identity of the deceased person and the date and place of death, or
 - (ii) in the case of an inquiry—the date and place of the fire or explosion, and after taking that evidence (or if that evidence has been taken), must suspend the inquest or inquiry and, if there is a jury, must discharge the jury.
- (3) If this section applies to an inquest or inquiry as provided by subsection (1)(b) the Coroner may:
- (a) continue the inquest or inquiry and record under section 81(1) or (2) the Coroner’s findings or, if there is a jury, the verdict of the jury, or
 - (b) suspend the inquest or inquiry and, if there is a jury, discharge the jury.
- (4) The Coroner is required to forward to the Director of Public Prosecutions:
- (a) the depositions taken at an inquest or inquiry to which this section applies, and:
 - (b) in the case of an inquest or inquiry referred to in subsection (1) (b) - a written statement signed by the Coroner that specifies the name of the known person and the particulars of the indictable offence concerned.

Role of the Inquest

An inquest is an inquiry by a public official into the circumstances of a particular death. Coroners are concerned not only with how the deceased died but also with why.

Deaths in custody and Police Operations are personal tragedies and have attracted much public attention in recent years.

A Coroner inquiring into a death in custody is required to investigate not only the cause and circumstances of the death but also the quality of care, treatment and supervision of the deceased prior to death, and whether custodial officers observed all relevant policies and instructions (so far as regards a possible link with the death).

The role of the coronial inquiry has undergone an expansion in recent years. At one time its main task was to investigate whether a suicide might have been caused by ill treatment or privation within the correctional centre. Now the Coroner will examine the system for improvements in management, or in physical surroundings, which may reduce the risk of suicide in the future.

Similarly in relation to police operations and other forms of detention the Coroner will investigate the appropriateness of actions of police and officers from other agencies and review standard operating procedures. In other words, the Coroner will critically examine each case with a view to identifying whether shortcomings exist and, if so, ensure, as far as possible, that remedial action is taken.

Recommendations

The common-law practice of Coroners (and their juries) adding riders to their verdicts has been given statutory authorisation pursuant to Section 82 of the *Coroners Act 2009*. This section indicates that public health and safety in particular are matters that should be the concern of a Coroner when making recommendations.

Any statutory recommendations made following an inquest should arise from the facts of the enquiry and be designed to prevent, if possible, a recurrence of the circumstances of the death in question. The Coroner requires, in due course, a reply from the person or body to whom a recommendation is made. Acknowledgment of receipt of the recommendations made by a Coroner is received from Ministers of the Crown and other authorities promptly.

- Unavoidable delays in hearing cases
- The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases is at times unavoidable and there are many various reasons for delay.
- The view taken by the State Coroner is that deaths in custody/police operations must be fully and properly investigated. This will often involve a large number of witnesses being spoken to and statements being obtained.
- It is settled coronial practice in New South Wales that the brief of evidence be as comprehensive as possible before an inquest is set down for determination. At that time a more accurate estimation can be made about the anticipated length of the case.
- It has been found that an initially comprehensive investigation will lead to a substantial saving of court time in the conduct of the actual inquest.
- In some cases there may be concurrent investigations taking place, for example by the New South Wales Police Service Internal Affairs Unit or the Internal Investigation Unit of the Department of Corrective Services.
- The results of those investigations may have to be considered by the Coroner prior to the inquest as they could raise further matters for consideration and perhaps investigation.

Table 1: Deaths in Custody/Police Operations, for the period to 2018.

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	37
1996	26	6	32
1997	41	15	56
1998	29	9	38
1999	27	7	34
2000	19	20	39
2001	21	16	37
2002	18	17	35
2003	17	21	38
2004	13	18	31
2005	11	16	27
2006	16	16	32
2007	17	11	28
2008	14	10	24
2009	12	18	30
2010	23	18	41
2011	20	9	29
2012	20	21	41
2013	26	17	43
2014	14	13	27
2015	26	15	41
2016	16	21	37
2017	28	19	47
2018	27	14	41

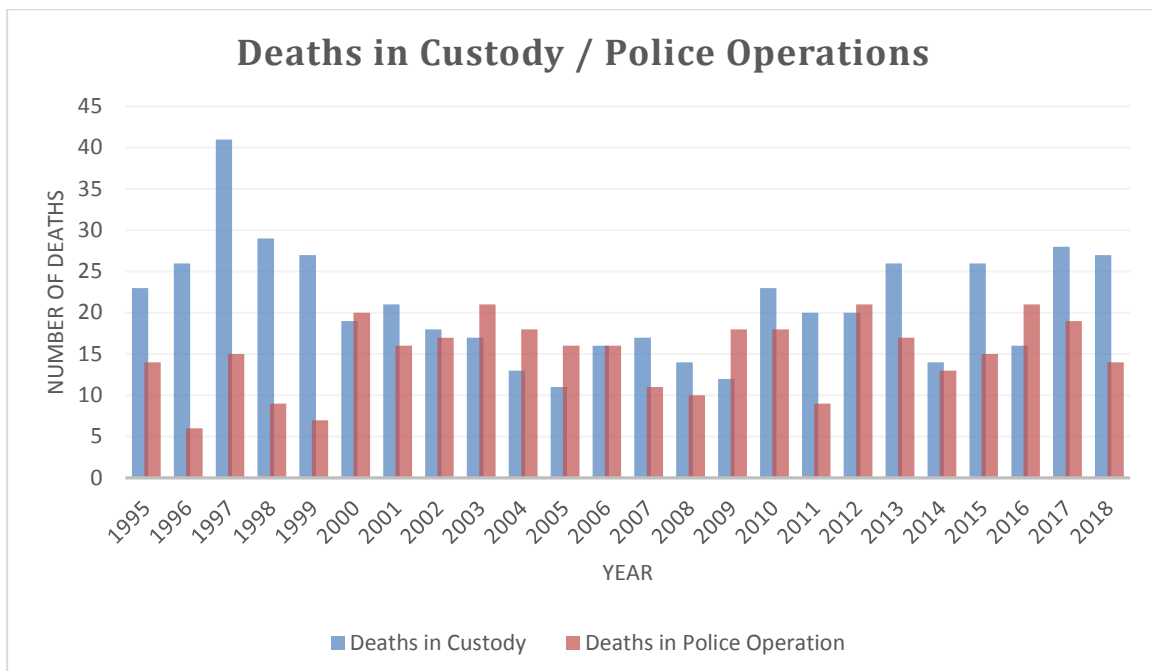
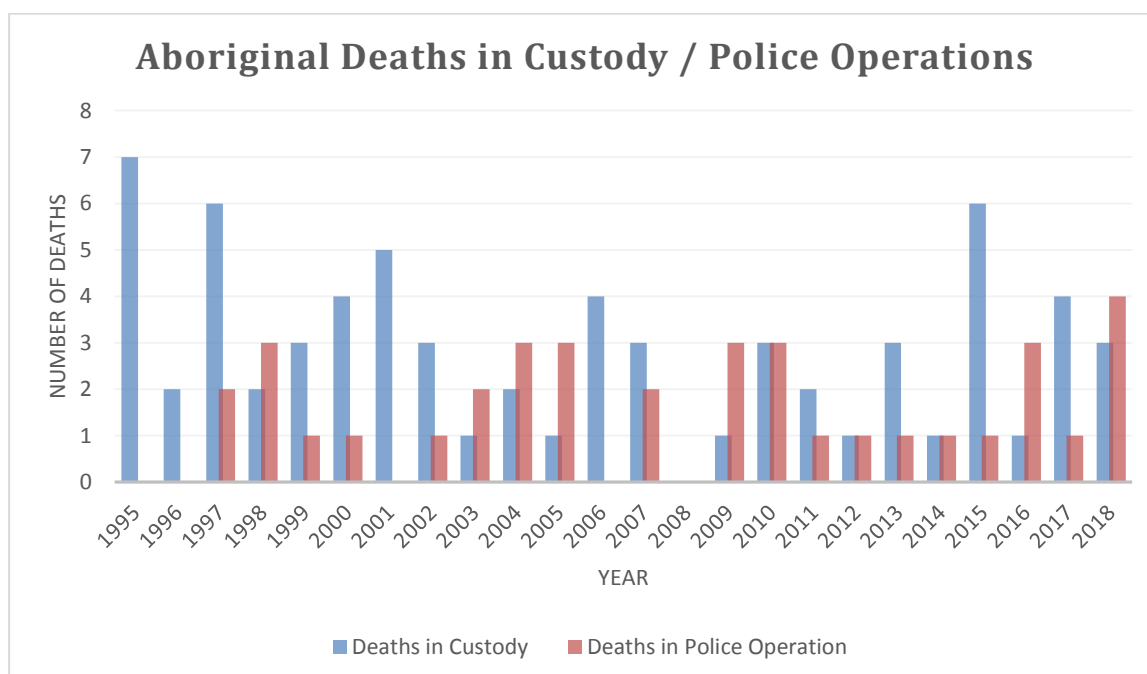


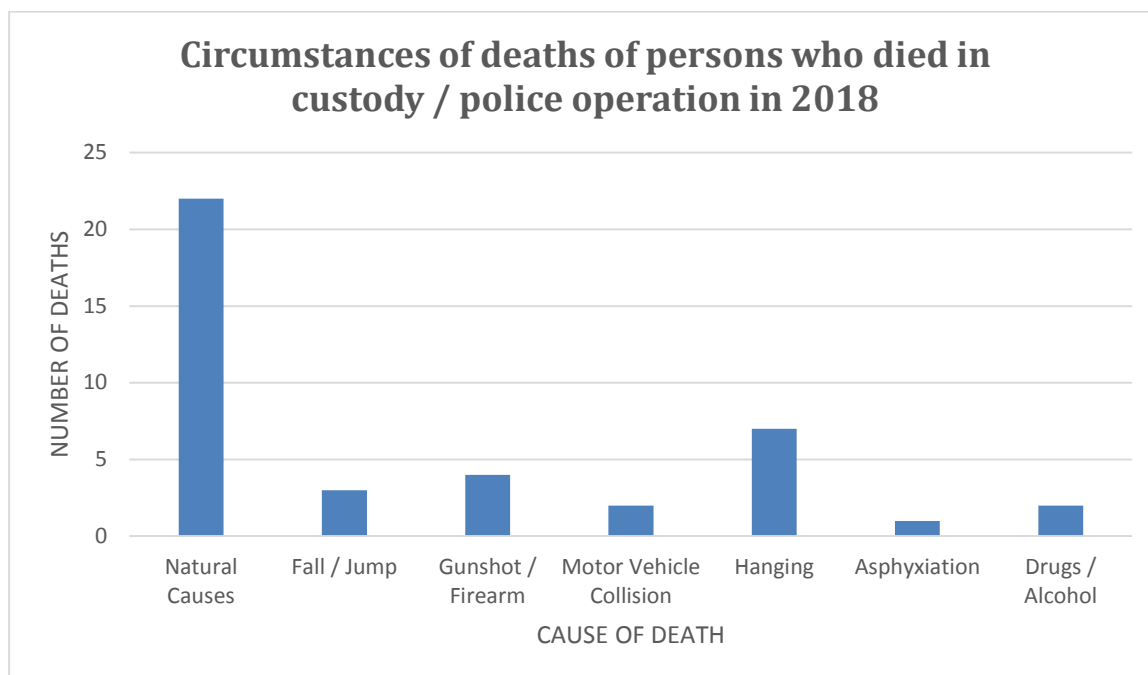
Table 2: Aboriginal deaths in custody/police operations 2018

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	7	0	7
1996	2	0	2
1997	6	2	8
1998	2	3	5
1999	3	1	4
2000	4	1	5
2001	5	0	5
2002	3	1	4
2003	1	2	3
2004	2	3	5
2005	1	3	4
2006	4	0	4
2007	3	2	5
2008	0	0	0
2009	1	3	4
2010	3	3	6
2011	2	1	3
2012	1	1	2
2013	3	1	4
2014	1	1	2
2015	6	1	7
2016	1	3	4
2017	4	1	5
2018	3	4	7



Circumstances of deaths of persons who died in Custody/Police Operations in 2018:

22 x Natural Causes
3 x Fall/Jump
4 x Gunshot/Firearm
2 x Motor Vehicle Collision
7 x Hanging
1 x Asphyxiation
2 x Drugs/Alcohol



SECTION 23 INQUESTS UNDERTAKEN IN 2018

Following are the written findings of each of the cases of deaths in custody/police operations that were heard by the NSW State Coroner or Deputy State Coroner in 2018. These findings include a description of the circumstances surrounding the death and any recommendations that were made.

Please note: Pursuant to Section 75(1) & (5) of the *Coroner's Act 2009* the publication of the names of persons has been removed where the finding of the inquest is that their death was self-inflicted, unless the Coroner has directed otherwise.

The deceased names pursuant to Section 75 (1) 7 (5) will be referred to as a pseudonym.

	Case No	Year	Name	Coroner
1	192526	2012	Mahmoud Hourii	DSC Lee
2	354840	2013	Sony William Tran-Bui	DSC Lee
3	6538	2015	Craig Daniel James Catley	DSC Ryan
4	23577	2015	Andrew Amos	DSC Russell
5	42730	2015	Courtney Topic	DSC Ryan
6	116507	2015	Richard Lewis	DSC O'Sullivan
7	125390	2015	GR	DSC Stone
8	139332	2015	Victor Russell	DSC O'Sullivan
9	155740	2015	MC	DSC Lee
10	265616	2015	Stephen Hodge	DSC O'Sullivan
11	268972	2015	FJT	DSC O'Sullivan
12	288035	2015	Ian McAuliffe	DSC Ryan
13	336444	2015	Carmelo Disano	DSC Lee
14	1459	2016	Saker Mohamed	DSC O'Sullivan
15	71814	2016	Clifford Deas	DSC Russell
16	72079	2016	Geoffrey Richardson	DSC Lee
17	87470	2016	KS	DSC Lee
18	94829	2016	Richard O'Connor	DSC Grahame
19	149781	2016	Ian Douglas Davidson	DSC O'Sullivan
20	151275	2016	Scott Bowden	DSC Ryan
21	199540	2016	Peter Woodcroft	DSC O'Sullivan
22	231300	2016	JM	DSC Lee
23	280295	2016	Laurence O'Connor	DSC Russell
24	291951	2016	Caillie Scott-Lewis	DSC O'Sullivan
25	347726	2016	MB	DSC Lee
26	371530	2016	HP	SC Mabbutt
27	5348	2017	Solomon Te Kohekohe Shortland	SC Mabbutt
28	39999	2017	Michael Clark	DSC O'Sullivan
29	63039	2017	Neville Betteridge	SC Mabbutt
30	76969	2017	Michael Joyce	DSC O'Sullivan
31	95138	2017	Ian Turnbull	DSC Lee
32	199884	2017	Zaydoun Al Qaser	Suspended
33	312005	2017	Jaland Small	Suspended
34	327738	2017	Kenneth Johnstone	DSC Russell
35	350282	2017	Jamie Walker	SC Mabbutt
36	358109	2017	Stephen John	SC Mabbutt

1. 192526 of 2012

Inquest into the death of Mahmoud Hourri. Finding handed down by Deputy State Coroner Lee at Glebe on the 26 October 2018.

Introduction

Mr Mahmoud Hourri died at Prince of Wales Hospital on 19 June 2012. At the time Mahmoud was in lawful custody, serving a sentence that had been imposed some years earlier. In May 2012 Mahmoud was transferred to hospital following deterioration in his condition related to gunshot injuries that he had suffered in 2002.

Why was an inquest held?

Under the *Coroners Act 2009 (the Act)* a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This is so even when the death of a person in lawful custody believed to be due to natural causes.

Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

Mahmoud's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most.

Therefore it is extremely important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

Mahmoud was born in 1984 and grew up in the Sydney suburb of Bankstown. He was the oldest of six siblings and was particularly close to his sister, Fatma. Mahmoud suffered from learning difficulties and, as a result, struggled with his studies at school from a young age. However, Mahmoud enjoyed taking part in sports activities at school and did well at them. He was a keen follower of the Canterbury rugby league team. Mahmoud was also an excellent soccer player and during his later years, according to Fatma, had attracted the interest of some higher grade soccer clubs.

Although he did not finish high school, Mahmoud always intended to do so. At the time of his incarceration Mahmoud was enrolled in a TAFE course to study marine mechanics. Mahmoud also had aspirations to eventually study in the fields of economics and management.

Tragically, Mahmoud's life was prematurely cut short at the age of 27. There is no doubt that Mahmoud was, and still is, loved by his parents and siblings, and is greatly missed. Mahmoud's parents and sister, Fatma, attended the inquest and each of the court appearances leading up to it. The grief which Mahmoud's death has brought them was plain to see. It is most upsetting to know that Mahmoud has been taken from them, and from the rest of his family, at such a young age.

Mahmoud's previous custodial and medical history

On 20 December 2003 Mahmoud was involved in an offence surrounding the attempted robbery of a petrol station. Mahmoud was armed with a weapon at the time and during the course of the offence, the console operator of the petrol station was fatally injured. Following a lengthy police investigation, Mahmoud was later arrested on 13 October 2005 and charged with the offence of murder.

Between the time of the offence in December 2003 and his subsequent arrest in October 2005, Mahmoud was involved in another offence. This occurred on 6 March 2004. During the commission of this offence Mahmoud was shot by a security guard, resulting in serious injuries to his chest. He was later taken to St George Hospital where surgery was performed. This resulted in the removal of Mahmoud's spleen and one of his kidneys. As a result of the gunshot injuries Mahmoud was rendered paraplegic.

Following his conviction for the December 2003 offence, Mahmoud was sentenced on 14 June 2007. He received a term of imprisonment of 18 years, with a non-parole period of 12 years and 6 months. Taking into account time spent in custody prior to being sentenced, Mahmoud was eligible for release to parole on 12 April 2018.

After being received in the custody of Corrective Services NSW (**CSNSW**) Mahmoud was initially housed at the Metropolitan Remand and Reception Centre. He was later transferred to correctional centres at Parklea and then Goulburn.

Between July 2006 and August 2008 Mahmoud attempted self-harm on a number of occasions. He was commenced on antidepressant and antipsychotic medication. On occasion, Mahmoud was transferred to Long Bay Hospital for mental health care and treatment.

On 21 August 2008 Mahmoud experienced an acute serious medical event resulting in his transfer to hospital. Surgery was performed the following day resulting in the resection of Mahmoud's small bowel. This led to Mahmoud being commenced on Total Parenteral Nutrition (TPN), a method of supplying a person with their nutritional needs intravenously, and thereby bypassing the usual process of eating and digestion. The circumstances surrounding the events of 21 August 2008 are discussed in more detail below.

Between 2009 and 2012 Mahmoud had multiple admissions to Prince of Wales Hospital for treatment of sepsis and central catheter line changes, pancreatitis, fungal septicaemia, jaundice and hepatitis, blood transfusions and intravenous antibiotics. Mahmoud was particularly susceptible to infections due to his need for TPN, and as a consequence of his injuries associated with his gunshot wound.

What happened in May and June 2012?

On 7 May 2012 Mahmoud was transferred to Prince of Wales Hospital for the final time, for treatment of sepsis. After having been diagnosed with kidney stones in March 2012, Mahmoud underwent lithotripsy (a treatment using sound waves or laser to break up stones in the urinary tract) on 24 May 2012. Following this, Mahmoud was transferred to the Intensive Care Unit as he was found to be hypotensive and in need of inotropic support (medication used to manage heart conditions). Mahmoud later developed renal failure and received dialysis.

Mahmoud was under the care of Professor Andrew Lloyd, a consultant infectious diseases physician. Professor Lloyd wrote to Mahmoud's solicitors on 23 May 2012 and explained that Mahmoud had several serious medical conditions:

- He was a paraplegic with substantive muscle weakness and wasting, and loss of bowel and bladder control;
- He had short gut syndrome (problems related to absorption of nutrients due to loss of parts of the small intestine), having essentially lost all of his small bowel and a significant portion of his colon, and was entirely dependent on intravenous feeding (TPN);
- He had several episodes of osteomyelitis (bone infection) complicating pressure sores on his heels;
- He had a single kidney and recent obstruction with a stone and associated infection in that kidney causing acute renal failure;
- He had frequent episodes of septicemia (blood infection) associated with bacterial or fungal organisms in the bloodstream.

Ultimately, Professor Lloyd described Mahmoud's prognosis as being "*very poor*" and that any one of the episodes of infection might be fatal. Professor Lloyd described the trend as being one of deterioration and offered the opinion that there was 50% probability that Mahmoud would have a fatal infection in the next two to three years.

By 7 June 2012 it was noted that Mahmoud had developed a right pleural effusion (an unusual amount of fluid around the lung) and his condition continued to deteriorate. Mahmoud's treating team discussed end-of-life arrangements with him and he was transferred to the high dependency ward on 15 June 2012.

Further end-of-life arrangement discussions took place between Mahmoud, his family and the treating team. It was later decided on 19 June 2012 that Mahmoud would be placed on a palliative care pathway and that he was not for resuscitation, intubation or dialysis. At about 10:26pm on 19 June 2012, Mahmoud was found to be unresponsive in bed with no signs of life. In accordance with palliative care arrangements, no attempt at resuscitation was made and Mahmoud was pronounced life extinct.

It should be noted that in August 2016, Professor Lloyd expressed the opinion that he was *“not aware of any specific failures either at Corrective Services or at Prince of Wales Hospital that may have contributed to Mahmoud’s prolonged illnesses and ultimate death”*.

What was the cause and manner of Mahmoud’s death?

Mahmoud was later taken to the Department of Forensic Medicine in Glebe where Professor Johan Duflou performed an autopsy on 22 June 2012 by. Professor Duflou found that there was extensive evidence of prior injury, consistent with multiple gunshot wounds. In particular, Professor Duflou noted that there were large quantities of fluid found around the heart and lungs, and that there were changes consistent with renal failure and liver failure. Professor Duflou ultimately offered the opinion that the cause of Mahmoud’s death was multiple organ failure due to the consequences of multiple gunshot wounds to the body.

In order to understand the connection between the gunshot wounds Mahmoud suffered in 2002 and his death in 2012, an opinion was sought from Dr John Raftos, an emergency medicine physician. Dr Raftos expressed the following opinion:

“Mr Houri would not have developed the adhesions that caused the volvulus of his small bowel that led to his short bowel syndrome if he had not been shot and required laparotomy to remove his injured spleen and kidney. Similarly he would not have become paraplegic and had recurrent severe urinary infections if he had not been shot in the spine. Therefore it is reasonable to say that his death was attributable to the consequences of the gunshot wounds to his abdomen and spine”.

Conclusion: Mahmoud died from multiple organ failure due to the consequences of multiple gunshot wounds he suffered in 2002. It is clear that the consequences of Mahmoud’s gunshot injuries made him more susceptible to natural disease process. Therefore, Mahmoud died from natural causes.

What happened on 21 August 2008?

Prior to the inquest, counsel for Mahmoud’s family raised in issue whether there was a causal connection between the surgery performed on Mahmoud in August 2008 and his eventual death in 2012. Further, an issue was raised as to whether Mahmoud was provided with appropriate care and treatment by Justice Health and Forensic Mental Health Network (**Justice Health**) staff on 21 August 2008. It is therefore necessary to more closely examine the events of that day.

On 21 August 2008 Mahmoud was housed at Goulburn Correctional Centre. According to the progress notes made by staff from Justice Health, Mahmoud activated his cell call alarm (commonly known within the correctional setting as “knocking up”) at about 3:35am, complaining of vomiting. A Justice Health nurse went to Mahmoud’s cell in response to the knock up.

On examination Mahmoud was found to be sitting on his bed, restless and hyperventilating. It became apparent that Mahmoud had vomited a small amount of liquid and some noodles into a bowl. Mahmoud's vital signs were taken and he was found to have a blood pressure reading of 138/76, pulse of 104 and his respiratory rate was 32.

Dr Mark Yee was the on-call medical officer on 21 August 2008. At about 3:35am he received a call for advice regarding Mahmoud's condition. He noted that Mahmoud had symptoms of vomiting but had normal vital signs and no fever. Dr Yee prescribed Maxolon, medication used for the treatment of nausea and vomiting, which was later given to Mahmoud. Following this, Mahmoud was moved to an observation cell and a note was made for him to be reviewed in the morning.

The Justice Health progress notes records the following entry relating to this interaction with Mahmoud:

"Inmate was again knocking up upon our arrival at the unit & stating he would kill himself if not seen. [On examination] inmate sitting on bed, restless & hyperventilating. A small amount of liquid [with] some type of noodle was in a bowl next to him and was the result of his vomiting".

RN Gail McLean assessed Mahmoud at 6:00am. She found that Mahmoud was complaining of abdominal pain just below the navel. She saw that Mahmoud had vomited some noodles onto the floor of his cell, but that there was no blood visible. She palpated Mahmoud's abdomen and noted that he had a full bladder but no guarding. RN McLean gave Mahmoud a catheter to self-catheterise (which he had done many times previously) and gave him some Panadeine for his abdominal pain. RN McLean measured Mahmoud's vital signs, which were all within normal limits, and made arrangements for him to be reviewed in the clinic later that morning.

Mahmoud later presented to the clinic at about 9:00am. He was complaining of abdominal cramping and pain to his abdomen, along with feeling lethargic and thirsty. RN Michael Harris took Mahmoud's vital signs which were within normal limits. RN Harris then made a call to the Justice Health ROBODOC service. In 2008 this was an on-call system which allowed for a full-time medical officer to be contacted during weekday business hours for medical advice. Phone calls made outside of weekday business hours were managed by an on call roster for doctors. The duty medical officer made an order for Buscopan, medication used to treat stomach and bowel cramps. Mahmoud was placed in the clinic for observation and rest. According to the progress notes it appears that Mahmoud was later given Buscopan at 11:00am and at that time it was recorded in the progress notes that he continued to tolerate water.

At 1:00pm Mahmoud was again reviewed by RN Harris. At that time it was noted that there was a significant deterioration in Mahmoud's condition. It was noted that his pulse was weak and thready. RN Harris contacted Dr Yee who recommended that immediate arrangements be made for Mahmoud to be transferred to hospital for further assessment and treatment.

At about 2:00pm paramedics arrived and conveyed Mahmoud to Goulburn Base Hospital. It was realised that the seriousness of Mahmoud's condition required him to be treated at a tertiary level hospital. Therefore, arrangements were made to transfer Mahmoud to Canberra Hospital. On arrival there Mahmoud was found to be in hypovolemic shock with metabolic acidosis. It was suspected, from x-ray results, that Mahmoud had a small bowel obstruction.

Surgery commenced at about 2:42am on 22 August 2008 during which it was identified that Mahmoud had extensive infarction (tissue death due to inadequate blood supply) of the entire small intestine, as well as of the right half of the colon. The cause of the infarction was a full 180 degree rotation volvulus of the root of the mesentery (a fold of membrane that attaches the intestines to the abdominal wall).

According to the report of the surgeon who performed the operation, *“the extent of intestinal infarction was initially deemed to be a non-survivable condition however, after careful discussion with anaesthetist, correctional facilities officer, and phone conversation with patients [sic] mother and father, it was decided to make an attempt at resection to see if the patient would survive”*. A laparotomy (surgical incision into the abdominal cavity) was performed, resulting in total small bowel resection with right hemicolectomy (removal of one side of the colon).

Following surgery Mahmoud was transferred to the intensive care unit where he remained until 23 August 2008 in a stable condition. Mahmoud was later transferred to the general ward. On 30 August 2008 Mahmoud was transferred to Prince of Wales Hospital.

Was appropriate care and treatment provided to Mahmoud on 21 August 2008?

In order to examine the appropriateness of the care and treatment provided to Mahmoud, opinion was sought from two experts. Dr Anthony Greenburg, a general and gastrointestinal surgeon, was briefed by the Coroners Court to provide a number of expert reports. Similarly, Justice Health made arrangements for Dr Christopher Vickers, a consultant gastroenterologist and hepatologist, to also provide a number of reports. Both Dr Greenburg and Dr Vickers gave evidence during the inquest.

A volvulus occurs when a loop of intestine twists around itself and the mesentery that supports it. This often results in bowel obstruction where the mesentery becomes so twisted that blood supply to the intestine is cut off, resulting in ischaemic bowel.

Dr Greenburg initially said that it was not clear what the underlying aetiology of Mahmoud’s volvulus was. He explained that small bowel volvulus involving the entire small intestine is, fortunately, a rare event. For this to happen, and to have the entire small bowel to have its entire blood supply interrupted, would be regarded as a catastrophic event.

However, he opined that *“the most likely cause of Mr Houris acute small bowel infarction (that led to the resection of the entire small bowel) was the result of adhesions”* following Mahmoud’s surgery in 2002 for his gunshot wounds. An adhesion is a band of scar tissue that joins two internal body surfaces that are not usually connected. Adhesions develop as the body attempts to repair itself. This normal response can occur after surgery or injury. They can cause a range of problems, including bowel obstruction and blockage. Dr Greenburg further opined in a subsequent report that *“irrespective of the cause the acute small bowel infarction was completely unpredictable and serendipitous and could not have been foreseen”*.

Ultimately, Dr Greenburg expressed the opinion that:

When Mahmoud was complaining about having abdominal pain, the severity of his intraabdominal pathology was not recognised, and Mahmoud was therefore misdiagnosed. In retrospect, the diagnosis was missed or not recognised by Justice Health staff on 21 August 2008; Letters written by Mahmoud after 21 August 2008 were consistent with him experiencing a serious intraabdominal event on that day.

Earlier transfer to Goulburn Hospital would have been appropriate; and the delay in reviewing Mahmoud until 9:00am on 21 August 2008 *“was significant and may have contributed to the ultimate outcome”*.

The two letters referred to by Dr Greenburg were written by Mahmoud on 19 February 2009 and 18 March 2009. In the first letter Mahmoud referred to events *“sometime in August”* 2008. He said that he felt *“very, very ill”* which prompted him to use the cell call alarm. Mahmoud said that whilst he waited to be seen by a Justice Health nurse, he *“started to feel more ill and the pain was worse than getting shot and I requested several times for a medical ambulance to go to the Hospital that’s how serious it was and it was only getting more worse as each time passed by”*.

In his second letter, Mahmoud wrote that he *“started to get very serious bad pain in the guts, the pain was unbearable and then [he] started to vomit a lot non-stop again and again. [He] could not stop vomiting and all along the pain in [his] guts was getting more worse [sic] and worse”*. Later in his letter, Mahmoud wrote: *“At around 8:00am I was in such bad shape I had to be put in a wheelchair to the in-house jail medical clinic to see the medical staff. I told them what had happened to me, all the symptoms and how I had fallen ill seriously that night. They said it could be food poisoning or a bad case of gastro bug so I was put in an observation cell for a few more hours until I then got more worse and sick and they finally decided to call an ambulance to go to the hospital after my continuous protesting that I needed urgent hospital [sic]”*.

Dr Vickers expressed the opinion that there was an appropriate duty of care present each time Mahmoud was assessed by Justice Health staff on 21 August 2008 at 3:35am, 6:00am, 9:00am and 1:00pm. In particular Dr Vickers opined that:

Mahmoud’s symptoms at 3:35am were consistent with a simple stomach complaint and anxiety, there was no report of abdominal pain, and it was reasonable for him to be moved to an observation cell in case he developed any further symptoms;

There was nothing about the 6:00am review which *“would indicate a serious medical event in evolution”* and Mahmoud’s symptoms were still consistent with an acute stomach complaint such as a common gastroenteritis;

At 6:00am a bowel obstruction related to gut volvulus would have produced profuse and bile- stained vomiting, however there was no bile-stained vomitus recorded, only noodles and possible (unwitnessed) blood;

At 9:00am Mahmoud’s blood pressure and pulse had actually improved and his *“examination showed no signs of serious concern”*l.

If Mahmoud actually had an evolving mesenteric volvulus since 3:35am then it would not be possible for his vital signs, blood pressure and pulse, to be normal six hours later. Instead, Mahmoud’s vital signs ought to have crashed and he would be *in extremis* (at the point of death).

By 1:00pm a clear and unexpected change had occurred, although the symptoms were still too early and non-specific to have predicted a calamitous event where Mahmoud would need surgery some hours later. In conclusion, Dr Vickers found that Justice Health staff *“found no acute surgical signs that warranted an upgrade in care for doctor call-back [or] for transfer to Hospital”*.

In response to the opinions expressed by Dr Greenburg, Dr Vickers opined that the symptoms that Mahmoud was displaying – abdominal pain with cramps, food only non-bilious vomiting, no abdominal tenderness – were common in the general population and not indicative of hospitalisation or requiring an extensive battery of tests. Dr Vickers opined that it was not reasonable for Dr Greenburg “to rely heavily on a subjective a posteriori letter from Mr Houry compared to the contemporaneous medical records of the Justice Health staff”.

Further, Dr Vickers referred to the fact that total mid-gut volvulus is a rare condition and difficult to diagnose. In support of this, Dr Vickers referred to an extract from academic literature which noted that, from a study of patients, in eight out of 11 cases a diagnosis of volvulus could not be made clinically, and only by CT scan. On this basis, Dr Vickers concluded that it was unreasonable for Dr Greenburg to refer to Mahmoud as being “*misdiagnosed*”.

In concurrent evidence given during the inquest, it was evident that Dr Greenburg took a more moderate view than the views expressed in his reports. He indicated that he and Dr Vickers had reached a consensus view and that Justice Health staff had demonstrated an appropriate duty of care to Mahmoud on 21 August 2008.

The only matter raised by Dr Greenburg was that, in his view, it would have been appropriate for Mahmoud to have been reviewed by a medical practitioner by 9:00am on 21 August 2008. However, in expressing this view, Dr Greenburg acknowledged that he was unfamiliar with the protocols involved in a correctional setting for such a review to take place. Further, Dr Greenburg acknowledged that even if such a review had occurred it was not possible to say whether Mahmoud’s intraabdominal pathology would have been detected.

Dr Greenburg repeated the view expressed in his report that the volvulus suffered by Mahmoud was a rare event and that it would have been difficult for an expert such as himself to detect, let alone a general practitioner (GP) attending as part of a medical officer review.

Dr Vickers acknowledged that, in his view, it would have been appropriate for Mahmoud to have been reviewed by a medical officer *at some stage* during 21 August 2008. In this regard, Dr Vickers drew an analogy between a person in the community who had experienced discomfort during the night calling a GP practice or medical centre the following morning to make an appointment to see a doctor later that day. Dr Vickers therefore expressed a contrary view to Dr Greenburg in the sense that he did regard that any of Mahmoud’s symptoms warranted Mahmoud being reviewed by a medical practitioner at 9:00am on 21 August 2008. In this regard, Dr Vickers repeated the opinion expressed in his reports that Mahmoud’s vital signs had actually improved by 9:00am and that his symptoms were consistent with a common stomach complaint.

Conclusion: The expert evidence established that the medical event experienced by Mahmoud on 21 August 2008 was rare and unpredictable. Studies in academic literature indicate that diagnosing the volvulus which Mahmoud suffered is exceedingly difficult, with a diagnosis only being made following CT imaging. Further, both Dr Vickers and Dr Greenburg indicated in evidence that in their combined experience of many years they had not seen another patient present with a condition similar to Mahmoud’s. Having regard to these factors it could not reasonably be said that on 21 August 2008 any Justice Health staff failed or diagnose, or misdiagnosed, the condition that Mahmoud was suffering from.

The letters written by Mahmoud in 2009 contained some descriptions of symptoms which, according to the contemporaneous progress notes, were not disclosed to the Justice Health staff assessing and treating Mahmoud on 21 August 2008.

It is most likely that Mahmoud was providing an accurate account in his letters of what he was physically feeling on 21 August 2008. Whilst these accounts are consistent with a serious intraabdominal event, as Dr Vickers noted these accounts do not appear to Justice Health staff. In particular the progress notes record no complaint of abdominal pain to have been communicated made by Mahmoud at 3:35am. There is no doubt that Mahmoud's letters would have been difficult and distressing for his family to read in retrospect. However, on the information available to Justice Health staff at the relevant time on 21 August 2008 Mahmoud was provided with appropriate care and treatment.

This is because the observations made of Mahmoud and the symptoms displayed and communicated by him at 3:35am, 6:00am and 9:00am were not clinically indicative of serious intraabdominal pathology. When there was an obvious deterioration in Mahmoud's condition by 1:00pm on 21 August 2008 there was an appropriate response by recognition of a medical emergency and escalation of Mahmoud's care. Given the improvement in vital signs by 9:00am, there was no clinical evidence to warrant Mahmoud being reviewed by a medical officer at that time.

Would earlier medical review prior to 1:00pm on 21 August 2008 have altered the outcome?

Dr Greenburg also expressed the view that although Mahmoud's *"prognosis was guarded and his situation grave, it is accepted that the earlier patients with severe small bowel ischaemia are diagnosed and operated upon, the more likely their chances of survival"*.

Dr Vickers hypothesised in his reports that even if Mahmoud had been transferred to hospital at 9:00am it would have meant his surgery would have occurred four hours earlier. However, he concluded that at this time *"the intestine would still have been substantially unsalvageable"* Dr Vickers noted that if it was assumed that the onset of vascular occlusion occurred at around 3:35am, at the sign of first symptoms, then total unsalvageable infarction of the gut occurred at 2:42am on 22 August 2008, some 24 hours later. This meant that if Mahmoud had surgery at 10:30pm, some 19 hours later, then the small difference of four hours *"would probably have made little difference given that the entire gut was dead by [2:30am]"*.

In evidence, Dr Vickers referred to the progress notes for 21 August 2008 and noted an entry which appeared to suggest that at 11:00am Mahmoud was able to tolerate water. In Dr Vickers' opinion this meant that the sudden decline in Mahmoud's condition occurred between 11:00am and 1:00pm, not between 9:00am and 1:00pm. This narrowing of time was significant because, in Dr Vickers' view, it meant that the first possible opportunity for Mahmoud to be transferred to hospital was sometime after 11:00am. If this had occurred, then it meant that the ultimate surgery could only have been performed two hours, and not four hours, earlier.

This shortening of a possible window of opportunity only reinforced in Dr Vickers' mind that earlier surgery would not have altered the outcome.

Dr Vickers also noted that Mahmoud was hypotensive at 1:00pm and that, in retrospect, this indicated the commencement of dead gut and endotoxaemia (endotoxins in the blood which may cause haemorrhages, necrosis of the kidneys, and shock). From this Dr Vickers opined that earlier surgery at 10:30pm may have salvaged little. Therefore, there would not have been sufficient viable small bowel length to avoid Mahmoud requiring long-term TPN. In evidence Dr Greenburg remained of the general view that a person suffering from an intraabdominal event had better prospects of a good outcome the earlier surgical intervention occurred.

However, Dr Greenburg acknowledged that in Mahmoud's case it was pure speculation whether earlier surgery would have allowed for his bowel to have been salvageable. Ultimately, Dr Greenburg expressed doubt that any earlier transfer to hospital would have made any difference to the outcome.

In this regard it should be noted that Dr Vickers opined that he did not think that the events in May and June 2012 "bear any direct consequence to the surgery in 2008". Dr Vickers explained that the cause of Mahmoud's death was renal failure due to chronic, and then acute, urosepsis from recurrent renal stones in his single kidney. This in turn was a consequence of the gunshot wounds suffered by Mahmoud where his kidneys were irreversibly damaged.

Conclusion: Even if Mahmoud had been reviewed by a medical officer at 9:00am on 21 August 2008, and it was recognised that he required urgent transfer to hospital, it is more probable than not that this would not have altered the outcome in any material way. This is because the evidence established that even if Mahmoud's surgery had taken place four hours earlier (around 10:45pm on 21 August 2008 instead of at 2:42am on 22 August 2008) by that time his intestine was unsalvageable. This, in turn, means that there would not have been sufficient viable bowel length remaining for Mahmoud to avoid TPN requirement. It should be noted that in evidence Dr Vickers explained that the surgery at Canberra Hospital was performed not to save Mahmoud's bowel but, rather, to save his life.

Further, the evidence suggests that Mahmoud's sudden decline occurred between 11:00am and 1:00pm on 21 August 2008. This then means that there was an even narrower timeframe within which surgery could have taken place. Logically, this means that there was even less likelihood for any of Mahmoud's bowel to be salvaged and, therefore, for the outcome to have been altered.

It should be remembered that regardless of the possible outcomes on 22 August 2008, the evidence established that there was no causal connection between the events of August 2008 and Mahmoud's ultimate death. The expert opinions expressed by Professor Duflou, Dr Raftos and Dr Vickers all establish that Mahmoud's multi-organ failure was a consequence of the gunshot wounds he suffered.

Should any recommendations be made?

In 2010 the Clinical Excellence Commission introduced the *Between the Flags* program.

This is a package which provides improved systems in managing deteriorating patients. Mahmoud's respiratory rate was noted to be 32 at 3:35am on 21 August 2008. According to *Between the Flags* policy, this measurement would have been in the red zone and triggered a rapid response.

It was submitted by counsel for Mahmoud's family that a recommendation should be made mandating that a Justice Health medical officer is to physically attend on an inmate patient and review them. It was further submitted that a doctor, with more training and experience than a nurse, would have been more likely to, in the words of counsel for Mr Hour's family, "pick up that something was not in order".

Conclusion: The available evidence does not establish that it is either necessary or desirable for a recommendation to be made pursuant to section 82 of the Act. This is because no clinical evidentiary basis has been demonstrated, either generally or specific to the events of 21 August 2008, for such a recommendation of the type submitted by counsel for Mr. Hour's family to be made.

It should be remembered that Justice Health nursing staff were in regular contact with on-call medical officers on 21 August 2008 and appropriately sought advice from them, and that Mahmoud's vital signs had actually improved by 9:00am. Further, it should be noted that the suggested recommendation advocated for by counsel for Mr. Hourí's family was vague and non-specific.

The evidence established that the medical episode experienced by Mr Hourí was rare and exceedingly difficult to diagnose. It further established that even if review by a medical officer (as opposed to nursing staff) had occurred prior to 1:00pm it was not possible to say whether earlier transfer to hospital would have occurred. Indeed, the evidence established that at least up until 11:00am on 21 August 2008 Mahmoud's symptomology was consistent with a common abdominal complaint not warranting hospitalisation.

Further, the introduction of the Between the Flags program since Mahmoud's death has created a safety net by which abnormal clinical findings in a patient's vital signs are escalated for appropriate clinical response. Although there was no direct evidence regarding this, it can be assumed that such a response would involve advice being sought from a medical officer. There is no evidence to suggest that, in such a scenario, a medical officer could not exercise appropriate clinical judgment so that it would be necessary to mandate their physical attendance on an inmate patient.

Findings pursuant to section 81 of the *Coroners Act 2009*

Before turning to the findings that I am required to make, I would like to acknowledge, and express my thanks to Mr Tim O'Donnell, Coronial Advocate, for his assistance both before, and during, the inquest. I also thank Detective Senior Constable Michael Roberts for his role in the police investigation and for compiling the initial brief of evidence.

Identity

The person who died was Mahmoud Hourí.

Date of death

Mahmoud died on 19 June 2012.

Place of death

Mahmoud died at Prince of Wales Hospital, Randwick NSW 2031.

Cause of death

The cause of Mahmoud's death was multiple organ failure due to the consequences of multiple gunshot wounds to his body.

Manner of death

Mahmoud died from natural causes whilst in lawful custody.

2. 354840 of 2013

Inquest into the death of Sony William Tran-Bui. Finding handed down by Deputy State Coroner Lee at Glebe on the 13th July 2018.

Introduction

Mr Sony William Tran-Bui was being held in lawful custody in a NSW correctional centre on the evening of 23 November 2013. He had been remanded in custody nine days prior. Earlier in the day Mr Tran-Bui had been reviewed by nurses working in the correctional centre and had been attended on by correctional officers in the evening after his cellmate had activated a call alarm. Unbeknownst to those involved in these interactions, during the course of the evening Mr Tran-Bui suffered a catastrophic gastrointestinal event that ultimately caused his death the following day.

Why was an inquest held?

Under the *Coroners Act 2009 (the Act)* a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the *Coroners Act 2009 (the Act)* makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure that the State discharges its responsibility appropriately and adequately. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

The coronial investigation into the death of a person is one that, by its very nature, occasions grief and trauma to that person's family. The emotional toll that such an investigation, and any resulting inquest, places on the family of a deceased person is enormous. A coronial investigation seeks to identify whether there have been any shortcomings, whether by an individual or an organisation, with respect to any matter connected with a person's death.

It seeks to identify shortcomings not for the purpose of assigning blame or fault but, rather, so that lessons can be learnt from such shortcomings and so that, hopefully, these shortcomings are not repeated in the future.

If families must re-live painful and distressing memories that an inquest brings with it then, where possible, there should be hope for some positive outcome. The recommendations made by Coroners are made with the hope that they will lead to some positive outcome by improving general public health and safety.

Mr. Tran-Bui's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Mr Tran-Bui's life.

At the conclusion of the evidence in the inquest the Court was privileged to be given some insight into the man, father, son and brother that Mr Tran-Bui was. Ms Anh Bui, Mr Tran-Bui's younger sister, and Ms Narelle Crowther, the maternal grandmother of Mr Tran-Bui's five children, spoke some heartfelt words and shared some painfully treasured memories of Mr Tran-Bui's life. The courage and dignity that they showed in doing so was humbling and I express my sincere gratitude and appreciation to them both for doing so.

Mr Tran-Bui was known to his family as Bo-Bo, or just Bo. Anh cannot recall how Mr Tran-Bui came by that nickname but, like most things in his life, he embraced it with gusto. Mr Tran-Bui arrived in Australia from Vietnam at a young age after experiencing many struggles in his youth. Through perseverance and determination he completed Year 12 and his Higher School Certificate. This was one of his parents' proudest moments. Anh recalls that to recognise the momentous occasion Mr Tran-Bui's parents gave their son a Walkman CD player with matching earphones. This gift was perfect for Mr Tran-Bui who was a lover of all music, from the hip-hop of Cypress Hill, Wu-Tang Clan and Tupac to classical music. Indeed, Mr Tran-Bui had reached accomplished levels in both piano playing and music theory.

Some eight years before his death, Mr Tran-Bui met his partner, Faye Forster. Whilst they experienced some difficult times, like any relationship, they also shared many wonderful moments together, especially later as a young family. Ms Forster's loving concern for Mr Tran-Bui's well-being upon his admission into custody was obvious. She visited him in custody just days before she would tragically have to attend Westmead Hospital in response to his collapse.

Mr Tran-Bui had many friends from all walks of life. No doubt they were drawn to his quick smile, sense of fun and caring nature. While the loss they feel must be great, the loss that Mr Tran Bui's partner, parents and family feel is immeasurable.

Whilst his parents were immensely proud of his academic achievements, Mr Tran-Bui's own proudest achievements were his five children: Tanh, Alex, Thomas, Lily and Grace. All five of Mr Tran-Bui's children were less than seven years old (and in Grace's case she had not yet been born) at the time of their father's death. It was therefore heartbreaking to hear the words spoken by Ms Crowther of the enormous void that has been created in the lives of Mr Tran-Bui's children due to the loss of their father.

It is sometimes easy to forget how seemingly everyday occurrences in life can sometimes cause painfully distressing memories for family members of a loved one, particularly so for children. It was upsetting to hear from Ms Crowther how Mr Tran-Bui's children become distraught when they see their cousins and friends going camping with their fathers and are unable to do so themselves; how Father's Day is a sensitive time for them; and how Tanh is unable to do something so simple as spend time with his father, amongst the other fathers and sons, after a football game.

Mr Tran-Bui was a loving father who is so greatly missed by Tanh; who shared a special bond with Alex (who he nicknamed, Ace) and went everywhere with him; who Thomas described as amazing; and who will never be able to share in and cherish his daughters' special moments in life. To those who knew him best and loved him the most, Mr Tran-Bui's life was enormously treasured and valued, and his death equally tragic and devastating.

Ms Forster, Ms Crowther, and Mr Tran-Bui's father and siblings were present in Court throughout the inquest. The enormous grief and loss that they have experienced, and continue to experience, along with other members of Mr Tran-Bui's family who were unable to be present in Court, should be acknowledged.

Background to events

On 14 November 2013 Mr Tran-Bui was arrested and charged in relation to a number of criminal offences. He was refused bail and remanded to appear at Burwood Local Court on 22 January 2014. On 15 November 2013 Mr Tran-Bui was taken to the Metropolitan Remand and Reception Centre (**MRRC**) at Silverwater.

Rochelle Abustan, a Primary Health Care Nurse, conducted a reception interview with Mr Tran- Bui when he arrived at the MRRC. RN Abustan became aware that Mr Tran-Bui had a recent history of drug and alcohol abuse, anxiety, depression and asthma and completed a Health Problem Notification Form (**HPNF**). It was noted during the interview that Mr Tran-Bui was displaying withdrawal symptoms in the form of vomiting, cramps, moodiness, and flu-like symptoms. RN Abustan made appointments for Mr Tran-Bui to be reviewed by a drug and alcohol nurse, a mental health nurse, and a chronic care nurse.

Ms Abustan noted that Mr Tran- Bui was not exhibiting any signs of withdrawal during her assessment, that his vital signs were within normal limits, and that he appeared "*comfortable, calm and cooperative*". At the conclusion of the interview, RN Abustan made the following notation in Mr Tran-Bui's progress notes: "*HOLD in Darcy until cleared by Detox*". This instruction meant that Mr Tran-Bui was to be housed in the Darcy pod until he had been reviewed by a drug and alcohol nurse.

RN Yang Guo later performed an initial drug and alcohol assessment the following day, 16 November 2013. RN Guo and RN Elaine Poynter reviewed Mr Tran-Bui again on 17 November 2013. At this time they noted that all of Mr Tran-Bui's vital signs were within normal parameters, although he was displaying some minor symptoms (tremor in his extremities) of alcohol withdrawal.

The next morning, RN Poynter reviewed Mr Tran-Bui again in order to monitor the progress of his opiate withdrawal. RN Astrid Munoz later performed a mental health review on 20 November 2013. On the same day Mr Tran-Bui was cleared from detox resulting in his transfer from Darcy pod to Goldsmith pod on 21 November 2013.

21 November 2013

On the evening of 21 November 2013 Mr Tran-Bui was in a cell with another inmate. At about 9:45pm the inmate activated a cell alarm for Mr Tran-Bui to receive medical attention. Corrective Services NSW (CSNSW) officers responded to the cell alarm and in turn alerted RN Margaret Matambanadzo that Mr Tran-Bui was experiencing a medical issue.

RN Matambanadzo attended on Mr Tran-Bui and saw that he was lying in his bed and complaining of lower back pain. RN Matambanadzo examined Mr Tran-Bui and found that he was diaphoretic (sweating heavily) but with nil respiratory distress and no complaint of chest pain. Mr Tran-Bui described his pain as being 5 out of 10. He was offered a wheelchair to be taken to the main clinic, but he refused the offer and instead made his own way there.

RN Natalie Boorer reviewed Mr Tran-Bui in the clinic. She noted that Mr Tran-Bui was sweating heavily, had goosebumps and was shivering intermittently.⁶ RN Boorer noted that Mr Tran-Bui's vital signs were within normal parameters, that he had a history of heavy daily alcohol use and that his last drink was one week prior. She also noted that Mr Tran-Bui had been cleared from detox the previous day.

RN Boorer formed the view that Mr Tran-Bui's symptoms were likely the result of detoxing and she gave him 200mg of thiamine, charted as a standing order. She also gave Mr Tran-Bui 4 tablets of Panadeine (with a further 2 tablets to take overnight) and told him to notify nursing staff if his pain persisted or if he had any other symptoms after he returned to his cell. RN Boorer also placed Mr Tran-Bui on the detox waitlist so that he could be seen the following morning by drug and alcohol staff.

23 November 2013

RN Poynter reviewed Mr Tran-Bui on 23 November 2013 after he had been complaining of sweating and goosebumps. RN Poynter took a history from Mr Tran-Bui in which he reported his past alcohol use and abuse of diazepam. He also told RN Poynter that he had had been feeling unwell since being transferred to Goldsmith Pod and that he had smoked some heroin, having last used the day before (22 November 2013).

Later that day, at about 2:00pm on 23 November 2013, RN Poynter called Dr Judith Meldrum (a general practitioner with a speciality in drug and alcohol treatment) as part of a routine review. According to notes taken by Dr Meldrum at the time, Mr Tran-Bui was described as appearing generally unwell.

Dr Meldrum asked if Mr Tran-Bui had any other conditions or symptoms to indicate the cause of his presentation but none were reported. Dr Meldrum prescribed diazepam for any residual alcohol, opiate, or benzodiazepine withdrawal. It was agreed that Mr Tran-Bui was to have his observations checked again at 5:00pm and that he should be transferred from Goldsmith pod to a medical observation cell in Darcy pod until cleared by detox.

RN Poynter completed a HPNF at about 2:11pm. The form contained instructions directed to CSNSW officers in the following terms:

Signs/symptoms to look for in the inmate: DCS officers – please monitor the inmate for the following signs and report any observations of these to JH staff so that they can address the health issue.

What signs/symptoms DCS officers need to look for: In withdrawal, paranoid thoughts. Observe for bizaar [sic] behaviour.

Later in the HPNF, the following further instructions were provided:

- **What the DCS officers need to do:** DCS officers – This inmate has special health needs that should be addressed. Please implement the recommendations specified below.
- What DCS officers need to do:
- Medical obs cell until clear by detox.

RN Nicole Keyes reviewed Mr Tran-Bui later in the day at about 5:15pm. She noted that his vital signs were normal and that he did not appear to have any symptoms of alcohol or opioid withdrawal. RN Keyes also noted that Mr Tran-Bui had no complaints of pain or any other presenting symptoms. Mr Tran-Bui indicated that the diazepam had worked well, that he had slept during the day, and that it was the first time he had slept for several days. Mr Tran-Bui later returned to his cell and was scheduled to be reviewed by a nurse from the drug and alcohol team the following morning.

Following his review in the clinic Mr Tran-Bui was taken back to his cell sometime between 5:00pm and 6:00pm. He was sharing the cell with another inmate, Tho Truong Ly. Mr Tran-Bui initially appeared well after his return. However after about an hour or two Mr Tran-Bui began to experience pain in his abdomen.¹⁴ Mr Ly described Mr Tran-Bui as holding his stomach and complaining of pain. He also recalled that Mr Tran-Bui “screamed that he had pain” when he used the toilet to open his bowels. Mr Tran-Bui managed to eat some of his dinner but he later vomited in the toilet a couple of times. When Mr Ly told Mr Tran-Bui that he was concerned for his welfare, Mr Tran-Bui told him not to worry. However, Mr Tran-Bui’s obvious pain appeared to worsen, leading Mr Ly to activate the cell call alarm (commonly referred to as a **knock up**).

Officers David Cassin and James Lannan attended the knock up at 9:52pm. Officer Cassin saw that Mr Tran-Bui was crouched down next to the toilet and not saying anything. Officer Cassin did not ask Mr Tran-Bui any questions. Mr Ly said that Mr Tran-Bui had stomach cramps and that he wanted some food. The officers advised Mr Ly that there was no food to provide to Mr Tran-Bui and left. Both officers reported their attendance at the cell to their supervising officer, Pepe Katieli. After the officers departed Mr Ly noted that Mr Tran-Bui appeared to look a little better. Mr Tran-Bui told Mr Ly that he felt better around this time and Mr Ly went to sleep at around 10:00pm.

However, between about midnight and 6:00am on 24 November 2014 CCTV cameras in Mr Tran-Bui’s cell recorded footage of Mr Tran-Bui in distress, holding and rubbing his stomach, crouched on the ground, and repeatedly going to the toilet.

24 November 2013

At about 6:45am on 24 November 2013 Mr Tran-Bui left his cell for a shower. A correctional officer described him as appearing off colour and unsteady on his feet, and saw him squat down several times.

Mr Tran-Bui later approached the pod office and made a comment that he wanted to “*get out*”. Mr Tran-Bui was subsequently taken back to his cell. At about 6:50am CSNSW Officer Karieann Odermatt checked on Mr Tran-Bui and saw that he was sliding from his bed onto the floor and appeared to have, what she described as, a “*fit*”. Other CSNSW officers were alerted and Justice Health & Forensic Mental Health Network (**Justice Health**) nurses were also called, arriving at the cell within about 5 minutes. Mr Tran-Bui was initially lying on the floor but attempted to sit up when the Justice Health nurses asked if he could hear them. Mr Tran-Bui was unable to sit up and it was noted that he was cyanotic. Mr Tran-Bui was given oxygen but the nursing staff were unable to take his pulse or measure his blood pressure. An ambulance was called as the nurses continued to treat Mr Tran-Bui. It was noted that Mr Tran-Bui was unable to follow simple commands and unable to verbalise anything. A short time later Mr Tran-Bui stopped responding to verbal stimuli and he was no longer responsive or opening spontaneously.

Paramedics arrived on scene at about 7:20am and began treating Mr Tran-Bui. By this time Mr Tran-Bui was in sinus tachycardia and his condition continued to deteriorate. A second ambulance was called at 7:35am. At 7:45am Mr Tran-Bui went into cardiac arrest and was in asystole. Cardiopulmonary resuscitation (**CPR**) was commenced and Mr Tran-Bui was given one shock with a defibrillator which was effective. At 8:08am Mr Tran-Bui was transferred by ambulance to the emergency department at Westmead Hospital.

Once there, Mr Tran-Bui was provided with Advanced Life Support measures, including oxygen therapy and inotropic agents to support cardiac function. Spontaneous circulation was eventually restored after about an hour of resuscitation but it was noted that Mr Tran-Bui was acidotic with multi-organ failure and fixed and dilated pupils. Given Mr Tran-Bui’s very poor prognosis, and following discussions with his family, a decision was made to withdraw all life support measures. Mr Tran-Bui was later pronounced life extinct at 3:46pm.

What was the cause of Mr. Tran-Bui’s death?

Mr Tran Bui was later taken to the Department of Forensic Medicine at Glebe where Dr Rebecca Irvine, senior staff specialist forensic pathologist, performed an autopsy on 28 November 2013. The autopsy revealed evidence of murky fluid in the peritoneal cavity, organising peritonitis and an obvious perforation of the anterior proximal duodenum due to an ulcer. On further examination of the stomach and proximal small bowel, three ulcers were eventually identified in this region, with an ulcer on the posterior wall appearing to penetrate into the head of the pancreas. Ultimately, Dr Irvine concluded that the cause of Mr Tran-Bui’s death was complications of acute peritonitis, with rupture of a peptic (duodenal) ulcer being an antecedent cause.

What issues did the inquest examine?

During the course of the coronial investigation, and the inquest itself, a number of issues came into focus. These issues fell into three general categories:

- Communication of information regarding an inmate’s health and welfare between Justice Health staff and CSNSW staff;
- The type of monitoring performed on an inmate in an observation cell;
- The response provided by CSNSW staff in relation to a knock up.

Within these categories a number of further issues were also examined. Each of these issues is examined in detail below.

Expert evidence

Given the sudden and unexpected nature of Mr Tran-Bui's death, opinion was sought from two independent consultant gastroenterologists in relation to a number of issues below. The Crown Solicitor's Office engaged Dr Christopher Vickers whilst Dr Johan van den Bogaerde was engaged on behalf of Mr Tran-Bui's family. Both of these experts set out their opinions in reports prepared prior to the inquest. A summary of the opinions offered by each of the experts is set out below.

In his reports, Dr Vickers:

- i. Opined that Mr. Tran-Bui died of complications arising from perforated peptic ulcer disease;
- ii. Described peptic ulceration as a chronic condition with a typical symptom of epigastric pain which waxes and wanes over several months but which, in some patients, can cause no symptomology and result in an acute complication, without warning, of haemorrhage or perforation;
- iii. Explained that diagnosis of peptic ulceration is most commonly made by a gastroscopy and that the usual complication if untreated is haemorrhage or perforation;
- iv. Opined that it was most likely that Mr. Tran-Bui perforated his ulcer between 9:20pm on 23 November 2013, when he was seen to hold his stomach, and when Mr. Ly sounded the cell alarm at 9:52pm.
- v. Explained that an acute perforated ulcer is usually heralded by sudden severe pain and collapse, followed by a period of partial recovery for a few hours until the signs of peritonitis start to develop;
- vi. Opined that it was reasonable in the circumstances for Justice Health staff not to have detected Mr. Tran-Bui's gastrointestinal pathology and described his case as *"one of those rare and tragic cases where the patient presented with a sudden acute severe complication of peptic ulcer disease without the typical preceding history of months of dyspepsia or epigastric pain"*;
- vii. Indicated that simple demands for food could not in any way be indicative of the presence of chronic peptic ulcer disease;
- viii. Noted that Mr. Tran-Bui's main symptoms when he presented on 21 November 2013 were lower or mid-thoracic back pain, sweatiness and diaphoresis, shivers and goosebumps which could have been accounted for by many simple conditions such as drug withdrawal, painful spondylitis or an evolving influenza;
- ix. Opined that appropriate vital signs were taken and that nothing about Mr. Tran-Bui's presentation on 21 November 2013 could have predicted later events;
- x. Opined that the diagnosis of drug withdrawal in relation to Mr. Tran-Bui's presentation on 23 November 2013 was reasonable, with nothing in the presentation that could have predicted later events;

- xi. Ultimately concluded that *“there were no clues or history at all...that could have reliably predicted an ulcer diagnosis, let alone the sudden and unexpected occurrence of an acute severe complication”*.

In his report, Dr van den Bogaerde:

- xii. Opined that Mr. Tran-Bui’s thoracic back pain when he presented on 21 November 2013 was the foundation symptom, for which an explanation should reasonably have been sought, and was the key to the clinical presentation;
- xiii. Opined that the thoracic back pain was not explicable by drug withdrawal, and did not fit in the clinical timeframe as Mr. Tran-Bui had been cleared of withdrawal on 20 November 2013;
- xiv. Asserted that there was 48 hours (between 21 November and 23 November 2013) of herald symptomology in the form of thoracic back pain, stomach pain, vomiting, dyspepsia, and inability to tolerate oral intake.
- xv. Opined that it was highly unlikely that focused questioning would have missed the presence of three large ulcers and that an appropriate history ought to have been elicited from Mr. Tran-Bui;
- xvi. Opined that Mr. Tran-Bui’s blood pressure measurements on 21 November 2013 showed a *“worrying trend”* and indicated hemodynamic compromise;
- xvii. Expressed the view that between 21 November and 23 November 2013 nursing staff ought to have performed an abdominal examination of Mr. Tran-Bui, and that Mr. Tran-Bui ought to have been reviewed and examined by a doctor;
- xviii. Opined that the diagnosis of Mr. Tran-Bui’s presentation on 21 and 23 November 2013 as being related to drug withdrawal represented adherence to an incorrect diagnosis and resulted in the poor outcome.

Was Mr. Tran-Bui appropriately assessed and treated on 21 November 2013?

Following a complaint of thoracic back pain, Mr Tran-Bui was taken to the Justice Health clinic for review. There, he was seen by RN Boorer. In evidence RN Boorer said that she formed the view that all the symptoms which Mr Tran-Bui was presenting with (sweating, goosebumps, shivering) were all linked to drug withdrawal. When asked about Mr Tran-Bui’s back pain she explained that complaints of body pain can also sometimes be associated with drug withdrawal. When asked specifically about Mr Tran-Bui’s back pain being in the mid-thoracic region she acknowledged that this area would generally not be associated with symptoms of drug withdrawal. However, RN Boorer noted that Mr Tran-Bui did have a history of cardiac issues and, accordingly, explained that this was why she referred him for an ECG test. RN Boorer said that by doing so she was considering other possibilities for the source of Mr Tran-Bui’s back pain.

When taken to the reference in Dr Van Den Bogaerde’s report regarding thoracic back pain being inexplicable by drug withdrawal Ms Boorer explained that this was (to her knowledge) Mr Tran- Bui’s first presentation with back pain and that a *“one-off”* presentation was not diagnostic of *“anything in particular”*. RN Boorer agreed that withdrawal from drugs and alcohol was a common health condition faced by inmates and that, in her estimation, approximately 50% of inmates experience such issues.

Although RN Boorer explained that she did not believe that the back pain was related to any condition other than drug withdrawal, she explained that she referred Mr Tran-Bui for a review by a drug and alcohol nurse in order to be certain. The overall view expressed by Dr van den Bogaerde in evidence was that the initial diagnosis of drug withdrawal was adhered to “*relatively obstinately*” by nursing staff, and that any of Mr Tran-Bui’s presenting symptoms would have been ascribed to drug withdrawal. Dr van den Bogaerde summarised it, bluntly, in this way:

“...if your only tool is a hammer, every problem looks like a nail. And unfortunately in medicine, patients present with different pathologies”.

In evidence, Dr van den Bogaerde explained that he would have expected RN Boorer to have in mind a number of differential diagnoses. He explained that whilst lumbar back pain is common, thoracic back pain is an unusual presentation and that such a presentation, particularly in someone of Mr Tran-Bui’s age, would be a concerning symptom.

Dr van den Bogaerde further explained that drug withdrawal could produce arthritic and joint pain but could find no reference in academic literature which discussed thoracic back pain in the context of drug withdrawal. However he did acknowledge that the most common cause of thoracic back pain was muscular-skeletal in origin and that in the context of drug withdrawal this might have been caused by muscle spasm, particularly if a person had sensitivity in the spine. As Dr van den Bogaerde was of the view that thoracic back pain in the context of suspected drug withdrawal was not easy to explain he was also of the view that a proper examination of Mr Tran-Bui’s back and abdomen should have been performed.

In expressing this view Dr van den Bogaerde emphasised that he had no expectation that RN Boorer, or any other Justice Health nurse, would have diagnosed Mr Tran-Bui’s penetrating ulcer; rather Dr van den Bogaerde’s view was that RN Boorer should have approached the question of diagnosis with a higher index of suspicion and sought appropriate input from a doctor. Dr Vickers had a different view generally to that of Dr van den Bogaerde. Dr Vickers said that in his view that it was reasonable to assume that Mr Tran-Bui’s mid thoracic pain was due to drug withdrawal. He explained that when a person is sweating and shivering (common symptoms of drug withdrawal) their whole muscle system is tense, and that it is very simple for a person to pull or strain a muscle attached to the spine (as a result of spasms associated with withdrawal), thereby causing pain in the mid-thoracic region.

Further, Dr Vickers said that a single presentation of pain would not alert a nurse to the presence of another underlying condition unless the pain was severe or accompanied by another serious symptom such as difficulty breathing or walking. Dr Vickers went on to say that if the pain was severe then he would have expected there to be follow up to determine if the pain was still present on any future presentation. Dr Vickers indicated that this, effectively, was why he was not critical of the overall review conducted by RN Boorer: because Mr Tran-Bui had presented with a one-off episode of pain which did not repeat itself.

Dr Vickers was asked in evidence whether he considered Mr Tran-Bui’s mid-thoracic pain to be an unusual presentation. He explained that if a person had been experiencing spasms and shaking then he would not expect that pain to indicate any other pathology.

When referred to the opinions expressed by Dr van den Bogaerde in his report, Dr Vickers said the mid-thoracic back pain “*absolutely*” could have been explained by drug withdrawal. Dr Vickers elaborated by explaining that the physical symptoms of withdrawal might involve spasms or the arching of a person’s back which could cause pain anywhere in the body. He explained further that if the pain continued it would warrant further investigation, but if it subsided it could be attributed most likely to muscular skeletal pain.

Conclusion: Dr van den Bogaerde and Dr Vickers disagreed on the issue of whether it was reasonable to attribute Mr Tran-Bui’s mid thoracic pain to drug withdrawal. Given the difficulty in reaching a consensus opinion between two experts in their field, there is no basis to conclude that the review conducted by RN Boorer on 21 November 2013 was inappropriate or inadequate in any way.

However, it appears that the consideration given by Dr Vickers to this issue was more carefully considered and should be preferred. Dr Vickers noted two important aspects specific to Mr Tran-Bui’s presentation: firstly, that it was single presentation of pain which was not accompanied by any other serious symptoms; secondly, that the physiological effects of drug withdrawal could have resulted in pain to the mid-thoracic region, and indeed any other region, of the body. On this basis, it was reasonable for RN Boorer to consider that Mr Tran-Bui’s presenting pain could be attributed to drug withdrawal.

Further, the evidence does not support Dr van den Bogaerde’s view that a diagnosis of drug withdrawal was adhered “relatively obstinately” by RN Boorer and that all of Mr Tran-Bui’s symptoms were attributed to this diagnosis. To the contrary, the evidence establishes that, by requesting that an ECG test be performed and being aware of Mr Tran-Bui’s cardiac-related history, RN Boorer had considered other diagnostic possibilities.

What the events of 21 November 2013 clearly demonstrate is the fact that inmates in correctional centres undergoing drug withdrawal often present with multiple co-morbidities which may sometimes not be causally related to the process of withdrawal. Given the high incidence of persons within the correctional setting that present with drug-related health issues (and the anecdotal evidence given during the inquest was that it was as high as 50%), it is necessary to make the following recommendation.

Recommendation 1: I recommend to the Chief Executive, Justice Health & Forensic Mental Health Network (**Justice Health**) that consideration be given to the circumstances of Mr. Tran Bui’s death (with appropriate anonymization, and conditional upon consent being provided by Mr. Tran Bui’s family and following appropriate consultation with them) being used as a case study as part of training provided to Justice Health clinical staff in relation to treatment of inmates presenting with drug withdrawal-like symptoms.

Was Mr. Tran-Bui appropriately assessed and treated at around 1:00pm on 23 November 2013?

After complaining of sweating and goosebumps, Mr Tran-Bui was taken to the Justice Health clinic at about 1:10pm on 23 November 2013 where he was seen by RN Poynter. She indicated that she did not review any of Mr Tran Bui’s previous progress notes because she did not have access to Mr Tran-Bui’s medical file. As a result RN Poynter was unaware that Mr Tran-Bui had reported experiencing mid-thoracic back pain when he presented two days earlier on 21 November 2013. In evidence RN Poynter said that if she had been aware of this presentation she would have elicited further history from Mr Tran-Bui and determined whether he continued to experience such pain.

She also said that she would have discussed the issue in her subsequent phone call with Dr Meldrum. In evidence Dr Meldrum herself said that, hypothetically, if the issue had been raised with her she would have queried whether Mr Tran-Bui was still experiencing the same symptoms, and may have suggested that the on-call GP be advised.

Dr van den Bogaerde initially said that it was difficult to focus on drug withdrawal issues because the timing “*makes no sense*”. He went on to say that if Mr Tran-Bui had been using heroin whilst in custody it would make withdrawal unlikely. However, when asked if a few spots of heroin would alleviate symptoms of withdrawal Dr van den Bogaerde said that he did not know.

Dr Vickers said that he would expect that a nurse who was reviewing Mr Tran-Bui on 23 November 2013 to review the progress notes from two days earlier and that it was important to do so. However Dr Vickers acknowledged that even in a non-correctional hospital setting this is sometimes not practically possible. Dr Vickers agreed that good medical practice suggests that a nurse should have at least had access to the notes. If Mr Tran-Bui’s previous progress notes had been available to RN Poynter then Dr Vickers said that he would have expected her to enquire about the past complaint of back pain in order to determine whether the symptoms had worsened or resolved.

Conclusion: As RN Poynter did not have available to her any information relating to Mr. Tran- Bui’s previous complaint of mid thoracic back pain, there is no basis to conclude that the review conducted at about 1:00pm on 23 November 2013 was inadequate. The clear evidence is that if RN Poynter had possessed such information, appropriate enquiry would have been conducted and the issue would have been raised with Dr Meldrum for discussion.

Evidence received during the inquest established that health records for all inmate patients in the MRRC are now stored in the main Justice Health clinic, or in a satellite health centre in proximity to a pod. Inmate patients are reviewed in the same health centres where their records are located. If an inmate patient is seen in Darcy pod (such as Mr. Tran-Bui was) then their health record must be retrieved from the main clinic. Given the clarification of the current state of health record keeping within Justice Health at the MRRC it is neither necessary nor desirable to make any recommendation.

Was Mr. Tran-Bui appropriately assessed and treated at around 5:00pm on 23 November 2013?

The evidence established that RN Keyes also did not refer to Mr Tran-Bui’s earlier progress notes when she reviewed him later in the afternoon on 23 November 2013. In evidence RN Keyes explained that it was not her usual practice to do so unless the clinical situation warranted it. She explained that because of the volume of the other duties that she was required to perform (looking after approximately 130 inmates during a night shift, distributing medication, monitoring observation cells) she would not spend time reviewing an inmate’s progress notes unless she had a particular concern regarding that patient.

When asked to compare Mr Tran-Bui’s previous vital signs with the vital signs that she took, noting a drop in blood pressure from 123/96 to 108/82, RN Keyes explained that such a change would not have concerned her. She said that the vital signs were still within normal parameters and could be explained by the fact that Mr Tran-Bui had been given diazepam and that he had just woken up shortly before the time of review.

RN Keyes was also asked if she turned her mind to other conditions that Mr Tran-Bui may have been suffering from. She explained that she had only been requested to assess Mr Tran-Bui for opioid withdrawal that she performed that assessment, and that Mr Tran-Bui did not complain of any other condition during that assessment.

In evidence Dr van den Bogaerde said that it was understandable that Tran-Bui's first presentation (on 21 November 2013) was not escalated given the dominance of his drug and alcohol issues. However Dr van den Bogaerde went on to express the view that by the time of his second and third presentations (on 23 November 2013) the "*cavalry*" should have been called in, meaning seeking input from a doctor and requesting that they attend on Mr Tran-Bui.

Dr van den Bogaerde expressed concern at the measurement of Mr Tran-Bui's vital signs and said that the decreasing blood pressure but increasing pulse rate required an explanation that could not be attributed only to drug withdrawal. When asked about RN Keyes' reasoning that Mr Tran-Bui's vital signs were explicable by his ingestion of diazepam and the fact that he had just woken up, Dr van den Bogaerde described this "*not a really good explanation*". Accordingly Dr van den Bogaerde remained of the view that Mr Tran-Bui's vital signs demonstrated haemodynamic compromise and that his increased pulse rate in particular, particularly for someone of Mr Tran-Bui's relatively young age, was a concern.

In evidence, Dr Vickers was asked about the vital signs taken on 23 November 2013. He said that the presumption made by Dr van den Bogaerde that Mr Tran-Bui was showing hemodynamic compromise was a serious one because it presumed that the previous higher blood pressure reading (leading to a suggestion that there had been a drop by 23 November 2013) was normal. However, Dr Vickers explained that it might equally have been the case that Mr Tran-Bui's normal blood pressure was lower, meaning that the decrease was not as marked. Further, Dr Vickers said that with Mr Tran-Bui's liver disease, state of stress, and dehydration (from drug withdrawal) it was reasonable to expect that Mr Tran-Bui's blood pressure would be elevated over normal.

When asked to examine the history of Mr Tran-Bui's blood pressure readings Dr Vickers accepted there was an increase in pulse rate but not a significant one. He explained that examining the readings in isolation was unhelpful without taking into account the clinical context. Dr Vickers expressed it in this way:

"...you're looking at figures not what's going on, okay, you've got to see the trees out of the woods. What's going on, he's been arrested, he's in a state of stress, he's then going through a drug withdrawal, and he's been anxious, he's been given diazepam because of anxiety, so all of these things are going to put up his blood pressure, and several days later on the 23rd he's had diazepam, he's been drugged, he's feeling better and his blood pressure has come down. You're not, you've got to look at everything together, not just figures".

Having regard to the above Dr Vickers offered the view that he would expect Mr Tran-Bui's blood pressure to initially increase in such circumstances, but for it to then drop after Mr Tran-Bui came through a period of withdrawal. Dr Vickers went on to explain that the process of withdrawal keeps pulse rate low and a "*vagal state*" predominates. Once released from withdrawal the body normalises and Dr Vickers explained that he would expect pulse rate to increase as overcompensation but then eventually settle. On this basis Dr Vickers did not accept that the changes in Mr Tran-Bui's vital signs represented haemodynamic compromise. It should also be noted that Dr Meldrum in evidence expressed no concern regarding Mr Tran-Bui's vital signs, noting that elevation in pulse rate could have been attributed to drug withdrawal.

Conclusion: Again, the evidence established disagreement in the expert evidence as to whether Mr Tran-Bui was haemodynamically unstable by the later afternoon of 23 November 2013, and whether such a clinical finding (if it could reasonably have been made) was representative of a more serious underlying condition other than drug withdrawal. Again, the more considered evidence provided by Dr Vickers in this regard is to be preferred on the basis that it was based on consideration of Mr Tran-Bui's clinical history, and consistent with the opinion expressed by Dr Meldrum. On this basis, the evidence does not establish that Mr Tran-Bui was haemodynamically compromised at this time. Further, the variations apparent in Mr Tran-Bui's vital signs were reasonably attributed to drug withdrawal and there was not an equally reasonable basis to conclude that they were indicative of some underlying pathology. This then leads to the conclusion that the review performed by RN Keyes was adequate and appropriate.

Was there adequate and appropriate communication between Justice Health staff and CSNSW staff regarding Mr. Tran-Bui's welfare?

At the conclusion of her review of Mr Tran-Bui RN Poynter completed the HPNF dated 23 November 2013 in the terms described above. Any fair reading of the HPNF indicates that it contains instructions as to what signs and symptoms CSNSW staff need to look out for, and what considerations need to be taken into account in housing an inmate. In Mr Tran-Bui's particular case the HPNF established that he was:

- i. in withdrawal, had exhibited paranoid thoughts and was to be observed for bizarre behaviour; and
- ii. was to be held in a medical observation cell until cleared by detox.

The answer is perhaps so obvious that it does not require confirmation, but RN Poynter was asked in evidence whether she intended for her instructions to be read by CSNSW staff. She confirmed that this was indeed her intention.

However, this did not occur. Officers Lannan, Cassin and Katieli all said in evidence that they had never even seen the HPNF before, let alone read it. Further, the evidence established that at the time of Mr Tran-Bui's death there was no applicable CSNSW policy providing for any requirement to do so. Instead, the combined evidence from all three officers was that, in general, information contained in a HPNF was only used to determine where to house an inmate. Officer Katieli expressed it in this way:

- Q:** *Does that mean that in practice in your experience Corrective Services officers ignore that front box [containing information relating to what signs and symptoms CSNSW officers need to look for] and you really just look at the information in the middle about where to place the prisoner?*
- A:** *Pretty much, yeah.*

The evidence also established that after a HPNF is so used, it is not referred to again by CSNSW staff. Officer Katieli again confirmed the following:

- Q:** *That just gets filed and is not given regard to any further in the management?*
- A:** *That's correct.*

Despite the above, both Officers Cassin and Lannan were taken to the section of the HPNF which indicates what signs and symptoms a CSNSW officer is to look out and agreed that being given such information would be helpful in ensuring the welfare of an inmate. Further, both officers also agreed that it would be useful for CSNSW officers to be provided with further instructions and training regarding how such observations are to be carried out.

However, notwithstanding this stated willingness to actually put into effect the intended purpose of the HPNF, a further consideration was revealed during the course of Officer Katieli's evidence. When asked whether he considered the content of the HPNF to be relevant to his duties, Officer Katieli indicated that it was a "*touchy subject*". When asked to explain what he meant by this he said the following:

"It's because it's become a union issue because the officers are saying we're not medically trained to recognise - even though they give us the symptoms we're not - how can we recognise or know if an inmate that is sitting, for example, that doesn't tell us anything. That just tells us, someone that's not trained, that he's just sitting there. Now, in our centre alone they don't even get an assigned officer to watch the medical obs because our governor says it's the [sic] duty".

The issue raised by Officer Katieli was put to Mr Terry Murrell (General Manager, State Wide Operations, CSNSW Custodial Corrections Branch) in evidence. Mr Murrell said that it was the first time he had heard of such an issue, expressed concern if such an issue had developed in practice, and that he did not condone such a practice. With respect to the "*union issue*" raised by Officer Katieli, Mr Murrell indicated that whilst CSNSW could provide training to, and re- education of, CSNSW officers in relation to the importance of the HPNF, any union-related issue was a matter for Human Resources.

The evidence establishing that the HPNF is not read in its entirety came as a surprise not only to RN Poynter and Mr Murrell but also to Therese Sheehan (Deputy Director of Nursing & Midwifery Services – Custodial Health, Justice Health). During the inquest, Ms Sheehan was asked whether she could think of any way to improve existing systems to allow for the transferral of information contained in a HPNF from Justice Health staff to CSNSW staff, particular in relation to where the HPNF is kept. She answered in this way:

"I must admit, not really, because I assumed that the officers would have to look at the case file notes, just [like] the nurses have to look at the medical file".

In December 2017 CSNSW developed a new Custodial Operations Policy and Procedures (**COPP**) to replace the Operations Procedures Manual (**OPM**) that was in force at the time of Mr Tran- Bui's death. Section 6.1 of the COPP specifically relates to Justice Health notifications and provides for the following in relation to a HPNF:

"Make sure advice or recommendations detailed in HPNF are implemented, unless there are overriding security concerns or issues impacting implementation.

Any concerns or issues about implementation must be discussed immediately with the Nursing Unit Manager (NUM) or Nurse in Charge (NIC) to make sure the inmate's immediate management is addressed and their health is not compromised".

Conclusion: Instructions given by RN Poynter in the HPNF dated 23 November 2013 regarding what signs and symptoms CSNSW officers were to look for relating to Mr. Tran-Bui were ineffectual. This was due to the simple reason that the HPNF was not read by any of the CSNSW officers on shift at the time.

The failure to read the HPNF was the product of a practice which seems to have been adopted by CSNSW officers where information contained in the HPNF was only used for half its intended purpose; that is, to determine where inmates were to be housed, and not to also ensure their general welfare and well-being. In this regard it is important to remember that this was the understood practice of Officer Katieli, a CSNSW officer of more than 27 years experience, and Officer Lannan, a CSNSW officer of more than 17 years experience. Such a practice is plainly inconsistent with ensuring the well-being of inmates with an identified health issue. The surprise expressed by senior personnel within both CSNSW and Justice Health at this general practice only serves to highlight the degree of inadequacy.

Notwithstanding the above, the need for a robust policy to ensure that instructions contained in a HPNF are actually implemented by CSNSW officers has been identified by CSNSW. The introduction of Section 6.1 of the COPP is reflective of this. Such an improvement is a welcome one. However it should be noted that Section 6.1 of the COPP does no more than repeat in general terms instructions that were contained in the version of the HPNF that was in operation at the time of Mr. Tran-Bui's death. Those instructions provided the following:

“Department of Corrective Services: Please advise Justice Health staff if you cannot understand the contents of the form, or if you are unable to implement the recommendations.

It is important to follow the recommendations on this form to maintain and improve the inmate's health. If the recommendations cannot be implemented, please notify a Justice Health staff member promptly”.

It would seem therefore that the issue returns to one of simply making the HPNF accessible to CSNSW staff, not only at the time of the placement of an inmate, but also for the duration that the inmate requires observation. Whilst it was indicated by Mr. Murrell that he proposed to place the issue of targeted training of CSNSW officers as to the importance of the HPNF on the agenda of his bi-monthly meeting with Justice Health, there is no evidence that this has yet been put into practice.

Having regard to all the above considerations it is necessary to make the following recommendations.

Recommendation 2: I recommend to the Commissioner for Corrective Services NSW that consideration be given to amending the Custodial Operations Policy and Procedures to provide that information contained in a Health Problem Notification Form (HPNF) relating to an inmate, particularly information that relates to the type of observation required, how frequently such observations are to be performed, and by whom the observation will be attended, be reproduced in a form and placed in a location that is readily accessible and visible by CSNSW staff rotating between shifts.

Recommendation 3: I recommend to the Commissioner for Corrective Services NSW that consideration be given to amending the Custodial Operations Policy and Procedures to provide that part of the responsibilities of a CSNSW Officer in Charge is to ensure that CSNSW staff under their supervision, who are rotating between shifts, are aware of: (a) information contained in a HPNF relating to an inmate, particularly information that relates to the type of observation required,

How frequently such observations are to be performed, and by whom the observations will be attended; and (b) information provided by a Justice Health & Forensic Mental Health Network clinical staff member, following the clinical assessment of an inmate, in relation to any ongoing health concern that the inmate may have.

Recommendation 4: I recommend to the Commissioner for Corrective Services NSW that consideration be given to collaboration with Justice Health & Forensic Mental Health Network (**Justice Health**) in order to devise appropriate and regular education and training programs delivered by Justice Health clinical staff to ensure that CSNSW staff are aware of:

(a) the importance of the contents of a HPNF in relation to an inmate's good health;

(b) how to correctly understand instructions contained in a HPNF which relate to observing an inmate's signs; and

(c) how to effectively carry out instructions contained in a HPNF which relate to ensuring that inmate's good health, particularly those instructions which relate to the type of observation required, how frequently the observation should be made, and by whom the observation will be attended.

Recommendation 5: I recommend to the Chief Executive, Justice Health & Forensic Mental Health Network that consideration be given to collaboration with Corrective Services NSW (**CSNSW**) in order to devise appropriate and regular education and training programs delivered by Justice Health clinical staff to ensure that CSNSW staff are aware of: (a) the importance of the contents of a HPNF in relation to an inmate's good health; (b) how to correctly understand instructions contained in a HPNF which relate to observing an inmate's signs; and (c) how to effectively carry out instructions contained in a HPNF which relate to ensuring that inmate's good health, particularly those instructions which relate to the type of observation required, how frequently the observation should be made, and by whom the observation will be attended.

Counsel for Justice Health submitted that **Recommendation 5** may be unnecessary in circumstances where CSNSW staff are obliged to read a HPNF and inform Justice Health staff if they can or cannot undertake any of the instructions contained within it. This underscores the fundamental issue identified by the evidence at inquest – namely, that the HPNF is not read by CSNSW with an understanding as to its importance in ensuring an inmate's welfare and good health (and not just as an inmate placement tool), or, worse, not read at all – and is precisely why Recommendation 5 is necessary.

Indeed, there is a need to ensure that CSNSW staff are provided with the most up-to-date and ongoing information regarding an inmate's health condition that may extend beyond the contents of an initial HPNF. Therefore, the following recommendation is also necessary.

Recommendation 6: I recommend to the Chief Executive, Justice Health & Forensic Mental Health Network that consideration be given to requiring that following the clinical assessment of an inmate by a Justice Health clinical staff member, and where the inmate is deemed to have an ongoing health concern, the Justice Health clinical staff member is to provide a verbal and written handover to the first available CSNSW Officer in Charge (OIC) of the area where the inmate is housed in order to ensure that the inmate's health concerns are adequately and appropriately managed.

It was submitted by counsel for Justice Health that such a recommendation is also unnecessary because any verbal handover would not contain information that was not already contained in a HPNF.

The difficulties relating to a HPNF actually being read by CSNSW staff in the way which is intended have already been discussed above and will not be repeated.

Suffice to say, the recommendation for there to be some kind of handover between Justice Health staff and CSNSW staff is necessary in order to act as a safeguard in the event that a HPNF is not read as intended (or not read at all), and to ensure that the most current information concerning an inmate's health condition is available.

Counsel for Mr. Huu Vien Bui submitted that a recommendation should also be made that provides for "refresher" training courses to CSNSW staff in relation to the COPP, suggesting that such training be provided at a minimum of every two years. In this regard it is noted that the COPP was published on 16 December 2017 and has only been in operation for some six months. Further the evidence from Mr. Murrell is that onsite training regarding the COPP was provided at the time of its inception. Further, there was insufficient evidence adduced at the inquest to establish that "refresher" training is required in relation to the COPP as a whole. Having regard to these factors, and the terms of **Recommendations 4 and 5** which provide for regular training specific to the issues identified at inquest, it is neither necessary nor desirable to make the recommendation as submitted by counsel for Mr. Huu Vien Bui.

Did Mr. Tran-Bui's placement in an observation cell allow for effective observation?

The above evidence indicates that information contained in the HPNF was used to determine that Mr Tran-Bui needed to be placed in an observation cell (as it was known at the time). The question that arises, even leaving aside the fact that the instructions to observe Mr Tran-Bui for specific signs and symptoms were not read and therefore ineffectual, is whether such a placement actually provided for effective observation of Mr Tran-Bui.

The evidence at inquest established that the cell in which Mr Tran-Bui was housed contained two cameras. Footage recorded by the cameras was displayed on monitors both in a central control area, and also on monitors within Darcy pod. In evidence Officer Katieli said that it was his understanding that there were two CSNSW officers in the central control area watching at least 40 monitors, with two monitors dedicated to the 21 safe cells in the entire MRRC.

Further, Officer Katieli indicated that footage from Mr Tran-Bui's cell, and 12 other cells, was also displayed on one of two monitors within the office in Darcy pod. However, with respect to these two monitors Officer Katieli said that he was not aware of any policy governing how the footage from Mr Tran-Bui's cell was to be monitored, that no officer during a shift was designated the task of watching the monitor, and that it was simply the case that any officer on might glance at the monitor if they happened to be in the office during a shift. However, Officer Katieli acknowledged that with the need to attend to other duties it was quite plausible that no officer would look at the pod office monitor for an entire shift. Further, Officer Katieli explained that images displayed on the monitors changed every 1.5 seconds as footage from the 13 cells was cycled through on a continuous basis. On this topic, Officer Katieli gave the following evidence:

Q: *How did you view the utility of those screens changing over every one and a half seconds, was that effective or not?*

A: *No.*

Q: *Why was that?*

A: *Well, it wouldn't give us a true indication of what's going on in the cell.*

Q: *Has that system changed?*

A: *No.*

Q: *Have you ever expressed your frustration or concerns about that system to anybody in senior management?*

A: *No, yeah.*

Q: *Are you aware of any changes being discussed in terms of that system?*

A: *No, I'm not aware.*

Q: *Are there staff meetings that you attend, Officer Katieli, where you can raise any of these operational issues.*

A: *No.*

These issues were raised with Mr Murrell in evidence. He initially said that he was unable to comment because he was unfamiliar with local procedures at the MRRC. After being asked to accept that the evidence demonstrated that the footage from Mr Tran-Bui's cell, and others, was not being regularly monitored by any CSNSW officer, Mr Murrell expressed the belief that such footage should be monitored and expressed uncertainty as to why this was not occurring.

Mr Murrell was invited to address the issue regarding the cyclic nature of the footage rendering effective observation of an inmate in a cell either difficult or impossible. He explained that there were advantages and disadvantages to having cyclic footage from a number of cells, as opposed to having the ability to focus on one particular cell, and said that this would be *"discussed by management and decision made"*. In evidence Mr Murrell explained that the advantage of having static footage was that it would allow for more time to be spent observing an inmate in a cell, whereas the disadvantage would be that this would mean that other cells were not being monitored. Mr Murrell went on to explain that *"if there is a particular concern on one of the inmates/cells [sic], then [a CSNSW officer] can contact Central Control and alert them to view and monitor a particular cell"*.

Despite the coronial investigation, it appears that the uncertainty expressed by Mr Murrell remains. Information included as part of the written submissions by counsel for the Commissioner for CSNSW indicates that new monitors and cameras are in the process of being installed in the MRRC in various locations, including Darcy pod. There are also further proposals to upgrade camera covers in Darcy Pod and add a dedicated monitor room. However, clarification sought regarding these new changes revealed that the cyclic nature of the footage remains unchanged, with only image quality being improved. Further, there appears to be no change to the matters raised by Officer Katieli regarding the absence of any policy, guideline, or instruction in relation to how footage from cells is to be actually monitored, by whom, and with what frequency.

Tragically, in Mr Tran-Bui's case it appears that even if the footage from his cell had been continuously monitored by a CSNSW staff member it would have been unlikely to prompt any further action. During his evidence Officer Cassin was referred to the written log of the footage from about 12:00am to 6:00am on 24 November 2013.

He was asked whether, after having attended on Mr Tran-Bui in his cell, he would be prompted to return to the cell if he had seen what was described in the footage as Mr Tran-Bui appearing to be in obvious discomfort, holding and rubbing his stomach, crouching down and repeatedly going to the toilet. Officer Cassin said that he would not necessarily have been so prompted and would have only returned to the cell if there had been a call for assistance. In contrast, Dr Vickers offered the opinion that any layperson who viewed the footage from Mr Tran-Bui's cell from 12:00am to 6:00am on 24 November 2014 would want to call someone for assistance on the basis that Mr Tran-Bui was in "*obviously in distress*". Quite apart from any potential observation that could have been made of Mr Tran-Bui from the footage of his cell, the evidence established that no other effective observation was performed by any CSNSW officer. Although the cell in which Mr-Tran Bui was housed contained Perspex walls to allow for greater visibility into the cell, it appears that no physical observation was performed. This issue was explored with Officer Cassin in evidence:

- Q:** *Is it your understanding that there is then - as at November 2013 at least there was no particular obligation on night staff to go and check on prisoners in an observation cell?*
- A:** *At the beginning of the shift we check, we do a head check in the observation cells, but apart from that, no.*
- Q:** *What does the head check involve, at the beginning of the shift?*
- A:** *Basically going to the, to the door and turning the light on and checking and making sure they're alive.*

It should be noted that Officer Lannan said in evidence that he did not consider that he had any responsibility to even check whether an inmate was alive at any time.

In her evidence RN Poynter said that she thought Mr Tran-Bui should have been observed at four-hourly intervals, agreed that intervals for observation should be specified on a HPNF, and acknowledged that she had made no such specification on the HPNF which she completed. To address these shortcomings evidence was provided by Justice Health regarding updates that have been made to two relevant policies: *Policy 1.231 Health Problem Notification Form (Adults)* and *Policy 1.340 Accommodation - Clinical Recommendations (Adults)*. The updates provide for the following:

"If clinical staff is recommending that a patient be placed in a camera cell for any reason, the HPNF must provide information on the type of observation required and by whom the observation will be attended. For example:

- The patient may require CSNSW to observe the patient via the monitor at set intervals for the duration of their placement in the camera cell;*
- The patient may need to be physically observed by CSNSW at set intervals for the duration of their placement in the camera cell;*
- The patient may need to be physically observed by JH&FMHN staff at set intervals for the duration of their placement in the camera cell.*
- If custodial staff advise that they are unable to undertake the type or frequency of observation recommended by JH&FMHN staff, consultation with the Remote Offsite Afterhours Medical Service must occur as the patient may need to be transferred to an external health service for the required level of observation."*

Conclusion: Despite placement in a specific cell, with physical measures to facilitate observation, no effective observation of Mr. Tran-Bui was actually performed by any member of CSNSW staff on 23 or 24 November 2013.

This was due to a combination of factors: lack of direction and guidance regarding how, when and by whom monitoring of cell footage was to occur; the rapid cyclic nature of the footage preventing effective viewing even if it had been monitored; lack of direction and guidance regarding how, when and by whom physical observation at the cell was to be performed; and insufficient instructions being provided on the HPNF dated 23 November 2013, if it had actually been read.

The footage from Mr. Tran-Bui's cell between at least 12:00am and 6:00am on 24 November 2013 both shows Mr. Tran-Bui in obvious distress, and is distressing to watch. Even with the benefit of hindsight, given the degree of distress that Mr. Tran-Bui is clearly in, it is difficult to understand how any viewing of the footage for a reasonable time, even by a non-medically trained person, would not prompt at least an enquiry being made as to Mr. Tran-Bui's welfare, let alone a call for medical assistance.

It is of course not possible to know whether if medical assistance had eventually been sought it might have altered the outcome. Dr Vickers expressed the view in his second report that *"if the perforation were diagnosed or strongly suspected at any time prior to Mr Tran-Bui's collapse then it is likely that his life would have been saved by surgery"*. This view is obviously dependent on a diagnosis having been made. Elsewhere in both his reports Dr Vickers also indicated that even the expert medical teams at Westmead Hospital were unable to make the diagnosis of peritonitis despite their combined expertise and available equipment, and in circumstances where Mr Tran-Bui's condition was at an advanced stage. On this basis, it cannot be stated with certainty whether the outcome might have been different; rather, diagnosis (if it had occurred) resulting in eventual surgery would have given Mr Tran-Bui the best chance of survival.

It should be noted at this point that Dr Vickers' reference to the medical teams at Westmead being unable to diagnose Mr. Tran-Bui's condition was also the subject of independent expert review. Opinion was sought from Associate Professor John Raftos, an emergency physician. In a report prepared prior to the inquest Associate Professor Raftos noted that no feature of Mr. Tran-Bui's history or examination at Westmead Hospital suggested that he had peritonitis. Associate Professor Raftos offered the opinion that the care and treatment provided to Mr. Tran-Bui at Westmead Hospital was reasonable and appropriate.

It would appear that the policy updates made by Justice Health address the shortcomings identified above regarding the type of observation to be performed, when they are to be performed and by whom. Given that instructions relating to such observations are contained in a HPNF, it is obviously of critical importance that the HPNF is read, and referred to for the duration of the observation. **Recommendations 2, 3, 4, 5 and 6** above have addressed this issue in part.

The remaining issue which has not been addressed concerns the effectiveness of any observation performed by a CSNSW officer watching video footage of an inmate which is shown on a monitor.

There are obvious technology and resource limitations to take into account in this regard. However, there is no demonstrated evidence that indicates that appropriate consideration is being given to these limitations and their resultant impact on effective observation of inmates.

Therefore, it is necessary to make the following recommendation.

Recommendation 7: I recommend to the Commissioner for Corrective Services NSW that consideration be given to conducting a review of local procedures at the Metropolitan Remand and Reception Centre in order to determine whether

(a) Appropriate directions are provided by senior CSNSW staff to other CSNSW staff; and (b) whether appropriate monitoring equipment exists; to allow for instructions contained in a Health Problem Notification Form which relate to observing an inmate are able to be followed and implemented effectively in order to ensure that inmate's good health.

Was there an appropriate response to the cell call alarm on 23 November 2013?

Officers Cassin and Lannan attended Mr Tran-Bui's cell at 9:52pm on 23 November 2013 following the knock up made by Mr Tran-Bui's cellmate, Mr Ly at 9:48pm. CCTV footage indicates that both officers remained outside the cell and departed at 9:53pm. Neither officer spoke to Mr Tran-Bui. No record was made of the cell attendance and no Justice Health staff member was advised or consulted.

In evidence Officer Cassin accepted that he had an obligation to *investigate* the knock up on the evening of 23 November 2013. Whilst initially accepting the premise that investigation would have involved a conversation with Mr Tran-Bui directly, Officer Cassin explained that his investigation was directed to Mr Ly because he was the one who had made the knock up. Officer Cassin agreed that he did not speak to Mr Tran-Bui because Mr Ly had mentioned food and this gave him the belief that the knock up was related to hunger and nothing else. Officer Cassin agreed that in hindsight he should have spoken to Mr Tran-Bui directly but said that at the time he did not even think twice about it. Officer Cassin also agreed that if Mr Ly had not spoken then he would have made an enquiry with both Mr Tran-Bui and Mr Ly.

By way of explanation Officer Cassin said that he had seen many inmates crouching in the manner that Mr Tran-Bui was crouching and that Mr Tran-Bui did not show any symptoms of pain that he could observe. Officer Cassin further explained that Mr Ly was "*taking the lead*" in talking and that if Mr Tran-Bui had said that he was in pain he would have taken Mr Tran-Bui to the clinic or called for assistance from someone with medical knowledge. It was put to Officer Cassin that if Mr Tran-Bui was in fact experiencing pain that this would have prevented his ability to communicate. Officer Cassin did not accept this proposition and instead offered his opposing view which was that if someone was in pain it would make it more likely that they would call for assistance themselves.

Officer Lannan was asked why he did not speak to Mr Tran-Bui directly after Mr Ly mentioned that Mr Tran-Bui had cramps. Officer Lannan said that when food was mentioned he deemed the situation not to be a medical emergency. Officer Lannan explained that he believed hunger was the explanation for the cramps and did not consider any other possible explanation. It was put to Officer Lannan that if a cellmate used the knock up and mentioned cramps that some further enquiry was required. However Officer Lannan explained that if confronted now with the same situation as on 23 November 2013 he would not act differently.

He said that it was not unusual for a cellmate to not speak to a CSNSW officer and that the mere fact that Mr Tran-Bui was in an observation cell was not suggestive of anything because sometimes inmates are placed in such cells for overflow reasons.

Ultimately, however, he agreed that if he had only been told that Mr Tran-Bui was experiencing cramps (without any mention of hunger or food) he would have called a nurse. He also said that he believed that if Mr Tran-Bui needed medical assistance he would have asked for it.

The reference to food seems to have taken a position of primacy in the minds of both Officers Cassin and Lannan in their investigation of the knock up. By way of background, Officer Cassin explained that he was aware that inmates receive their last meal of the day between 3:00pm and 3:30pm and that, in his experience it was not uncommon for inmates to be hungry and requesting food at around 10:00pm.

However, Officer Lannan rejected the suggestion that the mention of food by an inmate in relation to a knock up caused him to lose interest. Officer Lannan also agreed that, as general matter, inmates use a knock up for unintended purposes but rejected the suggestion that he had become complacent in his response.

Officer Katieli said that he could not recall whether Officers Lannan and Cassin made any mention of food or cramps to him after they had attended Mr Tran-Bui's cell. Officer Katieli was asked what his expectation of an officer would be if the officer was told that an inmate had cramps, was crouching, and wanted food. Officer Katieli said that he expected the officer to pass on the information to him and that he would make a decision about any further action. Officer Katieli was asked to assume that this information had been given to him and asked whether it would cause him to make any further inquiry. He responded by saying that it might have. Finally, the following matter was posed to Mr Katieli:

Q: *Do you agree with this proposition that if somebody is in an observation cell and you find out as one piece of information that they've got stomach cramps, so you know they've got detoxissues and they've got stomach cramps, aren't you better to be safe than sorry and get Justice Health to have a look at them?*

A: *Yes, if that's what's required.*

In this regard Officer Cassin agreed that it would have been helpful if he was in possession of information relating to any prior health problem that an inmate had had and whether a knock up had previously been used for a health-related problem. He also agreed that it would have been useful for him to have had such information on 23 November 2013.

Dr van den Bogaerde considered the issue of hunger to be irrelevant and described the failure to enquire with Mr Tran-Bui as a "*dereliction of duty*" on the part of the CSNSW officers.⁶⁹ Dr van den Bogaerde went on to express the view that the CSNSW officers should have entered the cell to look at Mr Tran-Bui and subsequently reviewed CCTV footage from the cell.

Dr Vickers was more guarded in his assessment of the cell attendance by CSNSW officers. In his second report he said from the CCTV footage Mr Tran-Bui did not appear to be in any great distress as he had in the previous hour before the knock up. On this basis, and also noting that "*abdominal pain is a very common complaint in the general population and can indicate a multitude of common benign causes*" Dr Vickers offered this opinion:

"There just does not appear to be any great display of distress by Mr Tran-Bui at the time of the Officer's visit to the cell door that would have made any reasonable non-medical person be concerned that a Justice Health review was required".

Section 12.1.5.1 of the OPM in operation at the time of Mr Tran-Bui's death concerns the response by CSNSW officers to cell call alarms (knock ups).

It provided as follows:

“Correctional Officers must respond to every call. Once notified of a cell call or alarm, the night senior or officer-in-charge shall proceed directly to the cell to further investigate the call and if necessary respond to any serious incident. If the night senior or officer-in-charge is not available to immediately respond, the night senior or officer-in-charge must delegate responsibility to another officer”.

Section 5.5 of the new COPP concerns cell security or alarm calls. In contrast to the above, procedure 2.3 within Section 5.5 provides that responding CSNSW staff are to proceed directly to the cell identified and: *“Ascertain if the inmate(s) that occupy the cell are in good health by:*

- *Speaking directly with the inmate(s) to identify the cause for the cell call; and*
- *Visually inspecting the inmate(s)”.*

Conclusion: Given the opinion expressed by Dr Vickers, which is preferred and accepted, there is no basis to conclude that the non-medically trained officers who attended Mr Tran-Bui's cell on the evening of 23 November 2013 should have escalated the attendance to Justice Health staff for further action. However, this opinion is based on the information known to the officers at the time. The questions that arise from this are whether further information ought to have been obtained by: (a) making a direct enquiry with Mr Tran-Bui as to his welfare; and (b) arranging

As to the first question, it appears from all of the available evidence that no direct enquiry was conducted with Mr. Tran-Bui simply because he did not activate the knock up, and because he did not initiate any conversation with the attending officers; rather, it was Mr. Ly who did so on both accounts. Given that Officer Cassin accepted in hindsight that he should have spoken to Mr. Tran-Bui directly, and that, as a general matter, the need to do so is now reflected in the new COPP, this leads to the conclusion that such a direct enquiry should have occurred.

There is no doubt that such an enquiry was simple to undertake and could have been accomplished in a matter of seconds. Even though Mr. Ly made the knock up call, the knock up itself related to Mr. Tran-Bui. Seeking some confirmation from Mr. Tran-Bui that he was experiencing cramps due to hunger (as was thought to be the case) would have represented a thorough and appropriate investigation of the knock up. Of course, it is impossible to know what Mr. Tran-Bui might have said if such a direct enquiry had been made (or if he would have responded at all, given the pain he had been experiencing), and whether any response from him might have prompted any action by the attending officers.

As to the second question, the idea of arranging for a Justice Health nurse attending knock ups with CSNSW officers was raised during the course of the inquest. In response, Ms Sheehan indicated that arrangements have been made with CSNSW for Justice Health staff to be notified of all knock ups that CSNSW staff at the MRRC were attending after lock-in so that a 3-month trial could be conducted. That trial commenced in December 2017 and appears to have continued at least until May 2018. Expecting non-medically trained personnel, such as CSNSW officers, to be able to make an accurate assessment of the welfare of an inmate is fraught with difficulty, except in cases where an inmate's condition is so obvious as to plainly indicate that medical attention is required. It is therefore necessary to make the following recommendations.

Recommendation 7: I recommend to the Commissioner for Corrective Services that consideration be given to amending the Custodial Operations Policy and Procedures be amended to provide that in response to a cell call alarm relating to an inmate with a health care issue previously identified by Justice Health & Forensic Mental Health Network (**Justice Health**) clinical staff:

(a) responding CSNSW staff should attend the cell in the company of a Justice Health clinical staff member in order to ascertain that the inmate is in good health;

(b) in the event that a Justice Health clinical staff member is unable to attend the cell, responding CSNSW staff should approach the task of ascertaining whether the inmate is in good health with a high index of suspicion; and

(c) in the event that a Justice Health clinical staff member is unable to attend the cell, responding CSNSW staff are to advise the Justice Health Nurse Unit Manager or Nurse in Charge as soon as possible after the cell attendance of the results of speaking directly to, and visually inspecting, the inmate.

Recommendation 8: I recommend to the Chief Executive, Justice Health & Forensic Mental Health Network (**Justice Health**) consideration be to amending *Policy 1.231 Health Problem Notification Form (Adult)* to provide that in the event of a request from Corrective Services (CSNSW) staff relating to responding to a cell call alarm initiated by an inmate with a health care for a medically trained person, in the form of a Justice Health staff member, to attend the cell and check on Mr Tran-Bui's welfare.

It was submitted by counsel for Justice Health that **Recommendation 8** is unnecessary because such attendances are already occurring, and that it should be noted that Justice Health staff are not normally present during the evening in many correctional centres. However, the evidence which the inquest received to date from Ms. Sheehan has been that attendances of Justice Health staff in response to cell call alarms has only been in relation to a trial period to allow for collection of data, and only at the MRRC. **Recommendation 8** envisages arrangements being made beyond any trial period, on a permanent basis, and at all correctional centres.

Counsel for Ms Crowther submitted that a recommendation should be made for CSNSW officers *"to make every attempt to communicate directly with any inmate they have concerns about or is the subject of their attention rather than rely on other inmates to provide opinions or second hand information about them"*. In view of the introduction of the COPP, and in particular Section 5.5 of the COPP, such a recommendation is already provided for and therefore unnecessary.

Findings

The findings I make under section 81(1) of the Act are:

Identity

The person who died was Sony William Tran-Bui.

Date of death

Mr. Tran-Bui died on 24 November 2013.

Place of death

Mr. Tran-Bui died at Westmead Hospital, Westmead NSW 2150.

Cause of death

Mr. Tran-Bui died from complications of acute peritonitis caused by the rupture of a duodenal ulcer.

Manner of death

Mr. Tran-Bui died of natural causes whilst in lawful custody on remand at the Metropolitan Remand and Reception Centre, Silverwater.

Recommendations: *To the Commissioner for Corrective Services NSW:*

1. I recommend that consideration be given to amending the Custodial Operations Policy and Procedures (**COPP**) to provide that information contained in a Health Problem Notification Form (**HPNF**) relating to an inmate, particularly information that relates to the type of observation required, how frequently such observations are to be performed, and by whom the observation will be attended, be reproduced in a form and placed in a location that is readily accessible and visible by Corrective Services NSW (**CSNSW**) staff rotating between shifts.

2. I recommend that consideration be given to amending the COPP to provide that part of the responsibilities of a CSNSW Officer in Charge is to ensure that CSNSW staff under their supervision, who are rotating between shifts, are aware of:

- information contained in a HPNF relating to an inmate, particularly information that relates to the type of observation required, how frequently such observations are to be performed, and by whom the observations will be attended; and
- information provided by a Justice Health & Forensic Mental Health Network (**Justice Health**) clinical staff member, following the clinical assessment of an inmate, in relation to any ongoing health concern that the inmate may have.

3. I recommend that consideration be given to collaboration with Justice Health in order to devise appropriate and regular education and training programs delivered by Justice Health clinical staff to ensure that CSNSW staff are aware of:

- the importance of the contents of a HPNF in relation to an inmate's good health;
- how to correctly understand instructions contained in a HPNF which relate to observing an inmate's signs; and
- how to effectively carry out instructions contained in a HPNF which relate to ensuring that inmate's good health, particularly those instructions which relate to the type of observation required, how frequently the observation should be made, and by whom the observation will be attended.

4. I recommend that consideration be given to conducting a review of local procedures at the Metropolitan Remand and Reception Centre in order to determine whether:

- appropriate directions are provided by senior CSNSW staff to other CSNSW staff; and
- whether appropriate monitoring equipment exists; to allow for instructions contained in a HPNF which relate to observing an inmate are able to be followed and implemented effectively in order to ensure that inmate's good health.

5. I recommend that consideration be given to amending the COPP to provide that in response to a cell call alarm relating to an inmate with a health care issue previously identified by Justice Health clinical staff:

- responding CSNSW staff should attend the cell in the company of a Justice Health clinical staff member in order to ascertain that the inmate is in good health;
- in the event that a Justice Health clinical staff member is unable to attend the cell, responding CSNSW staff should approach the task of ascertaining whether the inmate is in good health with a high index of suspicion; and
- in the event that a Justice Health clinical staff member is unable to attend the cell, responding CSNSW staff are to advise the Justice Health Nurse Unit Manager or Nurse in Charge as soon as possible after the cell attendance of the results of speaking directly to, and visually inspecting, the inmate.

To the Chief Executive, Justice Health & Forensic Mental Health Network (Justice Health):

I recommend that consideration be given to the circumstances of Mr. Tran Bui's death (with appropriate anonymization, and conditional upon consent being provided by Mr. Tran Bui's family and following appropriate consultation with them) being used as a case study as part of training provided to Justice Health clinical staff in relation to treatment of inmates presenting with drug withdrawal-like symptoms.

I recommend that consideration be given to collaboration with Corrective Services NSW (CSNSW) in order to devise appropriate and regular education and training programs delivered by Justice Health clinical staff to ensure that CSNSW staff are aware of:

- the importance of the contents of a HPNF in relation to an inmate's good health;
- how to correctly understand instructions contained in a HPNF which relate to observing an inmate's signs; and
- how to effectively carry out instructions contained in a HPNF which relate to ensuring that inmate's good health, particularly those instructions which relate to the type of observation required, how frequently the observation should be made, and by whom the observation will be attended.

I recommend that consideration be given to requiring that following the clinical assessment of an inmate by a Justice Health clinical staff member, and where the inmate is deemed to have an ongoing health concern, the Justice Health clinical staff member is to provide a verbal and written handover to the first available CSNSW Officer in Charge (OIC) of the area where the inmate is housed in order to ensure that the inmate's health concerns are adequately and appropriately managed.

I recommend that consideration be to amending *Policy 1.231 Health Problem Notification Form (Adult)* to provide that in the event of a request from CSNSW staff relating to responding to a cell call alarm initiated by an inmate with a health care issue previously identified by Justice Health clinical staff, a Justice Health clinical staff member is to accompany CSNSW responding staff to the cell in order to assist in ascertaining that the inmate is in good

3. 6538 of 2015

Inquest into the death of Craig Catley. Finding handed down by Deputy State Coroner Ryan at Glebe on the 10th October 2018.

Introduction

On 7 January 2015 Craig Catley aged 32 years died at Long Bay Hospital. The previous day he had been discharged from Prince of Wales Hospital following treatment for a pituitary tumour. Mr Catley was serving a custodial sentence for the manslaughter of his mother and for animal cruelty offences.

As Mr Catley was in custody, the responsibility for ensuring that he received adequate care and treatment lay with the State. Pursuant to sections 23 and 27 of the Act, an inquest is required when a person dies in custody to assess whether the State has discharged its responsibilities.

The role of the Coroner

Pursuant to section 81 of the Act a Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

In addition the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Mr. Catley's life

Craig Catley was born on 2 February 1982 to parents Rhonda Catley and Danny Fisher. His father had little or no involvement in his life. His mother developed a dependency on alcohol and heroin, and had a history of domestic violence perpetrated by her intimate partners. When Craig was ten years old she was imprisoned for robbing and wounding a taxi driver. She remained incarcerated for much of the following nine years. During this time Craig was raised by his maternal grandparents.

Soon after Rhonda Catley was released from prison she moved to Gateshead near Newcastle. Craig, now an adult, began to spend more time with her and moved in to live with her for periods of time. However their relationship was turbulent, and was made worse by Rhonda Catley's ongoing dependence on alcohol which often made her behave aggressively. While Craig loved his mother he felt resentment against her for not being around to raise him as a child. He also resented her drug and alcohol dependence.

Craig too had alcohol and drug dependencies, and became aggressive when intoxicated. During the years 2005 to 2007 there were a number of violent incidents involving Craig, his mother, and Craig's then girlfriend. Craig and his mother had Apprehended Violence Orders against each other at different times. However despite the anger and physical abuse which characterised their relationship, friends and family reported that Craig loved his mother and at times tried to protect her from the violence of her intimate partners. It was a troubled and complex relationship.

The offences and custodial sentences

On the evening of 16 October 2009 Craig came to visit his mother. They began to drink alcohol and to argue. In the early hours of 17 October Craig fatally stabbed his mother in the chest, and then killed two of her cats. He then walked to a neighbour's house and asked her to call police as he had *'just killed mum'*.

Craig was charged with murder and pleaded 'not guilty' on the grounds of mental illness. He was convicted of manslaughter and of two acts of animal cruelty. On 18 November 2011 he was sentenced to eleven years' imprisonment with a non-parole period of eight years. He also received shorter fixed terms of imprisonment for the animal cruelty offences.

Craig Catley's health and treatment in custody

Craig's death occurred after he had been five years in custody. Craig was first received into custody at Cessnock Correctional Centre on 16 October 2009. He reported untreated depression and a suicide attempt in 2007. He was commenced on anti-psychotic medication as he also reported psychotic-type symptoms.

In February 2012 Craig was transferred to Junee Correctional Centre where he was gradually weaned off his anti-psychotic medication, with no reported adverse effects.

Throughout 2013 and 2014 Craig suffered episodes of dizziness and fainting. In a medical review in August 2013 it was recommended he cease using his clonidine medication, but he was reluctant to do so. It was noted his dizziness occurred mostly when he was standing, and a cardiologist review in May 2014 confirmed he had Postural Orthostatic Tachycardia Syndrome (POTS syndrome). This is a condition in which a change from lying to standing causes an abnormal increase in heart rate. Its symptoms include light-headedness and blurry vision. Craig was treated with the medication metoprolol and an increase of salt in his diet.

However Craig's fainting episodes continued throughout the second half of 2014, and he reported deteriorating vision, gait disturbance, incontinence, confusion and lethargy. In November he received a brain CT which led to an urgent neurosurgery referral on 26 November.

At Prince of Wales Hospital Craig was found to have a brain tumour which compressed the optic chiasm and the hydrocephalus. The tumour was surgically removed on 27 November and Craig remained at Prince of Wales Hospital for a further six weeks, under the care of neurosurgeon Dr Jacob Fairhall. Craig also received treatment from intensive care, endocrinology, nephrology, psychiatry and ophthalmology medical teams.

Craig was transferred back to Long Bay Hospital on 6 January 2015. He was last seen in person by a Justice Health nurse who had a conversation with him that night at 8.37pm. She assisted him with his prescribed medication and gave him a urine bottle to use during the night. According to her notes, she also reminded him to use his hospital cell call button if he needed assistance. Craig's hospital cell did not contain a CCTV camera, but there was one installed in the main area outside his cell. It is able to capture images of the glass window in Craig's cell door. At about 3.37am on the morning of 7 January, CCTV footage retrieved from this camera shows Craig moving about in his cell. No further movement was shown.

Craig was found in his cell unresponsive at 8am that morning by a Corrective Services officer and a nurse who was to conduct a sugar level check. An ambulance was immediately called and CPR commenced, but he could not be revived and he was pronounced deceased at 8.41am. Craig's medical notes do not contain any reference to him seeking medical help during the night. Nor is there any reference to him activating his cell call button. Despite attempts, police were unable to obtain independent verification that Craig's cell call button had not been activated that night. This issue is addressed below.

What caused Craig Catley's death?

Pathologist Dr Kendall Bailey performed an autopsy examination of Craig's body. The examination did not reveal any significant abnormalities, and Dr Bailey could not ascertain a cause of death. She noted Craig's background history of tachycardia, and commented that a fatal arrhythmia could not be excluded.

At the request of the Coroner, consultant physician and cardiologist Dr John England provided an expert report. After examining the medical records and statements, Dr England confirmed the most likely cause of Craig's death was a sudden cardiac arrhythmia.

As to what had caused the arrhythmia, Dr England was unable to determine this with certainty. He did not think Craig's diagnosis of POTS provided the underlying reason, and considered other possibilities more likely. These included that through use of anti-psychotic medication Craig had developed long QT syndrome, a condition which creates an increased risk of irregular heartbeat and sudden death. Dr England also thought it possible Craig's pituitary brain tumour had contributed to his cardiac arrhythmia.

Dr England could not find a cause for death in any omission of Craig's medical treatment.

On the basis of the above medical evidence, I find on the balance of probabilities that the cause of Craig's death was a sudden cardiac arrhythmia. However it is not possible to ascertain what the underlying cause of this event was.

Was Craig's care and treatment at Prince of Wales Hospital adequate?

An independent expert report was obtained from Dr Jeffrey Brennan, a specialist neurosurgeon. Dr Brennan was asked to give his opinion on the adequacy of Craig's care and treatment at Prince of Wales Hospital, and whether this had contributed to his death.

In Dr Brennan's view Craig's hospital treatment and care was of a good standard, and fitted within accepted standards of care for Craig's complicated issues. Dr Brennan commented favourably upon the following features:

- the hospital's rapid diagnosis of and timely surgery for Craig's tumour
- the multidisciplinary approach taken to his health issues
- the care he received in the Intensive Care Unit and then on the ward
- the thorough endocrinological investigation and management of his fluid management issues, described below
- appropriate plans for follow up at discharge.

Was Craig discharged from hospital too early?

Craig's aunt Nicole Catley made regular visits to Craig while he was in gaol and hospital. After he died she wrote to the Coroners Court expressing concern that Craig had been discharged too soon from Prince of Wales Hospital. She wrote of her distress at visiting Craig in hospital and witnessing his loss of sight, his urinary incontinence, and his uninhibited and distressed mental state. She believed these conditions were not improving.

In response to Ms Catley's concerns, a report was requested from Dr Fairhall regarding the decision of Craig's treating team that he was suitable for discharge to Long Bay Hospital on 6 January 2015. The inquest was also assisted by relevant comments made by Dr Brennan on this issue.

In Dr Fairhall's opinion, the timing of Craig's discharge was appropriate. He noted that Craig had a lengthy postsurgical period in Prince of Wales Hospital, with input from all relevant medical disciplines.

Dr Fairhall noted some postsurgical complications. These included Craig's ongoing visual loss, his behavioural concerns, and most significantly, managing his diabetes insipidus.

Diabetes insipidus is caused by insufficient production of the hormone which instructs the kidneys to retain water. As a result large quantities of water are passed as urine and the patient experiences extreme thirst. In Craig's case this condition of hormone disturbance was considered an inevitable consequence of his brain surgery. In Dr Brennan's opinion it was being appropriately managed in hospital with observations, fluid replacement, and the medication desmopressin which aims to reduce nightly urine production. Dr Fairhall noted that on discharge Craig's diabetes insipidus was the subject of a clear management plan prepared by his endocrine team.

As regards Craig's visual loss, Dr Brennan explained this had been caused by the brain tumour compressing Craig's optic nerve. He noted that Craig's post-surgery visual impairment was not unusual and could take months to resolve. Dr Fairhall considered it had good prospects of improving over time. Like Craig's diabetes insipidus, his visual acuity was to be monitored on discharge with follow up appointments.

Craig's confusion and disinhibited behaviour continued throughout his postsurgical period. Dr Brennan considered this to be consistent with derangement as a result of the brain tumour. In his view it was appropriately managed in hospital with supervised care and medical therapy. Craig's discharge plan included ongoing psychiatric input at Long Bay Hospital, and Dr Fairhall was of the view there were prospects for recovery in the following months. Having reviewed the evidence, I conclude there is no basis to find that Craig's death was the result of premature discharge from Prince of Wales Hospital, or of any deficiency in his care and treatment there.

Craig's care and treatment on discharge

Dr Brennan was asked about the adequacy of Craig's observations conducted at Long Bay Hospital, in the short period between his discharge from Prince of Wales Hospital and his death. Dr Brennan commented that the observations conducted of Craig were adequate, and that it was normal for these to be reduced to twice daily once the patient has been transferred to a step down facility.

Given the suddenness of Craig's death, the question arises whether he might have attempted to get medical help during the night of 6 January. There is no notation in the medical records that Craig sought medical assistance during that period. As noted, his cell contained a call button. This was tested within a short period following his death and found to be in working order.

Nevertheless police sought independent evidence about whether Craig had attempted to get help that night. On 9 January 2015 they made a request for a Systems Activity Report for the button in Craig's cell. The purpose was to ascertain whether in the hours before his death Craig had attempted to activate it. The request was made to *[name redacted]* who are the contracted security systems company.

However the response from *[name redacted]* was that they were unable to comply, because their system had not been correctly configured to produce such a report. The unsatisfactory result is that it is not possible to ascertain through independent evidence whether Craig had tried to get medical help using the cell call button. I should note that *[name redacted]* has advised they have since carried out modifications to ensure Systems Activity Reports can be generated.

Notwithstanding the absence of this evidence, I am able to find on the balance of probabilities that Craig did not seek help by using the cell call button. There is no record in the medical notes of him having done so, and the device was found to be in working order.

What was the manner of Craig Catley's death?

The coronial investigation establishes that Craig's death was not brought about through any deficiency in the care and treatment he received at Prince of Wales Hospital or at Long Bay Hospital. This is also the case in relation to his general care and treatment as an inmate. From the outset of his time in custody it would appear that Craig's health problems were properly managed. Appropriate decisions were made and implemented about his medical treatment.

Nor is there any evidence that another person caused Craig harm, or that his death was caused by an accident or other form of misadventure. The manner of his death was by natural causes. On behalf of the coronial team I offer my sincere and respectful condolences to Mr Catley's family. I hope that this inquiry and inquest has gone some of the way to reducing their concerns about his death.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity

The person who died is Craig Catley born 2 February 1982.

Date of death:

Craig Catley died on 7 January 2015.

Place of death:

Craig Catley died at Long Bay Hospital, Long Bay Correctional Facility, Malabar NSW 2036

Cause of death:

Craig Catley died as a result of sudden cardiac arrhythmia.

Manner of death:

Craig Catley died as a result of natural causes while in custody.

4. 23577 of 2015

Inquest into the death of Andrew Amos. Finding handed down by Deputy State Coroner Russell at Glebe on the 5th October 2018.

Andrew Amos died at the Long Bay Correctional Complex at Malabar on 24 January 2015. He was 30 years old, having been born on 3 October 1984.

On 21 February 2014, an aggregate sentence of 2 years and 3 months with a non-parole period of one year and 6 months had been imposed on Mr Amos by the Parramatta Drug Court for two offences of breaking into houses and stealing and an offence of breaking into a house with intent to steal. That sentence was set to commence on 12 August 2013 and to conclude on 11 November 2015. Mr Amos's earliest possible release date was 11 February 2015.

He was, then, within the meaning of section 23 of the *Coroners Act 2009*, in lawful custody. An inquest in such circumstances is mandatory, pursuant to section 27(1) of that Act.

Mr Amos's classification within the prison system was as a minimum security prisoner. At the time of his death, he was housed in cell 17 of wing 16 at the Metropolitan Special Programs Centre at Long Bay Correctional Complex at Malabar, NSW.

Background

Mr Amos was born in Sydney. He had two brothers and an older maternal half-sister. His parents separated when he was a child and he and his brothers moved between his mother's and his father's homes. When he left school, Mr Amos worked as a removalist and as a labourer at a transport company.

When he was about 18 he became addicted to heroin and later started using amphetamines and methamphetamines. He started committing offences to fuel his addictions. He first entered adult custody on 16 October 2004 and had a number of periods of incarceration. Mr Amos had a de facto partner with whom he had been living since about 2003. They had three children together and Mr Amos was a stepfather to two older children belonging to his partner.

Mr Amos's partner spoke of the shock of Mr Amos's death and of the terrible loss that she, her children and Mr Amos's wider family continue to experience.

Functions of the Coroner

Section 81 of the *Coroners Act 2009* sets out the principal functions of a coroner conducting an inquest. Those are to record the identity of the person who has died, the date and place of his death and the manner and cause of his death.

Findings as to date, place, cause of death

Andrew Amos died on 24 January 2015 at the Metropolitan Special Programs Centre at Long Bay Correctional Complex, Malabar, New South Wales.

An autopsy was performed by Dr Istvan Szentmariay, forensic pathologist on 27 January 2015. Dr Szentmariay observed no suspicious external or internal injuries. He determined that the cause of Mr Amos's death was ischaemic heart disease.

Health

Mr Amos was an obese 30-year-old man. His body weight at autopsy was 102.5 kg and his body length 1.70 m. He was a heavy smoker and engaged in little exercise.

Mr Amos suffered periodically from depression. At the commencement of his final period of incarceration he reported that he had a history of several mild traumatic brain injuries resulting from assaults and heroin overdoses and had experienced loss of consciousness as the result of a car accident. He was assessed by a psychologist, a M Raymond, within the prison system. Mr Raymond did not find 'any indication of intellectual disability or cognitive impairment'.

Dr John England, cardiologist, reviewed Mr Amos's medical records and the post-mortem report of Dr Szentmariay. With reference to the findings of Dr Szentmariay, he noted that the left anterior descending coronary artery showed narrowing of at least 90% lumen obstruction due to a soft yellow plaque. He said:

[T]here was no evidence of a recent preceding scarring or death of heart muscle tissue to suggest a previous heart attack ... [T]here was no evidence of any other heart disease such as vegetations due to bacterial endocarditis on the heart valves.

A copy of Mr. Amos's medical notes from the Fairfield Medical Centre, attached to his Justice Health file, include an entry of 7 June 2004 in the following terms:

several episodes of sudden LOC [loss of consciousness] over the past few years - has been to hospital] but says has never been investigated.

Nil associated symptoms

Lousy diet - often misses meals and has long h/o [history of] recurrent head injuries due to fights bp [blood pressure] 110/70 ...

cvs [cardiovascular system]/cns [central nervous system]/ent [ear, nose, throat] nad [likely, in context, to mean no abnormality detected or no active disease]

ECG [electrocardiogram] – NAD – sinus rhythm.

Dr England's review of Mr Amos's medical records from the Fairfield Medical Centre, noted the normal electrocardiogram result and noted, in particular, the

normal sinus rhythm with no prolongation of the QT interval and ... nothing to suggest underlying coronary artery disease.

He said there was nothing in that medical history to suggest heart symptoms or any history to suggest angina of effort such as would be referred to underlying coronary artery disease.

Health records on admission to custody

A document entitled 'New Health Problem Notification Form for Inmates in Correctional Centres' was completed by a Justice Health registered nurse on 12 December 2013. That document noted that Mr. Amos 'denies any health issues' and that he was suitable for 'normal cell placement'.

Mr. Amos had, on eight previous occasions, been received into the custody of New South Wales Corrective Services. On his first reception into custody in October 2004, on a document entitled 'Medical Alert Form', under the heading 'Primary Health', a tick had been placed against 'Heart Disease/High Blood Pressure' with 'Heart Disease' underlined. Mr. Amos's doctor was noted to be Dr Fitch at Fairfield. On a document entitled 'Health Risk and Harm Minimisation Checklist Form', the question '[d]o you have heart disease?' was ticked and the comment added, 'irregular heartbeat'.

The 'Reception Risk Assessment Summary', in 2004, noted that Mr. Amos had had problems with irregular heartbeat and that Dr Fitch had prescribed heart medication but that Mr. Amos could not remember the name of the medication. It is apparent that Mr. Amos told the registered nurse on that occasion that he had used the medication for four months and then stopped taking it. He had stopped taking it three months before that assessment. A prescription for 'heart medication' is not apparent on Dr Fitch's records. On each subsequent occasion on which Mr. Amos was received into custody, it would appear that he did not indicate that he had any heart disease. There is no record in the reception documents to indicate that Mr. Amos had a heart condition or heart disease. In fact, the contrary is recorded. On a document called Reception Screening Tool, from 2012, for example, the question was asked:

Do you have a diagnosed heart disease, stroke hypertension, chronic heart failure, rheumatic heart disease, valvular heart disease or two or more risk factors?

The answer 'no' was chosen from available answers 'yes', 'no', 'unsure' or 'declined to answer'.

Should Mr. Amos's heart disease have been detected while he was in custody from December 2013?

It was Dr England's opinion that, 'after a careful consideration' of the Justice Health and private health records of Mr Amos,

there was no prior indication that Andrew Amos was suffering from coronary heart health issues which could/should have been detected by the medical staff prior to his death.

That opinion, as I understood it, reflected the normal ECG result in 2004 and the absence of medical or Justice Health records since 2004 which would suggest symptoms of any heart disease or condition. Mr. Amos was not investigated, during his final period of custody, for heart disease or a heart condition but there is no reasonable basis on which to conclude that Justice Health staff should have initiated such investigations.

Hours leading up to death

In the period leading up to his death Mr Amos was agitated about his grandfather who was dying and anxious to be free from custody in time to see him before he died.

On the day of his death, at about 4.30pm, Mr Amos told his cell mate that he was 'crook in the stomach'. As I understand the evidence, the afternoon muster of inmates took place outside the cells at 5pm on 24 January 2015. Mr Amos did not, at that time, complain to staff about any pain or discomfort. His cell mate said that he seemed 'okay' at muster. He spoke to another inmate after muster and seemed, to him, to be 'okay ... no complaints at all'.

At about 6pm he complained to his cell mate about pain in his chest and back. Another prisoner went to Mr Amos's cell on being called. Mr Amos appeared to him to be in distress and complained of pain in his back and left side around the shoulder blade. That other prisoner gave him a massage for about 3 to 4 minutes. Mr Amos then got up and sat on a chair. That other prisoner said 'you better go to the clinic'. Mr Amos said 'no, I just need to rest. Thanks mate.' He lay down on his bed watching television.

His cell mate went to check on him about half an hour later and found him face down on the bed. He did not appear to be breathing and his lips were blue. His cellmate notified Correctional Officer Steven Hokin, who was preparing the wing for 'lock in' that Mr Amos was 'not waking up'. Mr Hokin made an urgent call for assistance to the senior staff member on duty to respond with a medical team. This, Mr Hokin thought, was about 6:45pm.

Mr Amos's cell mate and another prisoner dragged him off the bed and commenced Cardiopulmonary Resuscitation (CPR). Correctional Officer Dan Xu heard Officer Hokin calling for assistance and ran with him to Mr Amos's cell. He, too, called for urgent medical attention. In response to the first call (by Officer Hokin) the senior staff member on duty, First Class Correctional Officer Campbell Dixon, went to the clinic and told Nurse Manju George and Nurse Duncan Newsome that they were required urgently in wing 16. Nurses Newsome and George were working in the dispensary at the time.

With the help of Officer Dixon, they obtained the two emergency bags and the heart start defibrillator from the central corridor of the clinic. Emergency bag 1 is a resuscitation bag containing oxygen, masks, pulse oximeter and other essential emergency resuscitation equipment. Emergency bag 2 contains pharmaceuticals and other items required for general emergency response. They then went straight to wing 16 and were taken directly to Mr Amos's cell.

They arrived at Mr Amos's cell, Officer Dixon estimated, at about 6:55pm. Correctional Officer Sean Powell places Officer Dixon's arrival in the wing at an earlier time. Nurse Newsome observed that Mr Amos was unresponsive with cyanosed lips and fixed and dilated pupils. He could detect no respiration or pulse. He commenced CPR while Nurse George attached a pulse oximeter, commenced oxygen therapy, attached the heart start defibrillator and commenced the heart start defibrillator diagnostic/action program. Correctional Officer Powell, who had been an ambulance paramedic, took over from the inmates who were assisting the nurses performing CPR on Mr Amos.

First Class Correctional Officer Dixon directed that a call be placed for urgent ambulance assistance. He estimated that he did that at about 6:57pm but the New South Wales ambulance service records a 000 call at 18:54:38. Ambulance officers arrived at the cell at about 7:15pm and continued CPR. Mr Amos did not respond and he was declared dead at 7:35pm.

There is no basis to conclude that the prison officers and prison nursing staff responded other than urgently and appropriately from the time that the first prison officer became aware of Mr Amos's situation.

Findings required by s81(1)

Andrew Amos died at Long Bay Hospital Correctional Centre, 1300 Anzac Parade Malabar, New South Wales on 24 January 2015. The cause of Mr Amos's death was Ischaemic Heart Disease.

He died of natural causes.

5. 42730 of 2015

Inquest into the death of Courtney Topic. Finding handed down by Deputy State Coroner Ryan at Glebe on the 30th July 2018.

Introduction

Courtney Topic was only twenty two years old when she was shot dead by a police officer near a busy intersection at Hoxton Park in Western Sydney. Courtney was holding a knife and she was not responding to police commands to put it down. The situation quickly escalated. Less than a minute after police officers arrived Courtney was on the ground, fatally shot to the chest.

Courtney's death is a tragedy. Three years later her family can still scarcely believe their daughter died in this terrible way. Their grief is still raw and will not be forgotten by those present at this inquest. The police officers involved in her death have been deeply affected by it. It is probable Courtney was not able to understand that police were telling her to put down her large knife. She was most likely suffering a psychotic episode due to undiagnosed schizophrenia.

Although her death should not have happened, it would be wrong to understate the seriousness of this situation. Although we do not know for certain what Courtney was intending to do, she was moving in the direction of the police officer who shot her and she was within two metres of him when he fired his pistol. He had reason to believe his life was in danger. But that cannot be all. Courtney's death is emphatically not one where it can be said '*This couldn't have been prevented*'. Her death raises broad issues about how police officers are trained to deal with people suffering a mental health crisis.

We ask a great deal of our police officers. We expect them to protect us in situations that are often unpredictable and dangerous. Sometimes the person they face is in the grip of a mental health crisis, as Courtney was. Her inquest forces us to ask: are there ways of reducing the risk of using lethal force, without unduly compromising police officers' safety? The conclusion I have reached is that there are.

If changes are not made there will be more deaths like Courtney's. The court heard that in Australia, of the persons shot by police between 1989 and 2011 nearly 42% were suffering from a mental illness. There is no reason to believe these numbers will reduce over time. More families will be left grieving, and police officers profoundly affected. Courtney's death exposed a compelling need for change. The NSW Police Force understands that responding to people in mental health crisis can be difficult and unpredictable work. Some years ago they commenced the process of building police skills in this area. But Courtney's inquest has exposed gaps in the way these processes work. Errors were made that morning which made the resort to lethal force a tragic inevitability.

In a recent 7.30 program on police shootings the NSW Commissioner of Police Michael Fuller stated:

'..I want the trend to be zero, but for mine it's about root cause analysis. Is there anything else we could have done? Again through oversight, through transparency, if there is anything, we will do it'.

Thus there is recognition at the highest level of the need to address this issue. Perhaps the greatest encouragement comes from the support the Commissioner gives to a number of the recommendations made as a result of Courtney's death. Along with so many who have been involved in this inquest, I believe swift action is required to help prevent others from suffering in this way. Above all, Courtney's family needs to believe that her death was not in vain.

The Inquest

An inquest is different to other types of court hearings. It is neither criminal nor civil in nature. It does not determine whether a person is guilty of an offence, and it does not make findings or orders that are binding on parties. This inquest into the circumstances of Courtney Topic's death is mandatory. As her death was a violent one it was required to be reported under section 6 of the Act. Section 27 of the Act mandates an inquest where it appears that a person has died as a result of homicide, and also where he or she has died in the course of a police operation.

A Coroner presiding over an inquest is required to confirm that a particular death occurred and make findings as to the identity of the person who died, the date and place of the death, and its cause and manner.

Issues of the inquest

There is no doubt that Courtney died on the morning of 10 February 2015, at Hoxton Park in Western Sydney. The direct cause of her death was a gunshot wound fired to her left chest by Senior Constable Ethan Tesoriero. Her death as a result of a single gunshot wound was confirmed in a post mortem report of forensic pathologist Dr Kendall Bailey.

These matters are not in dispute. It was the manner of Courtney's death which provided the focus for the inquest. Specifically:

- what was Courtney's mental state on 10 February 2015?
- what did police do in response to the situation?
- did police act in accordance with NSW Police Force policies and procedures?
- was the police response appropriate?

The inquest also raised questions about the way police officers are trained and tasked to respond to emergency mental health incidents. Two areas of training in particular are fundamental to police work. I will first briefly describe these two programs, as they are critical to an understanding of the police response to Courtney on 10 February.

Police training: Tactical Options and Mental Health.

All NSW officers below the rank of Senior Sergeant who carry arms and appointments must complete annual operational safety training. The purpose is to train officers in determining what tactical options and level of force is appropriate in different situations. There are scenario-based exercises to test officers' skills in using communication when people resist police directions. Sometimes but not always these exercises involve a high risk mental health incident.

Attending mental health incidents also requires specific training. The NSW Police Force understands this and wants officers to learn skills which will reduce the risk of harm to themselves and to mentally disordered people. Therefore since 2013 all NSW police officers have been required to complete a mental health awareness program. The mental health training is designed and delivered by the NSW Police's Mental Health Intervention Team [MHIT]. The MHIT's one-day program is mandatory for all sworn officers. Officers are instructed in identifying the signs of mental illness and appropriate ways of de-escalating situations where it is present.

The MHIT also offers an optional four-day program. This provides a stronger focus on communication and de-escalation techniques, and more role playing exercises. At the current time over 2,500 NSW police officers have been trained in this specialist program. I will return to these matters when dealing with the need for recommendations.

Courtney's life

Courtney was born on 27 February 1992. She was the much-loved and only daughter of Leesa and Ronny Topic, and beloved sister of older brother Kristopher born in 1989, and younger brothers Zachary born in 1995 and Brodie born in 1998. Courtney grew up in an exceptionally close and loving family. Leesa and Ronny Topic are loving, intelligent and attentive parents. From Courtney's early childhood they identified aspects of her social and emotional development which concerned them. They found professional help for her and supported her with consistent and loving care. Their raising of Courtney was informed by their desire that she develop into an independent, physically and emotionally healthy young woman.

The Topic family lived in a five-bedroom home at Carnes Hill in Western Sydney. They gathered each night for their evening meal and enjoyed spending time together on family outings. All four children received their high school education at Freeman Catholic College Bonnyrigg. Courtney was born a healthy baby. She was a bright girl who enjoyed her first couple of years of primary school. However when she was in Year 2 Leesa saw she was falling behind academically and socially, and losing confidence at school. She arranged for her to have a psychometric assessment.

The resulting report found Courtney to be an intelligent and imaginative girl with weaknesses in attention skills and auditory short term memory. She was diagnosed with 'Attention Deficit Disorder – Inattentive' and was prescribed the drug Dexamphetamine. This was soon changed to Ritalin when Courtney's parents saw that the Dexamphetamine was making Courtney sad. Throughout her primary school years Courtney's parents made sure she received tutoring and psychological support to build her confidence. She made friends, went to birthday parties and enjoyed doing gymnastics. Her parents described her as a calm girl who did not show extreme highs or lows in her emotions. By the time she was twelve years old her parents were confident she was ready for high school.

At high school Courtney made new friends, but as she got older it became evident to Leesa and Ronny that she found it a struggle socialising at parties. She completed her Higher School Certificate in 2009 but was unsure what she wanted to do next. When she was eighteen Courtney told her mother she wanted to get psychological help. Leesa went with her to Headspace Campbelltown where Courtney was initially assessed by Mental Health Nurse Tony Raeburn.

Mr Raeburn considered she was *'clearly exhibiting traits of dissociative personality disorder with some significant disorganisation, and emerging schizophreniform disorder'*. When Courtney was assessed a few days later by Headspace psychiatrist Dr Leonard Chin he did not think she had a psychotic condition. He did however note that she *'...does not experience a sense of emotional rapport with others [and] has been experiencing a lot of conversational internal dialogue of a somewhat dissociative nature, and even given names to the different internal voices'*.

Dr Chin diagnosed Courtney with Asperger's Syndrome.

After the assessment Courtney told her mother she had been hearing voices for a very long time. Leesa was concerned to hear this, but Courtney told her she was not worried by it. In October 2010 Courtney commenced casual work as a cashier at a Woolworths supermarket near her home. Her supervisor Ms Moyra Watson spoke highly of her as a very good worker who performed tasks well and without hesitation. Ms Watson commented however that Courtney did not generate conversation and preferred to spend her breaks by herself.

Courtney struggled with the short notice she often received for her work shifts. She also found it stressful to deal with people when she was working longer shifts. Her parents explained the problem to her sympathetic supervisor, who ensured Courtney received regular hours divided into four hour shifts. This worked better for Courtney and enabled her to continue her job. About 18 months before her death Leesa observed that Courtney became less motivated to do things, and more withdrawn from family life. Her father Ronny commented that around this time she began to spend more time in her bedroom with the door closed.

One evening in December 2014 Courtney became distressed and told her parents she wanted to seek professional help again. With Leesa's help Courtney was referred to child and adolescent psychiatrist Dr George Liangas in North Parramatta. Dr Liangas saw Courtney on three occasions before she died.

Dr Liangas cast doubt on the Asperger's diagnosis and was of the view she was suffering a major depressive disorder of moderate severity. He prescribed the anti-depressant drug fluoxetine. Leesa and Ronny thought that with this medication Courtney's mood gradually improved and she started interacting more with her family.

Courtney's mental state on 10 February 2015

The question of what was happening in Courtney's mind on the morning of 10 February was of great importance to those attending the inquest, especially her family. What could explain the confounding fact that Courtney, a gentle-natured young woman who had never displayed aggressive or antisocial behaviour, had left her home that morning holding a large knife? And why hadn't she put it down when police armed with weapons demanded her to?

At the inquest the court heard evidence that on the day of her death Courtney probably had untreated schizophrenia and was likely suffering a severe episode of psychosis. Forensic psychiatrist Dr Kerri Eagle reviewed the evidence and interviewed members of Courtney's family. She also reviewed Courtney's private writings which were discovered in her bedroom after her death.

Unknown to her family, these writings documented bizarre and highly disturbed beliefs of being controlled, of her mind being read by others, of being forced to participate in an experiment, and of having lost her true identity. The discovery of these anguished writings after Courtney's death must have been a fresh source of grief for her family. Dr Eagle explained that schizophrenia is a severe chronic mental illness characterized by delusions, hallucinations, and grossly disorganized behaviour. It is also associated with significant cognitive and functional deficits, including the ability to interpret emotions in other people.

Although Courtney had never been diagnosed with schizophrenia Dr Eagle thought she had suffered its symptoms for a sustained period. She cited Courtney's lengthy history of reporting auditory hallucinations. She also noted Courtney's report to Dr Liangas two months before her death that she was experiencing *'invasive memories – fear/panic ...I do everything out of fear ... Fear of safety if I don't do what I'm supposed to do'*.

Dr Eagle thought Courtney's private writings indicated a mind *'tormented for several years with an internal world characterized by identity disturbance, persecutory themes ...and perceptual abnormalities'*. Dr Eagle speculated that these feelings may explain Courtney's possession of a knife on 10 February. Dr Eagle also noted Courtney's increasing difficulties with social interactions, explaining that *'...empathy relies on an ability to be able to accurately perceive another person's emotions, beliefs and motivations in a given situation. This has been found to be impaired in schizophrenia.'*

In her opinion it was most likely that on 10 February Courtney was struggling to process what was happening around her, resulting in her being unable to respond to police commands that she put down her knife. Courtney's observed behaviour that morning supports Dr Eagle's opinion that she was cognitively disconnected from what was happening. As will be seen, almost all witnesses were struck by her extraordinary lack of responsiveness to a situation where uniformed police officers were shouting commands and pointing weapons at her. She was described as looking as though she was *'in a daze or in her own little world'*, of looking *'like a zombie'*, of moving *'in a jerky and uncoordinated way'*.

The involved police officers too had expressed bewilderment at her unresponsiveness to their actions and words. Constable Tyson commented she appeared to be *'in some type of trance, unaware of her surroundings'*. Senior Constable Jones remarked *'She was uncommunicative. That bothered me greatly'*; and Senior Constable Tesoriero repeated: *'she didn't even acknowledge we were there, she wasn't doing what normal people do in public ...it was as though ...it didn't register'*.

The court accepts Dr Eagle's opinion that on 10 February Courtney was suffering undiagnosed schizophrenia, and was probably experiencing a severe episode of psychosis. The tragic significance of this is that Courtney's ability to understand what police officers were asking her to do that morning was most likely severely impaired.

The events of 10 February 2015

Nothing about Courtney's behaviour in February 2015 struck her parents as particularly unusual or gave them cause for acute concern.

On the afternoon of 9 February 2015 Courtney worked her shift at Woolworths and then had dinner with her family as usual. After dinner Courtney followed her routine of having a shower, then having a snack and pacing up and down the dining area while the family watched television. Her mother went to bed at about 10.30pm after kissing Courtney goodnight. The next morning Leesa rose early as usual to get ready for work and was surprised to find Courtney up already. Leesa greeted her but Courtney did not respond. At about 10.00 or 11.00am Courtney's brother Zac knocked on her bedroom door to tell her he was on his way out. He heard Courtney reply from inside *'Not a worry, see you later'*.

Courtney left her family home soon afterwards. For reasons we will never know, she took with her a large knife from the kitchen. It had a silver blade 25cm in length and a 15cm wooden handle. Courtney had never done anything like this before.

The first call to police

At 11.05am a camera at Carnes Hill Shopping Centre captured an image of a female believed to be Courtney on Stonequarry Way, a few minutes' walk from the Topic family home. That Courtney would go out walking by herself was considered most unusual by her family.

Fourteen minutes later, Mr Robert Maguire was driving his delivery truck south along Cowpasture Road in West Hoxton when he saw Courtney walking northwards. Mr Maguire noticed Courtney's hand was up against her head. She seemed to be yelling and screaming, although he could not hear what she was saying. He then saw she was holding a large knife in her other hand. She was making no attempt to conceal it, and was moving it with her hand so the blade would *'go up and down in front of her'*.

In his evidence to the inquest Mr Maguire said he had felt concerned for the mental health of this young woman. He was worried she would harm herself or members of the public. At 11.19am he rang Liverpool Police Station and spoke to the officer performing station duties, Constable Grace Beasant. He told her: *'I think I just saw a female walking along the side of the road with a knife. I think she was talking to herself because there was no one else there'*.

When Constable Beasant asked Mr Maguire if he was sure about the knife he replied: *'Yes. She was carrying it in one hand and it looked like she was hitting herself in the head with the other'*. He went on to say: *'She looks upset. She might hurt herself'*. The first CAD message and radio broadcast

After taking Mr Maguire's call Constable Beasant entered details onto what is known as the police Computer Aided Dispatch [CAD] system. The police CAD system contains a computer generated police messaging system. When a call is made to '000' or to a local police station, the police officer or operator taking the call logs into the CAD system. He or she assigns an incident type and a priority classification, then keys in a narrative of what is happening. The message is then able to be sent out to police car units for their response.

The operator who takes the call also sends the CAD message on to police radio operations. A radio operator uses this to send a voice message over the police radio system.

Based on what Mr Maguire had told her, Constable Beasant allocated his call a 'Priority 2'. This is determined as: *'No police at the scene however an urgent response is required due to violent or the possibility of violent and/or exigent circumstances, or police at a scene require further assistance'*.

Constable Beasant entered the Incident Type as a *'Concern 4 welfare'*. Her CAD message about Courtney read as follows: *"Inf requesting police. He was driving along Kurrajong Road and observed a female talking to herself. She then hit herself with one hand and in the other hand she held a knife. POI distressed. POI described as female, Caucasian, long dark brown hair, blue and white striped shirt. Inf concerned that she is MH and going to hurt herself. Knife NFD."*

Constable Beasant explained that with the words *'inf concerned that she is MH'*, she intended to convey that the police response needed to be one that was sensitive to likely mental health issues. She had hoped the Incident Header detail of *'Concern 4 welfare'* would prompt a response from an officer who had completed the four day MHIT training.

As a result of Constable Beasant's CAD message, a voice broadcast was sent out to police units as follows:

'Green Valley car, thanks in the Kurrajong Road, Carnes Hill. Informant was driving along Kurrajong Road, observed a female talking to herself. Apparently she hit herself in the head with one hand, and in the other hand she was in possession of a knife. She was distressed. Informant's a bit worried she might be going to hurt herself. Female Caucasian, long dark brown hair, blue and white striped shirt. Green Valley car thanks.' At 11.31am, as no police car units had responded to the broadcast, a second voice broadcast went out. It repeated information that the young woman was talking to herself and hitting herself in the head with a knife.

Ms. C'Eladoure's call to 000

While this was happening Courtney was approaching the Hungry Jacks restaurant at the intersection of Cowpasture Road and Hoxton Park Road. This is a busy intersection with multi lanes in all four directions controlled by traffic lights. A footpath and grassed area wraps around the corner of the intersection which adjoins the Hungry Jacks restaurant and car park.

The time needed for Courtney to walk to this location from her home would have been about twenty minutes. Ms Annabelle C'Eladoure and her young son were sitting in her car which was parked about seven metres from the entrance to Hungry Jacks. Ms C'Eladoure saw Courtney rest the blade of her knife on her own head, and then enter the restaurant. Once inside Courtney held the knife behind her back and bought a frozen coke drink.

The Hungry Jacks staff member who served Courtney did not recall anything remarkable about her, except that she was wearing her sunglasses inside the restaurant and did not respond in any way to her greeting.

Ms C'Eladoure observed Courtney leave the restaurant and stand outside its entrance. After a few minutes Ms C'Eladoure rang 000 and asked for police. She told the operator of a girl walking around with *'a pretty big knife'*. She described Courtney as *'probably about 16 to 17 maybe'* and that she looked like *'a very odd girl'*.

Courtney was by herself, and was waving the knife at cars, brushing her hair back with it, and at one point had pointed it into her stomach *'as though she was gonna stab herself'*. Ms C'Eladoure continued: *'And so, I just don't know what she's doing ... it doesn't look like a safe situation'*. Regarding Courtney's movements Ms C'Eladoure told the 000 operator: *'She'll walk and then stop and then maybe walk somewhere else and then stop ...it's odd'*.

The operator promised to get police to attend as soon as possible. She asked Ms C'Eladoure if she thought the girl needed an ambulance as well. Ms C'Eladoure replied: *'Just the police at this stage, but I'm not sure what she could do...I have no idea what her intentions are'*. Ms C'Eladoure told the inquest that although the young woman's actions were not aggressive or threatening, she felt the situation was unpredictable. She was concerned Courtney might harm herself or someone else, so she wanted the police to disarm her.

As Ms C'Eladoure continued to watch, Courtney walked slowly through the car park and passed through some shrubbery. She moved onto the grassed area at the corner of the intersection. According to footage captured on a CCTV camera outside Hungry Jacks, Courtney spent the next three minutes alone on the grassed area. During this time she can be seen pacing from left to right with the knife down by her side, before the first responding police car arrived at 11.45am. It pulled up on the eastern kerbside of Cowpasture Road, and Constable Tyson and Senior Constable Tesoriero can be seen getting out and moving towards her. The second CAD message and radio broadcasts

After receiving Ms C'Eladoure's '000' call an operator prepared and disseminated a second Priority 2 CAD incident message. It read: *'Female seen walking around with a large kitchen knife. POI desc 16-17 old, Cauc app, wearing jeans and a blue and white striped short, brown hair, blk sunglasses. POI has been pointing it into her stomach and brushing her hair away from her face with it. Ambo declined.'*

At 11.43am and 11.44am two further voice messages were broadcast to police units. Both referred to a young woman armed with a large kitchen knife. The second broadcast mentioned reports she had been pointing the knife at her stomach, and that *'there's people concerned about she's going to self-harm with it'*.

What the responding officers recalled about the broadcasts

Four police cars responded to the messages and broadcasts, and drove to the Hungry Jacks intersection. Officers Tesoriero and Tyson arrived first, and Senior Constable Darren Jones seventeen seconds later. Senior Constable Stephen McEvoy and Sergeant Glenn Sadler were next, arriving in time to witness the fatal shot but too late to have any influence on events. They were followed almost immediately by Constable Sanya Djuric and Senior Constable Paul Falzon.

As can be seen, the police radio broadcasts contained elements signalling that the young woman with the knife was displaying behaviour consistent with disturbed mental health. A striking aspect of this matter however is the lack of recall which most responding officers had of those details. The three involved officers remembered registering that the young woman was armed with a knife and was in the area of a shopping centre. Only SC Jones described the thought crossing his mind that she may be suffering some kind of mental illness.

It is not surprising that responding police would focus on details which indicated a potential threat to public safety. However their inattention to the equally strong indications of disordered mental health meant that Courtney's likely mental state played no part in their decisions about how to interact with her once they arrived. I turn now to describe what happened when the first police officers arrived at the scene. These were Constable Angela Tyson, at that time a Probationary Constable, and Senior Constable Ethan Tesoriero. They were closely followed by Senior Constable Darren Jones.

It is important to understand that events unfolded with great rapidity. From the arrival of officers Tyson and Tesoriero, a mere forty one seconds elapsed before Courtney was shot. The speed with which things happened, and their violent and distressing nature, has inevitably affected the accuracy of the accounts provided by police officers and civilians.

The arrival of officers Tesoriero and Tyson

On 10 February Constable Angela Tyson was working with her Field Training Officer, Senior Constable Ethan Tesoriero. Constable Tyson had commenced work as a police officer in August 2014, and she had undertaken the mandatory one-day mental health workshop. SC Tesoriero had been working as a police officer for five years. He too had completed the one-day mental health workshop. When Courtney's location at the Hungry Jacks intersection was broadcast SC Tesoriero drove there with lights and siren on, pulling up on Cowpasture Road. As they pulled up Constable Tyson could see Courtney walking slowly on the grassed area near the intersection. Constable Tyson thought she looked *'dazed'*, not taking in her surroundings and not reacting to the police car's lights and sirens.

The two officers had a brief conversation. Constable Tyson pointed out Courtney's knife which she still held down by her side. SC Tesoriero said: *'Ange, you right, you've got your Taser?'* Constable Tyson understood from this that she was to be ready to draw and use her Taser if necessary. At the inquest both officers were asked whether prior to getting out of the car they had discussed what their best approach to the situation should be. Could they have taken a little time to observe Courtney's behaviour and assess the risk she posed, in order to decide an appropriate response? Could they perhaps have enquired whether other police cars were close by, which might have made available to them some additional responses?

Constable Tyson replied that from her point of view they did not have time to do any of these things. The young woman had a large knife, she might walk to the nearby intersection or car park and restaurant where people were. Their job as police officers was to get the knife from her as soon as possible. SC Tesoriero too replied that in his opinion the situation required an immediate response. There was not enough time to consider other measures such as clearing the car park or requesting further police assistance.

Both officers got out of their car. Constable Tyson walked then ran towards Courtney, calling out to her to put her knife down. SC Tesoriero followed, also telling Courtney in a loud voice to drop her knife. As she got nearer Constable Tyson saw with concern that Courtney didn't seem to be comprehending what was being said to her. For his part SC Tesoriero noticed that Courtney had not turned to look at them but was standing in the same position, eyes cast downward while moving her body to left and right.

It crossed his mind that mental health issues may have been present. But as he described it, the priority was: *'The weapon has to go'*. Courtney was not complying with their requests to drop her knife, so as SC Tesoriero approached he drew his pistol into the cover position – that is, he pointed it towards the lower half of Courtney's body.

Constable Tyson's attempt to discharge her Taser

Constable Tyson ran to a position a little ahead of Courtney and repeatedly called out to her to put her knife on the ground. Her evidence is that at this point Courtney took a couple of steps towards her with the knife slightly raised and pointing towards Constable Tyson. Fearing for her safety and that of SC Tesoriero, Constable Tyson said she drew her Taser and flicked the switch to arm it, then attempted to fire it. It did not discharge. She called out: *'Taser's not working'*.

Constable Tyson's Taser was fitted with a camera. The court heard evidence that when a Taser is armed, its camera begins to record within one to five seconds. The camera fitted to Constable Tyson's Taser recorded a video of twenty two seconds in duration. The Taser video footage shows Courtney standing on the grass with her back to Hungry Jacks. She has a drink in her right hand. Her left hand holds the knife down by her side. Officers Tyson and Tesoriero are not in view but they can be heard repeatedly commanding her to put the knife on the ground. After a few seconds Courtney tosses her drink to the ground, then turns her head to look in Constable Tyson's direction.

Seven seconds later SC Tesoriero can be heard saying a phrase containing the word *'Taser'*. Courtney begins to walk slowly to her left. From the left side of the screen SC Jones' outstretched arm can be seen holding a canister in Courtney's direction. She glances his way then breaks into a run in the opposite direction, heading towards Cowpasture Road. The video stops abruptly. The Taser video bears out the observations of numerous witnesses, that Courtney appeared oddly unresponsive to the people and events surrounding her. Until SC Jones deployed his OC spray her actions do not seem to bear any relationship to those of the police, unless her discarding of her drink can be interpreted as a confused response to the commands to put down her knife.

Did Courtney move towards Constable Tyson?

As can be seen from the above description, the Taser video does not show Courtney taking any steps towards Constable Tyson; nor does it record the words *'Taser's not working'*. It is possible these events occurred before the Taser was armed and the video commenced, as Constable Tyson suggested in her evidence. However this explanation seems unlikely in view of the following evidence: Twelve seconds into the video SC Tesoriero can be heard apparently prompting Constable Tyson to use her Taser. He is unlikely to have done this if she had already told him it wasn't working.

According to expert evidence, the most likely explanation for the sudden failure of the Taser camera to continue recording was Constable Tyson's attempt to fire the Taser, although this witness acknowledged that other possibilities existed. On balance it appears likely Constable Tyson's recollection of this sequence of events was affected by the stress of her situation and the speed with which events unfolded.

The most likely conclusion is that Constable Tyson attempted to fire her Taser not before the commencement of the Taser footage, but only moments before the footage came to an end. By this time Courtney was moving away from officers Tyson and Tesoriero, in the direction of Cowpasture Road. As to why Courtney decided to run towards Cowpasture Road, we cannot know this for certain. The likely reason is that she was fleeing the OC spray which by then was being discharged by the newly arrived SC Jones. This conclusion is reinforced by what can be seen on the Taser video. Just prior to its abrupt cessation it shows Courtney breaking into a run in the opposite direction to SC Jones' extended arm.

Given this, and the fact that Courtney was not moving towards either police officer at the likely time Constable Tyson attempted to fire her Taser, it was submitted on behalf of Courtney's family that using a Taser at that point may not have been a justified use of force. However it is also fair to acknowledge that if Courtney was fleeing the scene, this too posed a public safety problem for the responding police. This was because no perimeter had been established to prevent her from running to areas nearby where other people were present. Why did Constable Tyson's Taser fail to discharge? She had followed police procedure that morning by carrying out a 'spark' test. This is a limited check that the Taser is working correctly and the battery is sufficiently charged.

The Taser was subsequently given extensive testing by Sergeant Christian Halbmeier, Senior Armourer in the NSW Police Force. Sergeant Halbmeier found that it had battery degradation and damaged cartridges. These had most likely caused it to shut down when Constable Tyson attempted to discharge it. He said that Taser batteries required monthly extended testing which in this case appeared not to have been performed. This issue is addressed later.

SC Jones' deployment of OC spray

Only seventeen seconds after officers Tyson and Tesoriero arrived at the scene they were joined by Senior Constable Jones. On the morning of 10 February 2015 SC Jones was attached to Fairfield Highway Patrol and was patrolling the Fairfield/Liverpool area. When he saw one of the CAD messages about Courtney he acknowledged the job via police radio and drove to the Hungry Jacks intersection.

SC Jones got out of his car and immediately ran to the grassed area while pulling out his OC spray canister. He could see Constable Tyson with her Taser drawn and pointed towards Courtney. As he approached he also saw SC Tesoriero with his firearm pointed towards her. He could hear both officers telling Courtney to drop her knife. Courtney herself he described as looking pale and still. He said it *'bothered me greatly'* to see that she was not responding in any way to their commands.

SC Jones did not exchange any words with officers Tyson and Tesoriero, and so was not aware of the limited nature of their interactions with Courtney. He said he assumed they had been attempting de-escalation tactics. He thought Constable Tyson may have already discharged her Taser. He wanted to provide a further tactical option, being the use of OC spray. The aim was to temporarily incapacitate Courtney and enable them to disarm her without violent confrontation.

SC Jones positioned himself to the right of Courtney and slightly to her rear, then discharged his canister for a couple of seconds. Although he thought he had aimed with accuracy, he did not believe the spray had any effect on Courtney.

I accept the submissions of Counsel Assisting and Counsel for the Topic family, that SC Jones was mistaken in this belief. The autopsy report of Dr Bailey noted the presence of OC particles around Courtney's left eye and shoulder, her right cheek, her hair and her clothing. In addition the video evidence plainly depicts Courtney running to her left in a stumbling fashion almost immediately after the appearance of SC Jones' outstretched arm and canister.

The strong inference is that Courtney did feel the effects of the OC spray and was fleeing from it. Most unfortunately however, while she was affected she was not incapacitated by it. There is no basis to conclude that SC Jones gave intentionally false evidence on this matter. In common with many witnesses, certain impressions he formed during these critical moments proved erroneous in light of other evidence and the benefit of careful review.

Like officers Tyson and Tesoriero, SC Jones was certain that use of appointments was the only appropriate response to Courtney's non-compliance. This was despite his awareness that repeated directions to put down her knife were not having the desired effect. In his words, no other approach was appropriate so long as she had a knife. She had to be disarmed. At one point in his evidence SC Tesoriero qualified this position. Responding to questions from Counsel for the family, he agreed that Courtney had not reacted to repeated commands to put down her knife. He agreed with the further suggestion that he and officer Tyson therefore needed to re-assess the situation – however as he noted, at that point SC Jones intervened and the situation quickly escalated.

What might have happened had the OC spray not been used and Courtney had not run from the scene? Might SC Tesoriero have rethought their approach? We do not know. What happened was that the situation immediately escalated out of the control of the police officers, setting off a tragic chain of events.

The discharge of SC Tesoriero's pistol

SC Tesoriero's description of what followed is generally consistent with what can be seen on a second important piece of video evidence. This is footage taken on a mobile phone camera operated by Danijel Bogunovic. Mr Bogunovic was the driver of a car which had pulled up at the intersection. His recording commenced a second before the Taser video came to an end.

As the Bogunovic video commences SC Jones can be seen spraying OC in Courtney's direction. Officers Tyson and Tesoriero have their backs to the screen, pointing their weapons towards Courtney. She is running away from SC Jones, heading in the direction of Cowpasture Road. As she runs she pitches forward and appears to stumble, then straightens. Courtney pauses, then turns her face and body in SC Tesoriero's direction. She moves in his direction with her left arm bent, causing the knife to move to a level between her waist and chest.

As she moves, SC Tesoriero backs away to his right and is obscured by a traffic signal box. Courtney advances in the same direction. She is herself lost to view behind the signal box just as SC Tesoriero re-emerges at its other side.

SC Tesoriero continues to move backwards towards the footpath adjoining the intersection. Just as Courtney emerges from behind the signal box, the knife now in her right hand, the sound of a gunshot is heard. Courtney takes a few steps, then crumples to her knees and slumps forward. She collapses onto her right side. SC Tesoriero told the inquest that when he saw Courtney running towards Cowpasture Road he moved sideways in an attempt to keep pace with her, while covering her with his pistol. He said that after a few stumbling steps Courtney stopped and turned her face and body in his direction. Head facing downwards, she commenced to move forward. He responded by moving backwards and to his right until he was close to the footpath.

By then he felt he had little or no further room to retreat. When Courtney was less than two metres from him he fired a single shot from his pistol. The Bogunovic video supports SC Tesoriero's evidence that in the seconds before she was shot Courtney changed direction and, knife in hand, advanced towards him. She continued to do so while he backed away. Some witnesses described Courtney moving with deliberation; that certainly was SC Tesoriero's impression. When asked by Counsel Assisting what he thought was going to happen in those moments, SC Tesoriero replied simply: *'I thought she was going to stab me'*.

It was not asserted in submissions that SC Tesoriero did not have a basis for believing his life was in danger at the point he fired his pistol. I accept that he had a reasonable subjective basis for this belief.

Did Courtney intend to harm SC Tesoriero? Notwithstanding the above finding, in my view the answer to this question cannot be known. With the benefit of other evidence the court is able to dismiss the claims of some witnesses that Courtney was *'slashing'* at police officers with her knife. None of the attending officers made such a suggestion. Nor is this observation supported by the video evidence. It is not suggested that these witnesses deliberately fabricated their testimony.

In my view the evidence does not enable a finding as to what Courtney's intention was when she moved in SC Tesoriero's direction. It is possible she intended to harm him, given the likelihood she was frightened by the OC spray and may have felt herself to be under attack. It is equally possible that she remained distracted and confused, unable to appreciate the significance of what was happening, and wanted to get away from the situation. For these reasons I make no finding as to what Courtney's intention was in the seconds before she was shot.

The aftermath

Moments after Courtney was shot more police officers arrived at the kerbside. One of these was Senior Constable Stephen McEvoy, a police officer with over 28 years' experience who had completed the four day MHIT program. Another was Senior Constable Paul Falzon. He too had completed the four day program.

SC McEvoy ran to Courtney and immediately commenced first aid, taking the lead role with CPR. In between compressions he held Courtney's head and talked to her, telling her to *'hang on'* and *'keep with it'*. SC Falzon attempted to perform mouth to mouth resuscitation. SC McEvoy continued his CPR efforts until handing over to another officer, just before the ambulance crew arrived. The Bogunovic video shows that after firing the shot SC Tesoriero pulled on gloves, presumably to assist in the first aid efforts. By then however a small group of officers was kneeling around Courtney. SC Tesoriero can be seen dropping to one knee, apparently in shock. He was helped from the scene by Constable Djuric.

An ambulance arrived quickly, but paramedics immediately saw that Courtney could not survive her injury. Nevertheless they continued CPR efforts while she was taken to hospital. There she was pronounced deceased at 12.02pm. NSW Police immediately established a Critical Incident Team to investigate Courtney's death. Its Officer in Charge is Detective Chief Inspector Gary Jubelin. He proceeded to coordinate a thorough investigation into what happened that morning.

Did police breach NSW Police Force policies and procedures?

In closing submissions, Counsel Assisting the inquest and Counsel representing the Topic family took issue with the police response in this matter. The submissions of Counsel Assisting focused not so much on the actions of officers Jones, Tyson and Tesoriero in discharging or attempting to discharge their weapons, but rather at the decisions which had preceded these resorts to force and made them a tragic inevitability. The submissions of Counsel Assisting were therefore largely directed at decision-making within the NSW Police Force regarding training and deployment.

Those representing the family went further, asserting that it was open to refer officers Tyson and Tesoriero to the Law Enforcement Conduct Commission for their conduct in drawing their respective weapons as they approached Courtney. It was asserted that in doing so the two officers did not act in accordance with their powers under the *Law Enforcement and Powers and Responsibilities Act 2002*. Nor, it was claimed, did they act in accordance with the Tactical Options Model, the framework which guides NSW police officers in their decisions about use of force.

The court's attention was drawn to the Standard Operating Procedures for use of a Taser. These stipulate that a drawn appointment is a '*use of force*'. Officers Tyson and Tesoriero drew their weapons in circumstances where, it was argued, immediate action in the form of a use of force was not required or justified. The two officers were thus in breach of police powers.

I do not accept this submission. As noted in submissions of Counsel Assisting, the threshold set in the Standard Operating Procedures for drawing an appointment is not that the officer is justified in using it. It is that he or she is '*likely to be justified in using it*'. This constitutes a lower threshold than actual use. It reflects a common sense appreciation that drawing an appointment only at the point where a use of force is in fact justified may not leave sufficient time for it to be discharged.

As further noted by Counsel Assisting, the Tactical Options Model is best understood as a set of principles to guide decisions about the appropriate use of force. Given the unpredictability of high risk situations and the range of tactical responses available, it is not prescriptive. It is left open to an individual officer to judge which tactical option is, in his or her subjective view, required to control the situation confronting him or her. For these reasons I do not find that officers Tyson and Tesoriero breached NSW Police Force policies or procedures when they drew their weapons on their approach to Courtney.

No party submitted that the three involved officers breached police powers or procedures by discharging their weapons. The family's submissions fairly acknowledged that prior to discharging his OC spray, SC Jones was unaware of the limited interaction of his fellow officers with Courtney and of the non-confrontational nature of her conduct.

Regarding Constable Tyson and her attempt to discharge her Taser, it was not accepted that Courtney had actively threatened police or public so as to justify this response. However it was conceded that her flight from the area created a potential risk due to the absence of a perimeter within which to contain her movements. It was accepted that at the point of firing his pistol SC Tesoriero believed he was under threat of serious harm or death.

I accept these submissions. The evidence supports a finding that when the three officers discharged or attempted to discharge their weapons they had subjectively reasonable grounds to do so. Their actions did not breach NSW Police policies and procedures.

Was the police response appropriate?

This is a different question. Counsel Assisting the inquest submitted errors were made by those in the NSW Police Force who are responsible for tasking officers to respond to mental health related incidents. Errors were also made by the responding police in their approach to Courtney: specifically they failed to factor in the strong indications of her mental disturbance. This, it is asserted caused them to adopt an approach to disarming her which was entirely inappropriate and had the most tragic consequences.

I accept these issues go to the heart of what went fatally wrong that morning.

Taking issue with decisions made by first responders to a high risk situation should not be done lightly. At an inquest actions are assessed with the clarity of hindsight, with the benefit of information which those in the midst of the crisis did not have, and in entirely different conditions to those they faced. Moreover, as emphasised in the submissions of Counsel Assisting and those on behalf of SC Tesoriero, it is no part of the function of the Coroner's Court to assign blame for a person's death.

It is however central to the Coroner's task to identify cause, and to examine whether there are ways to prevent human lives being lost in the future. It is in this context that I now examine the appropriateness of the police response to Courtney. Counsel for the Commissioner submitted that the responding officers ought not to have been expected to realise that Courtney may have been suffering a mental disturbance.

I do not accept this submission. The CAD messages and radio broadcasts clearly signalled the likelihood that a response sensitive to mental health issues was going to be required. Courtney's appearance and behaviour could only have reinforced those signals. From the outset officers Tyson and Tesoriero saw she was not behaving in a way which might be expected: she seemed '*dazed*' and was unresponsive to their presence, commands, and weapons.

The Commissioner's further submission was that the reports about Courtney, and her observed behaviour and appearance, may equally have caused the responding officers to conclude she was drug-affected. I accept it was open for them to conclude this. But why would this not similarly alert them that a different communication approach may be needed to disarm her? Submissions made on behalf of the Topic family highlighted common features of communication which have been identified in studies of police shootings of mentally disturbed people. One such feature, the '*presumption of rationality*', is evident in the approach taken in this case.

It is described as the failure to recognise that the disturbed person may be unable to think and respond rationally, and that shouting commands and drawing weapons may panic or aggravate him or her. As noted, the NSW Police Force accepts that dealing with mentally disordered persons is a challenging part of police work. It can put police officers at risk as well as those they are dealing with. Hence the commendable decision to build skills in communicating with mentally unwell people, in the form of the MHIT training.

This understanding also informs the Tactical Options Model. It stipulates that a person's mental condition must be taken into account when applying the Model. The court heard expert evidence about this from Sergeant William Watt. Sergeant Watt is a senior operational instructor with NSW Police Weapons and Tactics Policy and Review [WTPR]. His unit trains the Operational Safety instructors who deliver tactical options training to police officers.

In his statement to the inquest Sergeant William Watt identified '*mental state*' as a special circumstance which needed to be considered in a risk situation. Thus: '*A subject who is affected by drugs/alcohol or suffers a mental disorder may require a different choice of tactical option or level of force response to maintain control in an effort to resolve the incident confronting the officer*'.

Sergeant Watt declined to be critical of the approach taken by the responding officers. In his opinion it was within the bounds of NSW Police protocols and procedures. He did however acknowledge they had missed important information about Courtney's mental disturbance which needed to be incorporated into their planning. Sergeant Watt emphasised that it was always important for officers to assess a situation and plan their approach, unless the level of risk required an immediate reaction. He acknowledged that alternative approaches could have been considered in similar situations. It may have been an option for the two officers to keep Courtney under observation, while ascertaining via police radio whether any MHIT accredited officers were nearby and able to act as first responders. The two officers could then have assessed whether it was consistent with safety to await their arrival.

Sergeant Watt also told the court that in de-escalation role plays involving someone who has to be disarmed, he would expect to see the responder attempt to persuade the person to put the weapon down, while maintaining a safe distance. There were different methods of persuasion, and shouting commands would not always be appropriate. It is a striking feature of the evidence in this case that despite all involved officers having completed the one-day mental health training course, none appeared to appreciate that the communications skills required to deal with a mentally disordered person were also applicable when the task was to disarm him or her.

This disconnect was exemplified in the following evidence given by one of the police officers:

Q. How do you respond to somebody with a mental health crisis in a mental health incident? What were you trained during that one day to do?

You obviously assess it and if they need help you give them help and – but in this situation there's a weapon, it's a different scenario.

Q. Are you saying ...you believe if they had a weapon then you treated it in a different way than if it was just simply somebody who looked like they were in the middle of a psychosis for example?

Yes. You would take the weapon out of play and then you can speak to them calmly, ... safety first, disarm and then you can reassess.

How could de-escalation strategies have helped?

Some of the communication strategies mentioned by Sergeant Watt were referred to in evidence given by Inspector Michael Brown, presently seconded to the College of Policing and the National Police Chiefs Council in the United Kingdom. Inspector Brown has extensive experience in police training. His expert comment had been sought as to whether a different approach was available on 10 February which might have led to an outcome not involving lethal force.

The specific challenges of this incident were acknowledged by Inspector Brown. Nevertheless in his opinion the optimum police strategy in such situations is to stop, observe and assess – but only to the extent consistent with public safety. This, he acknowledged, could be a very fine judgement call. Inspector Brown noted that Courtney had not threatened anyone with the knife. Nor was she immediately proximate to members of the public. In these circumstances the officers might have considered keeping her under observation for a short while to consider what their options were. He acknowledged this strategy would have to be reassessed if Courtney had started to move into an area where other people were present.

In Inspector Brown's opinion de-escalation strategies increased the potential for an incident to be resolved without use of force. As he described it: *'..the calmer the officers can be, the more empathetic they can be, the less rushed they can be, ... the more human they can be, all these things are potentially only going to increase the likelihood that they can resolve an incident safely without the use of force or by reducing the amount of force that is in fact necessary. And the opposite is also true that the more rushed they are, the more commanding and instructing and shouting that they do, all those sort of things only increases the level of anxiety. So the big message to police was just calm down, take your time, recognise where there is no urgency and deploy your tactics and your manner and your speech accordingly.'*

In her evidence to the inquest Dr Eagle confirmed that a calmer and slower approach would have been more likely to secure Courtney's compliance. Dr Eagle conceded that de-escalation tactics were more challenging when the situation was unfolding in an open space and there may be a sudden need to react quickly. However Courtney seemed disconnected and unresponsive - therefore a different mode of communication was needed to help her understand what the officers needed her to do. This would involve a slower-paced plan of trying to engage her in conversation aimed at showing her they understood she felt disturbed and unsafe, and wanted to help her.

Having reviewed the evidence in this inquest, I have concluded that the responding police took an approach to disarming Courtney which was not appropriate. The presence of mental disturbance as a special circumstance ought to have caused officers Tesoriero and Tyson to give thought to the communication skills that might be needed to disarm her.

The critical question is that posed by Counsel Assisting in his submissions: *'How best to persuade a person in mental health crisis to give up the weapon? That necessitates enabling police to understand and employ communication skills best suited to securing compliance by persons in mental health crisis'*.

This leads me to consider whether there are practicable reforms which might reduce the risk of such a tragic outcome in the future.

Question of recommendations

Counsel Assisting the inquest proposed recommendations within two broad categories: police training, and deployment of officers to emergency mental health incidents. The aim of the proposals was to reduce the risk of using lethal force in such incidents, without unduly compromising police officer safety. These were circulated to interested parties. All provided constructive submissions which have assisted me in deciding what recommendations should be made. Having reviewed the proposals and responses I have determined that it is necessary and desirable that all but one of the recommendations proposed by Counsel Assisting be adopted. I also adopt two recommendations proposed by Courtney's family. The recommendations and my reasons appear below.

Training: Recommendations 1- 4.

The question one is left with is why an understanding of mental health did not guide the approach of the responding officers, despite their having received MHIT training. I accept the submission of Counsel Assisting that the failure arose in part from a lack of integration of the skills taught in MHIT training with those in operational safety training.

In the recent Inquest into the death of Stephen Hodge (20 April 2018), Deputy State Coroner O'Sullivan made the following recommendation: *'That consideration be given to the greater integration of mental health informed training into tactical options training, with an emphasis on specific de-escalation techniques practiced by role play exercises.'*

The inquest into Courtney's death identified the same need. There would be real and demonstrable benefits in achieving a better integration of the skills taught in these two critical areas of training. This is the subject of four recommendations, as follows.

Recommendation 1: Consideration be given to the MHIT and WTPR establishing and documenting a joint review of training packages for defensive tactics training where mental health is likely to be a relevant factor.

Recommendation 2: Consideration be given to the greater integration of mental health informed training into tactical options training, with an emphasis on specific de-escalation techniques practiced by role play exercises.

Recommendation 3: Consideration be given to requiring all present Operational Safety instructors to complete the four day MHIT training. This should be undertaken as soon as practicable, while ensuring the availability of Operational Safety instructors to meet ongoing accreditation requirements.

Recommendation 4: Consideration be given to the MHIT and WTPR jointly pursuing a program of (1) reviewing international learning with respect to first responder interactions with persons in mental health crisis and (2) designing defensive tactics training that seeks to embody the learning obtained from the review.

These recommendations are supported by the Topic family. Most encouragingly, they are also supported by the Commissioner.

I note also in passing that Sergeant Watt, who attended each day of the inquest, told the court he had decided to undertake the four day MHIT training and wanted his team at WTPR to do so too.

Radio and CAD Communications: Recommendations 5 and 6

On 10 February 2015 the radio operators and Constable Beasant competently communicated the signs that Courtney was suffering a mental health crisis. The two recommendations below are made because at present there are no protocols or training concerning communications where mental health issues seem to be present. Operators would not necessarily require the one day MHIT training to achieve this purpose.

Recommendation 5: Consideration be given to requiring that all police radio and Triple 000 operators undertake training by the MHIT in skills which will better equip them to recognise signs of mental health disturbance in reports from police and civilians.

Recommendation 6: Consideration be given to developing criteria by reference to which police radio operators may identify an incident as possibly involving a person in mental health crisis.

Recommendation 6 is designed to facilitate the tasking of MHIT accredited officers as first responders, a key recommendation which I address below. It calls for a set of criteria to be developed which would guide police radio operators in identifying an incident as involving a person in mental health difficulty.

The Commissioner supports recommendation 5. The Commissioner does not support recommendation 6, for reasons which are explained below.

Priority deployment of MHIT accredited officers: Recommendations 7 and 8

Recommendation 7: Consideration be given to developing and implementing a system to dispatch four day MHIT accredited officers as first responders in cases which meet criteria indicating possible mental health crisis.

Counsel Assisting the inquest and Counsel for the Topic family emphasised the need for a system to task MHIT accredited officers as first responders wherever possible in likely cases of mental health crisis.

This recommendation was not supported by the Commissioner, for two reasons. The first is that NSW Police resources do not permit MHIT accredited officers to be available only for mental health related incidents. But this misunderstands the intention of the recommendation. It is accepted that MHIT accredited officers must be rostered for general duties work.

It is likewise accepted that there will be incidents where an MHIT accredited officer is unable to attend. These realities do not diminish the need for a system to deploy accredited officers wherever possible.

The second objection is that it is unknown whether the dispatch of MHIT accredited officers to this scene would have brought about a better outcome. Of course it is not possible to assert this. But to accept this argument is to beg the question why the NSW Police Force resources the MHIT program at all, if it is not the case that the Commissioner acknowledges its potential to deliver real benefits to the welfare of police officers and mentally unwell people. It is clear that accredited MHIT officers were intended to be deployed wherever possible as first responders to emergency mental health situations. This was the evidence of the former head of the MHIT, Chief Inspector Joel Murchie. He stated that graduates of the four-day program *'become prioritised first responders to mental health or suicide prevention incidents within their Local Area Commands'*.

This strategy is a rational one. It is designed to employ the skills of a corps of specially trained officers where they are needed most. But it emerged during the inquest that no system has been developed to prioritise accredited MHIT officers in this manner. It so happened that in this case two police officers with MHIT accreditation arrived at the scene just as Courtney was shot. They were SC McEvoy and SC Falzon. They arrived tragically too late to assist a young woman who was greatly in need of their help.

This was not the fault of officers McEvoy and Falzon. No one had directed them to attend the scene as first responders. They went there only because they happened to be in the area. That they were not specially tasked to respond was a consequence of the NSW Police Force's failure to develop a system to dispatch accredited officers in the manner contemplated by the MHIT scheme. SC Falzon told the inquest that at the time of Courtney's death he had never been tasked to attend an incident in his capacity as an MHIT accredited officer. Nor has he since that time. It was most disheartening to hear this evidence, given the numbers of people in Courtney's situation who have been fatally shot both before and after her death. This is not good enough. It makes no sense for the NSW Police Force to make such poor use of a highly valuable resource. Worse still it lets down a most vulnerable group of people.

I fully accept the submissions of Counsel Assisting and the family, that there is a compelling need for NSW Police to develop a system to triage and deploy accredited officers to emergency mental health incidents. I most strongly urge the Commissioner to reconsider his position on this recommendation. It would be difficult to envisage a situation which more starkly highlighted the need for it.

To support the proposal, Counsel Assisting proposed that all senior officers receive training to ensure they understand the new protocol for deploying MHIT accredited officers. This makes sense and I adopt it as follows:

Recommendation 8: the Commissioner consider developing a mandatory training package for all police officers other than commissioned officers, and specifically including Local Area Commanders, to ensure understanding of the protocol for responding four day accredited MHIT officers.

Post-incident counselling Counsel Assisting the inquest made a further recommendation, that NSW Police introduce a program whereby all officers involved in an event involving the death or injury of a person possibly in mental health crisis be counselled by an Operational Safety Instructor as to approaches which may have avoided the death or injury.

Counsel Assisting explained that the aim would be to allow instructors to better understand any gaps in their training, while giving involved officers the opportunity to enhance their own skills. This proposal was not supported by the Commissioner or by the NSW Police Association. Both were concerned about the impact such a process may have on the welfare of officers involved in civilian deaths or injuries. It is natural for them to be deeply affected by these events. It was noted that in almost all cases, involved officers would already have undergone a critical incident interview requiring them to relive their experience.

I accept the submissions of the Commissioner and the Police Association. I am not persuaded the benefits of this proposal will outweigh its potential impact on officer welfare.

Recommendations proposed on behalf of the Topic family

The Topic family proposed several additional recommendations, addressed below. Mental Health training:
Recommendations 9 and 10

The Topic family sought a recommendation that all general duties officers undertake the four day MHIT training. According to the submissions of Counsel for the Commissioner, the NSW Police Force plans to have all front line officers trained in this program. This is a most welcome initiative. However as I did not hear evidence detailing how this very significant commitment of resources would be implemented, I do not make it the subject of a formal recommendation.

A further recommendation is sought that the four day MHIT program include more role play-based exercises, and that refresher MHIT training be offered. This recommendation was earlier proposed by a team of independent experts who evaluated the NSW Police's MHIT program in 2015. The report's findings reflected the common sense principle that learning is more effective when it is delivered in a 'hands on' form; and that maintaining skills and competence usually requires booster training. I make recommendations as follows:

Recommendation 9: That the Commissioner consider reviewing the four day MHIT program to include more experiential learning, in the form of role play exercises.

Recommendation 10: That the Commissioner consider offering MHIT booster training on a one to three year basis.

Additional priority response category

Courtney's family asks that the Commissioner consider creating an additional 'Priority 2' CAD category. The current definition is set out at par 65 above.

On the basis that at the time the call was made Courtney did not pose any immediate threat to life, Counsel for the family urged a further category calling for immediate police attention, in circumstances where there was no immediate or serious threat to life. I do not consider this recommendation is necessary. I note that the current definition is not confined to situations of violent or exigent circumstances, but extends to the possibility of these. It could not be denied that the situation to which police were called on 10 February fell within the latter category.

Operational changes

Courtney's family urges the Commissioner to consider adopting the Victorian Police model based on the Ten Operational Safety Principles, and further that the NSW Police's Tactical Operations Model be reviewed with a view to removing 'Control Theory'.

I am not in a position to support these two recommendations. Evidence about how the Victorian model operates was not heard at the inquest. Furthermore it is evident that the NSW Tactical Operations Model expects officers to build into their response to an incident the elements of planning, risk assessment, and effective communication. The inquest exposed failures in the way these elements were put into practice on 10 February.

Extended Spark Tests

The Taser issued to Constable Tyson had a degraded battery. This caused it to malfunction at a critical point that morning. This failure was not the responsibility of Constable Tyson, who had performed the required 'spark' test when the Taser was issued to her that morning. This type of Taser required a monthly extended test to check its battery life, and there was no evidence this had been performed.

Counsel for the family rightly submitted the failure to properly maintain the Taser was a serious lapse. The family asks the Commissioner to institute a system of regular audits and records confirming that monthly extended spark tests have been carried out. I am satisfied this proposal is unnecessary. The inquest heard evidence that changes have been made to NSW Police's Command Management Framework bringing in mandatory checks to ensure the monthly tests take place. The changes include a system of audit.

Review of police shooting deaths

The Topic family wants the NSW Police Force to undertake a systematic review of fatal police shootings in NSW, to identify recurring themes and opportunities for improvement. While there may be value in such a review, a recommendation that it be undertaken goes beyond the scope of this inquest.

Final comments

Courtney's death and the way she died are profoundly sad. Her family loved her and miss her deeply. Leesa and Ronny, Kris, and Courtney's grandparents Bede and Judy attended each day of the inquest, and on the last day Leesa bravely bore witness to her daughter in a deeply moving statement. They will always grieve for Courtney, but I hope that in time they will find some measure of peace.

Acknowledgement is due to the NSW Police's comprehensive and transparent investigation into this tragedy. The inquest was attended throughout by the Officer in Charge Detective Chief Inspector Gary Jubelin and by Homicide Squad's Detective Sergeant Justin Moynihan. I am aware Courtney's family appreciated the sensitivity displayed by DCI Jubelin in his communications with them throughout the long process of the investigation.

I am deeply appreciative of the outstanding assistance given by Senior Counsel and Counsel Assisting the inquest, and the Crown Solicitor's Office. I acknowledge also the assistance received from the legal representatives for all the interested parties, and the support given to Courtney's family throughout the inquest by counsellors of the Department of Forensic Medicine.

Findings required by s81(1) Coroners Act 2009

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to make the following findings.

The identity of the person

The person who died is Courtney Topic born 27 February 1992.

Date of death

Courtney Topic died on 10 February 2015.

Place of death

Courtney Topic died at the corner of Hoxton Park Road and Cowpasture Road, West Hoxton NSW 2171.

Cause of death

Courtney Topic died from a gunshot wound to the chest.

Manner of death

Courtney Topic died in the course of a police operation. Her death was by gunshot in circumstances in which she was very likely suffering a mental health crisis and was in a public place holding a knife.

Recommendations pursuant to s82 Coroners Act 2009

To the NSW Commissioner of Police:

Recommendation 1: Consideration be given to the MHIT and WTPR establishing and documenting a joint review of training packages for defensive tactics training where mental health is likely to be a relevant factor.

Recommendation 2: Consideration be given to the greater integration of mental health informed training into tactical options training, with an emphasis on specific de-escalation techniques practiced by role play exercises.

Recommendation 3: Consideration be given to requiring all present Operational Safety instructors to complete the four day MHIT training. This should be undertaken as soon as practicable, while ensuring the availability of Operational Safety instructors to meet ongoing accreditation requirements.

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Recommendation 6: Consideration be given to developing criteria by reference to which police radio operators may identify an incident as possibly involving a person in mental health crisis.

Recommendation 7: Consideration be given to developing and implementing a system to dispatch four day MHIT accredited officers as first responders in cases which meet criteria indicating possible mental health crisis.

Recommendation 8: Consideration be given to developing a mandatory training package for all police officers other than commissioned officers, and specifically including Local Area Commanders, to ensure understanding of the protocol for responding four day accredited MHIT officers.

Recommendation 9: Consideration be given to reviewing the four day MHIT program to include more experiential learning, in the form of role play components.

Recommendation 10: Consideration be given to offering MHIT booster training on a one to three year basis.

6. 116507 of 2015

Inquest into the death of Richard Lewis. Finding handed down by Deputy State Coroner O’Sullivan at Glebe on the 11th July 2018.

These are the findings of an inquest into the death of Richard Lewis.

Introduction

Richard LEWIS was 91 years old (dob: 29/04/1923) at the time of his death on 19 April 2015. He was an inmate within the Kevin Waller Unit within the Long Bay Correctional Complex. The Kevin Waller Unit houses elderly inmates with mobility issues. As Mr Lewis was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the *Coroners Act 2009* (NSW).

The role of the Coroner

When a person’s death is reported to the coroner, there is an obligation on the coroner to investigate the death. The role of a coroner, as set out in s81 of the *Coroner’s Act 2009* (NSW), is to make findings as to the identity of the person who died, when they died, where they died, and the cause and manner of their death. If any of these questions cannot be answered then a coroner must hold an inquest.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the *Coroners Act 2009* (NSW) makes an inquest mandatory in cases where a person dies whilst in lawful custody. A coronial investigation and inquest seeks to examine the circumstances surrounding that person’s death to ensure that the State adequately discharges its responsibility. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

The Inquest

A short inquest was held on 11 July 2018. The officer in charge of the investigation, Detective Sergeant Garry James, gave evidence and the brief of evidence was tendered.

The Evidence

Background:

Mr Lewis resided the majority of his life on a rural property at Belmore River on the mid-north coast. He married in April 1948 and had two children, Narelle and Dianne. In 1975 his wife passed away and he remarried with Christine Lewis on 1 November 1991. They separated in 2013, but remained married. Richard LEWIS entered custody on the 11 December 2014. He was sentenced to a total of 16 years for a number of child sex offences. The non-parole period was 2 years and 6 months that expired on 10 June 2017.

The New Inmate Lodgement & Special Instruction Sheet dated 11 December 2014 notes that Richard LEWIS had “several life threatening health issues”. The lodgement sheet also states that these issues required review by Justice Health on reception.

The deceased suffered from multiple health conditions:

- Ischaemic heart disease including heart failure
- Pulmonary oedema
- Cardiac arrhythmia
- Degenerative osteoarthritis
- Chronic constipation
- Gallstones
- Squamous cell carcinoma of the left foot

An acceptance form from LBH (Long Bay Hospital) is within the brief and dated 12 December 2014. The “Transfer In and Out” form is dated 13 December 2014. General reasons for a transfer are recorded on the sheet and include the following:

- Address immediate health needs
- Identify risks and accommodate as necessary

The “Assessment Inpatient Form”, dated the 14 December 2014, contains the field “Diagnosis (provisional) or reason for admission.” It is subsequently recorded that Mr Lewis’ transfer to Long Bay Hospital was for assessment due to his age and frailty.

On 23 February 2015, Mr Lewis was transferred from Long Bay Hospital to the Kevin Waller Unit. A note on 24 February 2015 records that Mr Lewis was not happy about his transfer to the Kevin Waller Unit and thought that he should be in the aged care ward at the hospital. Mr Lewis complained that it was hard for him to breathe in his room because there was no air-conditioning. Mr Lewis was informed that none of the rooms in the Kevin Waller Unit had air-conditioning. He was further informed that while the Kevin Waller Unit is an extension of the Aged Care and Rehabilitation Unit (ACRU) within Long Bay Hospital, not all facilities are present in the Kevin Waller Unit.

Throughout late March the primary concern in the records appears to be a leg lesion. Mention was made in the medical notes on 31 March 2015 that Mr Lewis’ daughter made a complaint regarding his treatment.

The Fatal Incident:

On 6 April Mr Lewis was seen in the clinic. He complained of shortness of breath, general malaise and a slight cough productive of yellow sputum. He was transferred back to Long Bay Hospital on the same date due to his worsening condition. He was generally stable until 8 April when he developed a low grade fever and appeared unsteady.

On 9 April an echocardiogram revealed severe global impairment of left ventricular systolic function. On 9 April 2015 he was transferred to the Corrective Services Annex of Prince of Wales Hospital. Notes relating to 9 April indicate he was in a critical condition following a lung infection and suspected heart attack. Over the next few days he developed increased need for supplementary oxygen, a troponin leak (suggestive of acute myocardial damage) and fleeting chest pain.

On 14 April 2015 Mr Lewis underwent treatment following congestive cardiac failure that resulted in pulmonary oedema (fluid on the lungs). On 16 April 2015, palliative care treatment for Mr Lewis commenced. This included light sedation and pain relief. On 19 April 2015 at approximately 07:11 p.m., Nurse Louise Kelly found the deceased not breathing and she informed Correctional Officer Robert Cappelleri. Dr Wickremaarachchi attended shortly thereafter at 07:28 p.m. and pronounced Mr Lewis deceased.

Autopsy:

Forensic Pathologist, Rebecca Irvine conducted the autopsy. She found the direct cause of death to be “complications of pneumonia”. Other significant conditions contributing to the death, but not relating to the disease or condition causing it, were atherosclerotic cardiovascular disease and chronic lung disease.

Issues raised by Mr Lewis’ Family:

Narelle PENSON, Mr Lewis’ daughter, expressed concerns regarding the decision to move Mr Lewis from the Aged Care and Rehabilitation Unit (ACRU) within Long Bay Hospital to the Metropolitan Special Programs Centre, which contains the Kevin Waller Unit. She recalls Mr Lewis complaining about sanitary conditions at the Kevin Waller Unit.

Christine LEWIS stated that during Mr Lewis’ stay in the Long Bay Hospital, he never complained about his treatment or conditions. He told her over the phone that the hospital was fine. After he was transferred to the Kevin Waller Unit he complained to her about the sanitary conditions. However, she also states, “He never complained that he was not getting his medication or being looked after it was just the different environment.” Mr Lewis’ transfer from the Aged Care and Rehabilitation Unit to the Kevin Waller Unit

The Kevin Waller Unit’s eligibility and exclusionary criteria form part of the brief of evidence. A statement from Paul Holden, Manager of Security, states that the Aged Care Bed Demand placement committee vets inmates as to suitability for entry into the unit. The criteria for eligibility includes that they be male and over the age of 65 years. Poor mobility, age-related frailty and the need for additional resources such as shower chairs, bed rails, etc., are other criteria that require assessment.

The exclusionary criteria are as follows: Risk to Others (e.g., an inmate with an ongoing or recent history of violence/aggression), Significant Medical Issues (i.e., they require significant medical treatment that cannot be addressed by local clinic staff), High Dependency (e.g., they require ongoing practical/physical assistance with personal care tasks or daily living), Unstable Mental Health (e.g., dementia), and their Independence (e.g., older inmates functioning well in general population).

The Justice Health medical records for 23 February 2015 indicate that Mr Lewis was suitable for transfer from the ACRU to the Kevin Waller Unit. Medical notes for 22 February 2015 record that his chest was clear and his observations stable.

Expert Witness Statements of Professor Iven Young, respiratory physician

Professor Iven Young, a respiratory physician, prepared two reports commenting on any possible relation between Mr Lewis' environment, being the Kevin Waller Unit, and the pneumonia. He was provided with relevant documents, including the statements of both Narelle Penson and Christine Lewis. Professor Young was satisfied that Mr Lewis died of a lobar pneumonia as described in the post-mortem report. He reviewed Prince of Wales Hospital records and was satisfied that care and treatment provided at Prince of Wales Hospital immediately preceding the death was appropriate.

He stated that pneumonia is generally classified as community acquired or hospital acquired (nosocomial) pneumonia. The latter implies exposure to unusual organisms in a hospital setting that may require treatment with unusual and more powerful anti-biotics. As Mr Lewis acquired his pneumonia in the Kevin Waller Unit, he would be classified as having a community-acquired pneumonia. Professor Young states that by far the most common cause of pneumonia in the elderly is pneumococcal infection and that this infection is either caused by aspiration of resident pneumococci in the patient's nasopharynx from past contact, or a recent transfer of this organism from close contact with a pneumococcus carrier. It is a person to person infection and is not acquired from unsanitary surroundings.

Assessment by a speech pathologist indicated that aspiration pneumonia was unlikely. Although no causative organism for his pneumonia was found, Professor Young stated that this was very frequently the case. Professor Young stated that Mr Lewis' urinary antigen for Legionella was negative, making his infection from an environmental cause unlikely. Professor Young's opinion is that Mr Lewis had acquired a pneumococcal pneumonia. Professor Young states: "Although the physical circumstances of the Kevin Waller Unit (KWU) appear to have been less comfortable for Mr Lewis than those of the Long Bay Hospital, I cannot find any evidence that his accommodation in the KWU would have led to abnormally close person-to-person contact or exposure to second-hand cigarette smoke that may have contributed to causing his pneumococcal pneumonia."

Further to this, he states: "The cause of his infection was related to his age and chronic medical conditions and was, in my opinion, independent of his accommodation in the Kevin Waller Unit where the infection presumably developed." Professor Young reviewed the Prince of Wales Hospital and the Justice Health medical records. He did not identify any deficiencies in care and treatment.

Conclusion

Mr Lewis' death is not suspicious and he died of a natural cause process. Mr Lewis received health care of an appropriate standard whilst in custody. I do not find that any action or inaction by Corrective Services or Justice Health contributed to Mr Lewis' death. Given Mr Lewis' age and health issues and his rapid deterioration whilst in hospital, it does not appear that anything could have reasonably been done to prevent Mr Lewis' death.

Findings required by s81(1)

After considering all the documentary evidence and the oral evidence heard at the inquest, I make the following findings under s81(1) of the Act.

The identity of the deceased:

The deceased person was Richard Lewis.

Date of death:

He died on 19 April 2015.

Place of death:

He died at Prince of Wales Hospital, Randwick, NSW.

Cause of death:

He died as a result of complications of pneumonia

Manner of death:

Mr Lewis died of natural causes whilst serving a custodial sentence.

7. 125390 of 2015

Inquest into the death of GR. Finding handed down by Deputy State Coroner Stone at Newcastle on the 12th June 2018.

Introduction:

GR died on 27 April 2015, aged 32 years. As he was on remand at Cessnock Correctional Centre at the time of his death, an inquest is required to be held pursuant to sections 23(1)(d)(ii) and 27(1)(b) of the *Coroners Act 2009*

The Inquest:

Section 81 of the Act requires a coroner to make findings as to:

- the identity of the person who has died;
- the date and place of the person's death; and
- the manner and cause of the death.

In addition, under s82 of the Act, the Coroner may make recommendations in relation to matters connected with the death, including matters that may improve public health and safety in the future. As GR was in custody at the time of his death, the responsibility for ensuring he received adequate care and treatment rests with the State. For this reason, whenever a person dies in custody, an inquest is required to be held to assess whether the State has discharged its responsibilities.

Social History:

GR was born on 4 March 1983 and grew up in Woodberry NSW and various other locations in the Newcastle area. He was one of 5 children to his mother NJ. When GR was ten years old he was sexually assaulted by a male adult. Subsequent issues as a juvenile saw GR spend time in Department of Community Services (DOCS) custody, juvenile detention at Kariong and Worimi, refuges and boys' homes. He began to commit crimes such as break and enters and robberies.

When he was a teenager, GR starting experimenting with various substances. He started using heroin at age 17, developed mood swings and anger and was subsequently diagnosed with schizophrenia. He was later placed on methadone to deal with his heroin addiction. GR's mother believes that he used drugs to take away the pain of his sexual assault. At the age of 15, GR had a daughter, and more recently fathered a son, with his former partner, MD. Prior to his death he had formed a relationship with MTW, who had children of her own.

Criminal Justice History

As an adult, GR continued to be involved in criminal activity, spending various periods in custody. Justice Health & Forensic Mental Health Network ("Justice Health") records show periods in custody in 2002, 2007, 2008, 2009, 2010, 2011, 2013 and 2014. In April 2010, GR was in custody in the Mid North Coast Correctional Centre. An Incident Report dated 19 April 2010 notes that GR reported that an "old wound" had opened up on his left arm and that, while he made no admission to deliberately opening it up, he was placed on a Mandatory Notification with camera cell observation. On 20 May 2010, an Incident Report records that a phone call was received from a person claiming to be GR's uncle, who said that GR had talked about suicide in the days before coming into custody. GR was placed in a two-out cell.

In a Justice Health progress note dated 25 May 2010 GR was asked about some sutures to his left wrist and claimed to have put his hand through a window. The reviewing clinician described the wound as a "definite slash-up". In November 2012, GR was admitted back into custody. He was placed on a Risk Intervention Team ('RIT') order briefly after being "verbally aggressive and self-- harming in the police cells under the influence of heroin". A mental health assessment was conducted on 5 December 2012 in which GR claimed to have had schizophrenia as a child. His claim that he heard voices was seen as warranting an appointment with a psychiatrist. He was not assessed as being in an at risk mental state.

On 5 November 2013, GR was released from custody. In December 2013 he met HFG, a post-release and drug and alcohol manager with the Samaritans Foundation, who helped him, set up a house in Bull St, Newcastle, and with other issues relating to his reintegration and management in the community. On 4 May 2014, when admitted into custody to serve a short sentence at the Mid North Coast Correctional Centre, GR was assessed by Justice Health staff as being at risk of self-harm. He was made the subject of a RIT management plan, and was put in a safe cell with 24 hour CCTV observation. Following a review on 10 May 2014, at his own request and unable to guarantee his own safety, GR was kept in the observation cell until his release from custody on 16 May 2014. A case note on the Offender Integrated Management System ("OIM5") dated 10 May 2014 records that "this appears to be because he does not want to immerse himself back into the gaol culture. Inmate appears to be wanting to stay away from gaol influences until release."

Events Prior to GR's Return to Custody in March 2015

Sometime before he returned to gaol in March 2015, GR self-harmed by making what were described by Ms Fielder-Gill as "big cuts on his arm" which were seen by his GP, Dr Singh, with Samaritan intervention. While no specific date is recorded it can be gleaned from various police and ambulance records that this is likely to have occurred in February 2015. On Sunday 22 February 2015, at about 7.30pm, police attended the Mater Hospital after GR told staff that he had been stabbed by an unknown person. Shortly before 1.00am the same night, police were called to a domestic incident. They arrested GR who told them, "give me 5 minutes alone and I'll be dead. I was coming back to kill myself". GR then told police that he had cut his arm earlier in an attempt to kill himself however had claimed he had been stabbed to avoid being scheduled.

GR was taken to John Hunter Hospital, where his wounds were treated. He was ultimately detained by police and conveyed to the Calvary Mater Hospital for possible scheduling. GR was assessed as a mentally disordered person by Dr Josef McDonald, who stated: "Ongoing suicidal ideation with the means of 'jumping in front of a train'. Guarded in response to questions regarding psychotic symptoms." Dr McDonald concluded: "Ongoing risk of harm to self and would benefit from ongoing assessment to ensure safety."

GR was later released by the hospital without police being notified. On Saturday 28 February 2015, GR was arrested and charged with breach of an AVO that was current, involving Ms Te-Wake. The same day at about 12.39pm, GR was bail refused at Newcastle Police Station by Sergeant Checkley, on charges of contravene AVO, drive disqualified, resist arrest and assault. The Custody Management Record from that day, created at 10.45am by Sergeant Checkley, noted on page 2, "left lower arm bandaged after a self-harm attempt". It further noted, "observed 5 open + stitched lacerations across inner forearm, self-inflicted 2 days ago".

The same day, ambulance paramedics examined GR's arm injury at Newcastle Police Station. The Ambulance Service of NSW form describes "x7 lacerations of varying length and depth" with sutures already in place, greater than 48 hours old, with an unclear history. GR is recorded as saying that he had punched or put his hand through a glass window, however the paramedic recorded that "wounds appear consistent with being self-inflicted".

GR was admitted to the Calvary Mater Hospital Emergency Department at 7pm that night for examination, with the Discharge Summary recording a similar history of putting his arm through a window. Clinical notes queried if the wounds were self-inflicted and noted: "self-harm: at this time denied suicidal thoughts/plans/ideas" and "please reassess self-harm risk..." A NSW Police document entitled Prisoners/Intoxicated Persons Transfer Note, completed by Sergeant Checkley and dated 28 February 2015, records various information including: "May be suicidal information from carer of POI May inflict self-injury." GR was placed in Corrective Services NSW Corrective Services' custody to be taken to court the next day on 1 March 2015. On Sunday 1 March 2015, GR was bail refused at Newcastle Local Court on charges of contravene ADVO, drive whilst disqualified, resist arrest and assault, and was to be assessed by Justice Health and then brought to court the following day.

On 2 March 2015, Samantha MacCameron, a clinical nurse consultant from Hunter New England Health Forensic Services Court Liaison, faxed a request to Dr Singh for GR's current prescribed treatment, noting that "I assessed the above client today in custody". Dr Singh's records show that a Health Summary Sheet was printed the same day. Ms MacCameron subsequently made a statement in which she noted that GR was referred to the Court Liaison Service by Corrective Services. She noted that his left arm was in a bandage, and stated that he admitted to having self-harmed in previous weeks. She conducted a mental health assessment which concluded that GR was not at immediate risk of suicide or self-harm. Her report was provided to the court.

On 2 March 2015, GR appeared before Newcastle Local Court on charges of contravene ADVO, drive whilst disqualified, resist arrest and assault. He was granted bail and was to return to court on 12 May 2015.

Return to Custody

On 6 March 2015 GR was arrested on charges of break, enter and deprive person of liberty and other related charges at about 7.15pm and was subsequently bail refused. The NSW Police Custody Management Record reveals, in an entry recorded at 3.13am, that GR was "moved to the hospital for treatment of his injuries", having come into custody "with a number of injuries to his face arm and legs he refused treatment by the ambulance officers". GR was recorded as "returned to the charge room" in a further entry at 3.14am. The record also shows the comment, "prisoner has large open wounds to his left arm indicating previous self-harm".

GR was bail refused on 7 March 2015 and his matter was stood over until Monday 9 March 2015 at Newcastle Local Court. On 8 March 2015, GR was transferred to Cessnock Correctional Centre Cessnock CC'1 on a remand warrant. The last OIMS case note on file for GR is dated 21 January 2015. There is no record of GR having made any phone calls between 20 October 2014 and 27 April 2015 from Cessnock CC.

The Events of 27 April 2015

About 5.30am on 27 April 2015, GR's cellmate, Inmate Baglee, was taken from cell 15 to Toronto Local Court for a court appearance. CCTV from Cessnock CC shows GR at about 3.20pm entering cell 15 and the door being secured behind him. Inmate Baglee had not yet returned from court, and it is significant that this was the first time since entering custody that GR had entered lock-in alone. CCTV confirms that, between 3:20pm and the return of Inmate Baglee from court, no other person approached the door of cell 15 or entered the cell.

At about 7.50pm Inmate Baglee was returned to cell 15 by Casual Correctional Officer Marc Bender Correctional Officer Bender'1 and First Class Correctional Officer Kathryn Redfern Correctional Officer Redfern. The following summary of what occurred next is based on my observations of the CCTV footage played during the hearing of the inquest, the statements included in the brief of evidence and oral evidence given in the inquest. Within approximately three and a half minutes of entering the cell, Inmate Baglee used the cell alarm system (known as a "knockup") to contact Correctional Officers Redfern and Bender, who were in the Wing Office. He said words to the effect of "my cellie's done himself in". Correctional Officer Bender asked, "are you joking?" and Inmate Baglee replied "no".

Correctional Officers Redfern and Bender left the wing office and ran to cell 15, arriving within around 30 seconds of the "knock up" occurring. They looked through the cell door window and saw GR lying face down on his bed and Inmate Baglee pacing up and down in the cell. Correctional Officer Redfern radioed for the assistance of the Night Senior, the Assistant Superintendent and Justice Health nurses.

Senior Correctional Officer Stephen Neal ('Correctional Officer Neal') arrived less than two minutes later and Correctional Officer Bender unlocked the cell. Inmate Baglee walked out of the cell and into the pod. The correctional officers looked into the cell, but did not enter the cell at that stage. Correctional Officer Neal observed something white around GR's neck and left to go and get a 911 Rescue Tool.

Around one minute later, Assistant Superintendent Jedrzejczyk, Justice Health registered nurse Julie Wells ('Nurse Wells') and Correctional Officer Neal arrived and Nurse Wells and Correctional Officer Neal entered the cell.

Correctional Officer Neal observed a white cord around GR's neck. He saw it was very tight and digging into the skin. He cut the cord about the back of the neck area and, as he did so, noticed that GR's body was stiff. He could not see a knot in the cord. He saw some blood spots on the floor, a razor blade on the bed and he picked up a suicide note written by GR that was on the bed next to him. It was apparent that GR had used torn or cut up pieces of a bedsheet to make a ligature and tighten it around his neck.

Nurse Wells and First Class Correctional Officer Scott Eastwood ('Correctional Officer Eastwood') rolled GR onto his back and Nurse Wells attempted to apply oxygen to him however he was unresponsive and she stated, "he's too far gone." Correctional Officer Eastwood noted that GR's body was cold and stiff. At about 8:14pm ambulance personnel attended. At about 8:16pm the emergency cell alarm system or "knock up" for the cell was checked and found to be functioning. All persons exited the cell and the cell door was closed.

At about 9:25pm Inspector Tracey, Sergeant Scraysbrook and Constables Kirby and Proctor from Central Hunter Local Area Command attended the scene. Detectives Cooper and Ferguson also attended. No suspicious circumstances were noted. The suicide note was opened by police. It was addressed "to my beloved wife, next of kin". The note stated: *"hay sweetheart, I'm so sorry about everything, I pray that you forgive me for doing this. I have to do this, I can't do this no more. The voices, no sleeping much and not being able to see or talk to you. Always no (sic) I will be with you in your heart and mind. Love you MD good by (sic) and God bless you and the kids. Love your Dead Man. GR."*

Autopsy Evidence

An autopsy report dated 24 June 2015 was prepared by Dr Allan David Cala, a senior staff specialist in forensic pathology, located at the Department of Forensic Medicine, Newcastle. Based on his experience and training his opinion was that GR died on 27 April 2015 at the Cessnock CC, Alunga Avenue, Cessnock, and that the cause of death was asphyxia arising from neck compression. Under the heading "Comments" the doctor provided the opinion that it appeared GR "was face down during the application of the ligature around his neck. There was no evidence that the deceased was suspended at any time and appears to have committed this act whilst on the bed. The face down position may have contributed to the death by partially occluding the external airway (mouth and nose)." He further noted that the toxicological analysis showed no alcohol in the blood. Methadone, mirtazapine and quetiapine were detected in the blood at therapeutic levels although the methadone level was consistent with chronic use.

In a further letter to the Crown Solicitor's Office dated 11 July 2017, Dr Cala confirmed that GR's injuries were consistent with self-inflicted ligature strangulation. Further, he provided the opinion that the findings of being stiff and cold to touch suggested that GR had died much earlier than the time at which Corrective Services and Justice Health staff entered the cell.

He said if GR had died just prior to that he would have expected the body to feel warm to touch, have no stiffening and be entirely flaccid.

He said, "I would completely discount death occurring 6 to 10 minutes prior to being found if the body was described as being stiff and cold to touch". The doctor's opinion as to cause of death, his comments that form part of the autopsy report and his additional comments referred to in the letter of 11 July 2017 are uncontested. Accordingly, the identity of the deceased, the date and place of death, and the medical cause of death are known, and findings will be made at the conclusion of this inquest consistent with the opinion of Dr Cala.

Analysis Regarding Issues of Concern:

The inquest focussed on seeking to understand the manner of GR's death, which involved exploring whether certain aspects of the management and care of GR after he was received into Corrective Services custody may have contributed to his death occurring, or whether there was scope for procedures to be improved.

Helen Fielder-Gill

Before dealing with these issues, it is relevant to note that one of the first people called in the inquest was Helen Fielder-Gill. She had first met GR in December 2013 when he came to Friendship House, a residential program for people getting out of gaol. GR had been released to parole on 5 November 2013, after serving a sentence of almost one year for a break, enter and steal offence. By that stage GR was 30 years old and had spent around 11 years of his adult life in gaol.

Although GR spent a further 2 periods in custody after this, he continued to have an association with Ms Fielder-Gill and she continued to assist him, including arranging for him to move into his own accommodation in Mayfield. GR had lost contact with his mother since his early twenties, however ran into her in or about July 2014. This became a positive experience and there was considerable contact after this date not only with his mother but also his sister. He was observed, according to his mother, to be happy that he had a family and a place to call home.

By the end of 2014, GR was in a relationship with Ms Te-Wake and was living with her. On 17 February 2015, an Apprehended Domestic Violence Order ADVO was taken out against GR. This occurred after Ms Te-Wake's daughter told police that GR had assaulted Ms Te-Wake (Ms Te-Wake denied that an assault took place). In any event, GR was charged with common assault and the ADVO prohibited him from contacting or approaching her and certainly from living with her. Despite the ADVO, they continued living together.

A couple of weeks before GR returned to custody, DOCS officers came and took some of Ms Te-Wake's children away from the Mayfield home. Ms Fielder-Gill described this as a tipping point for GR and said that his world was going out of control. This provides some context regarding the issue of GR self-harming prior to going back into custody. GR admitted to Ms Fielder-Gill that he had self-harmed. After GR had gone back into custody, Ms Fielder-Gill rang Cessnock CC and advised them that GR was not in a good way; she believes that she may have informed the correctional centre that GR had been self-harming (although due to the amount of time that had passed she was not sure of the exact words she used).

She was reassured by the officer that she spoke to over the telephone that GR was being held in a "two-out" cell. The inference I draw is that the officer she spoke to was indicating a belief that this would offer some kind of protection in that a cellmate could alert officers to any issues. There are no notes recording either this conversation or any response by officers within Corrective Services and certainly there is no evidence of any steps being taken to draw this concern to Corrective Services officers or Justice Health nurses. The adequacy of the intake screening and assessment of GR by Corrective Services and Justice Health personnel during his reception into Corrective Services custody and into Cessnock Correctional Centre on 7 and 8 March 2015.

Screening & assessment conducted by Corrective Services

I will first deal with the adequacy of the screening and assessment performed by staff employed by Corrective Services. The officer in charge of the coronial investigation, Detective Sergeant Babb, gave evidence and was asked about the Prisoners/Intoxicated Persons Transfer Note dated 7 March 2015, that accompanied GR when he was transferred from police custody into Corrective Services custody. That document contained information in terms, "may be suicidal. Information obtained from Wendy Harley, carer of POI. "May inflict self-injury". Detective Sergeant Babb stated that he had made enquiries and had ascertained that this information was first entered into the police COPS system in 1997 or 1998, and was populated into the Prisoners/Intoxicated Persons Transfer Note from the "warnings" field in COPS along with any and all other warnings with respect to GR.

Screening by Correctional Officer Sylvester at the Newcastle Police Cells

When he was first handed over into Corrective Services custody, GR was assessed by Correctional Officer Darren Sylvester. Correctional Officer Sylvester in the Newcastle Police Cells at 4: 10am on 7 March 2015. Correctional Officer Sylvester's evidence comprised two statements dated 21 October 2016 and 11 May 2017. Correctional Officer Sylvester did not give evidence before the inquest as his solicitors made an application that he be excused on medical grounds, which was granted by me.

Assistant Superintendent Darren Kearney C'AS Kearney' gave oral evidence in Correctional Officer Sylvester's absence about the procedures that applied as at March 2015 with respect to the initial reception of inmates into Corrective Services custody. He provided information about the process for transferring inmates from police custody into Corrective Services custody and agreed that, at that time, certain records are provided by police to the screening Correctional Officer (Correctional Officer Sylvester), including the Custody Management Record and Prisoners/Intoxicated Persons Transfer Note. AS Kearney said that the screening correctional officer is required to conduct a strip search and a visual check for signs of self-harm. He identified that the version of the police Custody Management Record included in GR's Corrective Services Case Management File was missing page 2. Page 2 recorded a police observation in these terms: "prisoner has large open wounds to his left arm, indicating previous self-harm". Assistant Superintendent Kearney said that he would have expected that an officer familiar with these forms, if he had noticed it was missing a page, would have chased it up.

One of the forms completed by Correctional Officer Sylvester during the reception process was the Inmate Identification and Observation Form. At page 4 of that form the pro forma question "have you previously attempted suicide or self-harm" is ticked "no".

At page 5 of that document the pro forma question "does the offender have neck/wrist scars that suggest self-harm" is also ticked "no" (I note that a photograph taken of GR's arm after he died, tendered in the inquest, clearly shows scars on GR's wrists and that Correctional Officer Sylvester in his second statement said he had questioned GR about those scars and he had replied, "it was a long time ago when I was young and stupid". The same page records "graze to left side head scratches on arm." GR also had sutures in his left forearm at the times, which were removed in custody on 10 March 2015. Those sutures were not noted on the form. At the bottom of page 5 of the IIO form, towards the end of the section titled "Officers Visual Assessment Self Harm" Correctional Officer Sylvester ticked has "no" in response to the question after reading the Police CMR and completing this interview and visual assessment, in your opinion, is the offender at risk of self-harm or suicide?"

The Assistant Superintendent's evidence was that Correctional Officer Sylvester would have had access to OIMS when completing the reception process. On that system there was a current alert for GR which stated, "history of self-harm incident". The IIO form, on page 6, required the screening officer to check the computer system, asking the question, "are there any alerts on OIMS?" in response to which Correctional Officer Sylvester ticked, "no". This was plainly incorrect. In his statement Correctional Officer Sylvester indicated that he "did not enter the information from the interview on the OIMS" as "I have not been trained how to perform this function and do not have access to this function."

It appears that Correctional Officer Sylvester was saying that he had not been trained to input the information on OIMS. When taken to this statement Assistant Superintendent Kearney was somewhat surprised and thought that the officer may not have had training in how to input fresh data but he thought he would have had the knowledge and experience to use the system to look up information. He considered it inconceivable that someone with 18 years' experience (as Correctional Officer Sylvester had) wouldn't be trained at all in how to use the OIMS system.

As Kearney's evidence was that the sutures should "definitely" have been recorded on the IIO, if not in answer to the question about neck and wrist scars, then in the "comments" box underneath. He thought, in circumstances where an inmate had an alert on OIMS for a previous self-harm incident, that it would have been appropriate to raise concerns about the sutures sufficient for the information to be passed down the line. He stated that the 110 is relied on by the reception centre (in this case Cessnock CC) as a guide. It was the opinion of the Assistant Superintendent that the 110 form had been poorly done.

The Assistant Superintendent properly conceded that there may be a motive for a new inmate not to disclose self-harm on reception, the reason being that being placed on some form of RIT at the gaol of placement was not necessarily a pleasant experience in view of the isolation, what one has to wear and the constant observation in a safe cell. The Assistant Superintendent also said that the officers he supervised had not had any sort of training in relation to risk assessment until recently, but that in July 2017 there had been some training for him and his reporting officers in relation to Immediate Support Planning for inmates with mental health issues, which was directed at suicide and self-harm prevention.

The conclusion I reach, not contested in submissions by Counsel for the Commissioner of Corrective Services, is that there were deficiencies in the information Correctional Officer Sylvester recorded. In particular, the documenting of possible risk of self-harm in respect of GR was simply inadequate. Counsel for the Commissioner submitted that, notwithstanding the deficiencies in how Correctional Officer Sylvester recorded his assessment of GR, they were somewhat ameliorated by GR being further and properly assessed by officer Mark Hayes, Justice Health Nurse Wells and welfare officer Neville Bowen and that, as a result of their collective assessments (their evidence which I will shortly come to), there was no reasonable basis for any of those people to determine at the time each of them assessed him that GR was at risk of suicide.

It is important to draw a distinction between self-harm and suicidal ideation. They are two very different issues. While it cannot be extrapolated that the above deficiencies in any way affected the outcome on 27 April 2015, the importance of the initial screening process cannot be underestimated. It provides a guide to the receiving correctional centre as to what to look for and conceivably whether to engage a RIT to further assess the inmate.

The Assistant Superintendent was an impressive witness and was able to provide important and helpful evidence to the inquest.

Screening by Senior Correctional Officer Hayes at Cessnock CC

Once GR arrived at Cessnock CC a "Reception Checklist" assessment was carried out by Senior Correctional Officer Mark Hayes Senior Correctional Officer Hayes, who was an acting Assistant Superintendent at the time. This officer's evidence was largely uncontroversial. He gave evidence that: He had performed the inmate reception/assessment task many times previously; He had on-the-job training on the inmate reception/assessment task; Assessing an inmate for risk of self-harm was a "there and then" assessment based on their demeanour and their state of mind; He did not get records from Justice Health (who see the inmate in the police or court cells prior to his assessment) but he checked OIMS for alerts etc. on the inmate he was assessing.

He recalled seeing a stitch that looked infected and he asked GR to tell the nurse about it when he saw her; He often sees inmates come in with wounds on their arms, and not every wound around the arm is a result of self-harm; He knew GR from prior custodial sentences and if he had found he was not in a good place he would have put him on a RIT to be followed up the next day; A lot of inmates have alerts on OIMS for self-harm, but not all of those alerts are as a result of self-harm acts.

Some are for self-harm threats, for example, which may be made as a result of frustration, or as a way to get something the inmate wants; If he thought GR needed a psychologist or nurse, the fact of limited psychological resources within the prison wouldn't stop him from making a referral; GR denied thoughts of self-harm and suicide at the time of the assessment and one of the questions posed on the form completed by Senior Correctional Officer Hayes was "do you have any current thoughts of self-harm/suicide?" The word "no" is circled. If the answer had been "yes", the form requires that a Mandatory Notification Form is raised which would then require a RIT assessment;

He considered that GR's demeanour was no different from any other time he had seen him and did not see any cause for concern. *Although his recollection was poor he said he would have satisfied himself about whether the cuts on GR's arm were from self-harm or not. He accepted that he could have provided more detail about his assessment in the comments section of the form, and said that was something he had taken away from the inquest. He said he'd had some mental health training at the Brush Farm Academy about 10 years ago, but was considering doing a further course. He also indicated that he imagined some inmates might wish to downplay self-harm thoughts to an assessing officer for the reasons that I have already expressed.*

Screening by Welfare Officer Bowen at Cessnock CC

GR was screened by Mr Neville Bowen on 11 March 2015. Mr Bowen is a Corrective Services welfare officer with approximately 16 years' experience in his role. Prior to Mr Bowen's intake screening interview, GR had already been assessed by nurse Julie Wells on behalf of Justice Health who recommended "normal cell placement". Mr Bowen conducted the screening interview with GR which took approximately 40 minutes and filled in an Intake Screening Questionnaire (ISQ).

Mr Bowen did not have formal mental health training. He said that he made assessments of a person based on their presentation at the time. He would consider the answers they gave and his focus was on their current thinking. For example, Mr Bowen was asked whether, given that GR had disclosed a history of schizophrenia, it would have been a good idea to refer him to psychological services. He replied that it would depend on his presentation, such as, for example, if he reported that he was hearing voices or expressed delusional thoughts. If there was no indication of anything like that, he said he would not make a referral.

Mr Bowen was shown the Justice Health document titled "D&A and MH Summary of RSA for CSNSW", where GR had been recorded as saying that he had tried to self-harm in the past. Mr Bowen said that he had "more than likely" seen that document as it should have been in GR's case file. He said that this information wouldn't necessarily prompt him to refer GR to a psychologist as, in effect, he would have discussed it with GR and gauged his current thinking.

He accepted that question 75 of the ISQ combined the concepts of self-harm and suicide within the one question, asking, "do you have any plans to self-harm or take your life?" He stated that, in his role as a welfare officer, he had met inmates who had self-harmed for the "relief" or "release" it provides, or as a "cry for help". He accepted that there would be some benefit in asking those questions separately, as he saw self-harm and suicide as being separate issues.

Mr Bowen did not agree with a suggestion, made by the lawyer representing GR's family, that a physical inspection of the inmate's neck, arms, hands and face for self-harm injuries could be incorporated. He noted that inmates are already strip-searched when they first arrive at Cessnock. He did not consider it was his role as a welfare officer to be involved in a physical inspection and he thought it would be difficult to ask a person to disrobe.

Mr Bowen recorded in the ISQ, among other things, that GR presented as "well-groomed", denied having current plans to self-harm or take his life, said he was expecting Ms Te-Wake to visit him.

GR had a history of schizophrenia for which he took medication daily, and was not withdrawing from drugs. Mr Bowen noted the active alerts for GR on the OIMS. Mr Bowen was taken to the "Narrative Summary" section of the ISQ form, where he had written that GR "states ok for phone contact" and indicated that the note meant that GR had declined the offer of a telephone call. He said that GR did not provide him with any telephone numbers for external calls. What emerged from Mr Bowen's evidence was that he considered that the reason for phone contact was for the inmate's benefit (this appears to be the same understanding Mr Raper and Mr Mumford had of the offer of a phone call and, to some extent, Ms Ceeney, as was evident from their oral evidence).

The phone call is in fact a component of the intake screening and its purpose is for the screener to obtain further information from a third-party that may contribute to the assessment of risk (as is set out in the relevant section of the then current Operations Procedures Manual). Mr Bowen conceded that obtaining collateral information would be important, particularly if an inmate was downplaying their state of mind.

Mr Bowen did not see any scars or wounds on GR's arms during the 40 minute interview. The interview does not involve a strip search and GR was fully clothed at the time. Mr Bowen agreed that he must have reviewed the Custody Management Record completed by Sergeant John McManus on 6 March 2015, however did not recall seeing pages 2 and 3, which are missing from the copy in the Corrective Services Case Management File. As already mentioned, the missing pages referred to, "large open wounds on forearm". It is unclear how the CMR came to have missing pages and I do not make any criticism of Mr Bowen in relation to this. He said that, if he had seen pages 2 and 3, "it would have been something to refer to when I asked GR about previous self-harm".

From Mr Bowen's observations and experience, he did not form the view that GR was at risk of suicide on the day that he assessed him, nor did he consider that GR was downplaying his mental health status when he was assessing him. Mr Simon Raper, who held the position of acting General Manager at the time GR was in custody, and who is currently the Governor of Cessnock CC, gave evidence that training modules, including a three-day course called "Mental Health First Aid," were available to staff. The tenor of his evidence was that staff were encouraged, but not required, to complete all training on offer, although some was mandatory. He stated that, due to the pressure that Corrective Services was under, training had "fallen off over the last number of years". He said that it was now getting better, but that it was up to individual members of staff to submit a request if they wanted to do a particular course.

Mr Raper conceded that he had also thought that the screening phone call was primarily intended to permit family contact and not to obtain collateral information. He accepted that obtaining collateral information would assist in undertaking the risk assessment and said that steps could be taken to train officers in the appropriate application of the policy.

Mr Raper said that inmates are strip searched when they first enter the correctional centre from the police or court cells, and agreed that that was the appropriate occasion for any obvious injuries to the wrist, forearm or neck to be noted.

He suggested that the best way of dealing with any such injuries might be to verbally communicate them to the intake officer in charge who would be located right next door, and who would be conducting a reception interview with the inmate shortly afterwards. He said that, in contrast, the ISQ may not take place until several days later.

The lawyer for the family also questioned Mr Raper about the ISQ and the training of officers like Mr Bowen in mental health assessment. Mr Raper agreed such training would benefit that process. I will refer to Mr Raper and his evidence again later in this decision. Ms Donna Ceeney was, at the relevant time, the Manager of Offender Services and Programs at Cessnock CC. She gave evidence agreeing that question 75 in the ISQ form could be amended to provide the two discrete questions I have referred to in paragraph 68 above. She agreed that self-harm and suicide were two very different things.

She agreed with Mr Bowen that the ISQ assesses the inmate's current presentation described by Mr Bowen as a "pinpoint in time". However she said that, hypothetically, if a welfare officer saw sutures/injuries on an inmate's forearm, and they looked suspicious, that would warrant filling in a Mandatory Notification Form even if the injury was several weeks old. It would still be regarded as relevant to the inmate's current risk. She agreed that clarifying in the policy what is meant by the inmate's current presentation would be a good thing to do.

She was shown a photograph of the scars on GR's arm and was asked whether it would concern her that a person with those scars was not identified as at risk of self-harm. She answered by saying that she would be concerned if the scars were visible to the welfare officer conducting the screening and no note of them had been made. She considered that a physical inspection by a welfare officer conducting an intake screening would be a disadvantage. She said the welfare officer is trying to build rapport and trust with the inmate in order to elicit the information necessary to complete the ISQ. She indicated that asking someone to roll up their sleeves or remove clothing could potentially damage that trust and said that she didn't agree with it at all.

Ms Ceeney gave evidence that once in the gaol environment it would be very difficult for Corrective Services staff, in circumstances where GR was not actively psychotic or acting out, and was keeping to himself, to identify that his mental health may have deteriorated. She agreed that it illustrated the importance of the Intake Screening process. I note that there was no evidence to suggest that GR was displaying obvious symptoms of deterioration in his mental state after his admission into custody at Cessnock CC such that correctional officers should have noticed and responded. According to GR's cellmate, he was quieter than usual, but he did not notice anything alarming which would have indicated to him the need for intervention and assessment.

Screening & Assessment conducted by Justice Health Screening

I now turn to the Justice Health screening and assessment. GR's initial assessment was carried out by registered nurse Sue-Anne Henderson (Nurse Henderson"), who undertook the Reception Screening Assessment "RSA") in the Newcastle Police Cells on Saturday 7 March 2015. Nurse Henderson observed multiple cuts and sutures on GR's left forearm, which he told her were from putting his arm through a window, although he also disclosed having previously tried to hurt himself.

She was told by GR that he was on a medication called Mirtazapine and that he had been diagnosed with depression and schizophrenia. She identified that Dr Singh was GR's community GP although she was not able to ascertain Dr Singh's contact details from the police cells on the weekend.

As a consequence she only partly completed a form called a "Consent to Obtain Health Information from External Agencies" form which requested, among other things, written verification of GR's prescribed medications. She said she knew the form would accompany GR to his gaol of placement, where a further Justice Health screening would occur, and that she did not fill in Dr Singh's name in case it was assumed by the Justice Health nurse at the gaol of placement that the form had already been sent. She said she would have expected that the form would be faxed to Dr Singh early in the week following her assessment of GR.

Nurse Henderson explained that, currently, the Consent to Obtain Health Information from External Agencies forms are sent to an "ROI clerk", based in Sydney, who sends the forms out to the community health provider, keeps track of whether the inmate's health information has come in and, if so, places an alert on the computer system so that Justice Health staff in the correctional centre are aware. She said that this system was brought in because in the past the forms were not being followed up. She said that, in the early days of the ROI clerk system, there were no ROI clerks rostered on over the weekend, and she assumes that is why she did not fax the form to the ROI clerk herself, along with a note asking him or her to find out Dr Singh's contact details. Nurse Henderson said that now that is what she would do if she was unable to ascertain a community health provider's contact details herself.

Nurse Henderson also explained that the ROAMS protocol (ringing up an on-call doctor to have medication prescribed) would apply if the patient brought with them into custody previously prescribed and labelled medication in their name and it would also apply if the external GP had supplied information to the gaol as to the inmate's current prescribed medications.

As already noted, Nurse Henderson asked GR as part of the RSA whether he had ever tried to hurt himself, to which he replied "yes". This was a mandatory question, marked by an asterisk on the electronic RSA form. When the Justice Health screener receives an answer of 'yes' in response to that question, the electronic form displays a number of follow-up questions, including, "provide details", "when was your last attempt", "how" (did you self-harm) and "why" (did you self-harm). These follow-up questions are not mandatory and Nurse Henderson did not ask them of GR. Nurse Henderson also did not conduct a Kessler 10 survey with GR, which is included in the electronic RSA form as an optional component of the mental health screening. The Nursing Cluster Manager, Ms Roslyn Pavey, suggested in her evidence on 26 February 2018 that, clinically, it would be a good idea to ask the Kessler 10 questions where a person reported depression and schizophrenia. Justice Health's Operational Nurse Manager Custodial Health, Ms Terri Sheehan and Ms Pavey both suggested it would make good clinical sense to obtain further information about previous self-harm.

Nurse Henderson was cross-examined about whether it would have been appropriate to take a conservative approach to the sutures and cuts on GR's arm and to record them as a possible act of self-harm. She said that she would have discussed those injuries with GR and would have taken into consideration his response, as well as his history.

However she said that the focus of the RSA was on "what's happening now." She said she once had a patient who had attempted suicide 3 days prior to coming into custody and when they came into custody they were not suicidal anymore. She said that, while you take into account the history, you can't let it dominate the assessment.

She said that if GR had been expressing thoughts of self-harm or suicidal ideation when she saw him she would have put him on a RIT. Nurse Henderson also explained that she does not automatically get access to court-ordered mental health assessments, as the court liaison nurses in Newcastle are employed by Hunter New England Health and their records are entirely separate from Justice Health. She also explained that collateral information from family members was not generally sought.

Justice Health's Clinical Director, Primary Care, Dr Katerina Lagios said in evidence that reception nurses have a very busy job and have to go with what is in front of them. They don't have time to go back through old documents. Prior to working in the Newcastle Police Cells, Nurse Henderson worked at Cessnock CC for around five years. She said that, in mental health facilities, patients are observed constantly because it is known that someone's mental health can change "literally over the hours." She agreed that, to really monitor a person's state of mind would require much more frequent mental health assessments than are possible in the correctional environment. She agreed that, working on the model that you needed to assess how a person was at a "pinpoint in time" (there and then) and accepting that a person's mental health could change rapidly, the only way that Justice Health could assess a person more frequently than a recommended follow-up time in the Patient Administration System "PAS") or scheduled assessment, (outside of brief medication administration encounters), was if they self-referred for help.

Nurse Henderson considered that if she had been assigning GR a wait list priority level on PAS to have a mental health assessment carried out by a mental health nurse, she would have probably assigned him a priority level 3, as he was going to receive his medications and he was not presenting as unstable at that assessment. A priority level 3 meant he might not be seen for up to 3 months. I note that it was not in fact Nurse Henderson's role to make that classification, which fell to Nurse Wells at the gaol of placement. Nurse Henderson described her understanding that the models of care within Justice Health have changed within the last 12 months and that an inmate's initial mental health assessment is now carried out by a suitably qualified primary health nurse at the receiving gaol and, if things arise in that assessment that warrant further attention, the inmate is then referred to a mental health nurse. The aim of this policy change is that inmates are seen and assessed faster.

Given that the Kessler 10 survey and follow-up questions were not mandatory, together with GR's denial of current self-harm, it could not be concluded that the assessment conducted by Nurse Henderson was inadequate. Even if Nurse Henderson had asked the follow-up questions it is quite possible that GR may not have been candid with her, given that he had chosen not to disclose recent self-harm to those assessing him. No criticism can be levelled at Nurse Henderson in relation to the assessment undertaken by her on the day. Given the evidence of Ms Sheehan and Ms Pavey about the asking of follow-up questions (where a patient has said "yes" to previous self-harm or trying to end their life), it would be my recommendation that the RSA form be amended to make it mandatory to ask the further questions where a patient answers "yes" to either of these questions.

Ms Sheehan agreed that this should occur. It would still be a matter for clinical judgement to administer the Kessler 10 survey, but practitioners ought to be encouraged to do so when a patient reports a history of, or treatment for, depression.

I would also encourage Justice Health to obtain expert clinical consideration as to whether the focus on an inmate's "current presentation" for mental health in the Reception Screening Assessment ought to include not simply the presentation of the patient on the day of assessment but a gathering of information from the patient relating to, say, the previous 4 weeks of the patient's life. This would be consistent with the approach taken in the Kessler 10 survey and for drug and alcohol questions.

Screening by Nurse Wells at Cessnock CC

Nurse Wells assessed GR upon his arrival at Cessnock CC on Sunday, 8 March 2015. She was a primary health nurse of considerable experience, who had worked at Cessnock CC for twenty years. The paperwork provided to her from Nurse Henderson included the RSA and the part-completed "Consent to Obtain Health Information from External Agencies" form. Ms Sheehan gave evidence that a Justice Health nurse conducting a reception assessment at the gaol of placement will review the RSA and sometimes have to "add more to it". This was also the evidence of Ms Pavey.

Nurse Wells gave evidence on 2 occasions. On the first occasion she provided evidence while on holidays overseas and it was by telephone. It became quickly apparent that she had not taken the opportunity to refresh her memory from any material and it appeared that she may not have even had her statement with her. She said she had made her statement "off the top of her head" without the assistance of records. She repeated that assertion in oral evidence on the second occasion, on 26 February 2018. She said that she had resigned from Cessnock CC because she was tired of being understaffed and under pressure.

On both occasions that she gave evidence she said that she had spoken with GR for about an hour to conduct her assessment on 8 March 2015. The written documentation generated during the assessment consists of a short progress note, a PAS waiting list entry for a mental health assessment, a Health Problem Notification form and the document titled, "D&A and MH Summary of RSA for CSNSW". The D&A and MH Summary of RSA form has a time of 14.39 on it, and the progress note has the time 15.30 on it so that does in one sense support her evidence. However the actual records generated by her during the assessment lack detail and appear cursory. In cross-examination, when it was suggested that she had spent less than an hour, she said, "I can't recall, I really can't" but on the second occasion in her evidence maintained her original position. My assessment of her evidence on the first occasion was that it was unreliable - perhaps not helped by being over the telephone.

My assessment of Nurse Wells' reliability on the second occasion that she gave evidence was that she appeared to be too quick to give answers that she really hadn't thought through and again was unreliable. For example, she maintained in oral evidence on 26 February 2018 that she had asked the Kessler 10 questions. Her evidence was that she either wrote the answers on a piece of paper (which does not appear in the records) or she was called away before having a chance to save the amended RSA. Later she said that she had no specific recollection of asking the questions, but it was her normal practice

to do so. On balance, I do not believe she asked the Kessler 10 questions. Nurse Wells told the inquest that she did not inspect GR's arm as it was bandaged and she did not want to "aggravate" the injury.

She recorded in the progress notes the reason for his injury as, "cut himself when high on a pill." She also documented in the progress notes that he denied any thoughts of self-harm. In filling out the Health Problem Notification form, she left the section titled "signs/symptoms to look for in the inmate" blank. The purpose of that form, as I understand it, is for Justice Health staff, following their assessment of the inmate, to put Corrective Services staff on notice of signs or symptoms of any health problems suffered by the inmate.

That way, if those signs or symptoms arise, Corrective Services staff can report them to Justice Health staff, who can address them. Nurse Wells said on 28 August 2017 that she didn't feel she needed to include any information in that section because, although GR had a mental health history, he wasn't "presenting with it... he wasn't showing any mental health problems or any thoughts of self-harm." On 26 February 2018 she acknowledged that thoughts of self-harm can come and go and that a patient who is in a particular mindset on a given day may be in a completely different mindset a few days later. She agreed that it was a mistake not to refer to GR's history of depression and self-harm on the form.

On 28 August 2017, Nurse Wells did not accept that she had assigned GR a waiting list priority level of 5 on the PAS. She said she didn't remember what the categories were. She said GR probably shouldn't have received a referral for mental health at all, even with a history of self-harm and having reported depression and schizophrenia, "unless he was presenting with any of the symptoms or actually asked to see the mental health nurse". On 26 February 2018, Nurse Wells said that she now accepted she had created the waiting list priority level of 5 in PAS and that, based on what she now knows (and taking into account what happened to GR on 27 April 2015), GR should have been allocated a priority level of 2. Importantly, she said that she had not been aware that priority level 5 was reserved for patients who had already had a mental health assessment and who required follow-up.

Nurse Wells acknowledged that she would have received Nurse Henderson's part-completed Consent to Obtain Health Information from External Agencies form on 8 March 2015. She could not explain why she did not put Dr Singh's name on it. She said she had put the form on the Cessnock CC clerk's desk so that he or she could send it to the ROI clerk in Sydney the following day (it being a Sunday). She accepted, however, that the clerk would not have known who GR's GP was, unless it was included on the form or one of the nurses asked GR for that information.

Overall, little weight can be attached to Nurse Wells' recollection, particularly to her assertion that she completed a Kessler 10 survey. However I note that Dr Katerina Lagios said in her evidence that the Kessler 10 survey was used to check someone who was acutely unwell and there was no evidence in the inquest that GR was acutely unwell at the time of his presentation to either Nurse Henderson or Nurse Wells.

The categorisation of GR as a priority level 5 on the mental health waitlist, having reported a history of depression and schizophrenia, was entirely inappropriate and the strong inference I draw is that Nurse Wells' assessment of GR on 8 March 2015 was a more cursory assessment than that which she recollected performing.

Evidence of Mr. Mumford

Mr Mumford, who was the General Manager of Cessnock CC at the time (but on leave as at GR's death), agreed that reviewing the reception and screening tools was a good thing to do, particularly as the modern prisoner profile is changing and evolving.

Wait List Priority Levels in PAS for Mental Health Assessment

The assignment of a mental health assessment Wait List Priority Level on PAS was a recurring issue that arose in evidence at the inquest. Evidence as to the correct approach to the PAS waiting list priority levels was provided by Ms Terri Sheehan, the Operational Nurse Manager Custodial Health, on behalf of Justice Health. She indicated that: -

Priority Level 1 was for "patients whose health condition may deteriorate and require attention within 1 - 3 days". Priority Level 2 was for "patients where lack of intervention may result in an adverse outcome and requires attention within 3 - 14 days". Priority Level 3 was for "patients who are stable but will require attention within 14 days to 3 months" Priority Level 4 was for "patients who are stable but require a review within 12 months". Priority Level 5 was for "patients needing follow-up but within no specified time". The above explanation covers all categories of patients, not just mental health patients.

The evidence heard at the inquest suggested that there was a wide range of approaches to the categorisation of a patient being wait-listed for a mental health assessment. Ms Sheehan said that GR, as a new admission, could probably have been waitlisted as a priority level 1 or priority level 2, due to his reporting of a history of depression and schizophrenia. In oral evidence, she said that if there was evidence of a recent self-harm episode (or of what appeared to be a recent self-harm episode), then she would have assigned GR a priority level 1 or a priority level 2.

Ms Robyn Lloyd, the Nurse Unit Manager at Cessnock CC, indicated that, in her view, a priority level 3 would have been appropriate for GR, as he did not report suicidal ideation, was apparently stable on his medications in the community, and was presenting as calm, co-operative and not withdrawing from any substances that could have been affecting the assessment.

She said, however, that if she had known that the lacerations to his body were self-harm, she would have assigned him a Priority Level 2. Nurse Henderson said that she would have probably assigned GR a priority level 3, taking into account his current stable presentation, his admission to having tried to hurt himself in the past, and her belief that he would have access to his medications, (but she appears to have accepted his advice on face value that he had not self-harmed so far as the cuts on his arm were concerned). Nurse Henderson appeared to place particular emphasis on the presentation of GR at the time of the assessment.

Ms Rhonda Sharpe, who was the only mental health nurse for the maximum security section of Cessnock CC in 2015, described in her statement her understanding of the operation of the priority levels in a mental health context as follows,

Priority level 1 was high risk, most commonly suicidal ideation and/or attempt, and/or threatening harm to self or others; priority level 2 was suicidal ideation with no actual attempt/unstable. In her oral evidence she clarified this by stating that an inmate would be a priority level 1 if he had actually been self-harming or priority level 2 if he had only been threatening self-harm. She explained her reasoning with the illustration that if a person was actually self-harming, not intending to suicide, they may however accidentally cut an artery and die. In submissions it was conceded by counsel for Justice Health that assigning GR a PAS priority level of 5 on the mental health nurse waitlist was incorrect in the circumstances. However Justice Health does not concede that this categorisation was a material cause of GR's death on 27 April 2015.

Workload and Staffing Arrangements for Justice Health Nurses

A further issue arose during the course of the inquest. That issue concerned the workload and staffing arrangements for Justice Health nurses and an alleged instruction not to assign patients waitlist priority levels 1 or 2 in PAS. This evidence was given by registered nurse Kate Quarello ("Nurse Quarello") she said that she had been instructed at Cessnock CC not to assign anyone a higher priority level than 3, because there was difficulty seeing people allocated a priority level 1 or 2 within the requisite timeframes. The instruction was, she thought, contained in an email from the cluster manager (Ms Roslyn Pavey) and the nursing unit manager (Ms Robyn Lloyd) had reiterated it. She recalled that the mental health nurse (Ms Rhonda Sharpe) had also mentioned it. Nurse Quarello also thought she may have been copied into an email containing the instruction. She said that the instruction was in place when she first commenced at Cessnock CC in February 2015.

During the adjournment period (i.e. from August 2017 to February 2018) a thorough search was made by senior officers of Justice Health of emails sent by Ms Pavey, sent and received by Nursing Unit Manager Lloyd, and received by Nurse Quarello, during the relevant period. No email was located that suggested this instruction. There was located at an earlier time discussion concerning inappropriate categorisation of patients for the GP and it is possible that Nurse Quarello may have mistaken that as a directive not to use priority levels 1 and 2 however it could not be cleared up with Nurse Quarello as she had already been excused and was not recalled. Ms Pavey and Ms Lloyd denied issuing any such instruction or being aware of any such instruction.

Nurse Quarello said that the Justice Health nurses were responsible for around 300 inmates in the maximum security section of Cessnock CC. She said that pretty much every shift they were short-staffed. She said there was one mental health nurse and a drug and alcohol or sexual health nurse who would rotate roles. She said that, in respect of primary health nurses, a "well-padded" shift would have 4 primary health nurses (two doing medications, two doing clinics). She said that, as a registered nurse, if you were rostered on with an "EN" (enrolled nurse) it was "an incredible amount of pressure" because there are a lot of tasks the EN cannot perform, including obtaining phone orders and conducting RSAs.

There were medications the ENs could not administer. Nursing Unit Manager Robyn Lloyd agreed in cross-examination that all RSAs were conducted by the evening staff and when an Enrolled Nurse was rostered on the evening shift, those nurses were not authorised at that time to conduct an RSA.

Ms Robertson, appearing on behalf of Nurses Wells, Henderson and Quarello, has submitted that this resulted in placing more pressure on the registered nurse(s) working the evening shift. Ms Lloyd also conceded that the staffing at Cessnock maximum was "less than ideal" in terms of actual resourcing at times (that is, staff who were actually available on a given day to staff the positions) and the system was "under pressure". Ms Robertson submitted in written submissions that the rosters, in particular the sign on sheets, between February - May 2015 indicate the following:

On 27 occasions there were fewer than 3 nurses signed on for the morning shift; and on 22 occasions the skill mix on the morning shift included a registered nurse with 2 Enrolled Nurses or a Registered Nurse with an Enrolled Nurse and a new staff member or new graduate nurse. On 37 occasions a Registered Nurse was rostered on the evening shift with an Enrolled Nurse. (The above submission was not challenged, and on that basis its accuracy is assumed for the purposes of these findings).

Nurse Wells, when she gave evidence in February 2018, said she recalled a morning shift when an Enrolled Nurse was rostered on alone. The rosters clearly show that an Enrolled Nurse was rostered alone as the primary care nurse on the evening shift of 25 February 2015 and the morning shifts of 6 February 2015 and 10 April 2015. Nurse Gebhard-Long completed her nursing qualifications in 2014 and commenced employment at Cessnock Maximum Correctional Centre on 9 March 2015 in the new graduate program. Following orientation, she first appears on the roster on 23 March 2015 as a supernumerary working with Nurse Wells and an enrolled nurse on the evening shift. On 24 March 2015 she was rostered on the evening shift as supernumerary with Nurse Quarello and an enrolled nurse who was working 6 hours. On 25 March 2015 she was rostered on the evening shift as supernumerary with Nurse Wells and Nurse Quarello.

Nurse Gillies completed her nursing qualifications in 2013 and commenced employment at Cessnock maximum in April 2015 and worked for approximately 6 months before resigning. Nurse Gillies was not called to give evidence in these proceedings. She first appears on the roster on 20 April 2015 on a morning shift with Nurse Wells, an Enrolled Nurse, a new Registered Nurse and Nurse Quarello. On 23 April 2015 she was rostered with Nurse Gebhard-Long on the morning shift. On 27 April 2015 she was rostered with Nurse Wells on the evening shift. On 4 May 2015 she was rostered on the morning shift with an enrolled nurse, student nurse and a new staff member/casual registered nurse.

Dr Katerina Lagios, in her evidence, acknowledged that there was a problem attracting staff to a local area like Cessnock; it was common ground that there had been no qualified mental health nurse there since Nurse Sharpe left in April 2016, despite multiple attempts to recruit new staff. The current occupant of the position was undergoing the appropriate training and education. Assuming these quoted statistics to be reliably extracted, it is apparent from them in my view that Justice Health nurse staffing levels at Cessnock CC were and possibly to this day are still, vulnerable, particularly when people are absent or otherwise on leave at any given time. Certainly between February and May 2015 they were less than adequate.

Failure to commence GR on his medications in a timely manner

When GR was assessed by Nurse Henderson on 7 March 2015 he told her that he was taking Mirtazapine in the community, however the Justice Health records show that he was not re-commenced on Mirtazapine until 2 April 2015.

With respect to the failure to commence GR on his medication once he was in custody in a timely manner, the evidence was not contested - the Consent to Obtain Health Information from External Agencies form was part-completed on 7 March 2015; it should have been processed on 9 March 2015 (or shortly thereafter) by a clerk but it did not have Dr Singh's name on it, due to a failure to add that information to the form once GR was transferred to Cessnock CC. A fresh form was completed on 23 March 2015 by Nurse Quarello, then, inexplicably it was not sent off for a further week, by a person unknown who purported to be Nurse Quarello.

Evidence was received that there is a new system in place, with the ROI Clerk available 7 days per week. However that new system will still depend on appropriate compliance by staff, including filling in the form adequately. The inquest was greatly benefited by Dr Christopher Ryan's careful analysis of GR's medical records. On his evidence, it would appear that GR was unlikely to have suffered from major depression (although he was unable to exclude this as a possibility). He was comfortably satisfied that GR did not suffer from schizophrenia. So far as the delay in re-starting GR on appropriate medications was concerned, Dr Ryan concluded that there would have been neither therapeutic benefit in recommencing the drugs nor any harm. Had there been any relapse into major depression, it is likely that it would have been addressed, or substantially addressed, by the recommencement of mirtazapine on 2 April 2015. Accordingly, it appears likely that not being medicated for some three and a half weeks did not play any significant part in GR's decision to take his own life on 27 April 2015.

How Corrective Services and Justice Health monitor the wellbeing of inmates and to what extent is engagement by an inmate with the various services on offer a voluntary process

Mr David Mumford was the general manager of the Cessnock Correctional Complex in April 2015, however at the time he was on extended sick leave. He has over 30 years' experience working for Corrective Services. He was questioned about a Health Problem Notification Form dated 18 December 2014 (from one of GR's previous periods in custody), completed by Nurse Henderson, which listed the following signs and symptoms for Corrective Services officers to look out for: "inappropriate talking, laughing, moody, agitated, change of self-care, isolative or over-familiar behaviour".

Nurse Henderson's evidence was that this was a form of words she used on Health Problem Notification Forms for all inmates with a history of mental health issues, and that it came from a Justice Health document which provided guidance to nurses filling out those kinds of forms. Mr Mumford said that, unless there had actually been an agreement between Justice Health and Corrective Services as to what that particular form of words related to, this was a "very subjective document" (I note that there was no evidence before the inquest of such an agreement).

Mr Mumford was asked, in particular, about what a correctional officer would be looking for if they were asked to look for "isolative behaviour" on a Health Problem Notification Form. He replied that it would be "incredibly difficult" to work that out. He said that there are practical reasons that inmates might seek to isolate themselves, such as, to keep away from the gang culture in the gaol. He said, "that doesn't mean they're at risk of self-harm, it means they just want to do their own gaol...it's their way of surviving in a correctional centre". He did however make the obvious observation that if a correctional officer observed someone appearing mentally unwell they should report it.

Mr Mumford agreed with the proposition that, if an inmate was psychotic or acting out, then that would be easier for correctional officers to detect than if someone was withdrawing into their shell. He said that correctional officers have more contact with inmates on a daily basis than Justice Health nurses and that the process, if an inmate wants to see a Justice Health staff member, is to complete a self-referral note and take it to the "post box" or to contact a correctional officer and ask to go to the clinic. Justice Health nurses come in to dispense medications but there is no routine nursing triage each day.

Counsel Assisting asked whether Mr Mumford thought the following unusual: an inmate with no phone calls or visits, receiving limited correspondence, and with no case notes on the OIMS system despite having been in custody for some weeks. Mr Mumford said that he did not think that was unusual. He said that, from what he had read in the custody record, GR was, "quite a good inmate, wasn't a particular problem...someone like that knew how to do their gaol and...was just doing it quietly...he was a decent sort of young man, he wasn't somebody that was in people's faces, getting into trouble and involved in underhanded stuff within the centre...So, he wouldn't have been flagged at all other than by the methods that we've already discussed through screening."

Mr Mumford gave evidence that a mental health first aid course had been made available to staff at Cessnock CC and that quite a few did the course in 2013 and 2014. He said it was run to train staff in identifying and assisting inmates with mental health issues because more safe cells were being created. He said at any given time there will be a number of RITs being undertaken and that correctional officers' form part of the RIT process.

Mr Mumford was asked about the telephone call Ms Fielder-Gill made to Cessnock Correctional Centre, advising that GR was "not in a good state". He said that it more likely than not would have been picked up by reception and that, while receptionists and telephone switch operators can view the OIMS system, they are not able to make case notes in that system and so could not have passed the information on that way. He said that the information provided by Ms Fielder-Gill should have been relayed to the duty manager who would, in the ordinary course of things, have sought Justice Health appraisal of GR.

He agreed that the information should have been passed on, recorded and acted upon "without a shadow of a doubt". There are no OIMS case notes or Justice Health progress notes recording either the fact of this telephone conversation or any action taken in response to it. I agree with the comments made by Counsel Assisting that this was of potential significance. It was collateral information that GR was not in a good way, and Ms Fielder-Gill believes she may even have gone as far as informing the correctional centre that GR had been self-harming. Either way, the information could have been used to direct attention to the need for further assessment of GR.

It is my strong recommendation that attention be given to this omission as part of any ongoing revision of the Operations Procedures Manual to the extent that procedures for handling the recording and dissemination of collateral information about an inmate are being developed. Assistant Superintendent Vanessa White was, at the relevant time, the "wing officer" or officer in charge of G Block, the accommodation area in which GR was housed. Ms White's evidence was limited in that she had only generalised contact with the inmates in G Block. She handed out mail to the inmates and they could approach her with any enquiries or concerns and come to her for referrals - for example, to the psychologist or to a nurse. In her role, she had about 120 inmates who could approach her at any given time.

Her evidence was that it was not unusual for an inmate to not make phone calls or have visitors, as some inmates are ashamed and don't want contact with their family. She did not consider that inmates who withdraw from others are necessarily more at risk than the average inmate. She said some inmates just want to do their time and want their custody to be quiet. In her opinion there was nothing to suggest that that type of inmate was more at risk. From Assistant Superintendent White's observations, GR didn't isolate himself all of the time - he did get out and mix with others on occasion. She said that, generally speaking, if someone was behaving oddly she would talk with them first to better understand what was happening and she would go to the clinic and speak with Justice Health if needed. Entries on the OIMS system would be made if there was a request to see welfare or the psychologist (for example). Overall, the tenor of her evidence was that she did not consider it unusual for inmates to keep to themselves.

Assistant Superintendent White was asked about Nurse Henderson's Health Problem Notification Form, which referred to "inappropriate talking, laughing, and moody, agitated, change of self-care, isolative or over-familiar behaviour". She said she had seen that form of words "many times". She said, where Corrective Services officers received a form like that, they would look out for things like "isolative behaviour" where they could. However she also said that, from the perspective of a wing officer, when you have 120 inmates under your care and each inmate has a form specifying what to watch out for, it is an enormous task.

She agreed that correctional officers are not trained nurses or doctors or mental health experts. She said that, if she did become concerned about the mental health of an inmate, she would have a conversation with the inmate away from others "so that they feel more comfortable in divulging information" and assess whether there may be a risk. She would then refer them onto the Justice Health clinic as a first port of call "if there was no psychologist or psychiatrist available". The adequacy of the response by Corrective Services officers to the disclosure by inmate Baqlee that GR was deceased, including compliance with death in custody procedures, compliance with crime scene management and compliance with the 911 tool policy.

The Offender Management and Operations Deputy Commissioner's Memorandum No: 2012/01, dated 3 January 2012, contained the following direction:

"It has been brought to my attention that the first responding officers to a number of recent deaths in custody were not carrying a 911 Rescue Tool...I am concerned that staff failure or inability to locate a 911 Rescue Tool may become a contributing factor to the death of an inmate.

Accordingly, General Managers and Managers of Security are required to reinforce with all staff the importance of, and requirement to wear the 911 Rescue Tool.

General Managers and Managers of Security must also ensure that:

The 911 Rescue Tool is worn by: The Night Senior and ALL other correctional officers on C and B Watches

The Operations Procedures Manual, as it stood on 27 April 2015, set out a number of procedures with respect to crime scene management. They included instruction on the prevention of contamination of evidence, to prevent unwanted transfer of material from another source to the physical evidence; instruction on completion of a crime scene log (including detailing any activities that may have altered the crime scene from its original state and items taken from the crime scene); instruction on removing items from a crime scene and compilation of an exhibit book; first responding officer's duties; preventing entry to the crime scene; and supervising witnesses to ensure they do not communicate with anyone.

Deficits in crime scene management were first identified by the Corrective Services investigator shortly after GR's death. Mr Simon Raper, the Governor of Cessnock Maximum Security Correctional Centre, gave evidence and acknowledged that there were deficits, particularly in allowing Inmate Baglee to take items from the scene and wander around unsupervised as is clearly depicted in the CCTV footage. Mr Raper wasn't aware of whether a feedback session had taken place to discuss these deficits with the officers involved and he agreed that should take place.

Mr Raper also agreed that scenario-based training (in responding to a potential death in custody and in crime-scene management) is the best form of training, but said it is logistically difficult to implement as Corrective Services is under pressure to ensure that inmates are out of their cells for longer periods of time and to put scenario-based training on would ordinarily involve putting the gaol into lockdown. He gave evidence that there are times when centre-wide training is conducted in responding to fires and riots so, potentially, it would be possible to include it at that time.

Evidence of Correctional Officer Bender

At the time of the incident, Correctional Officer Bender was a casual correctional officer, having been in the job only 6 months (with 2 months of that being in training). Correctional Officer Bender remains employed with Corrective Services and is now a Senior Correctional Officer. Prior to Correctional Officer Bender being called, the inquest was shown CCTV footage of what occurred outside cell 15 of G 3 Pod in response to Inmate Baglee's use of the cell alarm on 27 April 2015. Correctional Officer Bender, along with other Corrective Services officers, was asked questions about the footage.

Correctional Officer Bender, accompanied by Correctional Officer Redfern, returned Inmate Baglee to cell 15 after his court appearance. Some minutes later, he was one of the two first responding officers to the cell alarm, along with Correctional Officer Redfern.

He gave evidence that he looked through the cell door window and could see Inmate Baglee standing there yelling and GR lying face down on the bed. He was not sure whether to believe Inmate Baglee (that his cellmate had "done himself in") or whether it might be a set up. He could not see anything obviously wrong with GR through the cell door window and he was not sure whether he might jump up or might have been waiting for them to open the cell door. He said he and Correctional Officer Redfern were waiting for officer assistance and also Justice Health assistance in case Inmate Baglee was telling the truth about GR. He understood his role, as a responding officer, was to render first aid if it was safe to do so.

The cell door was not opened for around two more minutes until two more correctional officers (Correctional Officer Neal and Assistant Superintendent Jedrzejczyk) arrived. Correctional Officer Bender said that when the cell door was opened, rather than being instructed to render first aid to GR, he was instructed by Correctional Officer Redfern to start a time log (she being the more senior officer). He could not really remember Inmate Baglee returning to the cell (to obtain his bedding) after he initially left it. He was not aware of the existence of the suicide note until after the police came. He cannot remember writing any of the time log, but he remembers that he was nervous.

Having watched the CCTV footage at the inquest he agreed that Inmate Baglee, once let out of the cell, was allowed to stay in the common area and appeared to be talking to other inmates through their cell doors.

Council Assisting asked Correctional Officer Bender about his understanding of the policy around entering a cell in an apparent emergency situation. The thrust of Correctional Officer Bender's evidence on this point was that, where there is a tension between rendering first aid as soon as possible and safety, it is always safety (of the officers) first. Correctional Officer Bender agreed that he and Correctional Officer Redfern had escorted Inmate Baglee to his cell only minutes before without requiring the assistance of a third officer. He said that he was concerned about safety when he responded to the cell alarm because of the agitated (and perhaps aggressive) behaviour of Inmate Baglee. His observation was that he saw him pacing, and heard him yelling and screaming although he could not remember any exact words. He said, with hindsight, and having watched the CCTV footage, he thought it would have been safe to enter the cell after Inmate Baglee walked out of the cell and into the common area. He said, with hindsight, that he should have entered the cell and checked on GR at that point.

In his statement dated 11 August 2016 Correctional Officer Bender said he was not carrying a 911 tool when he responded to the cell alarm because he had not been issued a 911 tool and was not aware he was required to carry one. He said he did not know where the 911 tools were located in G Block and had not been trained in how to use a 911 tool. In his oral evidence he repeated that he did not know at the time about any requirement for officers on the C Watch to carry a 911 tool. He said he currently works on C Watch and now all officers wear 911 tools.

Correctional Officer Bender received from the Professional Standards Committee a warning letter dated 22 December 2015. He didn't now recall the details of that letter but said he had taken on board its recommendations since then and had "learned his lesson".

He agreed that scenario-based training would be helpful in learning how to handle these types of emergencies.

Evidence of Correctional Officer Redfern

Correctional Officer Redfern, a correctional officer for 8 years, gave evidence that Inmate Baglee was yelling at her and was very agitated when she first arrived at the cell. She could also remember that other inmates were yelling out. She could not recall the order of who went in and out of the cell once the door was opened. Correctional Officer Redfern said she was shocked at the time, did not know what had happened in the cell, could see that Inmate Baglee was agitated and thought he could have been responsible for what had happened. She just did not know.

She said she had a lot of thoughts going through her head. She thinks that she instructed Correctional Officer Bender to keep a time log before the cell was opened, while they were waiting for a third officer to arrive. She gave evidence that she waited for a third officer because of Inmate Baglee's agitation. Looking back, she wasn't sure whether she had been trying to observe a policy or whether she was just thinking about the practical reality of the situation. She said she knew she needed to have the cell door opened, but she also needed to make sure that it wasn't a set-up. She said she did not feel she knew the inmates in cell 15 very well. She was also thinking about the need to render assistance to GR once it was safe. She could see GR lying there, and spots of blood on the floor.

She gave evidence that she had received training about 8 years ago at the Academy on first responding officers' duties, which involved face to face instruction by a senior officer, and she thought there may have been some role-playing training for a possible death in custody scenario.

She recalled seeing Inmate Baglee leave the cell with a cup and said it did not occur to her to ask him to return it. She said if faced with that situation today, she would have asked him to return the cup and would have recorded it in the time log. She was not aware that Correctional Officer Neal had removed a note from the cell until sometime later. She did not think of needing to contain Inmate Baglee once he had exited the cell. She did not remember the bedding being taken out of the cell by inmate Baglee. She handed over supervision of the scene to Assistant Superintendent Jedrzejczyk when she arrived, as she was more senior than her, however did not recall any verbal or formal handover as such. Her evidence was that she told Inmate Baglee he could not go back into the cell but Assistant Superintendent Jedrzejczyk had said it was okay. Correctional Officer Redfern said she did not think it was the right thing to do, as it risked contaminating items in the cell.

Correctional Officer Redfern was not carrying a 911 tool on the evening of 27 April 2015 as she wrongly thought she was not required to carry one. She gave evidence that there was one in the wing office, a 15 metre walk from cell 15. She stated that now all officers wear a 911 tool when on shift. When questioned about the policy of entering a cell at night, in maximum security, she gave evidence that she understood the policy to be that there should be 3 officers in attendance before the door is opened. She said she usually tries to comply with policy but that on occasion you may need to make a judgement call.

Correctional Officer Redfern said that, when she first looked into the cell, she did not immediately form the view that GR had hanged himself.

She had not had any previous experience of an inmate hanging him or herself on a bed and so she was not able to tell, (independently of what Inmate Baglee was reporting) whether GR's life was in fact in danger. All she could see was that he was lying face-down on the bed. She said she was aware that it was a possibility that GR was injured or deceased but said that she could not tell for sure. She said she had not been de-briefed by anyone at Corrective Services in relation to this incident or her response to it. Correctional Officer Redfern agreed that scenario-based training would be of assistance, but said logistically it would require a lockdown. She recalled scenario-based training (which was not directed specifically to managing a death in custody) occurring at Wellington Correctional Centre when she was there and to do the training they had to lockdown 600 inmates.

Evidence of Correctional Officer Neal

Correctional Officer Stephen Neal gave evidence that he had been employed as an officer of Corrective Services since the 1980s, receiving basic training in 1985. He said that, on the night in question, he was not conscious of Inmate Baglee coming out of his cell, as he was focussed on trying to see what was inside the cell. He said he saw GR lying face-down on the bed and noticed there was something white around his neck. There was a drawer inside the wing office that had a 911 tool in it, so he went to the office and retrieved it. He said he now has his own 911 tool as do all officers on B and C watch.

When Correctional Officer Neal entered the cell, he saw a razor near GR's waist, some blood and a note near his neck. He said he picked up the note (with gloves on) as he had knocked it off the bed when he was trying to get to GR's neck to cut the ligature. He placed the note in his pocket, and then cut through the ligature. He said he put the note in his pocket to preserve it as evidence rather than leaving it on the floor. He took it outside the cell to see what it was and said he did not return it to the cell due to the possibility of cross-contamination. He conceded during cross-examination that placing the letter into his pocket risked contamination, and said that was not in his mind at the time of responding to the incident. He said that, in his thirty years with Corrective Services, he has been involved in an incident with a crime scene on only two occasions. He agreed that scenario-based training would assist officers to prepare for emergencies such as this.

Correctional Officer Neal said, with respect to entering the cell, that he had no concerns for his safety once three officers were present. He also said that, if he had been the officer who had responded to the cell alarm with Correctional Officer Bender or Redfern, he would not have waited for a third officer before entering the cell. However he said he had known Inmate Baglee for many years and knew him to be cranky, but not violent. He agreed that his prior knowledge of Inmate Baglee would have allowed him to assess the situation differently from someone more junior.

Evidence of Assistant Superintendent Jedrzejczyk

Assistant Superintendent Jedrzejczyk gave evidence that she had been a first responding officer at a death in custody at Long Bay Correctional Centre sometime between 2002 and 2005.

When she arrived at cell 15 on 27 April 2015, the Justice Health nurses were already in the cell and the area as she remembered it was quiet. Correctional Officers Bender and Redfern were also present. She accepted now that she would have been the officer in charge of the scene by reason of her seniority and rank, however she said that, at the time, she "probably" didn't think she was responsible for crime scene management as there were already people there "doing what they needed to do". She remembered Correctional Officer Redfern informing her about what had happened when she arrived and she remembered that Correctional Officer Bender was keeping a time log.

She remembered that Inmate Baglee was agitated, walking backwards and forwards and agreed, in hindsight, that he should not have been walking around unattended. She said she did not actually see Inmate Baglee take his bedding out of the cell as she was walking out of the pod at the time and she accepted that it should not have happened. She did not recall telling Inmate Baglee that it was alright for him to go back into the cell. When asked how many officers she considered needed to be present in order to enter the cell, it was Assistant Superintendent Jedrzejczyk's opinion that there should be 3 officers. She said when she is the Night Senior and goes around checking cells she always has at least two other officers with her.

She was asked about the apparent contradiction inherent in Inmate Baglee having 2 officers escort him back to the cell after his appearance at the Local Court and then apparently needing three officers to open the cell a short time later. She said that Inmate Baglee would have been assessed on his return from court, so the officers would have felt more comfortable opening the door of the cell at that point. She conceded, however, that GR had not been assessed and so it would not have been clear at the time Inmate Baglee was returned to the cell whether GR posed any risk to the correctional officers.

While there is a conflict between the evidence of Assistant Superintendent Jedrzejczyk and Correctional Officer Redfern as to Inmate Baglee being allowed to take bedding from his cell, I do not consider that anything turns on it. I found both officers to be credible and there being some differences in evidence more likely than not arises from the effluxion of time between the event occurring and the giving of evidence at the Inquest.

Evidence of Mr. Mumford

When asked about scenario-based training for responding to a potential death in custody, rather than relying on the individual officer's knowledge of the Operations Procedures Manual, Mr Mumford said that, having sat and listened to the hearing of this inquest, he and Mr Raper would go back and develop an on-site training component in crime-scene management and the duties of the first responding officer.

Evidence of Mr. Raper

Mr Simon Raper, the Governor of Cessnock Correctional Centre, said that correctional officers are not robots and they need to make judgements on the spot and during the heat of the moment (such as whether to open a cell door). He said that different prison officers will make different decisions.

He said that, in his view, the safety of the staff is paramount. He said that, having watched the CCTV footage of the response to the cell alarm, he did not make any criticism of the officers involved in the incident (despite acknowledging that the response may not have been compliant with the Operations Procedures Manual in all respects). He said that an "after action review" with the involved correctional officers should take place to provide feedback as to what could have been done better. He gave evidence that there was an Emergency Response Group course available for staff to apply for, which takes you through "a lot of serious incidents and training on how to respond to those, duties of the first responding officer and risk priorities." He agreed that scenario-based training is best but logistically very difficult to do.

Whether there is any conflict between Corrective Services safety policies concerning entry by officers into an occupied cell and the Corrective Services policy requiring an urgent response to suspected hanging or life endangering incidents.

The Corrective Services investigator found that clarification was needed regarding the policy with respect to the opening of cell doors when responding to a cell alarm on B and C Watch in maximum security centres, where it is suspected that an inmate is hanging or his or her life is believed to be in danger.

As at 27 April 2015, section 12.1.5.1 of the Operations Procedures Manual provided that, when responding to a cell alarm: "a minimum of two officers must be present when opening a cell door. However, if the responding correctional officer finds an inmate hanging or believes the inmate's life to be in danger, they must immediately render assistance to the inmate, according to the duties of the discovering officer in the emergency procedures described in section 13 of the OPM (Serious Incidents).

Maximum security centres and high risk inmates

In maximum security correctional centres, when a cell alarm call occurs after lock-in, a third officer must attend a cell call and be placed in a position to observe the responding personnel. That third officer will keep the keys to the wing entrance".

As noted by the Corrective Services investigator, the section dealing with maximum security centres does not specify whether the emergency procedures in section 13.2 of the OPM take precedence over the procedure for responding to a cell alarm, in circumstances where an inmate is found hanging or the correctional officer otherwise believes the inmate's life to be in danger. Section 13.2, although it emphasises that staff should make sure it is safe before entering a scene to render assistance, does not specify that any particular number of officers must be present before doing so. Further, where an inmate is found "hanging, choking or strangling" it provides that the first responding officer must render assistance regardless of whether another officer is available to assist.

As at 27 April 2015, section 13.2 stated that:

"Section 13, 2 Deaths in Custody 13.2.1.1 The First Responding Officer upon discovering a death in custody, the FRO will: ***Determine and assess the situation. The FRO must immediately assess the situation for any potential risks or hazards and if necessary, take action to control or minimize them. For example...call for additional staff to assist.***

Prior to entering a scene to provide assistance, the FRO and all subsequent staff must make sure it is safe to do so. If responding to a cell area, ensure cell door is on-the-bolt. Protecting people and providing the injured with first aid and medical care is the first priority.

Establish and notify communications

The FRO... will immediately call for assistance from other officers via radio...It is the responsibility of all staff to provide first aid to injured people if in a position to do so and provided it can be administered safely. It is imperative that this is done as soon as possible to protect life.

Once the FRO has determined it is safe to enter the scene, the FRO must immediately check for signs of life and commence resuscitation (refer part 2(a) below). If the inmate has attempted to take their own life by hanging/choking/strangulation, then the FRO must take immediate steps to remove the means used by the inmate to hang/choke/strangle themselves so that resuscitation attempts can commence (refer part 2(b) below).

The FRO must ensure Justice Health personnel are summoned to attend as soon as possible...

2(a). Check for signs of life and commence resuscitation immediately

The absence of signs of life in a person does not necessarily mean that a person has died. It may just mean that the body is functioning at a very low level and medical instruments are necessary to detect such signs...If the inmate is not breathing or a heartbeat cannot be detected resuscitation attempts must be started...Resuscitation attempts must continue until medical personnel arrive and take over...

2(b). Immediate response to a hanging

Hanging is one of the most common forms of suicide amongst inmates. If an inmate is found hanging, choking or strangling, the FRO must attempt to remove whatever is causing the inmate to hang, choke or strangle. This must be done regardless of whether or not another officer is available to assist..."

Although some minor revisions have been made to the above sections of the Operations Procedures Manual since the date of GR's death, the issue identified by the investigator had not been clarified at the time of final submissions. Mr Raper accepted that there was a tension in the Operations Procedures Manual between section 12.1.5 and section 13.2. He said the Operations Procedures Manual was currently being reviewed and that something coming from this inquest could potentially have some impact on that.

While on the face of it there is an inconsistency from a lay perspective (it was considered safe to open GR's cell with only 2 officers present when Inmate Baglee was returned from court yet considered unsafe to reopen it some minutes later unless 3 officers were present) there are other factors. Correctional Officer Neal knew Inmate Baglee to be cranky but not violent and one could have some understanding as to the reasons why Inmate Baglee was agitated when the officers first came back to the cell on the alarm being given by him.

However Correctional Officer Bender was a new officer and Correctional Officer Redfern said she did not know either inmate that well. They were both worried about Inmate Baglee's agitation and because GR was lying down on his bed they were concerned the situation was a "set up". Further it is a maximum security wing of the facility. I cannot be critical of the officers in that situation. I hope however that the findings in this inquest will provide some impetus for executives of Corrective Services to review the policy to make it clearer for staff at times of emergency such as this.

What Corrective Services policy governs the distribution of mail to inmates including if the inmate may be subject to an ADVOJ.

The issue was whether GR had been deprived of correspondence from his de facto partner, as from his own letters the absence of correspondence from her appears to have affected his state of mind at times. Ms Te-Wake told investigators that the first of her letters to GR was returned with a letter that originated from GR, which suggests that he received that first letter from Ms Te-Wake. Other letters that Ms Te-Wake recalls sending were not returned; it is not known what happened to those letters. Assistant Superintendent White gave evidence that GR did not raise the issue of missing mail with her.

Mr Raper said that if Corrective Services was aware that a current ADVO prohibiting contact was in place, it would look at intercepting correspondence from the person in need of protection, returning that correspondence and advising why it had been returned. That does not appear to have been the case in this matter. There does not appear to be a formal policy that directly addresses the issue.

Counsel Assisting asked Mr Mumford about the effect of ADVOS on inmates' contact with persons outside the gaol, including calls and letters. Mr Mumford gave evidence that he checked return of property for GR (for letters and the like) and found nothing there. A letter could be returned to sender if there was an apprehended domestic violence order in place stating 'no contact'. It would be returned to sender and there would be a record made in a register. The evidence at the inquest did not reveal why, if letters had been sent to GR, they did not reach him. That they did not is evident from his own letters where he asks Ms Te-Wake why there had been no contact.

Expert Evidence of Dr Christopher Ryan:

Dr Ryan, a senior staff specialist at Westmead Hospital, is a well-regarded psychiatrist who gave evidence at the inquest. He said that suicide is a very rare event, even in an inpatient setting. He said that only a very small number of patients who are assessed as being at a high risk of suicide will actually go on to complete suicide and that people who are assessed as low-risk may still complete suicide, with the utility of risk assessment somewhat questionable in terms of assigning people categories ranging from low to high.

The doctor acknowledged that it was common for people to self-harm with no intention of ending their lives. He said that competent people, who don't want help, can't be forced to accept it and that you have to create an environment where people will be comfortable coming forward and seeking help. He added that, if the stressors on a person flow from personality type and substance use, their state of mind so far as suicidal ideation is concerned can change enormously from day to day.

Dr Ryan was of the view that there was a paucity of good psychiatric assessments in GR's medical records and said that, based on those records, he wasn't able to come to a view that GR definitely had any particular psychiatric condition aside from substance use disorder and, probably, some form of personality problem. The doctor indicated that people think about ending their lives for a range of reasons, usually in response to some form of crisis (a "crisis" meaning that the stresses the person is facing are overwhelming their resources). It would seem likely, based on the doctor's evidence, that GR was experiencing at times a situational crisis which included his incarceration and separation from his partner and her children, which was a major feature of his letters to her.

Findings:

All witnesses who gave evidence at the inquest were honest, candid and helpful, other than the comment that I have already made in relation to Nurse Wells. I find on the available evidence that GR's death was self-inflicted. I adopt and find the cause of death as disclosed in Dr Cala's reports, being asphyxia from neck compression, consistent with the mechanism of self-inflicted ligature strangulation.

There is some evidence in GR's letters to his partner from which an inference can be drawn that at times proximate to his death he was expressing suicidal ideation. This ideation was not, on my findings, communicated to any correctional officer or Justice Health nurse within the Cessnock Correctional Centre. On my findings, there was no direct evidence of suicidal ideation shown by GR or communicated by him or observed by any officer or nurse.

GR died in his cell number 15 sometime between lock-down at 3:20 pm and the return of his cell-mate to the cell at about 7:50pm on 27 April 2015, at Cessnock CC. Based on the material provided to him, in the opinion of Dr Cala he would completely discount that GR's death occurred in the 10 minutes or so prior to the arrival at his cell of Corrective Services officers and Justice Health nurses so that the latest time is around 7.40 pm.

Despite those matters that have been found at the inquest to have not been correctly undertaken, the evidence does not provide a foundation for concluding that a different outcome would have occurred if the deficits identified had not occurred. Whilst no individual staff member can be singled out for strong criticism at Justice Health, there was a comprehensive failure to organise the starting of GR's medication in a timely fashion. Further it would have been, in hindsight, advantageous to have asked more questions of GR, particularly about his arm and the aspect of self-harm. I am concerned at the differing levels of interpretation shown concerning priority levels under the PAS system. While I am aware from submissions made by counsel for Justice Health that this matter is being reviewed and is "already developed to an advanced stage" I still consider the matter warrants 8 recommendations.

While it is a system improvement and the cause of death cannot be directly attributed to any perceived deficit in the screening process, it arose in consideration of the manner of death and in that broader sense is "connected with the death " (see s 82 (1) *Coroners Act 2005!*),

I find that staffing levels of Justice Health nurses were under pressure at the time of GR's death. I have an understanding concerning the difficulty they are experiencing in recruiting qualified staff to a rural location such as Cessnock. I will not be making a recommendation in relation to funding resourcing where it was really not a direct issue at the inquest nor am I aware of the state-wide allocation of resources. At the inquest the focus was on nurses and not in terms of the broader area of mental health resources. I do consider it appropriate that I ask Justice Health to review its processes and staffing particularly at Cessnock CC where I am aware there is now an increase in inmates.

One of the unknowns is the extent to which suicidal ideation expressed on one day may be regarded as resolved (and the need for supervision consequently removed) if the patient the next day is not expressing current thoughts. Another unknown is whether GR would have shared such thinking with a clinician. The "pinpoint in time" approach to assessment, even taking past history into account, may not have suggested a level of concern warranting an extended RIT. GR's history of self-harm would not have necessarily been confuted with the risk of taking his own life, from a clinical perspective. Even an extended RIT is unlikely to have persisted beyond days rather than weeks, on the available evidence.

Ms MacCameron's assessment, as a qualified mental health nurse who considered the recent self-harm act as part of her assessment, concluded that GR was not at immediate risk of suicide. A distinction needs to be drawn between a person's thinking as at shortly prior to admission into custody and what that thinking might be seven weeks later.

Given the restrictions on patient access in a correctional setting and the inability to frequently and effectively monitor the prison population at large, the need for an accurate mental health nurse assessment priority rating in PAS and the need for consequent adequate mental health assessment assumes much greater significance in a correctional setting.

Given that the Kessler 10 survey and follow-up questions with respect to self-harm were not mandatory, together with GR's denial of current self-harm, it could not be concluded that the assessment conducted by Nurse Henderson was inadequate, although it would clearly have been desirable with GR's reported history to ask the follow-up questions about self-harm and to conduct a Kessler 10 survey. However, had Nurse Henderson done so, given GR's claim not to have self-harmed with his current injury, it could reasonably be inferred that he was unlikely to be candid in response to the follow-up questions or a Kessler 10 survey.

I have already commented on the amending of the RSA form given the evidence of Ms. Sheehan and Ms. Pavey about the asking of the follow-up questions in relation to self-harm. (see paragraph 94 of this decision). While it was outside the scope of evidence covered in this inquest, the issue of "current presentation" for mental health in the RSA should not be simply the presentation of the patient on the day of assessment. In my opinion it should be a gathering of information from the patient over the last few weeks prior to their incarceration.

I have already mentioned the importance of obtaining collateral information and I again draw to the attention of Corrective Services the appropriateness of obtaining and recording third-party information such as given by Ms Fielder-Gill.

Perhaps telephonist reception staff should be given access to add notes on the OIMS system or alternatively some procedure put in place whereby staff can record concerns as expressed by Ms Fielder-Gill. Better still it would be prudent to make some enquiries with outside sources such as family members or other people that the inmate places trust in. That is why attention should be given to further training to ensure that screening officers are aware of the basis for the screening phone call to family to be requested and, if approved, made. It should not simply be to permit family contact but it is crucially important to obtain collateral information particularly so in circumstances where an inmate may be reluctant to divulge current thinking (for example knowing that he or she might be placed in a safe cell under an RIT).

In the table attached to the Corrective Services Commissioner's submissions, some matters have already been accepted and are or will be implemented. Mental health training particularly for staff carrying out the screening process has now been incorporated into the preliminary training of correctional officers at their training academy called "Brush Farm". The Commissioner agrees that further mental health training is an advantage and should be included and I commend that response. It has also been accepted that scenario-based training is to be made available to staff with the prior arrangement of the governor at each centre.

I note that the Commissioner is also going to make clearer the policy in relation to mail where there are ADVOs in place against inmates. The Commissioner also agrees with the proposal to encourage searching officers to relay information about signs of injury to the officer filling in the Reception Checklist. At the conclusion of the inquest GR's mother Narelle Jarvis provided some insight into her son who she dearly loved. Ms Jarvis expressed the sentiment that no parent or family should have to go through what her family had gone through or feel the pain that she and her family have had to endure.

She had thought on GR's last release from custody and with the assistance from Ms Fielder-Gill that he was happy for the first time in a long time, particularly in re-establishing a connection with her and other members of the family. She said he would give you the shirt off his back if it meant to help. He would go out of his way to help anyone, always putting others before himself. She said he was a loving, caring and passionate person who put 110% into everything he did in life despite what he had been through. She said that he had made mistakes - stupid silly mistakes but he had learnt from them.

I sincerely hope that the process of this inquest has provided to Ms Jarvis some feeling of comfort that his death, while tragic, has brought some significant changes to the way in which people will be assessed and treated in future in a custodial setting. From his death other people have learned from their mistakes and that is a very important matter and one that Ms Jarvis can feel from which there is a significant and lasting benefit.

I extend again my sincere condolences to Ms Jarvis and her family on the death of her much loved son.

Formal Findings:

I find:

The date of death was on 27 April 2015. The time of death was between 3:20 pm and approximately 7:40 pm. The place of death was cell 15, G 3 pod, Cessnock Correctional Centre. The cause of death was asphyxiation arising from neck compression. The manner of death: GR died after using torn or cut up pieces of a bed sheet to make a ligature, which he tightened around his own neck while lying on his bed with the intention of ending his life.

Recommendations:

To Justice Health:

That the current template for the "Reception Screening Assessment" form, in circumstances where the patient answers "yes" to any of the 3 mandatory questions under the heading "Suicide risk assessment", be amended to also mandate that the clinician record answers to the further clarifying questions set out under that mandatory question;

That the current proposed clarification of the patient appointment priority rating categories from 1 - 5 on the "Patient Administration System" include clarification of the rating categories so far as they apply to patients requiring mental health assessments.

To the Commissioner for Corrective Services:

That the current ongoing revision of the Operations Procedures Manual (or its replacement, as the case may be) include clarification to Corrective Services officers on the interaction between

(a) the safety and security requirements for officers opening cells in response to a cell alarm in maximum security centres and (b) the duties of a first responding officer in a potential death in custody situation.

That consideration be given to amending the current CSNSW "Intake Screening Questionnaire", to ensure that currently consolidated questions concerning self-harm and suicide (both current plans and previous acts/attempts) are separated into separate questions as follows:

- *Do you have any current plans to hurt yourself?*
- *Do you have any current plans to end your life?*
- *Have you ever previously tried to hurt yourself?*
- *Have you ever previously tried to end your life?*

That consideration be given to amending the current consolidated question in the CSNSW "Reception Checklist" concerning "current thoughts of self-harm/suicide" to have two discrete questions, one addressing current thoughts of self-harm and one addressing current thoughts of suicide. (I note from the Commissioners submissions that this has already been revised).

8. 139332 of 2015

Inquest into the death of Victor John Russell. Finding handed down by Deputy State Coroner O’Sullivan at Glebe on the 9th July 2018.

The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Victor John Russell.

Introduction

Mr Russell died at John Morony Correctional Centre on 10 May 2015 at the age of 48. At that time, he was a sentenced prisoner and had been housed in C Unit, cell 53 as the only occupant.

The role of the Coroner

When a person’s death is reported to the Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what was the cause and manner of their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the *Coroners Act 2009 (NSW)* makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases, the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person’s death to ensure that the State discharges its responsibility appropriately and adequately. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

The Inquest

A short inquest was held on 9 July 2018. The officer in charge of the investigation, Detective Senior Constable Michael Cambridge gave evidence and the court considered numerous statements, medical records, photographs and reports.

The Evidence

Background:

Victor John Russell was born on 30 May 1967 in Walgett, New South Wales. He was one of seven siblings. His parents separated when he was young and was adopted by his paternal aunt and uncle, however he still maintained a relationship with his mother. Mr Russell never married, but has one 14-year-old daughter and an adult son.

There is no dispute that Mr Russell was in custody lawfully. He was charged on 9 June 2009 with 19 offences including sexual assault, take/detain for advantage and act with intent to pervert the course of justice. He was sentenced in the NSW District Court to a custodial sentence commencing on 15 April 2011 for a term of 8 years; his earliest possible release date being 8 June 2014. His attempts at parole were unsuccessful. The State Parole Authority refused parole because of his continuing drug use and poor behaviour in custody. Mr Russell had a history of poly-substance abuse that included the use of methamphetamine and heroin. His heroin addiction was being treated with methadone. He was transferred from Cessnock Correctional Centre to the Outer Metropolitan Multi-Purpose Correctional Centre (OMMPCC) on 3 July 2014. At this location, he participated in the Intensive Drug and Alcohol Treatment Program, which he successfully completed on 30 March 2015. His next scheduled parole hearing was 26 May 2015.

There was some history of heart problems in the family. In early March 2014, Mr Russell's older sister suffered a heart attack. Mr Russell was subjected to 4 ECGs between 16 July and 9 December 2014, the last test reflecting results of '458 millisecond QTc borderline'. He also suffered from asthma that was managed with Ventolin. It was reported he was a heavy drinker and a smoker of cigarettes. He was also prescribed Quetiapine and Serequel for schizophrenia. Throughout his incarceration, it was not uncommon for Mr Russell to refuse treatment and/or miss appointments.

Mr Russell's phone call records were obtained and the last phone call he made prior to his death was to his daughter on 7 May 2015. In this call, he made a complaint about an abscess on his tooth, otherwise there were no other complaints relating to his health.

The Fatal Incident:

Mr Russell was in an inmate in minimum security of C Unit within the OMMPCC. This unit allowed inmates to move freely from their cells to bathroom and kitchen amenities within the Wing after hours. Mr Russell was housed in cell number 53 as the only occupant.

About 5:30am on 10 May 2015, Jason Arthur West, an inmate in cell 49 went to the bathroom. At the same time, Mr Russell also exited his cell and was seen to make his way to the hot water dispenser to make a cup of coffee.

Mr West said to Mr Russell, "Good morning Unc".

Mr Russell replied, "Good morning Neph".

This was the last time; Mr Russell was seen alive.

About 8:10am, correctional centre officers were performing the morning muster procedures. Inmate Shane Pittman was standing outside cell 53 calling to Mr Russell, "Come on brother yo come on muster come on bro". Correctional officer Matthew Fawzy said to Mr Pittman, "You go outside, I'll get him". Officer Fawzy along with Officer McCready entered cell 53 and saw Mr Russell laying on his bed and it appeared to the officers that he was sleeping. Officer McCready put his hand on Mr Russell's left shoulder and said, "Come on Victor. Up. It's muster". With no response, the officer again gave Mr Russell a shake saying, "Victor, get up. Come on. Wakey wakey". Officer McCready squeezed Mr Russell's earlobe and rubbed his face between the eyes not receiving a response. After making checks for signs of life, Officer McCready called for medical assistance to Justice Health on his radio. At the same time, Acting Superintendent Frank Cunningham entered the cell and assisted Officer McCready in checking for a pulse.

Officers McCready and Fawzy pulled Mr Russell off the bed and placed him on the floor outside his cell. Acting Superintendent Cunningham commenced CPR and was assisted by Officer Domek who used a resuscitation shield to perform 'mouth-to-mouth'. The shield was ineffective and had to be replaced with a handkerchief.

At 8:15am, Justice Health nurses Ram Pant and Margaret Smith arrived with a defibrillator and face mask. The defibrillator was affixed to Mr Russell's chest. At 8:16am, the ambulance was called. Officer McCready used the face mask and exhaled twice when a 'coffee-like substance' came out of Mr Russell's mouth. CPR continued until the first ambulance arrived at 8:27am. Mr Russell was pronounced deceased at 8:44am.

Detective Inspector James of NSW Police spoke with Jason Paul Hodgson, who stated that he was a close friend of Mr Russell. He said that Mr Russell had been complaining about waking up at night, "gagging, vomiting and gasping for breath". Despite having an inhaler, Mr Russell was reluctant to complain about his health issues as he did not want to be placed on a nebuliser device.

Autopsy:

A post mortem examination was performed on 12 May 2015 by Dr Istvan Szentmariay at the Department of Forensic Medicine, Sydney. Dr Szentmariay found that the left anterior descending coronary artery showed full, nearly complete up to 90-95% narrowing due to the hardening of the vessel. Therefore, the cause of death was consistent with Ischaemic Heart Disease.

CSNSW Investigation:

Mr Russell's death resulted in an investigation conducted by Acting Senior Assistant Superintendent Shane Bagley of NSW Corrective Services. Mr Bagley prepared a report on 6 July 2015 where he expressed a concern regarding the accessibility of Laerdal resuscitation masks for correctional officers in the minimum-security section of John Morony Correctional Centre. Currently, officers can only carry resuscitation face shields that did not appear effective in successful breaths when CPR was performed on Mr Russell and was substituted by an ordinary handkerchief.

The correctional centre's Work, Health and Safety Committee considered Mr Bagley's report and have responded by making additional kits available in locations more easily accessible by correctional officers and placed near inmate accommodation units. This includes:

22 fixed first aid kits with Laerdal resuscitation masks in each kit; four portable first aid kits with Laerdal resuscitation masks in each kit; and Five ERKs (Emergency Response Kits) with two Laerdal resuscitation masks in each kit.

Despite the ineffectiveness of the face shield used by officers when performing CPR on Mr Russell, I do not find that this contributed to his death. Officers still performed the necessary task under the supervision of Acting Superintendent Cunningham who was a first aid trainer at the complex. There is no evidence to indicate the performance of mouth-to-mouth was performed inadequately. I commend NSW Corrective Services on their response to Mr Bagley's recommendations.

Findings required by s81(1)

After considering all the documentary evidence and the oral evidence heard at the inquest, I make the following findings under s81(1) of the Act.

The identity of the deceased:

The deceased person was Victor John Russell.

Date of death:

He died on 10 May 2015.

Place of death:

He died at John Morony Correctional Centre, Berkshire Park, NSW.

Cause of death:

He died as a result of Ischaemic Heart Disease

Manner of death:

Mr Russell died of natural causes while he was serving a term of imprisonment

9. 155740 of 2015

Inquest into the death of MC. Finding handed down by Deputy State Coroner Lee at Glebe on the 31st August 2018

Introduction

Mr MC was being held in lawful custody in a NSW correctional centre at the time of his death. Shortly before his death MC had been identified as a person at risk requiring specialist mental health assessment. At around 7:00pm on 25 May 2015 MC was found unresponsive in his cell after having apparently taken his own life. Only eight hours earlier he had been reviewed by a specialist team that had been formed to make an assessment of whether MC was at risk of harm.

Why was an inquest held?

Under the *Coroners Act 2009 (the Act)* a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the *Coroners Act 2009* makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately.

Inquests often have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

The coronial investigation into the death of a person is one that, by its very nature, occasions grief and trauma to that person's family. The emotional toll that such an investigation, and any resulting inquest, places on the family of a deceased person is enormous. A coronial investigation seeks to identify whether there have been any shortcomings, whether by an individual or an organisation, with respect to any matter connected with a person's death.

It seeks to identify shortcomings not for the purpose of assigning blame or fault but, rather, so that lessons can be learnt from such shortcomings and so that, hopefully, these shortcomings are not repeated in the future. If families must re-live painful and distressing memories that an inquest brings with it then, where possible, there should be hope for some positive outcome. The recommendations made by Coroners are made with the hope that they will lead to some positive outcome by improving general public health and safety.

MC's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge MC's life.

MC was born in Brisbane in 1983 and had an older sister (D) and two younger sisters (A and A). He and his siblings were raised by their mother, TP, as MC's father was not present in his life. TP and her children later moved to the Gold Coast and then to Macksville when MC was about 8 years old. MC went to primary school in Macksville and then high school, although he did not complete his secondary studies. Despite this, MC possessed a wide variety of skills that were self-taught and a product of his intelligence and talents. He was particularly adept at using computers and in the areas of automotive, and other, mechanics. He was known to regularly fix cars and bikes, and called it "bush mechanics".

In later life MC met Ms GG. After forming a relationship with her, MC moved to Port Macquarie to live with GG and her son, M. Eventually MC and GG had a daughter together, A. MC was the first person to hold A following her birth and this began an unbreakable and loving bond between father and daughter, a bond which GG describes as unlike any other that she has ever seen. It is perhaps only natural that such a bond existed as A, with her long curly red hair, bears MC's likeness as well as his mannerisms; she is truly her father's daughter.

MC was a devoted father not only to A, but also to M and to MC's son from a previous relationship, K. MC spent much time with each of them and was described by GG as a father who was very much hands-on and involved in his children's activities. There is perhaps no greater sign of the positive influence that MC had on his children than by the fact that M at a young age asked MC if he could call him "daddy". MC taught M to ride his first bike, and his first motorbike. After buying M his first motorbike he painted it in M's favourite colour and with his favourite number on it. This treasured item of M's is no doubt a physical reminder of the love and devotion that MC had for all of his children.

MC's relationship with GG and his children was focused on the simple, everyday aspects of life. GG describes herself and MC as homebodies, who enjoyed relaxing in each other's company at home as much as spending time with close family and friends.

One of MC's favourite places was the beach and he would often go there to unwind. MC also loved all different types of animals, as shown by the many pets that he kept in his home. GG fondly recalls that MC particularly liked keeping fish and that at one stage their home was full of aquariums in the bedroom, lounge room and garage. It is heartbreaking to know that at the time of his death MC was striving to overcome a number of personal issues that had resulted in his incarceration, so that he could build a life as a young family with GG and their children. The loss that they have suffered, together with MC's mother and other members of his family, is enormous.

MC's custodial history

When he started high school MC first started smoking marijuana and soon afterwards began to display behavioural issues. A product of this was associating with negative peer influences and TP found MC's behaviour to be challenging. At around the age of 15 or 16 TP noticed that MC had developed paranoia. Shortly afterwards MC began using amphetamines.

MC first came into contact with the criminal justice system as an adult in 2003. After being charged with driving, drug-related, and assault offences MC was later charged with a more serious offence of violence in July 2003. He was later tried and convicted of this offence, resulting in a sentence of imprisonment. On appeal by prosecuting authorities, this sentence was later increased resulting in a term of 7 years 6 months, with a non-parole period of 4 years 6 months. Following his release from custody at the expiration of this sentence MC continued to offend and to be found in breach of his parole conditions. Much of his offending was related to continued illicit drug use and resulted in the commission of varying offences of violence. This resulted in MC spending further periods in custody between 2008 and 2015.

Shortly after being released from custody MC returned to stay with his mother in March 2015. On 25 March 2015 TP woke up to find MC upset and crying, voicing suicidal thoughts and referring to using a knife to end his own life. TP attempted to seek assistance from the local police in order to have MC taken to hospital. However, MC was later involved in a police pursuit resulting in his arrest. He was subsequently refused bail at Coffs Harbour Local Court and on 26 March 2015 MC was received into custody at Grafton Correctional Centre (**Grafton**).

During an intake assessment at Grafton it was noted that MC had a history of mental health issues and making threats of self-harm; however, at the time of assessment there were nil signs or symptoms of either. Indeed, it was noted that MC appeared to be future focused and was guaranteeing his own safety. On 3 April 2015 MC was transferred to Cessnock Correctional Centre (**Cessnock**).

MC's medical history

Following MC's arrest in 2003, a court-ordered psychiatric assessment was conducted by a psychiatrist who diagnosed MC as suffering from drug-induced psychosis (with a possible differential diagnosis of an illness such as schizophrenia), substance dependence, and alcohol abuse.

Whilst in custody in 2003, MC was assessed by another psychiatrist who was concerned about MC having a possible persistent low-grade psychosis following on from his drug-induced psychosis, with a possible differential diagnosis of schizophrenia or schizoaffective disorder. A further psychiatric review was performed by another psychiatrist in about January 2010. At this time, it was found that MC demonstrated no evidence of psychotic symptoms and that his presentation at the time of review, and in the previous four years, was inconsistent with a diagnosis of chronic schizophrenia. On this basis, it was considered that it was more likely that MC's past psychotic symptoms were related to substance abuse.

When MC was released from custody on 23 February 2015, TP noticed that he was displaying signs of extreme paranoia, saying that people wanted to kill him. After being arrested in March 2015 MC was further assessed and found to be neither paranoid nor mentally disordered. During a screening process when MC was accepted into custody at Grafton it was noted that whilst he appeared agitated, he was displaying nil symptoms relating to mental health, or self-harm, issues.

Events of 18 and 19 May 2015

Whilst in custody at Cessnock between 3 April 2015 and 17 May 2015, MC had a number of interactions with staff from Justice Health & Forensic Mental Health (**Justice Health**). He referred himself to a Justice Health clinic reporting that he was feeling stressed. He later attended the clinic and further reported experiencing auditory hallucinations for which he was prescribed anti-psychotic medication (olanzapine).

At Cessnock MC made a number of phone calls to both his mother and GG. As part of routine procedure at all correctional centres in NSW the calls were recorded. During a call recorded at 11:16am on 18 May 2015 MC told his mother that that he felt like other people were talking about him and that it was "*a big conspiracy*". He also referred to other people pointing a gun, and to the fact that other people conspiring against him was like a puzzle.

During a subsequent call with TP at 1.32pm, MC referred to having a "*gut feeling*" that something was wrong, to other people "*hunting*" him, and to people putting "*a crane over in the yard at night...and they're gunna crane me out*". TP attempted to reassure MC but he told her that he did not believe her and again referred to the existence of a "*big conspiracy*" and that he did not know what was going on. TP told MC that she would attempt to arrange for him to be seen by a doctor.

In subsequent calls with his mother at 1:52pm and 2.37pm later that day, MC again referred to the existence of a conspiracy and subliminal messages, and spoke again about a crane. In other calls with GG at 2:54pm and 3:11pm on the same day MC also referred to the existence of a conspiracy, referred to the crane, and said that he was "*spinning out*". GG also attempted to reassure MC by informing him that she had contacted his solicitor to assist with a request to have MC transferred to Long Bay Correctional Centre (**Long Bay**).

The concerns expressed by TP and GG resulted in MC's solicitor sending an email to Emma Smith, a Client Liaison Officer with Justice Health.

The email indicated that MC's mother had formed the view that MC was psychotic, delusional and anxious and on this basis she was requesting that he be transferred to Long Bay. Ms Smith later called TP to acknowledge that she had received the email, and then forwarded the email to the Nursing Unit Manager (**NUM**) at Cessnock for further action to be taken, and to seek MC's consent for information to be provided to his mother. Later that evening MC was noted to be behaving in an angry and aggressive manner and was consequently placed in a detox cell.

The following day, 19 May 2015, Ms Smith received MC's written consent and an email from the NUM at Cessnock. Following a review conducted by a Justice Health mental health nurse at around midday, it was noted that MC had indicated that he had not been taking his medication for three days and that he was voicing paranoid thoughts, but not making any threats of self-harm. Due to MC's presentation, his assessed level of risk was changed, he was moved to a camera cell to allow for frequent observations, and he was placed on a Risk Intervention Team (**RIT**) protocol. A RIT protocol provides an interdisciplinary mechanism for staff from both Corrective Services NSW (**CSNSW**) and Justice Health to identify, assess and intervene when an inmate is at risk and/or making self-harm attempts. The aim of placing an inmate under a RIT Protocol is to assess an inmate's risk factors, ensure the inmate's safety, ensure the effective development and implementation of an individual management plan, to ensure appropriate specialise referral where applicable, and to provide continuity of crisis and case management care.

MC was also referred to the Mental Health Screening Unit (**MHSU**) at the Metropolitan Reception and Remand Centre (**MRRC**). He was later accepted into the High Dependency Unit (also known as pod 21) of the MHSU, with arrangements made for him to be seen by a psychiatrist.

Events of 21 May 2015

On 20 May 2015 the RIT protocol that MC was under was terminated in order to allow for his transfer from Cessnock to the MRRC. The following day, 21 May 2015, MC was received in the MHSU where he was seen and assessed by Dr Nhut Xan Phung, a psychiatry registrar. Dr Phung was one of two psychiatric trainees employed within the MHSU at the time. Dr Phung conducted an initial psychiatric interview to begin the process of assessing MC (a process which was expected to take a number of days to weeks) and to treat his psychosis. Dr Phung formed a provisional diagnosis that MC was experiencing a psychotic episode due to a relapse of schizophrenia, with a differential diagnosis of drug-induced psychosis.

Dr Phung described MC's mental state at the time as *"characterised as having a blunted affect, a slightly depressed mood, a reduced quantity and rate of speech, an impoverished thought form with relatively little spontaneous communication and expressed thought"*. Dr Phung noted that MC's thought content suggested he had persecutory ideation and that he had been experiencing auditory hallucinations, which had become a humming noise or mumbling in recent weeks. Dr Phung made a recommendation for MC to be admitted to pod 21 of the MHSU, which was the acute observation pod which offered the highest level of monitoring available in the MHSU at the time. Dr Phung noted that from the time of MC's release from the earlier RIT protocol at Cessnock up until his assessment in the MHSU, there had been no further reports of self-harm or self-harming behaviours.

Dr Phung made an assessment that MC was at medium risk of harm to others and a low risk of suicide. He also noted that MC's risk was likely to be highly changeable, that he was in an at-risk mental state and that there had been concern from others about risk. Finally, Dr Phung commenced MC on quetiapine (an anti-psychotic medication).

The initial management plan for MC was for him to remain in pod 21 and be housed in a one-out cell, meaning that MC would be the only occupant of the cell. He was transferred to pod 21 and later seen by Enrolled Nurse (EN) Paul McNulty at around 6:00pm who noted that MC did not present at that time as being depressed, anxious, worried or unduly distressed. EN McNulty also noted that MC did not verbally express any ideas or suggestions that he might be at risk.

Events of 22 May 2015

Registered Nurse (RN) Edwin Coronel was the Justice Health nurse allocated to care for MC on 22 May 2015. RN Coronel did not see MC displaying any unusual behaviour in the morning at breakfast but later spoke to MC and noted that he appeared agitated. MC said that a group of people had been hunting him and were going to kill him. RN Coronel reassured MC by telling him that he was in a safe environment and offered him some medication to settle his anxiety. However, MC refused the medication because he thought it would make him vulnerable and "*easily ganged up on*" by five people if he was sedated. MC did agree, though, to being interviewed by a RIT later that day.

MC later called his mother at about 9:19am. He told TP that he had seen the father of the victim of the offence he was charged with in 2003, and that this person was at the gaol the previous evening. In a later call to GG at 9:40am MC said that someone was hunting him. During a number of further calls between about 10:00am and 12:43pm MC made further references to a conspiracy and others wanting to harm him. During these calls both TP and GG continued to attempt to reassure MC and tried to convince him to take his medication. At around 10:00am, in between these phone calls, MC returned to the medication dispensary room in the Justice Health clinic in an agitated state. He complained that people were hunting him. RN Coronel again attempted to reassure MC and offered him medication; again, MC refused it.

Following the phone calls TP and GG both called Ms Smith separately to advise that MC had said that a person was coming to kill him. Ms Smith conveyed this information to the NUM at the MHSU, Sandra Momirovic.

At about 1:00pm NUM Momirovic told RN Coronel that she had received a call from Ms Smith and been told that MC's mother and partner had called to advise that MC had been threatening to kill himself. NUM Momirovic also advised RN Coronel that MC had told his mother that he had thoughts that he was going to be killed by another person. NUM Momirovic asked RN Coronel to document this information on MC's medical record and on the daily clinical handover sheet. Further, NUM Momirovic sent an email to other personnel to relay this information. NUM Momirovic asked RN Coronel to initiate a RIT for MC until a comprehensive risk and mental health assessment could be conducted, whilst at the same time requesting that a doctor on site attend to review MC.

Maggie Cruickshank, a psychologist from the MHSU, RN Coronel and a CSNSW Assistant Superintendent went to see MC in his cell a short time later. According to a retrospective note made by Ms Cruickshank dated 26 May 2015, MC presented as paranoid and appeared angry and agitated. He denied that he had told any family members about any intent to self-harm, and denied any such thoughts or intent to those interviewing him. He expressed the belief that he was in danger from others and said that the attending staff were attempting to “set him up”. Further, he believed that being placed in an observation cell would increase his access to others who he believed wanted to harm him.

Those interviewing MC determined that because of MC’s apparent paranoid mental state and agitated presentation he should be placed on a RIT protocol for his protection. RN Coronel created a Health Problem Notification Form (**HPNF**) with instructions for CSNSW officers to place MC in a safe cell with no sharps. As there were no safe cells available in the MHSU at the time MC had to be transferred to the Darcy pod, a different location within the MRRC, where a safe cell was available. This was routine practice when a safe cell was unavailable in the MHSU. Shortly before 3:00pm, MC was transferred to Darcy pod 1 in safe cell number 38.

At about 3:30pm Dr Phung went to the Darcy unit in order to provide a handover to the staff there regarding MC, and to review MC himself. Dr Phung noted in MC’s medical records that his mother had expressed concerns for his welfare, and that MC was in an agitated state and openly expressing persecutory fears. Dr Phung noted that as MC’s transfer occurred on a Friday afternoon, the only Justice Health staff available in the Darcy unit was MC’s primary care nurse; there were no Darcy unit psychiatrists or mental health nurses available at the time (as the day shift had ended at 3:00pm). Dr Phung wrote “Placed on RIT” in the progress notes for MC’s Justice Health medical file and spoke to a CSNSW officer within Darcy to ensure that MC was placed in a camera cell and that safe cell conditions had been initiated. As a HPNF had already been created by RN Coronel, no further written instructions were provided to CSNSW staff.

Events of 23 and 24 May 2015

At around 10:30am the following day, 23 May 2015, MC was reviewed by a RIT comprised of Assistant Superintendent (**AS**) Harry Bhalla, RN Geraldine Breen and a CSNSW Service and Programs Officer (**SAPO**), Suzanne Foster. It was noted that whilst MC said that he had been eating and sleeping well, he continued to display paranoid thoughts, said that he did not understand why he was in the MHSU, and complained that there was “morse code in his head, lots of banging”. RN Breen noted that MC was cooperative and compliant, but she formed the view that MC was guarded in answering questions about psychotic symptoms. She also noted that MC denied any suicidal ideation and repeatedly said that he would not harm himself.

The RIT assessed MC as being a medium risk of harm to himself, and a low risk of harm to others. The team decided to keep MC under a RIT protocol, to allow time for his medication to take effect, and he was placed on a waitlist for follow-up and to be reviewed in two days’ time. Accordingly, MC was placed on focused case management and housed in a one-out safe cell.

Following the RIT review MC called his mother at 10:43am. He asked her if she had called the gaol and reported that he was suicidal resulting in him being placed on a RIT. When TP confirmed that she had called Ms Smith this seemed to anger MC and he again referred to others wanting to harm him whilst he was locked in a cell and unable to defend himself.

The next day, 24 May 2015, MC called his mother again at around 11:00am. He again voiced paranoid thoughts and referred to a belief that something would happen to him in the next few days. On this basis he asked that his family visit him before it was too late. When TP indicated that she could visit MC the following weekend he replied, *"I don't even think I'll last that long"*.

Events of the morning of 25 May 2015

Sometime during the morning of 25 May 2015 TP called Ms Smith and told her that during a phone call with MC he had said that someone was going to kill him. At about 9:00am TP made a further call to the MRRC Chaplain, Elizabeth Lee. During the call of about five minutes, MC's mother said that she was concerned about MC's mental health and that the previous week he had told her that he had seen people from his past who were deceased as if they were still alive. Ms Lee told TP that she would do her best to follow up and check in on MC in the afternoon.

At around 10:30am Ms Smith sent NUM Momirovic an email in which she said that she had received a further call from MC's mother who was crying and worried at the time. Ms Smith said that MC had called his mother and told her that he thought someone was going to kill him, and asked NUM Momirovic for an update on MC's condition. NUM Momirovic replied to Ms Smith by email at around 10:53am and said that MC was in a safe cell in Darcy and that she would obtain some feedback after the RIT reviewed him later that day.

The RIT assessment on 25 May 2015

A RIT saw MC between about 11:00am to 11:30am. The team was comprised of AS Bhalla, RN Patricia Guilfoyle and SAPO Ralfs Aleidzans. AS Bhalla noted that the RIT had not received any adverse reports in the period between when MC last seen by a RIT on 23 May 2015 up until the time of review on 25 May 2015. As Bhalla described MC's presentation as *"good"* and that *"he was future focused and he wanted to have more contact with his family"*. AS Bhalla also noted that MC was cooperative and guaranteed his own safety. RN Guilfoyle noted that MC said that he had been eating and sleeping well, but that he was anxious to be out of the safe cell. She said that MC assured the RIT that he had no thoughts of self-harm and denied telling his mother, or anyone else, that he had thoughts of harming himself.

Mr Aleidzans described MC's presentation as being co-operative, appropriate and calm. He said that MC was communicative and denied any current or history of self-harm or suicidal ideation. Further, he said that MC guaranteed his own safety and appeared to be positive and future-orientated. He said that MC told the RIT that he had been eating and sleeping well and that he rated his mood as 8 out of 10. Finally he noted that MC was not displaying any psychotic symptoms.

Following the interview Mr Aleidzans said that he and the other members of the team discussed MC's case and developed a management plan. The team concluded that MC was a low risk of self-harm and on this basis terminated the RIT protocol that MC was on. It was noted that MC was suitable for normal cell placement, meaning that he could be placed in a cell alone (one-out) or in a cell with another inmate (two-out). However given that MC had originally been transferred from the MHSU to Darcy pod due to a lack of cell availability, it was noted that he was to remain in Darcy until a bed was available for him in pod 19 or 20 in the MHSU.

Events on the afternoon of 25 May 2015

At 1:07pm MC was moved from cell 38 in Darcy pod 1 to cell 64. He later spoke to his mother and GG on the phone at 1:52pm and 2:09pm, respectively. In both calls, MC told TP and GG that he loved them. During his call with his mother MC said that he did not need to take his medication and that there was nothing wrong with him. During his call with GG MC maintained that there was nothing wrong with him, but indicated that he had taken his medication.

MC later met with Ms Lee at about 2:20pm after she had noted that MC had earlier been cleared from the RIT protocol following review, and made arrangements for him to see her in her office. Ms Lee noted nothing unusual about MC's presentation other than he was barefoot when he came to see her. She also noted that MC appeared a bit sullen or sad (which was not remarkable) but that his posture changed and he seemed more relaxed after she introduced herself. Ms Lee explained to MC that she had asked to see him because his mother had rung and was concerned about him. MC smiled, said that he was good and later asked Ms Lee if she would say a prayer for him. Ms Lee did so and noted that MC "*appeared in a good space*" at the end of the prayer.

Following the prayer Ms Lee asked if there was anything else she could do for MC. He asked if he could speak with his mother. Although Ms Lee did not routinely make calls on behalf of inmates she agreed to do so in this case and called MC's mother. MC spoke to his mother for about five minutes. Ms Lee recalls that the conversation was supportive, that MC told his mother he was fine, and that it appeared that MC was providing as much encouragement and support to his mother, as she appeared to be providing to him. MC concluded the call by asking his mother to book a visit with him on the weekend and told his mother that he loved her.

Ms Lee had a brief follow-up conversation with TP during which she told her that she thought that MC was doing quite well. TP reiterated her concerns for MC but thanked Ms Lee for following up with him. Ms Lee told MC that she would follow up if his mother had any further concerns and told MC that he could also ask to see her again in the future for ongoing support. MC left Ms Lee at about 2:34pm and returned to the pod. Once there MC made a final call to GG at 2:36pm, during which he again repeated that there was nothing wrong with him and that he was not suicidal.

By the afternoon of 25 May 2015 NUM Momirovic had not received any feedback regarding the outcome of the RIT review of MC. She noted that according to computer records MC remained on an active RIT protocol within Darcy. Accordingly, at 2:57pm NUM Momirovic sent an email to a Clinical Nurse Consultant within Darcy requesting an update regarding MC's status.

At 3:13pm MC left the phone area within the pod and returned to his cell, where he was later locked in at 3:14pm.

At about 7:05pm CSNSW officers Falanisisi Setefano and Miram Ram conducted a medication round with RN Bernadette Timms so that medication could be dispensed to inmates in their cells. Officer Setefano opened MC's cell so that his medication could be given to him, and found that MC was sitting with his back against the cell bench facing towards the door. Officer Setefano then noticed that there was a green sheet wrapped around MC's neck which was attached to the bars over the cell window. Officer Setefano immediately told Officer Ram to call for assistance whilst he removed the sheet from MC's neck, placed him on the ground, and commenced cardiopulmonary resuscitation. Emergency services personnel arrived at the cell at 7:22pm and continued the attempts to resuscitate MC. However these attempts were unsuccessful and MC was pronounced life extinct by attending paramedics at 7:44pm.

What was the cause and manner of MC's death?

MC was later taken to the Department of Forensic Medicine at Glebe where a postmortem examination was performed by Dr Issabella Brouwer, forensic pathologist, on 26 May 2015. Dr Brouwer noted that there was no clear ligature mark present apart from some faintly visible abrasions on the front and left side of the neck. A full body CT scan showed possible fractures of the thyroid cartilage in the neck. Dr Brouwer concluded in her autopsy report dated 6 April 2016 that the cause of MC's death was in keeping with hanging. Having regard to the circumstances in which MC was found, the absence of any other identified anatomical or toxicological cause of death, and Dr Brouwer's opinion, I conclude that the cause of MC's death was hanging.

Given the gravity of a finding that a person has intentionally inflicted their own death it is well-established that such a finding cannot be assumed, but must be proved on the available evidence. Taking into account MC's history of previous suicidal ideation prior to his last period in custody and the circumstances in which he was found on 25 May 2015, I conclude that the evidence is sufficiently clear, cogent and exact to allow a finding to be made that MC died as a consequence of actions taken by him with the intention of ending his life.

What issues did the inquest examine?

Given MC's transfer from the MHSU to Darcy unit, and the proximity between MC's discharge from the RIT protocol on 25 May 2015 and his subsequent death, the coronial investigation into MC's death focused on three main issues:

- The adequacy of the psychiatric assessment and review that was conducted after MC was transferred to the MRRC;
- The adequacy of the assessment performed by the RIT on 25 May 2015; and

- The appropriateness of discharging MC from the RIT protocol on 25 May 2015.

In order to seek clarification of these issues, expert opinion was sought from an independent consultant psychiatrist, Dr Yvonne Skinner. In consideration of each of the above issues, Dr Skinner prepared three expert reports, which formed part of the brief of evidence, and also gave evidence during the inquest.

Each of these issues is considered in further detail below.

Was MC provided with adequate psychiatric assessment and review following his transfer to the MRRC?

In evidence Dr Phung explained that he did not expect, from a psychiatric point of view, to be able to gather every piece of important information from MC during his initial 90 minute assessment on 21 May 2015. Dr Phung explained that it was necessary to observe MC's mental state over a period of time – to observe longitudinal patterns – and to assess MC's response to treatment. Further, Dr Phung said that a period of time was required to monitor MC's response to a medication regime which would necessarily require adjustment as the effects of the medication, which might take days or weeks to have effect, were assessed.

Dr Phung agreed in evidence that the risk of suicide or self-harm cannot be accurately predicted and that classification of a person being at low, medium or high risk does not offer any absolute predictive power. He explained that he himself did not find such risk categories to be helpful and instead offered the opinion that it is more helpful to consider what may be done operationally in order to best assist a patient. However, Dr Phung agreed that there were a number of features of MC's presentation that placed him in a high risk group, namely his possible psychotic illness and the fact that he was incarcerated. Dr Phung explained that whilst on 21 May 2015 he was still in the early stages of forming a diagnosis for MC, he considered MC to be at low risk of self-harm because he denied any thoughts of self-harm and MC's past history did not suggest that he was at any higher level of risk.

In her first report Dr Skinner concluded that the initial assessment performed by Dr Phung was appropriate and adequate.

However, Dr Skinner noted that it did not appear that Dr Phung had made any written note regarding follow up, setting out a plan for psychiatric review, and any relevant recommendations. Further she offered the opinion that as Dr Phung had made changes to MC's medication regime by increasing it, and being aware of concerns expressed by MC's mother, the follow up should have included a plan for review by a psychiatrist to monitor MC's response to the medication and any possible side effects.

The matters raised by Dr Skinner were considered by Dr Phung who provided a supplementary statement in response to them prior to the inquest. Dr Phung said that it was unclear how long MC would remain in Darcy but that it was his expectation that MC would remain there with safe cell conditions in place until he could be returned to an available camera cell in the MHSU. Dr Phung said that it was his expectation at the time of MC's transfer on 22 May 2015 *“that safe cell conditions would not be removed without further psychiatric review”*.

On reflection Dr Phung explained that he was aware that a RIT is ultimately responsible for determining whether to discharge an inmate from a camera cell (and conferring with medical staff as they see fit). However, Dr Phung conceded that it would have been helpful to record a request in MC's progress notes that MC should be reviewed by a psychiatrist before he was discharged from a camera cell with safe cell conditions. In evidence Dr Skinner explained that such a request need not have been lengthy and could have been done by noting a single sentence on MC's progress notes.

Conclusion: Dr Phung's psychiatric assessment of MC was appropriate and adequate in the circumstances of Dr Phung seeing MC for the first time. The assessment of 21 May 2015 represented an initial step in a diagnostic and treatment process that was expected to take days to weeks. The expert evidence from Dr Skinner does not suggest anything to the contrary other than to observe that Dr Phung should have made a note setting out a plan for further psychiatric review. Such a note could have been easily made in a brief, but effective, form in MC's progress notes.

This was particularly important given that in his risk assessment of MC Dr Phung had noted that MC's level of risk appeared to be highly changeable and in the context where Dr Phung had made a change to MC's medication regime. Having had an opportunity to reflect upon the observation of Dr Skinner in this regard, Dr Phung made the frank and fair concession (both before, and during, the inquest) that it would have been helpful to request that MC be reviewed by a psychiatrist prior to his release from a camera cell with safe cell conditions. In this sense it should be acknowledged that based on his experience of working in the MHSU, Dr Phung had an expectation that in the ordinary course of events a RIT would contact him prior to releasing an inmate from a RIT protocol.

Was the assessment conducted by the RIT on 25 May 2015 adequate?

In her first report Dr Skinner observed that whilst Justice Health staff made adequate reference to MC's previous Justice Health, and other, medical records, this information was not conveyed to the RIT that reviewed MC on 25 May 2015. As a result, the RIT did not refer to MC's previous medical history and do not appear to have taken into account the following factors:

That MC had been transferred from Cessnock to the MHSU for psychiatric assessment due to the concerns of CSNSW staff;

That MC's mother had expressed concerns about his potential to self-harm; and that MC was to be assessed in the MHSU and that he was only in Darcy because there was no suitable bed available in the MHSU. Dr Skinner opined that the above factors ought to have alerted the RIT to the need for continued observation of MC. Given the opinion expressed by Dr Skinner, it was necessary during the inquest to examine what information the members of the RIT had regard to before the decision was made jointly to discharge MC from the RIT protocol. In this regard the evidence given by RN Guilfoyle is of critical importance.

Information available to the RIT members

As Bhalla, as the RIT coordinator, said that he reviewed MC's CSNSW case management file prior to the review and also checked whether any case notes, alerts, or incidents had been created for him. Similarly, Mr Aleidzans said he reviewed MC's case management file for about five minutes prior to the review commencing.

As Bhalla agreed that he was aware of the contents of the Mandatory Notification Form completed at on 22 May 2015 after MC had been reviewed at 1:30pm by RN Coronel, Ms Cruickshank and an Assistant Superintendent. That form noted that MC had made a threat of self-harm to his mother and partner. AS Bhalla agreed in evidence that he understood that the apparent threat had been reported by MC's mother, but said that it was not usual practice to contact the person who had reported such a threat. He explained that, for reasons of confidentiality, to do so would require authority being given by the inmate who reportedly had made the threat. When asked if the RIT discussed with MC whether he was content for his mother to be contacted regarding this issue AS Bhalla said that the team could ask MC about the matter directly without needing to speak to his mother.

RN Guilfoyle said that it was her usual practice, as a member of a RIT, to collect an inmate's Justice Health file from medical records on the morning of a RIT review and familiarise herself with the relevant and most recent parts of it prior to the review itself. On the morning of 25 May 2015 RN Guilfoyle followed this practice but when she went to collect MC's physical file from medical records at about 8:00am she discovered that it had already been collected and was with a Drug and Alcohol nurse. By the time the RIT was ready to review the first inmate at 8:30am that morning, RN Guilfoyle had not had an opportunity to retrieve the file. However, she was aware that the file was with a Drug and Alcohol nurse in a room next door to where the RIT review was occurring.

At 11:00am AS Bhalla indicated that MC was the next inmate to be reviewed. As Bhalla left the interview room in order to bring MC from his cell. RN Guilfoyle said in evidence that at this point she realised that she still did not have MC's file and informed the other team members of this. She said that she went next door to look through the files in the possession of the Drug and Alcohol nurse in the adjacent room but could not find MC's file. As the Drug and Alcohol nurse was interviewing another inmate at the time, RN Guilfoyle said that she was loathe to interrupt the interview in order to ask where MC's file was. Instead she returned to the RIT interview room without it. Upon her return RN Guilfoyle said that she took a blank progress note page in order to make notes of the review which she intended to later transcribe into MC's file once she obtained it. She also said that she had a brief opportunity to ask Mr Aleidzans about how long MC had been placed on a RIT protocol and the reason for it.

As Mr Aleidzans was in the midst of providing this information, MC arrived in the interview room with AS Bhalla and the review commenced. At the end of the review AS Bhalla left the room with MC to arrange for him to be returned to his cell. At this point, RN Guilfoyle said that she returned to the adjacent room and asked the Drug and Alcohol nurse where MC's file was. It was found under another inmate's file and RN Guilfoyle explained that this was why she was unable to locate it before MC's review began.

After returning to the interview room with MC's file RN Guilfoyle said that she had an opportunity to review the most recent progress notes in the file before AS Bhalla returned to the room. At this point the team members discussed whether MC should remain on, or be discharged from, the RIT protocol.

RN Guilfoyle said that after the team had completed reviewing all of the inmates who were to be seen on 25 May 2015 she commenced transcribing the notes she had taken during MC's review (which had been written on the blank, single-page progress note) into his progress notes in the Justice Health file. RN Guilfoyle's transcription only notes the date and time of the review, and the members of the RIT. No detail is provided regarding the review itself. Further, the transcription appears out of chronological sequence, following a progress note entry made on 23 January 2015. RN Guilfoyle sought to explain in evidence that she had started the process of transcription and then became distracted for reasons that she could not recall. As a result, she said that she slipped the single-page note of the review in MC's file, intending to complete the transcription at a later stage. However, she did not do so and the single-page note has not been subsequently located.

If the correct chronological order of progress notes had been maintained RN Guilfoyle's partial transcription should have followed the entry made by RN Breen on 23 May 2015. On this basis RN Guilfoyle was asked whether it was possible that she had not seen the entry made by RN Breen at all. RN Guilfoyle maintained that she did see the entry. To summarise her evidence, RN Guilfoyle was asked specifically about what information she had prior to the team making such a determination. She indicated that the totality of the information available to her comprised the information gathered from MC during the review, the progress note written by RN Breen on 23 May 2015, and information from the CSNSW case management file which had been conveyed to her verbally by Mr Aleidzans.

This was RN Guilfoyle's position at the conclusion of questions asked by Counsel Assisting. Later in evidence, however, RN Guilfoyle's position changed. Counsel for Dr Phung suggested to RN Guilfoyle that, knowing the sessions being conducted by the Drug and Alcohol nurse next door were confidential nature, it was unlikely she would have "raced" into the room to retrieve MC's file as she had indicated in her earlier evidence. This suggestion appeared to cause some doubt in RN Guilfoyle's mind about the accuracy of her recollection of the event. She subsequently acknowledged that it was possible she was misremembering what had actually occurred.

Further, RN Guilfoyle agreed that it was possible that she did not have MC's file at all at the point in time when the team made its decision to release him from the RIT protocol. In evidence RN Guilfoyle agreed that when making a decision regarding an inmate's RIT protocol status it would be best practice to be familiar with the contents of that inmate's Justice Health file. Similarly, RN Guilfoyle agreed that it would have been preferable if she had been able to read Dr Phung's mental health assessment of 21 May 2015. RN Guilfoyle agreed that that the option to postpone MC's review until she had had an opportunity to review his Justice Health file was available to her. However, she could not recall why she did not utilise this option; in hindsight, she agreed that she should have. Further, RN Guilfoyle said that she thought that she had mentioned the absence of the file in a statement which she made to investigating police dated 19 December 2016. When it was explained to RN Guilfoyle that she had not done so, she said that it was quite remiss of her.

RN Guilfoyle also said that she could not recall whether she had told her immediate superior, NUM Momirovic, on 26 May 2015 about the unavailability of MC's file but agreed that she had the opportunity to do so. Instead, RN Guilfoyle said that the only person she did inform was a "senior staff" person who was visiting Justice Health on 26 May 2015.

In evidence Dr Skinner was asked to assume that the RIT members had the following information available to them: TP reporting her concerns about MC harming himself, the contents of the CSNSW case management file, enquiries made with the CSNSW officers in the pod where MC was housed with nothing adverse reported, and the Justice Health nurse having no access to the Justice Health file before the interview started and either only limited or no reference to it before the decision was made to discharge MC from the RIT protocol. Dr Skinner that the totality of this information would not have allowed for an adequate assessment to be done as no regard was had to the assessment conducted by Dr Phung. This assessment noted that MC was suffering from psychotic symptoms and indicated that MC's medication regime had changed. Further, Dr Skinner explained that it was important to refer to the Justice Health file because it would have given insight into MC's personality, his impulsivity, the fact that he would sometimes be more communicative but at other times he would be less forthcoming and be fearful of being harmed.

Conclusion: The totality of RN Guilfoyle's evidence raises considerable doubt as to whether any of the relevant information contained in MC's Justice Health file was available to the members of the RIT prior to them making the decision to discharge MC from the RIT protocol. The concession made by RN Guilfoyle that it was possible she did not have access to MC's file at all was entirely inconsistent with her earlier evidence that she did in fact have access to it. Further, it appears that RN Guilfoyle specifically did not have regard to the progress note entry made by RN Breen on 23 May 2015. RN Guilfoyle's partial transcription of the notes of the review out of chronological order, and the overall inconsistency of RN Guilfoyle's evidence, supports this conclusion. It should be noted that neither AS Bhalla nor Mr Aleidzans had any recollection of RN Guilfoyle indicating that she did not have MC's file, or of her leaving the interview room in order to retrieve it. Taking these matters into account, the evidence given by RN Guilfoyle regarding the availability of, and access to, MC's Justice Health file is unreliable and cannot be accepted.

The effect of this is that the RIT members were not in possession of important information contained in the file that was relevant to the decision which the team was required to make on 25 May 2015. Specifically, the RIT members did not have an opportunity to adequately consider the following: the assessment made by Dr Phung on 21 May 2015 that MC's level of risk appeared to be highly changeable; the further assessment made by Dr Phung on 22 May 2015 that MC showed no insight and impaired judgment; and the assessment made by RN Breen on 23 May 2015 that MC showed poor insight. Without this information, as Dr Skinner noted, the RIT would have been unable to make an accurate assessment of MC, and in particular his degree of impulsivity.

RN Guilfoyle readily acknowledged that it would have been in accordance with clinical best practice for her to be familiar with the relevant portions of MC's file. The evidence does not establish that such a practice was followed on 25 May 2015.

Further, no adequate explanation was offered by RN Guilfoyle as to why she did not request that MC's review be postponed, an option that was readily available to her. Indeed, AS Bhalla said that he would have expected the review to be postponed in such circumstances. Mr Aleidzans said that whilst he had never been part of a RIT review where a Justice Health nurse member did not have an inmate's file, he had experience of RIT reviews being postponed. Taking into account each of these identified deficiencies regarding the RIT assessment conducted on 25 May 2015 leads to the conclusion that the assessment was inadequate.

Availability of information from MC's mother

Apart from the above information being unavailable to the RIT on 25 May 2015, it also appeared that the RIT was unaware that MC's mother had called Ms Smith that same morning. In her call TP reported that MC had told her that someone was going to kill him. Ms Smith notified NUM Momirovic about this via an email sent at 10:30am, which NUM Momirovic replied to at 10:53am. In that email NUM Momirovic indicated that she would "*get some feedback from the RIT*" when they reviewed MC. In the statement which she provided to police NUM Momirovic indicated that she could not recall who she spoke to on 25 May 2015 regarding Ms Smith's email.

This issue was explored with NUM Momirovic in evidence. She initially said that after reading Ms Smith's email she thought she had rung the Darcy unit and spoken to RN Guilfoyle. However, NUM Momirovic said that when she spoke to RN Guilfoyle on 26 May 2015 RN Guilfoyle told her that she had not mentioned Ms Smith's email. According to NUM Momirovic, this conversation left her "*stumped*" as to who she had spoken to. Later in evidence NUM Momirovic said that she could not remember who she had spoken to agreed that she could not say with any certainty that she had spoken to RN Guilfoyle. Eventually, NUM Momirovic acknowledged that she could not say at all if she did, or did not, pass on the report from TP that was contained in Ms Smith's email.

RN Guilfoyle said that she had no recollection of being made aware by NUM Momirovic (or anyone else) that TP had called on the morning of 25 May 2015 expressing concern for MC. RN Guilfoyle said that she recalled only being made aware of this fact when speaking to another staff member the following day on 26 May 2015.

RN Guilfoyle said that in some circumstances it might have been useful to have this information. However, in MC's specific case RN Guilfoyle referred to the fact that the team had information regarding the calls made by TP on 22 May 2015 and that MC had presented well on 25 May 2015. RN Guilfoyle said that in hindsight it may have been a concern that there was inconsistency between what TP had reported and what MC himself was telling the team, but RN Guilfoyle said that she remained comforted by MC's positive presentation.

Conclusion: Given the uncertainty expressed by NUM Momirovic, it is evident that TP's report of her phone call with MC on the morning of 25 May 2015 was not conveyed to the RIT members. The absence of this information was another factor contributing to the inadequacy of the RIT assessment conducted on 25 May 2015.

The effect of RN Guilfoyle's evidence is that this information, whilst inconsistent with what MC was reporting to the RIT members, would likely not have made a difference to the team's assessment given that MC had presented well.

However, best practice would suggest that the RIT should have been provided with all information relevant to their assessment of MC, particularly information that was so proximate to the time of their assessment. Indeed, the *NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff (the Framework)*, which applied at the time of MC's death, "provides detailed information on conducting suicide risk assessments and specific information on the roles and responsibilities of generalist and mental health services to guide the suicide risk assessment and management process". The Framework notes that "collateral information, particularly from a family or support person, should always be sought as part of the re-assessment of suicide risk".

Communication with the MHSU

As already noted above, the evidence from Dr Phung established that it was usual practice within the MHSU for a RIT reviewing an inmate within the MHSU to refer back to that inmate's treating team prior to making a decision about whether to discharge the inmate from a RIT protocol. In MC's case it appears that this did not occur (accepting that Dr Phung acknowledged that it would have been helpful if he had made such a note in MC's progress notes) fundamentally because MC was being reviewed by a RIT outside of the MHSU.

The RIT Management Plan for MC upon his discharge from the RIT protocol contained instructions that MC was to be held in Darcy until a bed was available for him in the MHSU. AS Bhalla was asked in evidence whether any contact was made with the MHSU given that it was the intention of the RIT to return MC there. AS Bhalla said that contact would only be made with the MHSU once the RIT had cleared MC and that it was the responsibility of the Justice Health nurse to make such contact. The purpose of this contact was only to determine if a bed was available for MC and which pod he would be sent to.

Conclusion: The usual practice within the MHSU was for safe cell conditions for an inmate under a RIT protocol to not be removed until a psychiatric review had occurred. This practice should have been followed in MC's case. It was not followed because MC's location in the Darcy unit created both a physical and therapeutical detachment between the RIT that assessed him and the MHSU treating team. As a component of a comprehensive suicide risk assessment the Framework provides that "*a consultant psychiatrist's opinion should be sought early, wherever possible, in the assessment and management of a person with suicide risk. This may be available as part of the team's routine case review meeting*". The lack of reference by the RIT back to the MHSU treating team resulted in a further inadequacy concerning the RIT assessment conducted on 25 May 2015.

Was it appropriate to discharge MC from the RIT protocol on 25 May 2015?

It appears that MC's presentation on 25 May 2015 was an important factor in the decision made by the RIT members to discharge him from the RIT protocol.

RN Guilfoyle said that MC presented as initially irate and angry, wanting to know why he was still being kept in his cell, but settled after a short time and appeared happy to answer questions from the team. RN Guilfoyle noted that MC was not distracted, made good eye contact, showed no perceptual disturbances and denied any thoughts of self-harm and hearing voices; RN Guilfoyle regarded all of this as positive signs. AS Bhalla explained that there was a discussion between the team members regarding MC's presentation with specific reference made to the notes made by Ms Foster on 23 May 2015. AS Bhalla indicated that nothing adverse was detected in MC's presentation and noted that MC gave assurances that he was not going to harm himself.

However Dr Skinner was of the opinion that MC's presentation at the review was not a positive one. She explained that because MC wanted more freedom (to be taken off the RIT protocol, and allowed to smoke), his statements to the RIT were skewed towards positive answers so that he would be moved to a place which he found more preferable. Dr Skinner emphasised that Dr Phung had found MC's risk status to be changeable. Further, she also referred to the fact that MC had a change of medication so that it was possible the quetiapine he had been started on had had a calming effect so that any anxiety or fear that he had might have been reduced or eliminated; in this state he might give positive answers and appear well.

Conclusion: It appears that because the RIT on 25 May 2015 was not provided with the information it should have been, as already referred to above, there was an inaccurate assessment made of the apparent positivity of MC's presentation. Lack of awareness of the assessment of MC's changeability and the effects of his new medication regime contributed to this inaccuracy. As a result, it appears that insufficient consideration was given to follow-up measures to be put in place upon MC's discharge from the RIT protocol.

The RIT Management Plan that was completed upon MC's discharge from the RIT protocol noted that he was for normal cell placement, that he could have access to all of his normal possessions, and that focussed case management would be implemented. AS Bhalla said that he understood that once MC was deemed suitable for cell placement he would be subject to the normal routine of the pod where he would be housed. Specifically, this meant that MC would be locked in his cell at around 3:00pm where he would remain overnight until the following morning. The only interruption to this period would come in the form of the evening medication round at about 7:00pm. In this regard, AS Bhalla explained in evidence that the routine in Darcy was no different to the routine in the MHSU, in the sense that the door of a cell would only be opened in the event of an alarm raised by an inmate or the need to dispense medication to an inmate.

With this in mind, AS Bhalla was asked in general whether any consideration was given to the fact that there might be a continuing risk to MC. He said that once it was decided by the RIT that MC was at low risk, there was no reason to place him in any higher degree of restrictive environment. As Bhalla was also asked whether any consideration was given to a step-down period or some degree of oversight. Again AS Bhalla indicated that this was unnecessary on the basis that once MC returned to the MHSU he would be subject to the more intensive management that was available in that area.

RN Guilfoyle was also asked whether she had any concerns that MC would go from a situation where he was under almost constant observation to a situation where he would be subject to almost no observation. She said that she had no such concern because it was her understanding that MC would be returned to the MHSU, as he had been admitted there, and that he could not be discharged from the Darcy unit.

RN Guilfoyle agreed that instructions could have been given on discharge for MC to remain under some observation however she said that such instructions were not warranted given how well MC had presented at the time of review. In her first report Dr Skinner opined that *"it was not appropriate to discharge [MC] from the RIT protocol...without a carefully prepared plan for follow-up"*. In particular, Dr Skinner noted that MC *"should have been transferred to a transitional cell arrangement with a 'step-down' before normal cell placement was considered"*.

Section 13.3 of the CSNSW Operations Procedures Manual (**OPM**), which was in force at the time of MC's death, defines step-down to be *"a gradual reduction in restricted access to amenities and specialist support within a structured RIT or 'focussed' case management plan"*. Focussed case management is further defined in section 13.3 to mean *"a step-down procedure where specific requirements relating to shared accommodation and staff and allocation to monitor the inmate's mood and behaviour every two to three days is established for identified 'high risk' inmates with ongoing risk factors"*. Section 13.3.9 of the OPM deals with case management and progression planning for an inmate and provides that *"focussed case management may require the Case Officer to interact with the inmate and review the inmate's presentation every two to three days, to monitor that no reoccurrence of known triggers for suicidal behaviour have occurred. Usually the inmate's accommodation regime will be accompanied by a 'two out' shared accommodation placement with a 'buddy'"*.

AS Bhalla was asked specifically about his understanding of what focussed case management (**FCM**) meant. He explained that FCM refers to a situation where an inmate cannot be managed in a normal accommodation area and requires a high level of supervision. AS Bhalla was taken the definition of FCM in the OPM and asked if MC had a Case Officer allocated to perform the role as indicated. AS Bhalla said that he was unable to comment because his only interaction with MC occurred during the reviews conducted by the RIT and that the RIT expected MC to be returned to the MHSU on the same day as his discharge. However, AS Bhalla later explained that FCM in MC's case simply meant that MC was to be eventually returned to the MHSU where there would be increased and more intensive observations conducted.

Dr Skinner was asked in evidence what kind of step-down protocol she envisaged. She expressed concern that there had been no communication with the MHSU in general and no communication with the MHSU in particular about appropriate cell placement for MC in the interim period between his expected return to the MHSU. She also indicated that some consideration ought to have been given to limiting MC's access to bedding and to sharps. Further, Dr Skinner said that some kind of more frequent monitoring ought to have been provided for MC in order to give him some reassurance and reduce his anxiety, rather than simply leaving him alone.

AS Bhalla was asked whether he was familiar with the guidance provided in the OPM regarding the available step-down options for persons discharged from a RIT protocol. AS Bhalla said that there were no “*hard and fast*” guidelines and that adjustments were frequently made to ensure that inmates were managed in the best possible way. Upon MC’s discharge from the RIT a mandatory notification for offenders at risk of suicide and self-harm form was also completed by the RIT members. The form contains a section titled “*Monitoring (e.g. case officer to chat with inmate for (5) minutes each day)*” in which the words “*AS REQUIRED*” are pre-printed, and not completed by hand like other sections on the form. AS Bhalla was asked about the words “*AS REQUIRED*” and indicated it was standard protocol for the phrase to be included on the form.

He explained that the phrase simply meant that the monitoring requirements of the accommodation area where an inmate was returning to following discharge would be applied.

Conclusion: It appears that little, or no, specific consideration was given by the RIT to the need for some form of step-down protocol for MC following his discharge from the RIT protocol. It is accepted that the RIT expected that MC would be returned to the MHSU on the same day as his discharge and that the same procedures regarding cell lockdown would have been followed there as in the Darcy unit. Even allowing for this, due to MC’s history of psychosis, his recent change in medication, and the fact that his risk level appeared to be highly changeable, some transitional arrangements were warranted.

It is acknowledged that the opinion expressed by Dr Skinner in this regard was offered with the benefit of hindsight. However, it appears that at least some greater consideration ought to have been given as to precisely what, if any, focused case management was to be provided for MC according to the terms of his RIT Management Plan. The evidence suggests that the only additional management to be provided for MC was his return to the MHSU, a more intensive environment than the one in which MC was housed in at the time of his discharge. This appears to be supported by the contents of the mandatory notification form and the words “*AS REQUIRED*” which suggest that no specific consideration was given to whether some additional monitoring of MC was needed. As noted by Dr Skinner this may have provided MC with some degree of reassurance. Of course, it is not possible to conclude, even if some level of additional monitoring had been provided for MC, whether this would have altered the eventual outcome in any way.

Having regard to the ways in which a psychiatric review prior to the removal of safe cell conditions and MC’s discharge from the RIT protocol might have materially affected the RIT assessment process it is necessary to make the following recommendation.

Recommendation: I recommend to the Commissioner for Corrective Services NSW; the Chief Executive, Justice Health & Forensic Mental Health Network; and the Governor, Metropolitan Reception and Remand Centre, that consideration be given to collaboratively developing and implementing Local Operating Procedures for the Metropolitan Reception and Remand Centre.

The procedures specifically relate to inmates from the Mental Health Screening Unit (**MHSU**) who have been placed on a Risk Intervention Team (**RIT**) Management Plan. The procedures should address the following:

(a) Identify the circumstances in which a RIT should seek information from an inmate's Justice Health treating team in order to formulate a RIT Discharge Plan, particularly in situations where that inmate is placed in an assessment cell that is not within the MHSU; (b) How information relevant to an inmate's RIT Discharge Plan is to be shared between the inmate's Justice Health treating team and a RIT; and (c) The means by which any recommendation made by a psychiatrist that an inmate be subject to psychiatric review prior to discharge from a RIT Management Plan is to be communicated to a RIT.

Findings

Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Mr Jake Harris, Counsel Assisting, and his instructing solicitor, Ms Kathleen Hainsworth of the Crown Solicitor's Office. Their assistance during both the preparation for inquest, and during the inquest itself, has been invaluable.

I would also like to thank them both for the sensitivity and empathy that they have shown throughout this matter. I also thank Detective Sergeant Damien Babb for his role in the police investigation and for compiling the initial brief of evidence

The findings I make under section 81(1) of the Act are:

Identity

The person who died was MC.

Date of death

MC died on 25 May 2015.

Place of death

MC died at the Metropolitan Reception and Remand Centre, Silverwater NSW 2128.

Cause of death

The cause of MC's death was hanging.

Manner of death

MC died whilst in lawful custody as a consequence of actions taken by him with the intention of ending his own life.

10. 265616 of 2015

Inquest into the death of Stephen Paul Hodge. Finding handed down by Deputy State Coroner O’Sullivan at Glebe on the 20th April 2018.

Introduction:

Mr Stephen Hodge was born on 10 December 1963 and died on 9 September 2015, aged 51 years. His death took place in circumstances of an apparent mental health crisis and in the context of having difficulties performing his role as an employee at Warners Bay Post Office. On 9 September 2015, Mr Hodge purchased a large kitchen knife and followed his manager, Mr Brendan Hogan, from the office area, through the public area of the Post Office and into a car park behind the building. Police were called and within a short time of arrival, two officers discharged their firearms resulting in Mr Hodge’s death.

The Inquest:

The role of a Coroner as set out in s. 81 of the *Coroners Act 2009* (“the Act”) is to make findings as to:

- the identity of the deceased;
- the date and place of the person’s death;
- the physical or medical cause of death; and
- the manner of death, in other words, the circumstances surrounding the death.

I am required to hold an inquest where there is a death as a result of a police operation pursuant to sections 23 and 27 of the Act. Those sections apply in this matter because two police officers attended Mr Hodge’s location behind Warners Bay Post Office in response to a broadcast over the Police VKG radio and following a number of triple 0 calls from members of the public. Upon attending the location, and as events unfolded (which I will outline further below), the two attending police officers discharged their firearms resulting in Mr Hodge’s death.

The Evidence:

Background:

Mr Hodge was born on 10 December 1963 in England and lived there until the age of 13 years at which time he immigrated to Australia with his parents and elder brother. He lived with his parents throughout his life and was reportedly close to his brother and nephew. In October 2014 Mr Hodge’s father died from cancer having suffered for three years.

Medical records for Mr Hodge identify a history of mental health issues dating back to 1987. According to Mr Hodge’s general practitioner of 29 years, Dr Christopher Morrissey, Mr Hodge suffered from anxiety and depression from 2008. Mr Hodge was employed by the Australian Postal Corporation (“Australia Post”) from 1992 and he worked at Warners Bay Post Office from 1999. Mr Hogan worked with Mr Hodge, as his Manager, from at least a time prior to July 2008.

Records indicate that in July 2008, Mr Hodge first notified Australia Post that he was suffering from depression, and he took a short period of time off work. From 2009, there were reported occasions of Mr Hodge behaving unusually or inappropriately at work. His employer sent Mr Hodge for psychiatric assessments to determine whether he was fit to return to work duties, on each occasion returning to his role in the Post Office.

Mr Hodge's mental health and behaviour appears to have deteriorated from 2013. As an example, in October 2013 he allegedly told a colleague that a book he had received at work was a book on how to kill the staff of Warners Bay Post Office. A short time later, on 22 November 2013, Mr Hodge was found in an agitated and intoxicated state in front of Warners Bay Post Office. He refused to leave, lay down in the loading dock and an ambulance was called to assist him. He was taken to John Hunter Hospital Emergency Department and transferred to James Fletcher (Mater Campus) with suicidal ideation.

Mr Hodge had further mental health and alcohol related admissions, including short admissions in November 2013, December 2013 for alcohol detoxification, in March 2014 and in May 2014. Mr Hodge's mental state appeared to deteriorate further following the death of his father in October 2014, with further mental health, alcohol and behavioural issues being documented by Dr Morrissey and by Australia Post.

The Fatal Incident: 9 September 2015

Mr Hodge's movements on 9 September 2015 have been captured in CCTV footage and at the time of the fatal shooting, through videos recorded on the mobile telephones of three members of the public.

At about 8:26am, before his shift at Warners Bay Post Office, Mr Hodge entered Nextra Newsagency, Warners Bay and purchased a 600 ml bottle of Solo, and a packet of Longbeach Mild cigarettes where he shared a joke and a laugh with the sales assistant. He arrived at the Post Office just before 9:00am in time for his shift. At around 10:00am, Mr Hodge went into Liquorland and bought a two litre cask of Lachlan Ridge Pinot Grigio. The sales assistant asked if he was "finished for the day" to which he replied, "Yes". He also told the sales assistant his job was going well and he was slowly building his hours back up.

At about 12:15pm, Mr Hodge took his lunch break at a nearby café. A lady he served in the Post Office earlier that day offered to buy him some apple pie and, when he declined the offer, she paid for his meal. Another customer in Lena's Café, Tracey Kidd, observed Mr Hogan surreptitiously drink from the silver bladder of a wine cask 2-3 times whilst seated at the café. She also saw Mr Hodge put the silver bladder to his coffee cup at least five times. She noticed that the silver bladder was almost empty.

The argument with Mr. Hogan and departure from work

Sometime prior to about 2:19 pm, Mr Hodge had returned late from his lunch break.

Mr Hogan had been looking for Mr Hodge and eventually found him in a cubicle in the male staff toilets. Mr Hodge exited the toilet and the two had an argument. This argument was loud enough to be partially heard by other staff and customers in the front of the Post Office. Mr Hodge allegedly said to Mr Hogan, "You don't respect me, you don't care about me", "I've got mental problems, I've got bipolar, I've got depression. What do you know about depression?"

Mr Hogan told Mr Hodge to go home. Mr Hodge swore several times at Mr Hogan and walked out to the back whilst Mr Hogan returned to the counter to serve customers. Mr Hodge returned to the counter to "finish up"; count his money, hand over his cheques and place his money in the safe. He then left, and staff assumed he was finished for the day.

At around 2:45 pm, Mr Hodge was seen sitting alone on the concrete wall "at the back of Coles" on Lymington Way, which is in the Warners Bay Village Shopping Centre (opposite the Post Office on John Street). Civilian witness Heather Jones saw Mr Hodge walking up the ramp from the Warners Bay Shopping Centre car park. Ms Jones said Mr Hodge appeared to be under the influence, dishevelled in appearance and was "staggering and unsteady on his feet". Mr Hodge said hello to Ms Jones and asked if she was going home. Ms. Jones said he was slurring his words and "was not himself".

The purchase of the knife and confrontation in the Post Office

Also around 2:45 pm, Mr Hodge purchased a large kitchen knife from the Warners Bay Coles Supermarket. The attendant was drawn to the self-serve checkout as Mr Hodge had placed the knife in the bag without scanning it. The attendant has said that Mr Hodge did not seem stressed or panicked, just "over the top happy". She thought he appeared drunk. At about 3:10 pm, CCTV cameras captured footage of Mr Hodge talking on a mobile phone as he left the shopping centre and while on the steps outside the Post Office main entrance. Call charge records indicate that the call was made to his home landline and lasted for a little over 2 minutes. It is apparent that the other party to that telephone call was his mother.

Regrettably, Mrs Hodge did not provide any detail as to the content of the conversation to give insight into Mr Hodge's state of mind and his motivations immediately following the purchase of the knife. However, Mrs Hodge did later tell a police officer that during the course of the conversation, Mr Hodge had said to her words to the effect, "*You're going to see me on the news tonight*".

Shortly before about 3:15 pm, Mr Hogan called the Australia Post area office to inform them Mr Hodge was going home sick. Whilst on the telephone, Mr Hogan heard a knock on the "middle door" of the Post Office. He opened the door and saw Mr Hodge pointing a knife at him. Mr Hogan noticed Mr Hodge's right hand had blood on it and he thought Mr Hodge must have cut himself. Mr Hodge followed Mr Hogan out the front doors of the Post Office, along the cement footpath and around the side to the car park at the rear of the Post Office, via Postmans Lane. Mr Hogan ran to the back door of the Post Office (which opens onto the car park), entered the combination lock and entered the back entrance, closing the door behind him.

Mr Hogan then held himself up against the door from the inside and heard/felt Mr Hodge slam into it from the outside twice. Mr Hodge was seen to hold the knife to his throat, and then “slash” his wrist, which civilian witness Mark Dolbel described as “fairly deep”, to the point of “arterial spurts”. At this time, several witnesses attempted to close the gate to the loading dock. Civilian witnesses describe Mr Hodge as “pacing around erratically” giving “the impression he was distressed about something”, and pacing around “like he couldn’t decide what to do”, and that Mr Hodge “seemed to be talking to himself and moaning and groaning”.

The police broadcast and events in the Post Office car park

Members of the public made calls to 000. Shortly after the first of the numerous 000 calls were received, the police VKG broadcast an urgent call (preceded by 2 beeps) seeking available Lake Macquarie cars in the vicinity to attend Warners Bay Post Office in response to information that “Employee Steve Hogan [sic] has a large knife and he’s trying to stab the Postmaster there”. The first car to acknowledge the broadcast was Lake Macquarie 180, which was manned by Constables Jamie Taylor and Darren Hamilton. They advised the police radio that they were proceeding code red (that is, lights and sirens) and estimated they were 5 minutes away.

Less than a minute after the first broadcast, VKG provided further information concerning the job. That further information was limited to the following: *“POI described as male, Caucasian appearance, with white hair, about sixty years old, skinny and scrawny. Wearing a white shirt with a black jumper and a black backpack. He’s got black glasses on.”*

Twenty seconds later, Lake Macquarie 180 advised they had arrived in John Street. Less than a minute had elapsed since they first acknowledged the job. In response to their notifying they had arrived, the Police VKG operator reminded them, “he’s armed with a large knife”. Constables Taylor and Hamilton parked at the front southern corner of the Post Office and ran down the side of the Post Office to the car park area, where there were several civilians directing them to Mr Hodge’s location, who they saw holding a knife. Much of the following is taken from a close viewing of the footage captured by witnesses David Turton and to a lesser extent Reece Burnett on their mobile telephones. Constable Taylor was the first to arrive at the car park area. He immediately drew his firearm and pointed it at Mr Hodge stating in a loud, clear and commanding voice, “Police. Put it down!” Constable Hamilton also drew his firearm and pointed it at Mr Hodge.

It is apparent from the mobile phone footage that immediately prior to the arrival of the involved officers, Mr Hodge had both of his hands down by his side with the knife in his right hand. Upon Constable Taylor announcing his office, drawing his firearm and commanding Mr Hodge to “put it down”, Mr Hodge took two small backward steps away from Constable Taylor, who said in a loud, clear commanding voice, “Put the knife on the ground, right now!” At that point, Mr Hodge raised his right hand in which he held the knife to about head height and commenced to take a number of steps towards the police officers with the knife in that position. As he moved towards the police officers, they moved backwards, continuing to hold their firearms pointed at Mr Hodge. Constable Taylor can then be heard to say, “Put it down mate! Don’t make me have to shoot ya!”

Mr Hodge continued to advance towards the police officers with the knife in his right hand and his right arm raised to about shoulder height. Constable Taylor can be heard repeatedly calling upon Mr Hodge to “Put it down! Put it down! Put it down! Put it down or we will shoot. Put the knife on the ground!” After motioning to civilians and calling upon them to “Get out of the way! Get back!” Constable Taylor again called upon Mr Hodge to “Put it down! Come on mate, stop muckin’ around. You don’t wanna do this. Mate, put it on the ground!”

At that point, Mr Hodge turned away from the officers and walked further into the car park area with both hands down by his side and the knife in his right hand. The police officers can be heard to again ask him to put the knife down and as Mr Hodge moved further into the car park area, both officers followed him, continuing to hold their firearms pointed in Mr Hodge’s direction. One of the officers can be heard to say, “Put it down mate! We’re here to help you!”

At that point, Mr Hodge pivoted to face the police officers and began moving towards Constable Taylor in what might be described as a striding manner, raising his right hand with the knife to about head height and extending his left arm towards Constable Taylor. Both of the officers moved backwards while continuing to hold their firearms pointed at Mr Hodge. As he moved backwards, Constable Taylor found himself being backed into a corner of the car park area with his egress via the entrance blocked by one of the gates that was opened inwards. He repeatedly called upon Mr Hodge, “Put it down! Put it down! Put it down!”

Mr Hodge continued to advance on Constable Taylor and both officers discharged their firearms. Ballistics evidence establishes that Constable Taylor fired two shots, both of which struck Mr Hodge. Constable Hamilton fired three shots, two of which struck Mr Hodge (although one only superficially) and one of which missed Mr Hodge completely. The time that had elapsed between the arrival of the officers at the car park area and the discharge of their weapons was only 40 seconds.

CPR was commenced, and ambulance officers arrived shortly after to take over. Unfortunately, Mr Hodge did not respond to medical intervention and at about 3:45pm, CPR was ceased and he was pronounced dead.

Autopsy Report

Dr Brian Beer, Senior Staff Specialist in Forensic Pathology performed an autopsy on Mr Hodge at the Newcastle Department of Forensic Medicine on the morning of 11 September 2015. He concluded that Mr Hodge died as a result of the combined effect of gunshot injuries to the chest and abdomen.

There is a further matter to note from Dr Beer’s post mortem examinations. Screening of a preserved blood specimen of Mr Hodge’s abdominal cavity blood determined that it had 0.46grams of alcohol per 100mL as well as 1.0mg per litre of citalopram, which is a metabolite of Escitalopram, the medication Mr Hodge had recently commenced. In addition, screening of samples of Mr Hodge’s vitreous humour and urine were found to contain alcohol at concentrations of 0.310g per 100mL and 0.355g per 100mL respectively.

Consultant forensic pharmacologist, Dr John Farrar, also provided an expert opinion concerning the concentrations of these substances. Briefly: Dr Farrar concluded that the result of the analysis of alcohol in the sample of abdominal cavity blood may not represent Mr Hodge's blood- alcohol concentration at the time of his death because it may have been affected by contamination by alcohol arising from the intestinal tract and/or the liver as well as by post-mortem changes;

It is highly probable that Mr Hodge's blood-alcohol level at the time of his death was not less than the concentration of alcohol in the vitreous humour and not more than the concentration measured in the blood taken from the abdominal cavity – that is, between 0.31 and 0.46 g per 100 mL;

As a result of the blood-alcohol concentration, there would have been profound impairment of Mr Hodge's cognitive and psychomotor function and his ability to make judgements and to form rational decisions would have been substantially impaired or entirely absent; There may have been increased aggression; The reported concentration of citalopram was toxic and it is probable that Mr Hodge had consumed a supratherapeutic dose of citalopram or escitalopram; However, any toxicity caused by the high dose of citalopram or escitalopram is not likely to have contributed significantly to his demeanour immediately prior to his death.

The appropriateness of the tactical response and actions of Police

There was little controversy over the evidence that the injuries that caused Mr Hodge's death were inflicted by Constable Jamie Taylor and Constable Darren Hamilton when they intentionally discharged their police issue Glock-9 self-loading pistols in the direction of Mr Hodge at or shortly before 3:19 pm on 9 September 2015. The evidence is sufficient to comfortably conclude that the two bullets that caused the fatal injuries to the chest and abdomen were discharged from Constable Taylor's firearm; and that the two bullets fired by Constable Hamilton that hit Mr Hodge did not have any more than a minor contributory role in the cause of death.

The evidence of the eyewitnesses and the mobile telephone footage also establishes that at the time the police officers discharged their firearms, Mr Hodge had a large kitchen knife in his right hand, which he was holding in a manner consistent with what Constable Taylor described as a stabbing position that is, with his index finger and thumb closest to the bottom of the knife handle and his little finger closest to the point where the handle meets the blade of the knife; and that Mr Hodge was advancing towards Constable Taylor with the knife raised at least to shoulder height such that the tip of the blade of the knife was pointed in the direction of Constable Taylor.

At the time the Constables discharged their weapons, Mr Hodge was just 2.4 metres away from Constable Taylor. It was Constable Taylor's evidence that he believed that if he didn't discharge his firearm he was going to be stabbed. I accept that evidence and further accept that certainly at that point, there was no other available tactical option to Constable Taylor and, to the extent that Constable Hamilton considered Constable Taylor to be in immediate danger, it was also the only tactical option available to him.

One reason for that was that Constable Taylor found himself in a position where his back was almost up against the cyclone wire fence of the car park area with his egress via the car park entrance blocked by the open gate. How he came to be in that position was one of the matters that was explored in this inquest. In that regard, it was acknowledged by Senior Constable Titmuss of the Weapons and Tactics Policy Review Unit that police officers are instructed to avoid getting themselves into a position in which they find themselves trapped. Senior Constable Titmuss agreed that one reason they are given that instruction is because it removes the availability of disengagement as a tactical option, but more pointedly, by allowing him or herself to be placed in a position of danger, it increases the likelihood of a fatal outcome.

It was Senior Constable Titmuss' evidence, however, that the prospect of avoiding becoming trapped will depend on the individual circumstances, including, in particular the actions of the offender.

In this case, the evidence was that very soon after the officers initially challenged Mr Hodge, he advanced towards the two officers and they both moved backwards to maintain a degree of distance between themselves and Mr Hodge. Mr Hodge then stopped and turned away from the officers moving back into the car park area in a direction towards the loading dock area. Up to that point, the officers had not been able to see the entire area of the car parking area or the loading dock; they had not been able to establish whether there was any other person – whether injured or not – who may have been out of their view; or whether there was some other means of escape from the area available to Mr Hodge. It was their evidence that they followed Mr Hodge into the car park in order to ascertain what was in the area beyond their initial view. In the case of Constable Hamilton he was also concerned about a red and black backpack that came to his notice as they moved into the car park area.

Constable Taylor's evidence was that as he moved into the car park area he effectively continued along the line of the open gate to his right in order to maintain a degree of distance between himself and Mr Hodge. However, when Mr Hodge pivoted to face him and then commenced his advance upon him, Constable Taylor's options as far as his direction of movement were limited. He could not move further to his right (and further into the car park area), because he says he was aware that to do so could place him in a cross-fire position relative to Constable Hamilton and to his left could place him in a position where he was between Constable Hamilton and Mr Hodge. This left a backwards retreat as the only (and perhaps most instinctive) alternative, but with the consequence that he came to be in a position where his back was almost against the fence and his way to the car park entrance blocked by the gate itself.

It is to be noted that the time that elapsed from the time that Mr Hodge pivoted to face Constable Taylor and Constable Taylor's discharge of his firearm was only two seconds. In that time: Mr Hodge pivoted to face Constable Taylor; Mr Hodge began moving towards Constable Taylor in a striding manner, raising his right hand with the knife to about shoulder to head height and extending his left arm towards Constable Taylor; Mr Hodge took six to seven strides towards Constable Taylor; and Constable Taylor took approximately five steps backwards away from Mr Hodge.

It is true that the final circumstances limited the ability of Constable Taylor and Constable Hamilton to implement an alternative option to the use of lethal force and that the fact that Constable Taylor came to be “trapped” behind the gate was a significant aspect of those circumstances. However, it is also true that an equally significant aspect of those circumstances was brought about by the actions of Mr Hodge in advancing upon Constable Taylor; knife in hand and raised with the tip pointed forwards in a stabbing position. I am satisfied that Constables Taylor and Hamilton identified themselves to Mr Hodge as police officers. This is evident from the mobile phone footage in which Constable Taylor is heard to say, “Police” in a loud clear voice as soon as he arrives at the entrance to the Post Office car park area.

The extent to which Mr Hodge was able to rationally process that information is not so clear. The evidence of Dr Farrar and Dr Kerri Eagle (the latter being a forensic psychiatrist who conducted an expert psychiatric review) was to the effect that the extent of Mr Hodge’s intoxication at the time was such that his cognitive functioning was severely impaired. That evidence is also supported by observations of witnesses such as Mr Mark Dolbel and Ms Lyn Sartori. Mr. Dolbel and Ms. Sartori were speaking with Mr. Hodge prior to the arrival of police. They said that at times Mr. Hodge looked like he might faint. Ms. Sartori also gave evidence that after pleading with Mr. Hodge to put down the knife and talk about it, Mr. Hodge said, “I know you”. It would appear from that evidence that Mr. Hodge was experiencing some difficulties in processing information, but was not entirely devoid of cognition.

Certainly, upon the Constables arriving, Mr Hodge was cognisant of their presence. It is apparent from the video footage that upon the officers announcing their office, drawing their firearms and calling upon him to put the knife down, Mr Hodge took one or two steps backwards and then moved towards the officers, raising the knife at the same time. That does not mean that he appreciated they were in fact police officers.

The evidence establishes that the nature of the initial engagement with Mr Hodge consisted of the announcement of their office as police coupled with a simultaneous drawing of their firearms and pointing them at Mr Hodge and issuing repeated demands that he drop the knife. It seems it soon became apparent that engagement was not working as Mr Hodge did not comply with the demand and in fact moved towards the officers. The officers then added a further level to their communication, which comprised of statements as to the consequence of continued noncompliance with the demand to drop the knife: “Put it down mate! Don’t make me have to shoot ya!”, “Put it down or we will shoot!”

It is a curious aspect of the officers’ evidence that they both seemed reluctant to accept those descriptions of their interactions and in particular demurred to the suggestion that the act of pointing their firearms was a threatening act on their part. In that regard, their evidence seemed to be focused on their own subjective intention and betrayed a lack of appreciation for how those actions may have been perceived by Mr Hodge.

That said, it must be acknowledged that the evidence also establishes that when Mr Hodge turned away from the officers and walked back into the car park area, the officers did alter their approach – if only slightly, by suggesting, “We’re here to help you”.

Constable Hamilton also says he took his left hand off his firearm and motioned to Mr Hodge to drop the knife, and used a softer voice to ask Mr Hodge to “please drop the knife”. Nevertheless, both the officers continued to keep their firearms trained on Mr Hodge. Constable Taylor explained that was because their training provides that once they have drawn their firearms, they are required to hold it in one of two positions, both of which involve the firearm effectively being pointed at the suspect and they considered the risk that Mr Hodge presented with the knife was such that it was not considered appropriate to re-holster their firearms.

The evidence of Senior Constable Titmuss was that the police officers’ actions were consistent with training in the tactical options model. That model is predicated upon the officers’ subjective assessment of the risk posed to the community and themselves and the need to meet the encountered resistance with an equal or greater level of force (to paraphrase the evidence of Constable Taylor). In the present case, the risk the officers encountered was that posed by Mr Hodge being in possession of the large knife.

In so far as the tactical options they had available to them, the evidence was that Constables Taylor and Hamilton did not have Tasers because they were in plain clothes and there are no Tasers that are able to be concealed when working in plain clothes. For the same reason, they did not have batons with them. Although Constable Hamilton had his pepper spray in his cargo pants, he deemed that to be an inappropriate tactical option due to its limited range.

There was also some evidence that the fact Mr. Hodge was wearing sunglasses would also have adversely affected the effectiveness of capsicum spray. Thus, the only tactical options available to the officers were their presence, communication, the possibility of disengagement or the use of their firearms. The nature of the officers’ communications with Mr Hodge was explored in the course of their evidence as well as the evidence of Dr Eagle, Senior Constable Titmuss and Acting Sergeant Dawn Pointon of the Mental Health Intervention Team (MHIT).

Senior Constable Titmuss considered the initial manner of communication employed by the officers to be appropriate in the circumstances and consistent with their training in the tactical options model. He accepted that the approach used was one that was based around a concept of control based on the offender submitting to the will or authority of the police officer.

For her part, Acting Sergeant Pointon said that the training provided by the MHIT was focused on communication that is based around things such as taking time, empathy, respect and dignity. She acknowledged that there is a tension between the approach of the tactical options model which is directed to stopping the immediate threat and the MHIT approach. Acting Sergeant Pointon also considered there would be some benefit in greater integration of de-escalation communication techniques in the tactical options model training.

Nevertheless, Acting Sergeant Pointon also said that there may be circumstances where an officer does not have the opportunity to employ the kinds of de-escalation techniques that are favoured by the MHIT approach, such as where the immediacy of the risk precludes such an approach.

This suggests that where an officer is faced with a person suffering from a mental disturbance, they may be encouraged to consider a more empathic approach to communication, but in the event of any doubt, the tactical options approach is to be preferred. Furthermore, the mental health training that is offered to the majority of frontline officers is the one-day course. This course does not provide any instruction as to specific de-escalation techniques that may be used. The problem with the prioritising or bias towards the tactical options approach is that it is contrary to current thinking in respect of communication techniques when dealing with persons in the midst of a mental health crisis. As Dr Eagle said in her evidence, the use of de-escalation techniques has been shown to reduce the likelihood of a fatal outcome.

Dr Eagle also gave evidence that forensic psychiatrists are trained in specific de-escalation techniques aimed to reduce heat or emotion or arousal. She said that where a person is distressed or agitated, aggressive, or suicidal, the goal is to buy some time. Sometimes the level of arousal might reduce of itself because the body can only burn adrenaline for a short time. The emphasis is on engagement rather than shock and intimidation to reduce the person's emotion and reduce one's own emotion and then reorientate by asking the person's name, acknowledging their state ("I can see you're in distress"). The person might listen if they feel they are being heard and their distress has been recognised.

It is noted that Dr Eagle's evidence was that the use of de-escalation techniques may not have altered the ultimate outcome in this case and it was submitted by those representing the Police that the fact that witnesses such as Mr Dolbel and Ms Sartori had been attempting to de-escalate the situation without success would suggest de-escalation techniques would not have worked. In fact the de-escalation techniques employed by Ms Sartori and Mr Dolbel had some success. For a number of minutes they had managed to keep Mr Hodge from leaving the car park area; he had not lunged at anyone with the knife; and they had elongated the incident to the point where the police arrived. There had also been at least the start of some re-orienting of Mr Hodge as evidenced by his response to Ms Sartori, "I know you".

In any event, it remains a source of disquiet that as soon as Constables Taylor and Hamilton arrived on scene the nature of the communication being attempted with Mr Hodge changed dramatically in terms of volume, tone and content and was coupled with the visceral threat of death or serious injury presented by the drawing and pointing of firearms at Mr Hodge. In the circumstances, I will make a recommendation to the Commissioner of Police directed to greater integration of mental health informed training into tactical options training with an emphasis on specific de-escalation techniques practiced by role play exercises.

Evidence of suicidal ideation / intent

It was Dr Eagle's evidence that there was some evidence of suicidal ideation on the day and in the period leading up to Mr Hodge's death. As to the former, that comprised of evidence of suicidal gestures such as cutting at his throat and wrists with the knife. As to the latter, Dr Eagle placed some emphasis on the detail of Mr Hodge's final consultation with Dr Morrissey.

However, that evidence needs to be considered against the qualification that Dr Eagle did not have the opportunity to assess Mr Hodge in person and the evidence of Dr Morrissey that he did not consider Mr Hodge to be suicidal at the time of his final consultation on 4 September 2015. Dr Eagle also noted that while it was likely Mr Hodge was considering ending his life on 9 September 2015, he remained ambivalent about his suicidal gestures.

Dr Eagle was asked about the reference in her supplementary report to the hypothesis that Mr Hodge intended to provoke the shooting. Dr Eagle was not prepared to come to a conclusion that he did so. She acknowledged that for the purposes of research there are accepted criteria for suspect provoked shootings, but cautioned against the use of those criteria in individual circumstances. In any event, Dr Eagle was of the view that there was no evidence of one of those criteria, namely, that Mr Hodge wanted to be shot by police. On the evidence before me, I could not conclude that it was Mr Hodge's intention to provoke the police to end his life by shooting him.

Effect of alcohol and citalopram

The evidence establishes that Mr Hodge's blood alcohol level was such that there would have been profound impairment of Mr Hodge's cognitive and psychomotor function and his ability to make judgements and to form rational decisions would have been substantially impaired or entirely absent.

In so far as the low toxic level of citalopram in his system is concerned, Dr Eagle hypothesised that Mr Hodge could have taken an increased dose of his Lexapro in an attempt to medicate his distress. In that regard, there was evidence that for a period of approximately five months prior to August 2015, the only medication Mr Hodge was taking for his anxiety and depression was the benzodiazepine alprazolam (Xanax), which has an immediate effect upon the patient. While Mr Hodge had commenced on Lexapro in August 2015 and, according to Dr Morrissey, had increased his dose to 20 mg by 4 September 2015, at least as at that date (4 September 2015) Mr Hodge had not yet got his dosage to the desired 40 mg per day.

Having regard to the evidence that, unlike Xanax, Lexapro does not provide an immediate effect upon the patient, but only works once it has been slowly increased to the desired dosage, it is a reasonable hypothesis that Mr Hodge sought to compensate for not having got his level of Lexapro up to the desired level by taking an excessive amount, possibly in a misconceived attempt to feel more of an effect from it. However, given the evidence in his medical records of prior occasions where he had taken deliberate overdoses, I am not able to come to a concluded view as to what his motivations were in doing so.

Mental health status

The various psychiatric assessments of Mr Hodge's fitness for duty prepared over the years from 2009 up to as recently as August 2015 all note Mr Hodge's history of recurrent episodes of depression, but also raised the possibility of some form of bipolar disorder. Mr Hodge's treating GP, Dr Morrissey, considered Mr Hodge to have anxiety and depression related to that anxiety as well as an alcohol use disorder, although the latter had developed more recently.

Dr Eagle's view was that Mr Hodge suffered from a major depressive disorder that was moderate to severe, noting the evidence of recurrent depressive episodes that predated his harmful and problematic use of alcohol. Dr Eagle considered that it was possible that Mr Hodge may have had a bipolar II disorder, but he did not appear to have the necessary symptoms of a manic or hypomanic episode. She acknowledged that the retrospective nature of her assessment as well as Mr Hodge's excessive use of alcohol and his treatment with mood stabilisers complicated the interpretation of his symptoms.

Perhaps the greatest barrier to Mr Hodge's treatment was his severe alcohol use disorder over the last 10 years. It is clear from Dr Morrissey's evidence that Mr Hodge was a most difficult patient to treat. He was very sensitive to criticism and to engaging with any treatment that might involve an acceptance that he had a problem. Mr Hodge was not willing to subject himself to any voluntary assessment by an expert psychiatrist and was reportedly resentful of the questions asked by those psychiatrists who conducted the assessments of his fitness for duty. He was also non-compliant with medications prescribed for him by Dr Morrissey and difficult to follow up.

It is clear that over the course of his treatment of Mr Hodge, Dr Morrissey continued to try different medications with a view to getting the right one. There is a consensus in the evidence that the prolonged use of Xanax in the treatment of Mr Hodge's depression and anxiety was not appropriate, particularly having regard to the fact of his alcohol use disorder. Dr Morrissey accepted this and it is apparent that he did not intend it to be so. Dr Morrissey's evidence was that at the time he prescribed Xanax to Mr Hodge in March 2015, it was only intended for the short term as it was his intention to review Mr Hodge's medication three days' time. Dr Morrissey gave evidence that it was his intention at that time to commence Mr Hodge on Lexapro, although he accepted he did not record as much in his notes.

As it happened, Mr Hodge did not present to Dr Morrissey's rooms for another three months. Over that time, the only medication Mr Hodge had been taking for his depression and anxiety was the Xanax. There is also a suggestion in the fitness for duty assessment of Dr Vickery prepared in April 2015 that Mr Hodge may have been taking more than what had been prescribed and that this may have been contributing to his troubling behaviour in the workplace. In any event, Dr Morrissey did cease the prescription of Xanax and commence Mr Hodge on Lexapro in August 2015. Dr Eagle considered that to be an appropriate course of treatment.

The significance of the management of his behaviour in the workplace

It is apparent from material before me and from the evidence of Mr Hogan that Mr Hodge was a difficult employee to manage in the workplace. While this inquest did not seek to explore the rights or wrongs of the particular incidents of concern, it did seek to explore the significance of the manner in which Mr Hodge's workplace behaviour was being managed, to his thinking and motivations on 9 September 2015.

It is apparent that prior to late 2013, Mr Hodge's problematic behaviours were managed as a medical issue only, with occasions where he was required to subject himself to assessments as to his fitness for duty; assessments that he invariably passed and was either determined fit to return to full duties or fit to undertake a graduated return to work. It is also apparent from Dr Morrissey's evidence that Mr Hodge's employment was the only thing in his life that was a source of self-esteem and that Mr Hodge resented being subjected to the fitness for duty assessments.

Dr Morrissey also said Mr. Hodge's level of resentment towards those processes had increased over the last two years of his life, which incidentally (and unknown to Dr Morrissey) coincided with his employer dealing with his problematic behaviour variously as both a medical issue and a matter to be dealt with under its Employee Counselling and Discipline Policy ("ECDP"). According to Dr Morrissey, it was only in 2015 that Mr Hodge appeared to have directed the focus of his resentment towards his "boss", Mr Hogan, who he perceived as "dobbing him in".

The evidence establishes that Mr Hogan was given little information as to the underlying medical issues that may have been impacting upon Mr Hodge's performance and behaviour in the workplace. His role in that regard was limited to counselling Mr Hodge in respect of minor matters but otherwise simply notifying others in Head Office of behaviours of more serious concern and then taking guidance from them as to what was required.

Notwithstanding there had been previous occasions of counselling Mr Hodge under the ECDP for unacceptable workplace behaviour and performance, there was an elevated response in 2015 in the form of a Disciplinary Inquiry that resulted in a determination that Mr Hodge be subject to a 2-increment pay reduction for 12 months. It is reasonable to infer that the gravity of the penalty imposed would have created in Mr Hodge a concern about the prospect of his employment being terminated in the event of any further workplace incidents and that may have heightened the focus of his resentments upon Mr Hogan.

The significance of that to his motivations and actions on 9 September 2015 is evident from the nature of his verbal attack upon Mr Hogan that day after returning late from his lunch break. It is also evident from Mr Hodge making comments to Mr Hogan about contacting head office to inform them that he was going home sick. Exactly what Mr Hodge intended to do that afternoon is difficult to discern. His level of intoxication was such that his judgment and capacity for reasoning would have been significantly impaired. I do not know the full detail of what he told his mother or what he meant when he told her "You're going to see me on the news tonight". Whilst Mr Hodge purchased the knife and then pursued Mr Hogan with it, he did not lunge at him and there appeared to be some ambivalence in his actions in that regard.

Nevertheless, it does appear that his perception of Mr Hogan as a threat to his continued employment was a catalyst or lightning rod around which his impaired thinking coalesced into the actions that led him to be armed with a large knife in the car park area of the Post Office where Constables Taylor and Hamilton would encounter him in the course of their duties as police officers.

Conclusion

Mr Hodge's death was tragic. It has deeply affected his family, his work colleagues and the police involved in the incident. It is clear that no one wanted such a tragic outcome for Mr Hodge and attempts were made to avoid it. I intend to make a recommendation to the NSW Commissioner of Police directed to greater integration of mental health informed training into tactical options training with an emphasis on specific de-escalation techniques. Police have an extremely difficult job to do and often very little time to plan and find out all the information they need, particularly about someone's mental health.

Any education and training to better assist police in handling a situation such as this one can only be a positive and important step in the efforts to reduce such tragic outcomes occurring in the future.

Findings required by s. 81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it:

The identity of the deceased

The deceased person was Stephen Paul Hodge

Date of death

Mr. Hodge died on 9 September 2015

Place of death

Warners Bay in New South Wales

Cause of death

The medical cause of death was the combined effect of gunshot injuries to the chest and abdomen

Manner of death

Mr. Hodge died in the course of a police operation. The death was by police shooting in circumstances where Mr. Hodge advanced upon police with a knife.

Recommendation

To The NSW Commissioner of Police

That consideration be given to the greater integration of mental health informed training into tactical options training with an emphasis on specific de-escalation techniques practiced by role play exercises.

Non Publication Orders

The non-publication orders and non-access orders made over exhibits 2 and 4 continue. On the first day of the inquest I made a further non-publication order pursuant to s.74 of the *Coroners Act 2009* over the supplementary report of expert psychiatrist Dr Kerri Eagle and over two express phrases. As I indicated to the interested parties at the conclusion of the inquest, having heard the evidence, I do not consider that order is necessary and I lift that order.

11. 268972 of 2015

Inquest into the death of FJT. Finding handed down by Deputy State Coroner O'Sullivan at Glebe on the 13th July 2018

Introduction

FJT was last seen alive at about 2.30pm on 11 September 2015 by correctional services officers performing their rounds at that time. He was being held in custody in the High Risk Management Correctional Centre ("HRMCC") within the Goulburn Correctional Facility. Tragically, FJT was found by correctional services officers at about 8.30am on 12 September 2015 in Cell 15 of Unit 7 of the HRMCC cold to the touch and unresponsive. He was confirmed deceased by a Justice Health nurse who attended the cell at about that time and then by a medical practitioner later that day. He was aged 24 years.

The Inquest

When a person's death is reported to a Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow the Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it. When someone is in custody, the State assumes responsibility for the care of that person. Section 23 of the *Coroners Act 2009* ("the Act") makes an inquest mandatory in cases where a person dies in custody. In such cases, the community has an expectation that the death will be properly and independently investigated.

The Evidence

FJT (born on 26 December 1990) was a New Zealand citizen of Samoan descent who moved to Auburn North, NSW, Australia from Wellington, New Zealand with his family at a young age in 1996.

Both his parents, F and AF, were Samoans and he had four other siblings. FJT had two older sisters, J and S, a younger brother, R, and a younger sister, G. The entire family spoke Samoan. At the age of 13, while attending secondary school in Mt Druitt, FJT began to fall afoul of the law. He assaulted a local doctor and then resisted arrest by police. FJT had a criminal history including predominantly offences of violence, and property offences. He was first charged and convicted on 16 September 2006 of an aggravated robbery which occurred when he was 14 years old. This was followed by an array of offences including having custody of a knife in a public place, assaults, affray, shoplifting, and aggravated robberies.

On 2 December 2008, FJT was housed at Kariong Juvenile Correctional Centre where he continued to commit offences of a violent nature against other inmates. On 9 September 2009, he was sentenced to 6 years imprisonment with a non-parole period of 3 years and 2 months for an offence of Aggravated robbery with wounding/grievous bodily harm where he and 3 juvenile co-offenders punched, kicked and stomped on the victim until he fell unconscious and then robbed him of his possessions.

On 8 April 2010, FJT was transferred from Kariong Juvenile Correctional Centre to the Goulburn Correctional Facility to serve the remainder of his sentence in an adult correctional centre. On 19 August 2010, he assaulted a correctional officer by punching him in the face then, on 11 February 2012 he assaulted another correctional officer by spitting in his face. On 29 July 2012, he again assaulted a corrective services officer inflicting actual bodily harm and he assaulted yet another corrective services officer on 27 December 2013.

In addition to attacking correctional officers, FJT was also involved in violent altercations with fellow inmates. On 6 June 2013, he attempted to assault another inmate using a weapon. On 21 January 2015, he punched another inmate in a scuffle. There were also several incidents where FJT threatened and shouted abuse to other inmates and corrective services staff. FJT also committed various acts of arson and other disruptive acts such as flooding. FJT set fire to his cell on at least two occasions on 27 December 2012 and 20 July 2015. He is also noted to have flooded his cell on at least two occasions on 11 September 2013 and 18 November 2013.

A specialised management plan was implemented for FJT due to the high risk he presented to all corrective services staff. To facilitate any movement of FJT, the presence of at least four officers in full protective gear and armed with chemical munitions was required. According to Justice Health records, FJT was charged on more than 30 occasions with internal offences. Consequently, he was often placed in segregation for prolonged periods.

On 13 January 2015, FJT's visa was cancelled pursuant to s. 501 of the *Migration Act 1958* (Cth) and he became a 'prohibited non-citizen'. He unsuccessfully appealed against the cancellation. FJT was adamant that he did not want to be deported to New Zealand and went on a hunger strike between 22 July 2015 and 31 July 2015 to protest his potential deportation. Up until 6 August 2015, FJT understood that he would be housed at Villawood Detention Centre upon release from custody on 11 August 2015.

On 6 August 2015 he received a telephone call from DIBP advising him that he will, instead, remain in custody with NSW Corrections after his full time sentence expires and will not be moved to Villawood Detention Centre based on information contained in Correctional Reports. When FJT asked what the reports were based on, DIBP stated they could not disclose that information. On 7 August 2015, DIBP requested he be kept in his current place of custody as an alternative place of Immigration Detention.

On 11 August 2015, FJT's sentence expired but he was kept in custody at the HRMCC on behalf of the DIBP pending deportation back to New Zealand. On 3 September 2015, FJT communicated to Immigration Officers who attended the HRMCC that he wished to be sent to Samoa instead. FJT also suffered from drug and alcohol abuse and mental health issues. FJT self-reported that he began to binge drink to the point of "alcoholic blackouts" and smoke 7 grams of cannabis per day from the age of 12. He commenced using crystal methamphetamine from the age of 14 and heroin from the age of 18. As of May 2014, he expressed no interest in rehabilitation for drug and alcohol abuse.

With regard to his mental health, it is first noted that FJT has a possible or definite psychotic illness in Justice Health records on 16 October 2008, when he is 17 years old. Justice Health records note that FJT's father also suffered from mental illness for which he was medicated. FJT self-reported that he tried to hang himself in 2006 when drunk but changed his mind.

A psychiatric report dated 16 December 2013 noted that FJT presented as depressed and demoralised. On 19 May 2014, Professor Greenberg diagnosed him with polysubstance abuse, post-traumatic stress disorder, prolonged sensory deprivation, pseudo auditory hallucinations, paranoid ideation and an anti-social personality disorder that included difficulties with violence and aggression.

FJT was diagnosed with a psychotic disorder and was prescribed the daily anti-psychotic Amisulpride for schizophrenia, anti-depressant Mirtazipine, and Pizotifen for migraines, which he started on 1 November 2013. From 29 May 2015, FJT began to frequently refuse to take his regular medications, possibly on advice from his family, and this may have exacerbated his mental health issues. It was noted frequently on offender case notes and on his medical records that he refused to take his medication, and that even when he accepted it, he was unsupervised so that it could not be guaranteed he took it. It was noted that he therefore may have been unmedicated during this time.

On 6 August 2015, a psychiatric assessment noted that FJT presented with increased psychotic and depressive symptomology but he denied any thoughts of deliberate self-harm or thoughts of suicide. By 13 August 2015, a psychiatry report noted he was suffering from auditory hallucinations and persecutory delusional beliefs such as his food being poisoned. By the 27 August 2015, this progressed to not wanting to talk about his immigration issues, his family or plans for the future.

On 3 September 2015, FJT used the inmate knock-up system 50-60 times claiming that correctional officers were plotting to kill him despite constant reassurances to the contrary. He communicated these persecutory suspicions to his family, specifically to his sister's (JT) partner, MT. He told Mr T that the government wanted him dead and would do away with him during the deportation process. According to JT, this call may have been made on 6 September 2015.

On 4 September 2015, FJT expressed thoughts of self-harm to the nursing staff and requested to be put into a safe cell. He was placed into an observation cell and a Risk Intervention Team ("RIT") review was commenced. The RIT was terminated on 5 September 2015 when FJT stated he no longer had thoughts of self-harm or suicidal ideation.

It appears however, that his mood fluctuated over the next few days. On 9 September 2015, CCTV footage of the rear yard to FJT's cell shows him writing, probably with soap, "GOD FORGIVE ME", "LOVE US ALL" and the date of "9.9.15" as well as placing a blue container on the concrete seat of the rear yard before standing in the yard appearing to be in deep contemplation. These factors may suggest FJT was potentially considering suicide by hanging himself from the steel cage of his rear yard. Eventually, he removed the blue container and used what appears to be a pillow case to remove what he had written on the ground. It is of note that the next day, on 10 September 2015, FJT specifically asked for the rear yard to his cell not to be opened which was considered unusual. FJT also tries to unsuccessfully call five members of his family.

The Fatal Incident

On 11 September 2015, FJT was housed in cell 15 of unit 7 in the HRMCC at Goulburn. It was noted he presented with *"a sullen and disengaged demeanour"* when he was seen in his segregation cell. At about 2:02pm on that day, he was last seen by Assistant Superintendent David Smithson and Senior Correctional Officer David O'Connor who were performing final head and security checks of the prisoners in unit 7 while also distributing meals. They provided him with his meal then proceeded to lock and secure his cell.

CCTV footage shows that around 8:49pm, a light is turned on in FJT'S cell and at 8:50pm, a dark substance appears at the bottom of the door to his rear yard which gradually increases in size along the door line. This substance is speculated to be blood. Crime scene photographs confirm this to be the case. At [9:17pm], FJT activated the cell alarm system known as the "knock-up" and informed Correctional Officer Mark Kuczynski in the control room that he had "*slashed up*".

Mr Kuczynski did not understand what was said by FJT and requested that he repeat himself. Mr Kuczynski was purportedly unable to hear anything the second time and ended the call. Following this call, Mr Kuczynski rang the rostered Rovers for the HRMCC, Correctional Officers Barry Hockey and Wayne Lang, who were in the meal room. He informed them of the knock-up from cell 15 of unit 7. He advised the fact that he did not understand what the inmate had said and requested that they attend the cell.

At 9:23pm, FJT called the control room again using the knock-up system and informed Mr Kuczynski he "*just slashed up.*" However Mr Kuczynski misunderstood this as FJT asking "*[w]here's my stuff?*" He told FJT that officers would come see him shortly. On neither occasion did Mr Kuczynski reverse call FJT to verify what had been said although it was possible to do so. It should be noted however, that it was not possible for Mr Kuczynski to replay the call to listen again for security reasons preventing corruption and deletion of data.

According to CCTV footage, Correctional Officers Hockey and Lang left the meal room at 9:40pm and they proceeded to the Officer's Station of unit 7 then looked through the glass towards cell 15 without actually approaching it. From this vantage point in the officers' station, it is not possible to see inside the cell. Mr Hockey noted that viewed from the Officer's Station, cell 15 was quiet and they could not observe anything out of the ordinary. Mr Hockey then called Mr Kuczynski from the Officer's Station and was informed by him that there had been a second knock-up where the inmate asked for his "stuff". He responded to Mr Kuczynski saying that it was already late at night and property enquiries would have to wait till the morning. Furthermore, as afternoon shift rovers, neither Mr Hockey nor Mr Lang had access to cell keys which would enable them to open the cells.

CCTV footage then shows at about 9:46pm, Correctional Officers Hockey and Lang left unit 7. Correctional Officers Hockey and Lang's actions were a breach of the Corrective Services' Operation Procedures Manual section 12.1.5 which stipulates that responding officers "*shall proceed directly to the cell to further investigate the call and if necessary respond to any serious incident.*"

At a similar time, CCTV footage of the rear door to the cell depicts water being washed out of the cell with a mix of blood and water flowing out into the rear yard and further, onto the "sterile zone" which is a walkway for patrolling correctional officers. This flow of water continued until about 9:55pm at which point it appears the source was turned off. It is highly suggestive of FJT still being alive and able to move at this time.

At 10:52pm, CCTV footage from the same angle records Correctional Officers Graham Beer and Andrew Oberg walking over this mix of blood and water and paying no attention to it. Similarly, at 4:21am on 12 September 2015, Correctional Officers Trent Tapper and John Murfitt also walk across the wet area without paying it any attention. At approximately 8:30am on 12 September 2015, Senior Correctional Officers Stephen McDonald, David Smithson and Daniel Hewson were conducting head checks in unit 7. When they opened the door to cell 15, they discovered FJT in a sitting position on his bed with his back against the shower bulkhead, a large gash observable on his left wrist and blood all over the cell.

The correctional officers responded immediately. Mr Smithson began banging on the inner cell door and yelling to try and get a response from FJT. FJT however, remained unresponsive. Meanwhile, Mr Hewson called for an immediate action team ("IAT"), medical staff and an ambulance by radio. Correctional Officer Paul Donohoe commenced an audio/video recording using a hand-held camera while Correctional Officer Joseph Stephens commenced the recording of a time log.

At about 8:33am, IAT staff arrived on the scene. They were followed shortly afterwards by Justice Health nurses Meredith Picker and Narrell McLaren. NSW Ambulance Officers also arrived at the unit but did not enter the cell. At around 8:42am, after putting on personal protective equipment ("PPE") for blood spills, the IAT entered cell 15 and secured FJT by pressing a shield against him and grabbing both his arms. The IAT had also donned gas vests and one member was armed with a gas gun. It was noted that there was a laceration on FJT's left wrist which was about 5cm long and 2cm wide. He was also cold and unresponsive. A razor blade was sighted on top of the bed near his left arm. Because he was cold to touch and his limbs were difficult to move, rigor mortis was suspected.

Written in blood on the wall opposite to FJT's cell wall were, among others, the words: "GOD KNOWS DA TRUTH", "AVA POROLE" and "ĀIGA LOVE YA's". The word "Āiga" appears to be Samoan connoting family. With the inmate secured, Justice Health nurses entered to examine him. At approximately 8:47am, FJT was declared deceased by the Justice Health nurses. All correctives services and Justice Health staff exited the cell by 8:48am and a crime scene was declared. Around 9:15am, Goulburn Police Detectives arrived and took over the duties of handling the crime scene. As at 12 September 2015, "Self-harm" and "Mental Illness" remained active alerts on FJT's Inmate Profile. It is noted that on the P79A Report to the Coroner Form, it is recorded as 'unknown' whether the deceased had any mental health history, and that he was not being treated by any professional, including a psychiatrist or psychologist.

On 14 September 2015, an autopsy was performed by Dr Rebecca Irvine. In the Limited Autopsy Report for the Coroner dated 27 October 2015 Dr Irvine records FJT's direct cause of death as "*incised wounds of left upper extremity*". Superficial incised wounds were found on his left wrist, left dorsal hand and the right side of his neck but the fatal wound was in his left antecubital fossa (elbow crease) which cut into the medial cubital vein and was likely the source of the majority of the blood on scene. There was also a "*subscapular haematoma with superficial abrasion*" to the right side of his head. Preserved blood samples taken from FJT were analysed, and his blood was found to contain 0.15mg/L of Amisulpride and <0.05 mg/L of Mirtazapine.

On 16 September 2015, the family of the deceased requested an inquest into FJT's death. Based on gaol call conversations between Mr T and FJT where the latter disclosed his beliefs that the government was trying to kill him and the abrasion on his head, his family have come to suspect foul play from prison staff being involved in his death. Ms T also cited that when FJT spoke to their parents on 8 September 2015, he showed no signs of suicidal ideation, asking for socks and underwear for the weekend. She also recalled speaking to FJT's counsellor who assured her that FJT "*seemed very well and fine*". The family have taken issue with why they were not informed of FJT's mental illness in gaol.

A review of unbroken and time stamped CCTV footage from the day of FJT's death until his discovery however, does not show anyone else entering cell 15. This most probably rules out the direct involvement of any other individual in his death. It is the opinion of police that FJT's disclosures to Mr T of prison officers conspiring to murder him were the result of his mental illnesses.

Cause of death

The following items of evidence indicate that FJT died as a result of self-inflicted wounds:

- FJT told the officer in the Control Room that he had "*slashed up*";
- FJT was found with clear wounds to his left arm particularly at the wrist and cubital fossa;
- There was blood seen (on the CCTV) flowing from his cell on the evening of 11 September 2015;
- There was a considerable amount of blood painted on the walls of his cell, the shower recess and the floor of his cell;
- The wounds were caused by a sharp object;
- The pathologist (Dr Irvine) was of the opinion that he had compromised a major vein at the cubital fossa and that he died as a result of incised wounds of his left upper extremity;
- A razor blade was found on the bed close to FJT's body at about 8.42am on 12 September 2015; and
- CCTV footage of Unit 7 reveals that no person entered Cell 15 between when FJT was checked at 2.30pm on 11 September 2015 and 8.30am on 12 September 2015.

It was clear that in order to inflict the apparent wounds FJT must have cut himself with a razor a number of times in the same location on his arm. The evidence also indicated that the abrasion to FJT's head was superficial and was not causative of death. On the evidence available to me I find that FJT died as a result of massive blood loss caused by self-inflicted wounds with a razor blade to the left side of his body (incised wounds of his left upper extremity).

Could FJT's death have been prevented?

Accident and Emergency Specialist, Dr John Vinen, gave evidence that it was likely that FJT was alive and moving at about 2.00am on 12 September 2015 based on the CCTV footage of the cell's rear yard. Dr Vinen said that FJT could have been given medical treatment at any stage from when he first called the Control Room by knock-up between 9.00pm and 9.30pm on 11 September 2015. There was accordingly a window of about 5 hours from then until 2.00am when medical attention could have been given.

The medical treatment he needed was simple and involved first, applying pressure to the wound to stop the bleeding and then, second, transfer to a hospital. The initial treatment to staunch the bleeding could have been provided by correctional services officers.

Ambulance Officer Rod Whittle gave evidence that if an ambulance had been called at about 9.40pm on 11 September 2015 an ambulance would have been able to respond quickly to an emergency call at the HRMCC. He estimated an arrival time at the gaol of 5 to 7 minutes upon being called. He had been called to the gaol at Goulburn a number of times and was familiar with the process of accessing cells within the gaol. He estimated that it would take between 50 and 64 minutes from the time of the call for an ambulance to be dispatched, for ambulance officers to make their way to the patient, for the inmate to be attended to in the cell and for the patient to be transferred to Goulburn Hospital.

Dr Vinen was confident that if FJT had had medical attention to staunch the bleeding in a timely fashion then there was a high likelihood FJT would have achieved a complete recovery. While a Directive from the Manager of Security required attendance of other officers or an IAT if entry to FJT's cell was required, that is unlikely to have delayed emergency access to the cell. On the morning of 12 September 2015 such a team was assembled in less than 15 minutes to enter Cell 15.

I accordingly find on the evidence available to me that FJT's death could have been prevented at any time up to the early hours of 12 September 2015 if Corrective Services officers were aware that he was in need of medical attention and either provided it themselves or called for an ambulance to attend. The critical issue arising from this in the inquest was why no Correctional Services officer understood that medical assistance was required until FJT was discovered at about 8.30am on the morning of 12 September 2015. The focus of the inquest was accordingly on why FJT was not discovered bleeding from self-inflicted wounds notwithstanding that he had attempted twice to use the 'knock-up' system to alert correctional services officers to that fact. This issue is considered below.

Monitoring of inmates in Unit 7 of the HRMCC, the knock-up system and the rover's response

Correctional Services Officers at the HRMCC work on a three-watch system. The A Watch is approximately from 8.00am to 4.00pm; the C watch is from 4.00pm to 12.00am; and the B Watch from 12.00am to 8.00am. Sometimes officers start their watch earlier to allow for a handover. It is apparent that most meal, health, medication, programs, exercise, visits and telephone calls occur during the A watch. Breakfast is served approximately at the start of the A Watch and dinner at its conclusion about 2.30pm. Inmates are then at 'lock-in' from approximately 2.30pm. Medications are provided to inmates by a Justice Health nurse for the whole day at about 8.00am. As a result, the routine in the HRMCC is that inmates do not leave their cells and do not have contact with correctional services officers or others for about 16 hours in any given day.

The evidence revealed that the A Watch was when inmates had most interaction with officers and staff at the HRMCC. However, after dinner was served at the end of the A Watch there was no further direct contact with correctional officers. Officers on the C and then the B Watch had no direct contact with inmates. The only available mode of communication was via the 'knock-up' system which sounded first at the officers' station in Unit 7 and then in the Control Room if not answered within the first minute. Security was provided by correctional services officers on the C and B Watch. The officers worked in pairs and spent half a shift "in the towers", monitoring the perimeter of the HRMCC from a high point. The other half of the shift was spent as "Rovers" monitoring Units 7, 8 and 9 in the HRMCC by undertaking visual inspections and patrols.

Roving duties were conducted at irregular intervals so that their rounds were not predictable. They included visual inspections of the units from the internal side and from the external side.

On the internal side the inspection involved attending the monitoring room to observe the CCTV cameras and looking at the cell doors from the officers' station without entering the "deck" (the area between the officers' station and the cell doors). In Unit 7 all cells have two secure doors as many if not all inmates are in segregation. The external door has a small hatch which allows an officer to see into the cell. The internal door has large clear windows in it to allow for easy visual inspection of the interior of the cell.

On the external side of the Unit each cell has an individual caged rear yard. The yards open onto an area known as the sterile zone between the rear of the cell yard cages and a perimeter wall. The area is similar to a bituminised street. Rovers are able to check rear yard doors but also look into individual yards many (but not all) of which are lit by a yellow light at night. The cages on the yards allow for the floor of the yard and the rear door of the cell to be visible from the sterile zone. In between visual inspections officers were able to attend the meal room or access computers to undertake their work.

The procedures at the HRMCC at the time of FJT's death specifically prevented correctional services officers on duty from conducting either a physical or visual inspection of cells. The result was that inmates in Unit 7 were locked down from as early as 2.30pm until 8.30am the next day during which they had no contact with any correctional services officers and were not visually sighted by them.

The procedures also required that, on a C or B Watch, if two officers are to enter the deck then they must have a reason to do so and have notified the Night Senior. Secondly, they require a third officer to accompany them for such an entry being an officer who is tasked with holding the relevant keys and is to stand on the inside of the door in the officers' station 7 i.e. not on the deck. Of course, the Night Senior can accompany Rovers entering onto the deck. Otherwise Rovers are not to enter the deck.

It was evident that the deck was not considered to be safe by senior CSNSW officers notwithstanding that there was constant CCTV of the deck and it was clearly visible from the officers' station. Senior management gave evidence that additional staff would be required if the rovers were to be able to enter the deck. However, the evidence revealed that only one additional staff member was available to allow entry onto the deck at the changeover from the B Watch to the A Watch. The issue was relevant because FJT could easily have been checked by the Rovers if they had looked through the hatch of the external door. The reason no one did so was firstly because of the deck protocol described above and, secondly, the Night Senior was not contacted, contrary to the local operating procedures.

The 'knock-up' system

The evidence was that calls to the knock-up system were not clearly audible in the Control Room. The evidence from Officer Matthew Damaso was that the system was in working order but that the hard surface of cells often made knock-up calls inaudible. Mr Damaso was pessimistic about being able to improve the audio quality of the current system because of the cell audio conditions. It was also evident that those in the Control Room had the option of using a 'speaker' and microphone system to communicate with the inmate or a telephone handset.

Different officers preferred different methods. Officer Kuczynski relied on the speaker and microphone system and did not use the latter. On 11 September 2015 Officer Kuczynski received two knock-up calls from FJT: the first at 9.17pm and the second at 9.23pm.

Officer Kuczynski did not understand what FJT said on the first knock-up call because he asked FJT to repeat what he said. He then asked Officer Hockey (who was in the meal room at the time) to attend and respond to the knock-up call. On receiving an unclear call, the clear option available to Officer Kuczynski was to call FJT back and ask for the reason for the knock up call. This is a well-known technique and was known at the time as a 'reverse knock-up'. Officer Kuczynski failed to reverse knock-up FJT when the first call was unclear and that failure draws my criticism. If Officer Kuczynski had established that FJT had cut himself then, subject to any additional instructions from the Night Senior or the Manager of Security, he would have called for an ambulance to attend and treat FJT.

Officers at the HRMCC at the time, including senior officers, were required to inform the Night Senior if they received a knock-up call which "potentially" may have been an emergency. This was not well understood at the time by officers to include calls which were unclear. That was so, notwithstanding that the knock-up system is meant, in large part, for emergency calls and is the only form of communication that inmates have during a C and B Watch.

Officer Kuczynski did not understand this was required and did not wish to bother the Night Senior because he assumed he was busy. This was partly because the procedures were not clear, he had not been trained on the procedures and partly a failure of his judgment. If the Night Senior had been informed and as he had the available authority to enter the deck, he could have entered the deck at Unit 7 and visually inspected Cell 15 to determine what the knock-up was for. Such an action is likely to have led to an ambulance being called shortly after the 9.23pm call.

It is apparent that Officer Kuczynski did not clearly hear what FJT said during the second knock-up call. He told FJT that officers were on their way to him. Officer Kuczynski said that he (mis)interpreted FJT saying "I've slashed up" as "Where's my stuff?" which he assumed was a reference to his property. Officer Kuczynski said that at the end of his shift he told the Night Senior Officer Timothy Price of the two knock-up calls for FJT. Officer Price recalls that he was told that the calls were about property and that the Rovers had been informed. As the matter was about property and should be dealt with by the A Watch, Officer Price considered no action was required.

While playing back such calls is one way in which to clarify an unclear call, it is a cumbersome one. The evidence indicated that the more efficient way is to reverse knock-up the inmate and to report the unclear call to the Night Senior for action. Clearly the instructions to those receiving knock-up calls needs to be clear and during the hearing senior management at the HRMCC took action to amend local operating procedures to ensure that where a knock-up call is unclear then it must be reported to the Night Senior. According to the local operating procedures the Control Room officer should have informed the Night Senior as soon as the reason for the knock-up call was unclear. The Night Senior would then have an obligation to respond to the knock-up. The Night Senior is the key officer and the Control Room officer has a different function.

The evidence was that when an inmate is on a RIT and placed in an observation cell (which can be viewed in the Control Room) then the Control Room officer is informed of the RIT. FJT had been placed on a RIT on 4 September 2015 for a period of about 24 hours but was not on a RIT at the time of his death.

The Rovers' response

Officers Hockey and Lang were the responsible Rovers when FJT knocked up the Control Room. Officer Hockey was the more senior of the two and was a very experienced officer. Both were in the meal room at the HRMCC when Officer Kuczynski called to alert them to the knock-up from FJT.

Neither was in a hurry to attend Unit 7 to check on FJT and they did not leave the meal room for at least 15 minutes to do so. They were the only officers in the Meal Room and the Meal Room has a TV which, according to Officer Lang, was on at the time. Both had already eaten. The first round of the National Rugby League finals was on that night and the game was likely to have been concluding at about the time of Officer Kuczynski's call. The game was being watched in the neighbouring Correctional Centre by a number of guards on duty. In oral evidence neither Officer Hockey nor Lang said that they could remember watching the football. When asked what he was doing after he received the call and before leaving the Meal Room Officer Hockey said he was having a cup of tea and reading the paper.

Officer Kuczynski did not tell Officer Hockey during the (first) call that the knock-up was or may have been an emergency. As Officer Kuczynski was not aware what the call was for, it was at least possible that it was an emergency (as indeed it turned out to be). Officer Hockey was not told what the knock-up was for and, as Officer Kuczynski had not said it was an emergency he did not understand that it was an emergency situation.

Both Officers Hockey and Lang did leave the Meal Room and went to the officers' station in Unit 7. They conducted a visual inspection of the Unit including the deck and the cell doors including Cell 15 where FJT was incarcerated. They also smelt (presumably for smoke) and listened. Nothing unusual was seen, heard or smelt. As per operating procedures they did not enter the deck or approach the external door to Cell 15.

Facilities are provided at the Officers Station in Unit 7 for officers to reverse knock-up a cell. Officer Hockey did not reverse knock up Cell 15 from the officers' station and nor did Officer Lang. This was the obvious thing to do because no one knew why the knock-up call had been made and it was the easiest way to contact FJT. It was a clear failure by the two officers to take an obvious step and is deserving of censure. It is likely that if the call had been made that FJT would have told them he had slashed up and they could then have taken immediate action including informing the Night Senior and asking for an ambulance to be called.

Instead Officer Hockey called Officer Kuczynski and told him "*all was normal*". The check undertaken was inadequate for Officer Hockey to reach that conclusion. Crucially Officer Kuczynski then told Officer Hockey that FJT had "*asked for his stuff*".

That was a dangerous conclusion for Officer Kuczynski to have reached based on his hearing of what he knew was an inaudible knock-up line from FJT. Officer Hockey accepted Officer Kuczynski's description that FJT had made a request for property, and he concluded that a response would have to wait until the next Monday.

No attempt was made by either Officer Kuczynski or Officers Hockey or Lang to reverse knock-up FJT to clarify what he wanted. Officer Lang and Officer Hockey then left Unit 7. They had been in the officers' station for about 2 minutes.

In oral evidence Officer Hockey said that he did not reverse knock up FJT even though he knew the main reason there is a knock-up system is for emergencies. He said that FJT had a history of making nuisance calls but he agreed he did not know the particular knock-up call was a nuisance call. I do not accept that prior making of nuisance calls was a legitimate reason to ignore FJT's knock-up call on 11 September 2015. The knock-up system is the only available way for an inmate to communicate an emergency and the risks of not responding to a call are evidenced in this inquest.

As Officer Hockey acknowledged, the local operating procedures require that every knock-up call must be responded to. I find on the evidence available to me that Officers Hockey and Lang failed to properly respond to FJT's knock-up calls of 11 September 2015 contrary to local operating procedures. I also find on the evidence available to me that if Officers Hockey or Lang had reverse knocked-up FJT from the officers' station in Unit 7 on 11 September 2015 it is likely they would have discovered that he was in need of medical attention and taken appropriate action.

Again it is likely that had they discovered that FJT had slashed up, the Night Senior would have been informed, an ambulance called and FJT would not have died.

Rovers - Water in the sterile zone

It was clear from CCTV tendered in the proceedings that there was water escaping from the rear of Cell 15 into the sterile zone where it then went into a drain. While CCTV footage of the rear yard reveals a dark substance visible in the water on the floor of the yard, it was not clear that the water was so coloured, or blood clearly visible, when the water flowed out of the yard into the sterile zone. The reason for the water being flushed out of the cell was also not clear. It could have been because FJT wanted to signal those in the sterile zone, but he could also have yelled out to the officers and apparently did not. It may have been because he wanted to stop his blood from clotting by washing out the wounds. The reason need not ultimately be determined.

The next set of Rovers, Officers Beer and Oberg, can be seen walking in the sterile zone at 10.52pm. There is a considerable amount of water in the sterile zone which the officers walk through. Neither officer appears to examine the rear yard to Cell 15. Certainly neither officer reported the water or anything unusual about the yard. The rear yard to Cell 15 was well lit at the time and covered by CCTV. That footage reveals that there was a dark substance flowing out of the rear door to the cell which we now know was blood. It is reasonable to conclude that neither officer noticed the blood on the floor of the yard. No doubt that was because they were looking for unlocked yard gates and any obvious signs of escape. Neither was concerned about the water flowing from the cell as it was apparently a common occurrence and did not report it.

Officers Tapper and Murfitt undertook a similar patrol of the sterile zone at 4.21am and did not notice anything. The water from the rear of Cell 15 was far less than at 10.52pm. There is merit in Rovers undertaking a closer visual inspection of yards to see whether there is anything unusual in those yards that might warrant further investigation.

Closer inspection in this case may have led to further investigation of FJT's cell. The evidence did not reveal whether Rovers are required to inspect the ground of rear yards. There is merit in amending instructions to Rovers to inspect the rear yards of cells for anything unusual such as blood or water. Such an inspection could be undertaken without further additional time or resources required. Given that flowing water may be used to flood a cell and destroy clothing and bedding there is merit in reporting such an occurrence to the Night Senior for investigation, notwithstanding that its occurrence is commonplace.

Access to Razors

FJT used a common razor to inflict the wounds to the left side of his body that ultimately led to his death. The evidence was that no restriction had been placed on his access to such a razor for normal purposes.

The primary way for an inmate not to be given a razor is for Justice Health to advise Corrective Services NSW ("CSNSW") that there are concerns that the inmate will self-harm and should not have access to sharps. CSNSW may also form its own opinion. Where the inmate has been placed on a RIT and is in an observation cell then CSNSW can be advised that an inmate not have access to such equipment. There are two ways for this to occur:

Via the last page of the Mandatory Notification form for a RIT, where discharge planning is set out; and via a Health Problem Notification Form (from Justice Health to CSNSW). Neither form appears to expressly require consideration of access to razors or other sharps, ligatures or clothing that could be used to make a ligature. While it would be possible to add such a warning (eg "not to have access to razors") there is nothing to prompt the Justice Health officer to give specific instructions. This may be because it is assumed that if the inmate is at risk of self-harm they should be placed in an observation cell.

FJT was subject to a RIT on two occasions in the month or so before his death: 23 July to 3 August 2015 and 4-5 September 2015. There is no mention on the last page of the first RIT ("Discharge to case Management and Progress Plan") that he should be prevented from having access to a razor. That was notwithstanding that he had been placed on a RIT because of concerns that he would self-harm by a hunger strike. Similarly there is nothing on the last page of the second RIT. On 5 September 2015 he was to be returned to a "normal cell". That was notwithstanding that he had been placed on the RIT because he was having thoughts of self-harm. The last Health Problem Notification Form, dated 6 August 2015, indicated to CSNSW officers that there was a high risk for aggression and violence with staff and that he should be given a "normal cell placement".

There is merit in amending both forms so that there is a requirement for Justice Health to nominate whether the inmate should have access to razors, sharps or obvious ligatures.

What policies, procedures and protections are in place to prevent access to sharps such as razor blades within Goulburn Correctional Centre?

The primary protection mechanism available at the HRMCC was that an inmate who was at risk of self-harm should be placed in an observation cell with camera monitoring.

While Justice Health and CSNSW were in possession of information about self-harm, in the RIT process, neither took action to restrict FJT's access to a razor. There is merit in the amendments to the forms as indicated above, that there is a requirement for Justice Health to nominate whether the inmate should have access to razors, sharps or obvious ligatures.

Treatment of FJT'S Mental Illness

FJT's mental health was monitored over a number of years by CSNSW psychologists and by Justice Health psychiatrists. On 18 November 2013 Dr AP McClure thought that he hints at PTSD, he was not suffering from depression and his affect was reactive. However, he did note that a prolonged regime of sensory deprivation placed him at risk of psychosis "*given his premorbid vulnerability*".

On 29 January 2014 Dr O'Dea recorded that FJT was suffering from auditory hallucinations and had already commenced using Amisulpride (an anti-psychotic medication). While he recorded that there was no acute psychosis he did record that there was a history of personality disorder, substance use disorder and ongoing problems with anger, aggression and psychosis. Dr O'Dea increased the amount of Amisulpride to 200mg per day. FJT was seen by a further psychiatrist on 22 April 2014 where the auditory hallucinations and paranoia were noted with a diagnosis of anti-social personality disorder, polysubstance abuse, PTSD and sensory deprivation. The Amisulpride was increased to 600mg daily. A similar diagnosis was made by Professor Greenberg on 19 May 2014.

On 21 October 2014 FJT was transferred to Parklea Correctional Centre to undertake the Violent Offenders Therapeutic Program ("VOTP"). He had frequent contact with psychologists during this time (about once per week). However, on 21 January 2015 he was involved in a violent incident with another inmate and was suspended from the VOTP. There was a further violent incident involving him on 16 February 2015 where the notes record that he was experiencing paranoid thoughts and he was "*psychotic ... appeared to develop in context of prolonged segregation ... general hypervigilance/paranoia*". FJT was transferred back to the HRMCC on 5 March 2015.

Shortly before FJT's transfer he was seen by psychiatrist Dr Fay who noted that he was suffering from psychosis which had developed in the context of prolonged segregation. Dr Fay noted an increase in paranoia and homicidal ideation, thought interference, general hypervigilance and paranoia. Dr Fay increased the Amisulpride to 800mg daily and added Quetiapine (another anti-psychotic) for sleep.

After his transfer back to the HRMCC FJT was not seen by a psychologist and did not see a psychiatrist until August 2015. The evidence did not reveal why FJT was not seen by a (CSNSW) psychologist between 5 March 2015 and the time of his death 6 months later. Registered Nurse Michael Harris had seen FJT frequently while he was in Unit 7. During 2015 FJT was referred for mental health review in June 2015 (to which he did not attend) and was referred to a psychiatrist when he was placed on a RIT on 24 July 2015.

The Court heard evidence from Dr Sarah-Jane Spencer, who was the Deputy Clinical Director of Custodial Mental Health for Justice Health in 2015. Dr Spencer also provided clinical services to inmates including to FJT in August 2015. Dr Spencer was asked why FJT was not seen by a psychiatrist until August 2015.

Dr Spencer indicated that she and Dr O’Dea provided psychiatric treatment to about 200 inmates at the HRMCC and adjacent Goulburn Correctional Centre, and visited about 24 times per year between the two of them. The notes record that Dr O’Dea attempted to see FJT in June 2015 but FJT refused the consultation. Otherwise the process relies on a Justice Health nurse to triage the patients and refer them, where considered necessary, to the visiting psychiatrist.

Dr Spencer saw FJT for an extended consultation on 6 August 2015. Her clinical notes stretched to 6 pages of detail. She noted his past history of psychotic symptoms in the context of prolonged segregation, paranoid ideation, and persecutory delusional beliefs. She noted that his behaviours had changed recently in the context of increasing isolation. She noted that he was presenting with an increase in psychotic depressive symptomatology and denying thoughts of self-harm or suicide. She increased his medication to 200 mg Amisulpride during the day with 800mg at night (a total of 1000mg per day) as well as Mirtazapine (an anti-depressant) 30mcg at night.

FJT’s head sentence expired on 11 August 2015 and he had been told he would continue to be held at the HRMCC rather than be transferred to Villawood Immigration Detention Centre. The Justice Health and OIMS case notes record that this was markedly increasing his stress. On 13 August 2015 he said he would abandon his immigration appeal and accept deportation, although he then did not complete the relevant forms to do so. On 13 August 2015 he was involved in an altercation with Correctional Services Officer Troy, an IAT was called and both gas and force were used to restrain him. Dr Spencer attempted to see FJT that day but was denied access by CSNSW.

Dr Spencer returned on 27 August 2015 to see FJT but this time, she was only allowed to see him in the vestibule between his two cell doors with 3 or 4 correctional services officers standing within earshot. This was vastly inferior access compared to the caged room where the first consultation occurred without the presence of officers. The consultation was short and FJT was not forthcoming but did say that he was happy with the increase in medication. Dr Spencer hoped to review him in the future but no date was set.

Expert evidence of Drs Olav Nielsen and Adam Martin

Evidence was taken in conclave from two eminent psychiatrists well-experienced in the provision of psychiatric treatment in the custodial environment. While Dr Olav Nielsen was in private practice at the time of the hearing, Dr Adam Martin was an employee of Justice Health. Both were of the opinion that FJT was suffering from schizophrenia at the time of his death, Dr Martin also considered that he had a personality disorder. Both agreed that his mental illness was accompanied by psychoses during 2015 in the nature of delusions of persecution and auditory hallucinations.

Both doctors agreed that placing FJT in segregation, as he was at the time of his death, precipitated, amplified and perpetuated his mental illness. This was because segregation for him meant an absence of human contact and sensory deprivation. There is ample medical literature to evidence the adverse effects of segregation on mental health.

At the time of FJT’s death the following regime applied to his custody:

- He was in a one out cell – that is, by himself;

- He had access to a rear yard for limited periods during the A Watch, again by himself;
- He had access to phone calls on the deck of Unit 7, but was shackled and handcuffed when doing so, was accompanied by a number of guards so that calls could take place, and he stood in a locked cage to make those calls;
- He had a brief interaction with a mental health nurse every morning which included the dispensing of anti-psychotic medication to him;
- He had a limited number of consultations with a psychiatrist in 2015: with Dr Fay on 16 February 2015 and then with Dr Spencer for an extended consultation on 6 August 2015 and for a short cell door consultation on 27 August 2015;
- He had interactions with correctional services officers through his cell door for meals and other related matters but remained in his cell or yard;
- He had no other interaction with other inmates at all;
- He did not see any person, including a correctional services officer, during the C and B Watches, - a period of at least 16 hours.

Dr Nielssen was of the view that FJT's mental illness was not being adequately treated in the HRMCC because of the nature of the environment and lack of therapy. Dr Martin said he partially agreed. FJT was taking an anti-psychotic but had limited human contact and access to mental health services and was not responding to Amisulpride. Both doctors agreed that a transfer to the MHSU was not possible for "*logistical reasons (non-clinical)*" but that clinically it was desirable to transfer him. Dr Martin said that once the logistical aspects were removed from the decision to transfer "*anyone in that situation would be better having more access to mental health services which were available either at Long Bay or in Silverwater.*"

However, the doctors were split about whether transfer to Long Bay Hospital was possible. Dr Nielssen considered that transfer there was needed to properly treat his mental illness. Dr Martin said that transfer was not likely because FJT was taking his medication and there was a reasonable expectation that there would be a response to the medication he was taking and any decision should be made after a period of assessment.

Dr Martin indicated that the practice was to not refer patients to the Mental Health Screening Unit ("MHSU") unless the inmate was "*very unwell*". He said that this clinical decision was "*absolutely*" affected by the high demand and low supply of mental health beds. He continued that if there were more beds available then the threshold for transfer "*would be lowered*".

Access to the MHSU and Long Bay Prison Hospital

There are two facilities available for the treatment of those suffering from mental illness in the custodial environment: the Mental Health Screening Unit ("MHSU") at Silverwater (part of the Metropolitan Remand and Reception Centre) and the Long Bay Prison Hospital.

Currently there are 44 beds at the MHSU including 5 acute beds with camera cells (there were only 3 in 2015) and 30 sub-acute beds. At Long Bay Prison Hospital there are 40 available beds, five of which are camera cells in G Ward with further beds in E and F Wards. There are four consultant psychiatrists at each facility (two days a week each) with two full-time registrars who see patients daily. They are assisted by mental health nurses. Dr Spencer said that admission to those units delivers a better therapeutic outcome to treatment at the HRMCC due to the intensity and regularity of the treatment.

Dr Spencer's clinical notes do not reveal consideration of whether FJT should have been transferred to the MHSU or to Long Bay. She said that the "*only reason*" he was not transferred to the MHSU was due to his security classification. While she had never received a written direction to that effect, she said that the practice was that high-risk security inmates were not to be admitted to the MHSU. As that was her understanding, she did not actively consider his transfer.

In correspondence subsequently received from the legal representatives of CSNSW, it was asserted that there was "*no policy which prohibited or discouraged the transfer of mentally ill inmates who were high risk*" from the HRMCC to the MHSU. The correspondence also states "*arrangements would first have been required to be settled in relation to the staffing and level of security required for housing an inmate away from the HRMCC*". This proviso probably explains Dr Spencer's understanding. The practical effect of that statement is that such security arrangements were not in place at the relevant time to allow such a transfer.

I find on the evidence available to me that at the time of FJT's death, senior executives at Justice Health believed that CSNSW would not permit high-risk security inmates from being transferred from the HRMCC to the MHSU for treatment, and accordingly no application was made to transfer FJT in 2015 to the MHSU for assessment and treatment.

The MHSU provides an important mental health treatment service in conjunction with mental health services provided at correctional centres and at Long Bay Prison Hospital (and Long Bay Forensic Hospital). There is high demand for the limited number of beds available at the MHSU and at Long Bay Prison Hospital for those suffering mental illness within the correctional system. It would be a substantial detriment to the rights of an inmate to obtain proper health care for them to be denied access to relevant treatment at the MHSU.

As CSNSW denies there is such a policy, there is merit in CSNSW and Justice Health establishing clear guidelines as to the circumstances under which a high-risk security inmate will be allowed to be transferred from the HRMCC to the MHSU. No doubt security concerns will need to be addressed but that should not stand in the way of providing proper medical treatment.

Dr Spencer said that high risk patients can be treated on an involuntary basis at G Ward at Long Bay Hospital but there are no facilities to treat them in the other wards where there are beds for voluntary patients. Dr Spencer said that the *Mental Health Act 2009* and clinical principles require that mentally ill patients be treated in the least restrictive way possible. That means a preference for treatment of an inmate patient on a voluntary basis rather than an involuntary basis. For high risk inmates, such as FJT, the only option was to treat him at the HRMCC on a voluntary basis or in G ward at Long Bay Prison Hospital as an involuntary patient. Dr Spencer's understanding of the availability of beds was shaped by her understanding of the CSNSW security practice which excluded referral to the MHSU.

Dr Spencer also indicated that there is also merit in the provision of 'telehealth' facilities at the HRMCC because the inmate would have the opportunity to be seen more frequently by Justice Health clinicians. Dr Spencer came across as very professional and compassionate and was clearly affected by FJT's death.

Resources for mental health services

Both Drs Nielszen and Martin were clear that the demand for mental health beds was far higher than beds that are available. While a number of those with mental illness could lawfully be made involuntary patients there simply were not enough beds to accommodate them. Dr Nielszen said that he had published an article estimating that there are 5-7% of the prison population currently that are suffering from psychosis, being about 600 to 1000 people. While all those persons do not need to be treated at the MHSU or Long Bay Dr Martin estimated, based on his experience on the bed demand committee, that if there was double or triple the number of beds available they would be easily filled. He said there was merit in a properly planned and studied analysis of demand for mental health beds in the NSW correctional system.

As a result I recommend that a review be undertaken to determine whether the number of beds available for the treatment of mentally ill patients is adequate for the demand for such beds by those in the NSW correctional system and whether additional beds may be provided for those who are mentally ill and in need of various levels of mental health care.

Conclusion:

I find that FJT's death could have been prevented at any time up to the early hours of 12 September 2015 if corrective services officers were aware that he was in need of medical attention and either provided it themselves or called for an ambulance to attend.

I find that if corrective services officers had reverse knocked-up FJT from the control room or the officers' station in Unit 7 on 11 September 2015 it is likely they would have discovered that he was in need of medical attention and taken appropriate action.

I also find that consideration was not given to transferring FJT for mental health treatment to the Mental Health Screening Unit or to Long Bay Hospital because of high demand for and low supply of mental health beds for correctional inmates.

Findings required by section 81(1) Coroners Act 2009:

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was FJT.

Date of death

12 September 2015.

Place of death

The High Risk Management Correctional Centre in Goulburn, New South Wales.

Cause of death

The death was caused by massive blood loss caused by incised wounds of left upper extremity.

Manner of death

FJT used a razor to cut himself and then used the intercom system in his cell at 9.17pm and 9.23pm to alert a Corrective Services Officer that he had done this. I am not able to determine his intentions at the time he cut himself. If Corrective Services Officers had responded appropriately to the intercom calls, it is likely that he would have received medical treatment and his death would have been prevented.

Recommendations:

For the reasons stated, I make the following recommendations pursuant to section 82 Coroners Act 2009:

To the Minister for Corrections, the Minister for Health, Justice Health and Commissioner of Corrective Services NSW

1. That CSNSW and Justice Health, undertake a review to determine whether the number of beds available for the treatment of mentally ill patients is adequate for the demand for such beds by those in the NSW correctional system and whether additional beds may be provided for those who are mentally ill and in need of various levels of mental health care. This review should include inpatient, step-down and low acuity beds Statewide.

To Corrective Services New South Wales (CSNSW)

Knock-Up System

1. That steps be undertaken to improve the audio-quality of the Knock-up System at the High Risk Management Correctional Centre (HRMCC).
2. That the Local Operating Procedures at the HRMCC be amended to require a Corrective Service Officer, in the Control Room or elsewhere, who receives an unclear knock-up call to reverse knock-up the caller to clarify the reason for the knock-up.
3. That a Corrective Services Officer who receives a knock up call records the call, the action taken (if any) and the officers involved.
4. That all Corrective Services Officers at the HRMCC be provided with regular training on COPP and Local Operating Procedures including new Local Operating Procedure HRM/002.

Rovers

5. That Rovers on C and B Watch enter the HRMCC deck and open the hatch to the external door of each cell to conduct a visual check on the welfare of the inmate at least once per Watch. That additional security support for the Rovers be provided, if necessary, in order to do so.
6. That Rovers on C and B Watch inspect the rear yards of cells at the HRMCC on their rounds and report anything unusual to the Night Senior, including the escape of blood or water from cells.

Access to Razors

7. That CSNSW formally consult with a Justice Health Mental Health Nurse as to whether an inmate at the HRMCC should have access to razors, other sharps or obvious ligatures where the inmate has recently engaged in or threatened self-harm or suicide, or has been supervised by a Risk Intervention Team (RIT).

Transfer of Inmates to the Mental Health Screening Unit

8. That sufficient security support be provided by CSNSW to allow for the transfer and admission of HRMCC inmates to the Mental Health Screening Unit at Silverwater for medical treatment of mental illness.

Family Visits

9. That CSNSW streamline the process for approving visits for inmates in the HRMCC.

To Justice Health & Forensic Mental Health Network (“Justice Health”) and CSNSW

10. That CSNSW ensure that Justice Health are provided with:

- a) real time information about inmates in isolation at the HRMCC;
- b) appropriate access to inmates kept in isolation at the HRMCC, and
- c) access to telehealth facilities.

and, on that basis, Justice Health are to amend Justice Health Policy 1.360 Segregated Custody to apply to those kept in isolation at the HRMCC and who have a mental illness, whether or not the patient is in segregation.

To Justice Health

11. Where the treating psychiatrist has concluded that isolation or segregation is adversely affecting the mental illness of a patient at the HRMCC the treating clinician, by way of a formal notification process, brings to the attention of the General Manager of the HRMCC the effect of isolation on an inmate’s mental health.

12. 288035 of 2015

Inquest into the death of Ian James McAuliffe. Finding handed down by Deputy State Coroner Ryan at Glebe on the 9th February 2018.

Introduction

On 1 October 2015 Ian James McAuliffe aged 67 years died of metastatic prostate cancer. Mr McAuliffe was serving a custodial sentence when he died; therefore the responsibility for ensuring that he received adequate care and treatment lay with the State. Pursuant to sections 23 and 27 of the Act, an inquest is required when a person dies in custody to assess whether the State has discharged its responsibilities.

The role of the Coroner

The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death: Section 81 of the Act. In addition the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question: Section 82 of the Act.

Mr. McAuliffe's life

Ian McAuliffe was born 2 May 1948. For much of his adult life he worked as a mechanic. He was married and had two children and eight grandchildren. At the time of his death Mr McAuliffe was estranged from his immediate family. He developed a relationship with a person he had met in 2012. This person visited Mr McAuliffe in jail and regularly spoke to him on the phone. In September 2013 Mr McAuliffe was found guilty by a jury of charges of sexual intercourse and indecent assault in relation to a child under 10 years of age. The offences were committed against a family member in 2010.

Mr McAuliffe was sentenced on 17 December 2013 to 8 years' imprisonment with a non-parole period of 5 years. This made him ineligible to be released before 16 December 2018. In passing sentence the Court found there to be special circumstances based on Mr McAuliffe's age, reduced life expectancy owing to his ill health (details of which appear below), and the likelihood that he would be serving his sentence of imprisonment in protective custody. Shortly after entering custody Mr McAuliffe requested and was granted placement in Long Bay's Special Programs Centre for prisoners requiring protection.

Mr. McAuliffe's medical history

When Mr McAuliffe entered custody in 2013 he received a medical screening. This confirmed he had multiple chronic health conditions, including metastatic prostate cancer, bladder cancer, a myocardial infarction suffered in 2009, ischaemic heart disease, non-insulin dependent diabetes, emphysema, impaired renal function, and an epigastric hernia. Mr McAuliffe's prostate cancer had been diagnosed in 2009. He had received radiotherapy for this condition while in the community, as well as ongoing hormone therapy with the drug Zoladex. Unfortunately these treatments had not been able to prevent him developing incurable metastatic disease.

Mr McAuliffe's treatment with Zoladex continued after he entered custody. However following a full medical review by his treating oncologist Dr Elizabeth Hovey, in January 2015 his cancer medication was changed to the drug cyclophosphamide. During his time in custody Mr McAuliffe had regular external medical appointments. These included cardiology and oncology reviews, urology consultations, renal function tests, and regular admissions to Prince of Wales Hospital annex for the purpose of changing his ureteric stents and catheter. These devices had been inserted in December 2013 to assist with his problems of urethral blockages. They had to be changed on a regular basis and under general anaesthetic. Mr McAuliffe also underwent bone and CT scans.

As a result of his serious health conditions, much of Mr McAuliffe's time in custody was spent in the Long Bay Hospital. Mr McAuliffe spent periods there in 2014 and was readmitted on 28 January 2015, effectively remaining there for the eight months of life that were left to him. During this time he also had frequent admissions to the Prince of Wales Hospital annex for the specialised treatment referred to above.

Throughout the latter part of 2015 Mr McAuliffe's condition steadily deteriorated. By September he was considered to be in the terminal phase of his life. On 26 September 2015 he asked not to receive any further medical investigations or invasive treatment, requesting treatment only to alleviate his symptoms. At his request he was also transferred back to the Long Bay Hospital. An order was approved for his hospital cell door to be kept permanently open so that clinical staff could have access at all times. On 30 September the Palliative Care Registrar at Long Bay Hospital recorded that Mr McAuliffe was minimally responsive. He continued to be monitored on a regular basis, and was last noted to be alive at about 8.45pm on the night of 1 October. At this time he was breathing with the assistance of an oxygen mask. However when he was checked at 9.15pm there were no signs of life and he was pronounced life extinct.

On 9 October 2015 Deputy State Coroner Dillon issued a Coroner's Certificate giving the cause of death as metastatic prostate cancer.

The issue at inquest

Following Mr McAuliffe's death the Legal Aid Commission wrote to the Coroner's Court drawing attention to a matter raised by Mr McAuliffe's treating oncologist, Dr Elizabeth Hovey. Dr Hovey is a Senior Staff Specialist at Prince of Wales Hospital's Oncology Department, and treated Mr McAuliffe from November 2014 until his death. She asserted that Mr McAuliffe had not been able to access a cancer treatment that was otherwise available to public patients with a subsidy from the Commonwealth Government's Pharmaceutical Benefits Scheme.

The background to Dr Hovey's assertion was an application to the State Parole Authority made on Mr McAuliffe's behalf on 27 August 2015 by Mr Stephen Eccleshall of the Legal Aid Commission, seeking an early compassionate release to parole. Mr McAuliffe was by then bed bound and in poor general condition with a short prognosis. Citing Dr Hovey's claim, the Legal Aid Commission submitted that Mr McAuliffe's pain and suffering would be better addressed by him receiving treatment as a public patient in the community rather than as an inmate. Dr Hovey had provided a report dated 17 June 2015 in support of Mr McAuliffe's early release application. In her report she explained his complex palliative care and analgesia requirements. She had treated Mr McAuliffe's cancer in the early months of 2015 with the drug docetaxel, but by May 2015 it had to be discontinued '*in part due to a mixed response*' but also because of deterioration in his nerve conduction function.

Dr Hovey went on to state that had Mr McAuliffe not been in custody, at that point:

'..we would have commenced him on a new generation hormone therapy called enzalutamide which is on the PBS [Pharmaceutical Benefits Scheme] however prison inmates in the medical unit at Long Bay are not covered by the PBS and it is my understanding that the medical oncology unit would have had to bear the cost of the enzalutamide which we do not have the budget for as it involves thousands of dollarsIn view of this we recommended the use of a more old-fashioned chemotherapy drug called oral cyclophosphamide...'

Dr Hovey went on to state:

'I have no doubt that he would be better served being out in the community in terms of both our therapeutic choices and level of care.'

The State Parole Authority declined Mr McAuliffe's application for early release, due to the serious nature of his offences, the small amount of time he had served in custody to that date, and the Board's finding that Mr McAuliffe was currently receiving adequate care and treatment at Long Bay Hospital. Mr McAuliffe died three weeks after this decision. On 25 October 2105 the Legal Aid Commission wrote to the Coroner's Court raising the matters referred to above in Dr Hovey's report.

Given the matters raised by Dr Hovey, a central issue in this coronial inquiry was whether the level of care which Mr McAuliffe was able to receive as an inmate was less than that regarded as adequate for patients not in custody. Dr Hovey's comments had suggested there was a financial disincentive to prescribe the drug enzalutamide to Mr McAuliffe, because he was in prison rather than in the community, and the costs would not be covered by the PBS.

Dr Hovey's report dated 27 September 2017

Following receipt of the above letter from the Legal Aid Commission the Coroner's Court requested Dr Hovey to assist its inquiry, by providing her opinion as to:

- whether enzalutamide would have been an appropriate treatment for Mr. McAuliffe; and
- whether she would have prescribed it for him had he been in the community.

In response Dr Hovey provided a detailed and most helpful statement dated 27 September 2017, supplying an overview of Mr McAuliffe's diagnosis and prognosis, and explaining the treatment decisions she had made. Dr Hovey described Mr McAuliffe's primary disease of prostate cancer, as well as his other health conditions of bladder cancer, ischaemic heart disease and diabetes. Mr McAuliffe's diabetes made him vulnerable to infections of his urethra and kidneys, the treatment of which disrupted his cancer chemotherapy. A contributing factor in his recurring infections were the uretic stents and catheter which were required to deal with his kidney blockages. When Dr Hovey commenced Mr McAuliffe's treatment in November 2014 these co-morbidities and conditions had caused her to assess his prognosis as likely to be between 10 to 12 months, if not shorter. A bone scan on 8 January 2015 confirmed multiple bone metastases affecting Mr McAuliffe's back, hip and pelvis and causing him significant pain.

After consultation with Mr McAuliffe Dr Hovey decided to commence palliative chemotherapy with the drug docetaxel. Mr McAuliffe received monthly cycles of this drug in January, February, March and April 2015. On 4 May 2015 Dr Hovey decided to discontinue docetaxel and replace it with second line chemotherapy, namely the drug cyclophosphamide. This was because a scan had revealed a new lesion, and there was evidence that the docetaxel treatment was impairing Mr McAuliffe's neuropathic system. Unfortunately repeated kidney and urinary tract infections interrupted Mr McAuliffe's cyclophosphamide therapy, which had to be suspended while he received antibiotics. Then in August 2015 an ultrasound confirmed likely liver metastases.

Mr McAuliffe's condition deteriorated throughout September 2015 and in consultation with him Dr Hovey determined that he would not be assisted by further chemotherapy. He was placed in the care of Long Bay Hospital's Palliative Care Team and he died on 1 October. In answer to the question whether the drug enzalutamide would have been an appropriate treatment for Mr McAuliffe, Dr Hovey made the following points: Enzalutamide was considered as a potential treatment for Mr McAuliffe. The appropriate time for consideration of it was following completion of the docetaxel therapy. Dr Hovey discussed with the Prince of Wales Medical Oncology Team the possibility of arranging oral enzalutamide for Mr McAuliffe. She was informed by a colleague that as he was a prisoner a PBS authority script could not be written for him; nor would the Hospital's Oncology Department be able to meet the cost of the drug.

She was unable to recall to what extent she escalated her request for consideration of enzalutamide. In response to the question whether she would have prescribed enzalutamide for Mr McAuliffe if he had been in the community, Dr Hovey made the following comments: In her 15 years of using palliative cyclophosphamide she had had good results; therefore on reflection there was a high chance she would have decided to administer cyclophosphamide to Mr McAuliffe prior to considering enzalutamide, even if he had been in the community.

Although enzalutamide was a relatively new drug with promising results, the decision as to what therapeutic option to use in his case would have been *'more complex and nuanced'* and enzalutamide *'might not in fact have been the first choice post-docetaxel depending on his clinical status at the time'*. Dr Hovey commented further that Mr McAuliffe's death on 1 October 2015 was in keeping with her prognosis in November 2014 of 10-12 months. In her view, had Mr McAuliffe been discharged from jail for his last few months he would have had other therapeutic options and a likely better quality of life. However she concluded her report as follows:

'Despite my letter to the Parole Board, it was my view then, and continues to be my view now that his death could not have been prevented by treatment with enzalutamide, nor that he received inferior treatment without it'. In retrospect therefore, Dr Hovey is of the view that treatment of Mr McAuliffe with cyclophosphamide was clinically appropriate, and that had he been in the community she would likely have elected to proceed with cyclophosphamide prior to considering enzalutamide. On the basis of Dr Hovey's statement of 27 September 2017 therefore, I conclude there is no evidence to support the assertion that because of his ineligibility for the PBS subsidy for enzalutamide, Mr McAuliffe received inferior treatment for his prostate cancer to that which he would have received had he not been a prisoner.

Funding of treatment and medication for prisoners

The above conclusion is determinative of the central issue in this inquest. However it may be helpful to consider a related question: whether the ineligibility of prisoners for PBS-subsidised medicines such as enzalutamide may result in them receiving a level of care inferior to those in the community. During the coronial investigation information was sought from the NSW Department of Health regarding the funding of treatment and medication for prisoners. In response information was received as follows:

All patients receiving treatment from NSW public hospitals, whether they are prisoners or not, are excluded from receiving PBS-subsidised pharmaceuticals. This is because by the combined operation of the Commonwealth *National Health Act 1953* and *Health Insurance Act 1973*, a person is not entitled to receive benefits from the PBS if their services are provided by a State Government. This means that prisoners, in common with other NSW public hospital patients, are not entitled to PBS-subsidised medicines. In the case of prisoners, their health care is the responsibility of the States and Territories. NSW Health Policy directs that a prisoner's inpatient and outpatient treatment costs are to be borne by the public hospital treating that prisoner. This includes costs for medication. As their health services are provided by the NSW Government, PBS subsidies are not payable for them.

Prisoners are only entitled to receive PBS-subsidised medicines where these are listed under the Highly Specialised Drug Program [HSD Program] of the PBS. Enzalutamide is not listed under the HSD Program, so Dr Hovey's understanding of the situation (ie that a PBS subsidy would not be available for enzalutamide if prescribed for Mr McAuliffe) was correct. It is understood that a Local Health District is able to provide a mechanism for a treating clinician to apply for authority for supplementary funding to supply a certain medicine to a patient.

In summary therefore, prisoners such as Mr McAuliffe receiving treatment from a public hospital are not eligible for a PBS-subsidised medicine, because their treatment costs are the responsibility of the NSW public hospital treating them. However the situation is the same for all other members of the community who receive public hospital treatment. They too are excluded from the PBS scheme, other than in relation to Highly Specialised Drugs. It is not the case therefore that NSW public hospitals bear a greater cost with respect to medicines for prisoners than for other members of the community.

According to information received, NSW Health officials have raised the issue of prisoner access to the PBS scheme with the Commonwealth Minister for Health, but they have been advised that there is no present plan to change the policy.

Conclusion

As Mr McAuliffe was in custody, an inquest is required into the circumstances of his death to assess whether the State has discharged its responsibilities in relation to him. Having considered the evidence I am able to conclude that Mr McAuliffe died as a result of natural causes. There are no suspicious circumstances, and no evidence that the care and treatment he received when he was in custody was inadequate or inferior to that which he would have received had he not been an inmate of a prison. This is the case in relation to the specific issue highlighted above as to whether his treatment was inadequate because he was not eligible for a PBS subsidy for the drug enzalutamide.

For the reasons given above, my conclusion is that his treatment for cancer whilst an inmate was adequate and was not inferior to that which he would otherwise have received. It is also the case in relation to his general care and treatment as an inmate. From the outset of his time in custody Mr McAuliffe had a serious health problem which together with his other health problems was properly managed. Appropriate decisions were made and implemented about his treatment and palliative care.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity

The person who died was Ian McAuliffe, born 2 May 1948.

Date of death

Ian McAuliffe died on 1 October 2015.

Place of death

Ian McAuliffe died at Long Bay Correctional Centre, Malabar NSW.

Cause of death

Ian McAuliffe died as a result of metastatic prostate cancer.

Manner of death

Ian McAuliffe died of natural causes while in custody.

13. 3336444 of 2015

Inquest into the death of Carmelo Disano. Finding handed down by Deputy State Coroner Lee at Glebe on the 5th October 2018.

Introduction

At the time of his death Mr Carmelo Disano was being held in lawful custody in a NSW correctional centre. He had been in custody since 2004 and was serving a sentence after being convicted and sentenced in relation to a criminal offence. In September 2014 Mr Disano was diagnosed with a terminal illness and given a prognosis of limited life expectancy. On 13 November 2015 Mr Disano succumbed to the debilitating effects of this illness and died.

Why was an inquest held?

Under the *Coroners Act 2009 (the Act)* a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died when and where they died, and what was the cause and the manner of that person's death. When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This is so even when the death of a person in lawful custody believed to be due to natural causes. It should be noted at the outset that there is no suggestion in this case that the State has not discharged its responsibility in anything other than an appropriate and adequate manner.

Mr. Disano's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

Mr Disano was born in Castiglione in the Sicily region in Italy. He had four sisters and one brother, and was the second youngest child in the family.

After leaving high school early, Mr Disano took on an apprenticeship as a tiler. He worked in Italy in the ceramic tiling industry for a number of years, and later spent some time working in Switzerland as well. In 1976 Mr Disano migrated to Australia with some of his siblings. They established a home in the suburb of Drummoyne in Sydney. Mr Disano continued his work as a tiler, working for a ceramic company. Mr Disano became self-employed and often worked as a sub-contractor. When not working, Mr Disano often pursued his hobby of fishing.

In 1978 Mr Disano married and later had two daughters. The family subsequently moved to Concord. In his later years, Mr Disano began to experience difficulties in his marriage, leading to his divorce from his wife in 2004. Following the divorce, Mr Disano became estranged from his children. However, he remained in close contact with his other family members, especially his nieces. There is no doubt that Mr Disano is greatly missed by those who were closest to him.

Mr. Disano's custodial and medical history

On 2 January 2004 Mr Disano was arrested and charged in relation to an offence arising from a physical altercation with a family member. Mr Disano entered Corrective Services NSW (**CSNSW**) custody on 3 January 2004. On 15 December 2004 Mr Disano pleaded guilty to an offence of manslaughter. He was subsequently sentenced to a term of imprisonment of 17 years with a non-parole period of 12 years, commencing on 2 January 2004 and expiring on 1 January 2016.

Mr Disano was housed at multiple correctional centres during his subsequent years in custody including at Parramatta, the Metropolitan Remand and Reception Centre, Lithgow, Bathurst, Junee, Goulburn and Oberon. On 15 July 2014 Mr Disano reported feeling unwell. He had developed a lump in his abdomen and had experienced several months of decreased appetite and weight loss. Mr Disano was reviewed by a medical officer on 4 August 2014 and subsequently referred for a CT scan of his abdomen on 8 September 2014. The scan revealed that Mr Disano had caecal adenocarcinoma Stage IV B with liver and lung metastases and lymph node involvement.

On 19 September 2014 Mr Disano was transferred from Oberon Correctional Centre to Long Bay Hospital at Long Bay Correctional Complex. He was initially placed in the Prince of Wales Hospital (**POWH**) Secure Unit before later being transferred to the Medical Sub-Acute Unit (**MSU**) on 22 October 2014. On 29 October 2014 Mr Disano commenced palliative chemotherapy treatment. At this time it was noted by Mr Disano's treating clinicians that treatment of his metastatic caecal cancer was not curative, and only for the purpose of hopefully extending his life expectancy. Further, it was noted that "*without treatment, the median overall survival is about 6 months and with treatment, this can potentially double to 12 months in 50% of cases*".¹ Given Mr Disano's poor prognosis, an advanced care directive was discussed with, and signed by, him which confirmed that he was not for resuscitation.

Between October 2014 and April 2015 Mr Disano was regularly reviewed by the oncology and palliative care teams at POWH. A CT was conducted in April 2016 which showed worsening local and metastatic disease. Mr Disano was also noted to be frail and lethargic, and required regular analgesia for pain management. Mr Disano's chemotherapy treatment was changed at that time, and changed again two months later when it was noted that his tumour marker had risen. On 1 October 2015 Mr Disano's treating clinicians discussed available treatment options with him.

Mr Disano elected to continue with chemotherapy but no further cycles of palliative chemotherapy were administered. On 2 October 2015 Mr Disano was transferred for the final time from the POWH Secure Unit to the MSU. During this period it was noted that Mr Disano was extremely weak and frail, that he began refusing medication, and that he had not been eating and only drinking very little. Mr Disano remained on strong pain relief medication and pressure care was also provided as Mr Disano was spending most of his time in bed.

Due to Mr Disano's declining condition, arrangements were made for his family members to have increased access to bedside visits from 22 October 2015 onwards. Welfare support services were also provided to Mr Disano and his family members.

What happened on 13 November 2015?

On the morning of 13 November 2015 it was noted that Mr Disano's breathing was shallow and that his condition was declining rapidly. Arrangements were made to notify members of Mr Disano's family who had planned to visit him later in the day. Instead, an earlier visit was arranged and Mr Disano's family spent time with him between about 11:00am and 2:30pm. They were supported by welfare officers and CSNSW chaplain.

At the end of the visit, CSNSW and Justice Health & Forensic Mental Health (**Justice Health**) staff continued to monitor Mr Disano. During a physical check conducted at around 3:55pm it was noted that Mr Disano was breathing. However, when Mr Disano was checked five minutes later at around 4:00pm he was found to be unresponsive with no signs of life. In accordance with the advanced care directive in place, resuscitation measures were not taken.

What was the cause and manner of Mr. Disano's death?

Mr Disano was taken to the Department of Forensic Medicine at Glebe where a post-mortem examination was performed by Dr Rianie Janse Van Vuuren on 18 November 2015. Dr Van Vuuren reviewed Mr Disano's available medical records from POWH and concluded that the cause of his death was metastatic caecal adenocarcinoma. There is no evidence to indicate that any external factor contributed to Mr Disano's death. Therefore, his death was due to natural causes.

What conclusions can be reached regarding Mr. Disano's care and treatment whilst in custody?

Having considered the available records held by both CSNSW and Justice Health in relation to Mr Disano, I cannot identify any matter associated with Mr Disano's care and treatment whilst in custody that contributed to his death. It is evident that at the time that Mr Disano was diagnosed with his terminal illness, his treatment options were limited as the illness was at an advanced stage. The options were confined to palliative, rather than curative, treatment.

There is no evidence to suggest that the health care received by Mr Disano whilst in custody was not within an expected standard of care. There is no evidence to suggest that any act or omission by either CSNSW or Justice Health contributed to Mr Disano's death in any way.

The evidence indicates that clinical and administrative steps were taken to appropriately manage Mr Disano's declining condition in accordance with his palliative care pathway. One matter related to Mr Disano's care whilst in custody requires some further consideration. Due to Mr Disano's declining condition, his family members submitted two applications to the State Parole Authority (**the Authority**) for his early release to parole due to exceptional extenuating circumstances. Both of these applications were declined. In October 2015 additional material in support of a further application was submitted to the Authority. Arrangements were also made to expedite consideration of this material by the Authority. At the time of Mr Disano's death the Authority had not yet made any final determination.

One of Mr Disano's nieces has queried why the applications for early release to parole were declined. Examination of the previous determinations made by the Authority is beyond the scope and jurisdiction of this inquest. However, on the evidence available there is nothing to suggest that any aspect of the applications made to the Authority was associated with Mr Disano's death.

Findings

Before turning to the findings that I am required to make, I would like to acknowledge, and express my thanks to Ms Tina Xanthos, Coronial Advocate, for her assistance both before, and during, the inquest. I also thank Detective Sergeant Andrew Tesoriero for his role in the police investigation and for compiling the initial brief of evidence.

The findings I make under section 81(1) of the Act are:

Identity

The person who died was Carmelo Disano.

Date of death

Mr. Disano died on 13 November 2015.

Place of death

Mr. Disano died at Long Bay Hospital, Long Bay Correctional Complex, Matraville NSW 2036

Cause of death

The cause of Mr. Disano's death was metastatic caecal adenocarcinoma.

Manner of death

Mr. Disano died from natural causes whilst in lawful custody.

14. 1459 of 2016

Inquest into the death of Saker Mohamed. Finding handed down by Deputy State Coroner O’Sullivan at Glebe on the 7th March 2018.

Introduction:

Mr Saker Mohamed was born on the 11th of February 1971. At the time of his death he was serving a custodial sentence at Long Bay Correctional Facility, and was being held in Long Bay Hospital due to his poor health. As Mr Mohamed was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act.

The Inquest:

The role of a Coroner, as set out in s 81 of the Coroners Act, is to make findings as to:

- (a) the identity of the deceased;
- (b) the date and place of the person’s death;
- (c) the physical or medical cause of death; and
- (d) the manner of death, in other words, the circumstances surrounding the death.

Pursuant to s 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

The Evidence:

Background:

Saker Mohamed, also known as Saher Hamed Ramadan Mohamed, was born in Egypt on the 11th of February 1971. Little information has been received regarding his early years and background, but it is known that he has a brother, believed to be residing in Saudi Arabia. He spoke Arabic and limited English. In 2008, Mr Mohamed travelled to Australia. He commenced an intimate relationship soon after, which led to Mr Mohamed becoming the father of two female children. They married in 2014, however the relationship ended later that year.

On The 16th of May 2014, Mr Mohamed was charged by police with aggravated sexual assault of a victim with cognitive impairment. He was initially bail refused, but was later released on conditional bail in August 2014. A plea was entered on the 11th of June 2015 in the Downing Centre District Court. Mr Mohamed was entered into the Surry Hills Court Cells, before being placed at Parklea Correctional Centre on the 16th of June. On the 4th of August 2015, Mr Mohamed was sentenced to two years imprisonment, commencing on the 14th of March 2015, and was due for release on the 13th of March 2017.

The events leading to his death:

On the 24th August 2015, during a mental health review, Mr Mohamed showed the nurse some lumps under his armpits that were causing him pain.

He was placed on the Primary Health waiting list, and then on the 26th of August, reported that the lumps were no longer causing him any pain. On the 31st of August, Mr Mohamed presented to staff with headaches and dizziness. At assessment he had low blood pressure and his temperature was elevated. He was treated with paracetamol.

On the 4th of October at 2:10pm, Mr Mohamed reported lower abdominal pain. He was initially treated for constipation, but then at 3pm his physical observations deteriorated and he was transferred to the Prince of Wales Hospital. On the 30th October, following numerous clinical investigations at the Prince of Wales Hospital, a liver biopsy resulted in a diagnosis of non-Hodgkin's Lymphoma, stage 4B. Mr Mohamed declined chemotherapy treatment, stating through interpreters that he would leave his fate to God. On the 24th of November, Dr Carol Cheung, Senior Medical Officer at Prince of Wales Hospital, reported that Mr Mohamed was likely to die within a few weeks or months if chemotherapy was not commenced and recommended palliative care. Mr MOHAMED's condition continued to deteriorate and he was also diagnosed with anaemia. The treating team at the Hospital reported that the risks of treatment far outweighed the benefits, and palliative care at Long Bay Hospital was recommended.

On the 2nd of December, Dr Anne Wand at Prince of Wales Hospital completed a Mental Health Assessment and diagnosed Mr Mohamed with delirium. He was deemed to be lacking the capacity to make medical decisions and an application for a guardianship order was made as there was no reasonable Next of Kin available in Australia. Mr Mohamed was transferred back to Long Bay Hospital on the 4th of December to continue receiving palliative care. On the 8th of December, Mr Mohamed received a blood transfusion at Prince of Wales Hospital, before being transferred back to Long Bay Hospital on the 10th of December. On the 11th of December, Mr Mohamed confirmed through an interpreter that he did not wish to be resuscitated if his health deteriorated.

On the 24th of December, a marked deterioration in Mr Mohamed's presentation was recorded by nursing staff. On the 31st of December at 4:32am, nursing staff found Mr Mohamed no longer had a pulse or heartbeat, and had stopped breathing. He was declared deceased.

What caused Mr Mohamed's death?

Based on the post mortem report, and medical records obtained as part of the investigation, it is evident that Mr Mohamed died as a consequence of Hodgkin's Lymphoma.

Care and treatment:

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility. The Corrective Services and Justice Health records reveal Mr Mohamed's care and treatment were appropriate. The Officer in Charge of the Investigation, Inspector Ben Johnson, reached the same conclusion, and wished to raise no issues with the care and treatment afforded to Mr Mohamed.

Conclusion:

I find that Mr Mohamed's death is not suspicious and that he died as a consequence of natural causes. I also find that Mr Mohamed received care and treatment of an appropriate standard whilst in custody.

Findings required by s 81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was Saker Mohamed.

Date of death

Mr Mohamed died on the 31st of December 2015

Place of death

Mr Mohamed died at Long Bay Hospital, 1300 Anzac Parade, Malabar, New South Wales

Cause of death

The cause of death was Hodgkin's Lymphoma

Manner of death

Mr Mohamed died of natural causes whilst serving a custodial sentence.

15. 71814 of 2016

Inquest into the death of Clifford Deas. Finding handed down by Deputy State Coroner Russell on the 22nd March 2018.

At the time of his death Clifford Deas was in custody on remand on a warrant from Port Macquarie Local Court. He had been in custody since 10 December 2015, having been charged with an offence of knowingly contravening a prohibition or restriction in a personal violence order and was said to have breached his bail undertakings. He was, then, within the meaning of section 23 of the *Coroners Act 2009*, in lawful custody. An inquest in such circumstances is mandatory pursuant to section 27(1) of that Act.

Background

Mr. Deas was born on 1 August 1951. He grew up in Padstow and, on finishing school, joined the armed forces. He later worked as a lithographer at Halstead Press in Kingsgrove. In more recent years he had been on a disability pension and had lived with his parents until his mother died in 2006, his father having died in 1995. Mr. Deas lived in Port Macquarie prior to his being taken into custody in 2015.

Health

Mr. Deas had many health problems. On 12 December 2015 he was transferred to the Aged Care Rehabilitation Unit of the Long Bay Hospital and, from there, to the Prince of Wales Hospital Emergency Department. He was suffering arteriosclerotic coronary artery disease, acute myocardial infarction, pneumonia, emphysema, anxiety, hyperlipidaemia and hyperparathyroidism.

On 13 December he was transferred back to the Long Bay Hospital. Mr. Deas was, on a number of other occasions during the time he was in custody, admitted to Prince of Wales Hospital for conditions including cellulitis. He had a large hiatus hernia, previous gastrointestinal bleeding, had TB in 2009 and was normally hyperkalaemic. Mr. Deas had end stage renal failure secondary to IgA nephropathy.

He required haemodialysis 3 times a week and was taken to the Prince of Wales Hospital for that purpose. Mr. Deas was, on numerous occasions, non-compliant with fluid and diet restrictions and would often refuse to continue a dialysis session to completion. On 2 March 2016 Mr. Deas was 15.4kg above his ideal weight before commencing dialysis but completed only 1 ½ hours of a scheduled 5 hour dialysis session after refusing to continue. On 3 March 2016 Mr Deas was 20kg above his ideal weight and had increased swelling because of fluid overloading. Strict fluid restrictions and monitoring were recommenced.

Hours leading up to death

At about 12:30pm on 5 March Mr Deas was found lying on the floor of his cell by corrective services staff. He said that his legs had collapsed underneath him and said he had no pain or injury. At about 2:25 pm Mr Deas was observed lying on his bed resting. At ward checks prior to dinner he was again observed resting on his bed. At about 5:30pm he was given dinner and, at about 6:20pm, his blood pressure was checked and he appeared to be in good spirits. At about 8:30pm he was given his medications and again appeared to be in good spirits.

At about 10:55pm he was located unresponsive on the floor of his cell. CPR was commenced but he could not be revived. Mr Deas' cell was fitted with a cell alarm but he had not activated it.

The cause of death

An autopsy was performed by forensic pathologist, Dr Liliana Schwartz who determined that the direct cause of his death was arteriosclerotic coronary artery and hypertensive heart disease. A significant condition contributing to his death was chronic renal failure (end-stage renal disease).

Mr Deas was 64 years old at the time of his death.

Formal Finding:

Clifford Deas died at Long Bay Hospital Correctional Centre, 1300 Anzac Parade, Malabar, New South Wales on 5 March 2016.

Mr Deas died as a result of arteriosclerotic coronary artery and hypertensive heart disease. A significant condition contributing to his death was chronic renal failure (end-stage renal disease). He died of natural causes.

16. 72079 of 2016

Inquest into the death of Geoffrey Richardson. Finding handed down by Deputy State Coroner Lee at Glebe on the 6th July 2018.

On the evening of 5 March 2016 Sergeant Geoffrey Richardson was on duty at Raymond Terrace police station when he responded to a request for assistance that was broadcast over police radio. The request related to events which were at that time taking place in the central Hunter region where a number of police vehicles were taking part in the pursuit of another vehicle. In the course of responding to the request, Sergeant Richardson was involved in a collision which resulted in him suffering fatal injuries.

Why was an inquest held?

Under the *Coroners Act 2009 (the Act)* a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

Due to the circumstances of Sergeant Richardson's death on 5 March 2016, he was regarded as having died in the course of a police operation. This meant that, according to the relevant section of the Act which applied at the time, an inquest into Sergeant Richardson's death was mandatory. In most cases of deaths which occur in the course of a police operation the person who died is not a police officer. Inquests are mandatory for these types of deaths to ensure that there is an independent and transparent investigation of the circumstances of the death, and the relevant conduct of any of involved police officers. Even though the death of Sergeant Richardson involves the death of a serving police officer, these same principles still apply.

Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

The coronial investigation into the death of a person is one that, by its very nature, occasions grief and trauma to that person's family. The emotional toll that such an investigation, and any resulting inquest, places on the family of a deceased person is enormous. A coronial investigation seeks to identify whether there have been any shortcomings, whether by an individual or an organisation, with respect to any matter connected with a person's death. It seeks to identify shortcomings not for the purpose of assigning blame or fault but, rather, so that lessons can be learnt from such shortcomings and so that, hopefully, these shortcomings are not repeated in the future.

If families must re-live painful and distressing memories that an inquest brings with it then, where possible, there should be hope for some positive outcome. The recommendations made by Coroners are made with the hope that they will lead to some positive outcome by improving general public health and safety.

Sergeant Richardson's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Sergeant Richardson's life.

Sergeant Richardson had completed almost 18 years of dedicated service as a highly-regarded police officer. He commenced training at the police academy in Goulburn in November 1997 and attested from the academy in May 1998. After commencing initial duties at Campbelltown police station in Sydney, Sergeant Richardson later transferred to Cobar police station, before eventually moving to the Central Hunter Local Area Command (**LAC**) in 2010. Within a short time he was promoted to the rank of Sergeant and later became a supervisor within the Lake Macquarie LAC. In July 2015 Sergeant Richardson transferred to the Port Stephens LAC and became a general duties supervisor at Raymond Terrace police station. Sergeant Richardson brought his considerable policing skills to bear throughout the course of his career. These skills earned Sergeant Richardson the respect and admiration of his colleagues and meant that this career was a decorated and distinguished one.

Despite his many professional achievements, Sergeant Richardson's greatest and proudest achievements were most clearly demonstrated within his loving, young family, and in particular his oldest son, Patrick. Sergeant Richardson's wife, Margaret, described her husband as an amazing and doting father, someone who loved and guided Patrick in every aspect of his life, and who was Patrick's best friend. The time they spent together created many lifelong memories, in particular four wheel driving on Stockton beach, which was Patrick's favourite activity. Sergeant Richardson's devotion to his younger son, Aiden, was no less. Sergeant Richardson had planned to take time off from work so that he could spend time with Aiden, to nurture him, and bond with him, just as he had when Patrick was of a similar age. It is therefore most distressing to know that Patrick's time with such a wonderful father was so brief, and that Aiden will never even have the brief time with his father that Patrick had.

At the conclusion of the evidence in the inquest, Sergeant Richardson's wife spoke of how she had lost her life partner, best friend, and deepest love. Sergeant Richardson's father, Graham, also spoke of his beloved son and best mate and the enormous pain caused by the separation from his son. The dignity and strength that they showed in sharing their treasured memories was truly admirable.

What happened on 3 March 2016?

At about 4:00pm on Thursday, 3 March 2016, a white Ford Falcon was seen by police to be travelling at excessive speed on the New England Highway in Lochinvar, heading towards Rutherford. Checks revealed that the vehicle of interest (**VOI**) was bearing registration plates that had been reported as being stolen from a vehicle in Bingleburra, sometime around 14 February 2016. The VOI was directed to stop by a police vehicle, and failed to do so. As a result, the police vehicle commenced pursuing the VOI. During the pursuit the VOI was seen to overtake several vehicles at speed and almost collide with a vehicle at a roundabout in Rutherford. Due to this dangerous manner of driving, the police vehicle disengaged and terminated the pursuit.

Following this, information concerning the last direction that the VOI was seen travelling was broadcast over police radio, also known as **VKG**. Acting Sergeant Anthony Blythe was patrolling the New England Highway at Rutherford at the time in a police vehicle with call sign Central Hunter 14 (**CEH14**). In response to the broadcast, Acting Sergeant Blythe began patrolling the streets of Rutherford in an attempt to locate or intercept the VOI.

At about 4:05pm, Acting Sergeant Blythe saw the VOI travelling in his direction. He noticed that the VOI had three holes in its windscreen which appeared to resemble bullet holes. Acting Sergeant Blythe performed a U-turn and activated the warning lights and sirens of his vehicle. The VOI did not stop and instead accelerated away at speed. Acting Sergeant Blythe commenced pursuing the VOI and saw it drive in excess of the designated 50km/hour speed limit, cross to the incorrect side of the road, and drive over a median strip near other vehicles and a pedestrian. Due to the dangerous driving by the VOI, the pursuit was terminated after about two minutes. Instructions were subsequently broadcast over police radio not to re-engage in a pursuit with the VOI.

What happened on 5 March 2016?

Just before 11:00pm on Saturday, 5 March 2016 Acting Sergeant Blythe was again driving CEH14 along the New England Highway, Rutherford. He saw the VOI approaching him from the opposite direction, recognising it from the three holes in its windscreen. Acting Sergeant Blythe also noticed that the VOI was bearing different registration plates to when he had last seen it two days earlier. Checks revealed that the plates had been reported as stolen from a vehicle parked in East Maitland sometime between about 11:00am and 10:50pm that day.

Acting Sergeant Blythe turned and followed the VOI into Maitland where he activated the warning devices on his vehicle intending to stop the VOI. The VOI did not stop and a pursuit commenced. The initial stages of the pursuit took place in the streets of Maitland. At 11:03pm another police vehicle with call sign North 240 (**NTH240**) advised that they were on their way from Maitland police station to assist. At about 11:04pm, whilst in Louth Park, the VOI slowed and reversed towards Acting Sergeant Blythe's vehicle resulting in some minor damage to the front bumper of CEH14.

The pursuit continued into East Maitland. By this time, NTH240 had travelled to the intersection of Mount Vincent Road and Chisholm Road, East Maitland with the intention of deploying a tyre deflation device (commonly referred to as **road spikes**) to stop the VOI. However, before this could occur, the VOI drove through the intersection. As a consequence of being unable to deploy the road spikes, NTH240 joined the pursuit, following after the VOI and CEH14. A short time later, Acting Sergeant Blythe requested that NTH240 take over the role of primary pursuit vehicle due to the fact that there were two police officers in NTH240 (whereas he was driving alone), and because NTH240 was fitted with in-car video recording equipment.

As a result of NTH240 taking over as primary pursuit vehicle, it was no longer capable of being used to deploy road spikes. Therefore, a request was broadcast over VKG for any other vehicles in the neighbouring commands of Newcastle or Lake Macquarie that may be equipped with road spikes and able to assist.

At this time Sergeant Richardson was on duty at Raymond Terrace Police Station and heard the request for assistance. He informed his superior officer, Inspector Alan Jansen that he had road spikes in his car, call sign Port Stephens 12 (**PTS12**), and was able to assist the pursuit. Inspector Jansen told Sergeant Richardson to travel the “back way”, meaning travelling to East Maitland via Raymond Terrace Road and through Millers Forrest. Inspector Jansen suggested this route, believing that it would increase Sergeant Richardson’s chances of intercepting the pursuit.

At 11:09pm Sergeant Richardson left Raymond Terrace police station in PTS12. He broadcast over VKG that he had road spikes in his vehicle and could travel to East Maitland. Between 11:10pm and 11:21pm the pursuit continued through a number of streets in the Maitland area. At around 11:14pm another police vehicle with call sign **NTH248**, advised VKG that they were equipped with spikes and were travelling from Muswellbrook to assist.

At about 11:21pm the VOI drove into Rebecca Close, Rutherford, a no through road. At this time NTH240 was still the primary pursuit vehicle with CEH14 following as the secondary pursuit vehicle. Two other vehicles, with call signs **CEH186** and **CEH102**, and which had been following the pursuit at a distance to assist if necessary, also followed the VOI into Rebecca Close. The VOI performed a U-turn at the end of the street and drove past the police vehicles back towards the New England Highway. At this time, CEH14 took over as the primary pursuit vehicle again with NTH240 becoming the secondary vehicle. Another police vehicle with call sign **CEH35**, which had responded from Maitland Police Station, also followed the other police vehicles out of Rutherford Close. By this time the pursuit had been running for approximately 20 minutes.

At 11:22pm police vehicle with call sign **NTH268** advised VKG that they were on their way from Heatherbrae to assist with deploying road spikes. Three minutes later at 11:25pm NTH240 once again took over as primary pursuit vehicle with CEH14 as secondary pursuit vehicle. At 11:28pm the pursuit entered Majors Lane at Sawyers Gully before travelling onto Mears Lane at Keinbah, and then onto Barnard Road.

These last two roads are dirt roads which lead into the Werakata National Park in Lovedale. By 11:32pm NTH240 was unable to follow the VOI any further due to the poor condition of the road. CEH14 continued along the road but it could no longer see the VOI and was only following its dust trail. The pursuit was therefore terminated, after it had been running for about 32 minutes. VKG advised that the road where the VOI was last seen travelling would exit at Gibsons Road, Lovedale and requested that a car attend that location.

At this time Sergeant Richardson advised VKG that he would not be able to travel to the location where the VOI was last seen in time. Sergeant Richardson drove past another police vehicle (with call sign **CEH38**) which was parked by the side of the road on Mears Lane, performed a U-turn, and drove back in the opposite direction towards Majors Lane. At 11:33pm Sergeant Richardson made a broadcast over Police radio requesting assistance as to whether he was to turn left or right onto Lovedale Road from Majors Lane. Sergeant Richardson was told to turn left and he later advised VKG that he was travelling along Wine Country Drive at Lovedale. Subsequently, there followed a discussion over VKG amongst a number of the police vehicles as to where the VOI might be next sighted.

At 11:35pm a police vehicle fitted with a mobile automated number plate recognition (**MANPR**) system identified Sergeant Richardson's car at the intersection of Lovedale Road and Brickmans Lane. Two other police vehicles (CEH38 and CEH186) drove past moments later and also sighted Sergeant Richardson's vehicle stopped at the intersection. Other MANPR records later confirmed that at 11:39pm Sergeant Richardson was travelling south on Lovedale Road.

At around this time the VOI was sighted travelling west on Lomas Lane, Nulkaba, with its headlights turned off, and then seen to turn right onto Wine Country Drive, heading north. This sighting was broadcast on VKG which in turn led to an enquiry being made with Sergeant Richardson as to whether he was in the vicinity of the sighting. There was no audible response over VKG from Sergeant Richardson. At 11:40pm the VOI drove past CEH38 and CEH186 which were stopped at the intersection of Lovedale Road and Wine Country Drive. CEH38 followed the VOI along Wine Country Drive, activating its lights and sirens. The VOI did not stop and second pursuit began. CEH38 became the primary pursuit vehicle with CEH186 acting as the secondary pursuit vehicle.

At around this time NTH240 was setting up at a location along Lovedale Road, north of Green Lane, with the intention of deploying road spikes. However, NTH240 soon learnt that the pursuit had already passed Lovedale Road and was continuing on Wine Country Drive. A request was broadcast over VKG for any vehicles with road spikes in the vicinity of Wine Country Drive. Sergeant Richardson responded and indicated that he was setting up road spikes on Wine Country Drive south of Brickmans Lane. However, by this time CEH38 broadcast that the pursuit was continuing north and had passed the intersection of Broke Road and Wine Country Drive. It became evident that Sergeant Richardson was confused about his location because the location that he described does not exist.

At 11:41pm the pursuit continued north on Wine Country Drive past the intersection of Palmers Lane. When the pursuit reached the intersection of Wilderness Road, VKG told Sergeant Richardson that they could not see where Brickmans Lane was.

They enquired whether he was ahead of the pursuit. CEH38 broadcast that Brickmans Lane was far behind the pursuit leading VKG to indicate that there was no point in Sergeant Richardson setting up spikes; instead what was required was a car that was ahead of CEH38 on Wine Country Drive. At 11:45pm the pursuit turned east from Wine Country Drive onto Tuckers Lane, North Rothbury heading towards Greta. As Tuckers Lane is a dirt road, CEH186 disengaged from the pursuit as secondary vehicle due to the dust cloud left by the vehicles which led to poor visibility. At this time it is believed that Sergeant Richardson's vehicle was sighted by civilians travelling north on Lovedale Road, near the intersection of Wilderness Road.

At 11:46pm police vehicle call sign **CEH102** was driving along Lovedale Road in a northeast direction towards the New England Highway. CEH102 stopped at a roundabout on Lovedale Road in Allandale, about 80 metres east of the Hunter Expressway. At this time the police officers in CEH102 saw Sergeant Richardson drive past with warning devices activated and heading in a north east direction on Lovedale Road. Shortly afterwards, Sergeant Richardson drove past a civilian vehicle travelling on Lovedale Road. The vehicle was travelling at about 80km/hour and the vehicle's occupants described Sergeant Richardson's vehicle as pulling away from them. At 11:47pm CEH38 broadcast that they were still on Tuckers Lane at Greta in pursuit of the VOI. At the same time NTH238 advised that they were on Camp Road, setting up road spikes under the Hunter Expressway.

At the same time, Sergeant Richardson was traveling along a straight downhill section of Lovedale Road leading to a sweeping left hand bend. Whilst driving through the bend at speed, Sergeant Richardson failed to negotiate it, causing his vehicle to leave the road and collide with a medium sized tree. About 30 seconds later, CEH102 drove through the bend and sighted Sergeant Richardson's vehicle. The police officers inside CEH102 immediately stopped and went to check on Sergeant Richardson's welfare and call for assistance. Tragically, it was discovered that Sergeant Richardson had suffered catastrophic injuries and was showing no signs of life.

Initial attending paramedics arrived at the collision scene at 12:08am on 6 March 2016. They found that Sergeant Richardson was unresponsive and when defibrillator leads were attached to him there was no sign of any electrical activity in the heart. The paramedics also could find no pulse or respirations, and saw that Sergeant Richardson's pupils were dilated, leading to the conclusion that Sergeant Richardson was deceased. Meanwhile, at 11:48pm, the pursuit was occurring in Greta. It continued onto the New England Highway headed towards Branxton. The VOI was seen with its headlights turned off and overtaking three cars over double unbroken lines. Due the manner of driving displayed by the VOI, NTH240 ceased pursuing, but other police vehicles (NTH248 and CEH186) continued to follow the VOI.

The pursuit continued towards East Branxton. At this time CEH38 sustained damage to its tyres and ceased pursuing. At 11:51pm NTH248 lost sight of the VOI in East Branxton and also ceased pursuing. This resulted in the end of the pursuit.

What was the cause and manner of Sergeant Richardson's death?

Sergeant Richardson was later taken to the Department of Forensic Medicine in Newcastle where Dr Leah Clifton performed a postmortem examination on 8 March 2016. Dr Clifton found that Sergeant Richardson had sustained multiple injuries to the chest, head and limbs which alone or in combination could have resulted in death. She noted that the pattern of injuries was in keeping with those sustained in the blunt force trauma of a motor vehicle collision.

Dr Clifton also noted that there was evidence of ischaemic heart disease with moderately severe coronary artery atherosclerosis in three of the major coronary vessels. However, Dr Clifton found no evidence of an acute cardiac event to suggest that a natural episode was the cause of the collision, noting that this cannot always be demonstrated at autopsy.

Conclusion: The obvious evidence of the collision, the observations of Sergeant Stace at the collision site, and the clinical findings from the postmortem examination all establish that Sergeant Richardson died from multiple injuries as a result of a collision involving a single motor vehicle impacting with a tree.

What were the results of the collision investigation?

Sergeant Peter Stace, an investigator from the Traffic and Highway Control Command, Crash Investigation Unit attended the collision scene at about 2:45am on 6 March 2016 to examine it. Sergeant Stace also undertook a further scene examination on 23 March 2016. In a report dated 18 April 2016 Sergeant Stace concluded that as Sergeant Richardson travelled along a straight and downhill section of Lovedale Road leading to a sweeping left hand bend he was travelling at a speed between 136 and 151 kilometres per hour. This section of Lovedale Road has a designated speed limit of 80 kilometres per hour with advisory signage warning drivers approaching the left hand bend to reduce their speed to 35 kilometres per hour.

Sergeant Stace concluded that Sergeant Richardson, in an attempt to negotiate the bend, began his braking and reaction at a point with insufficient time to stop his vehicle and tyre markings on the road indicate that harsh ABS braking was applied. The inability to brake or negotiate the bend resulted in Sergeant Richardson's vehicle leaving the road and impacting with a post and wire fence before the front driver's side of the vehicle impacted heavily with a medium sized tree causing significant intrusion into the driver's compartment of the vehicle. The vehicle then rotated clockwise, disengaging from the tree, before the passenger side of vehicle impacted with another wooden post before coming to rest.

Ultimately, Sergeant Stace expressed the belief that excessive speed was the major contributing factor to the collision. Sergeant Stace explicitly excluded alcohol, drugs, road, traffic, weather and vehicle conditions as contributing factors.

On 11 March 2016 Senior Constable Ben Wilson, a forensic examiner with the Engineering Investigation Unit examined Sergeant Richardson's vehicle, a Toyota Camry sedan. Senior Constable Wilson concluded that there was no mechanical defect or component failure which may have contributed to the collision occurring.

Conclusion: The mechanical and scene examinations performed following the collision establish that excessive speed was the sole contributing factor to it. The evidence demonstrates that Sergeant Richardson's vehicle was travelling well in excess of the speed limit at a speed which meant that the sweeping left bend could not be negotiated in a safe manner. This resulted in Sergeant Richardson's vehicle leaving the road and caused the consequent high-speed, fatal impact.

What issues did the inquest examine?

As is apparent from the above, the brief of evidence prepared as part of the investigation into the circumstances of Sergeant Richardson's death contained sufficient evidence to establish both the cause and manner of death. However, in reviewing the brief of evidence it became apparent that there were aspects of the two pursuits which took place on 5 March 2016 which were connected with Sergeant Richardson's death.

Many of these aspects were identified in a report dated 11 August 2016 prepared by Sergeant Kris Cooper of the Traffic Policy Section, Traffic & Highway Patrol Command. The report followed a review of: the first pursuit on 5 March 2016 which began with Acting Sergeant Blythe's sighting of the VOI at around 11:00pm and ended at about 11:32pm when police vehicles were no longer able to see or follow the VOI along dirt roads in the Werakata National Park (the first pursuit); and the second pursuit which began at about 11:40pm when the VOI was seen by CEH38 at the intersection of Lovedale Road and Wine Country Road, Lovedale and ended at about 11:51pm in East Branxton when NTH248 lost sight of the VOI (**the second pursuit**). The review was conducted in order to examine the conduct of the police involved and, in particular, whether the NSW Police Force Safe Driving Policy (**SDP**) had been complied with. Part 6 of the SDP specifically governs pursuits. The review and Sergeant Cooper's report established that there were a number of breaches of the SDP, which are relevantly summarised in general terms below:

Firstly, the evidence established that a number of police vehicles were involved in both pursuits without seeking authorisation to do so, and without advising VKG of their involvement. This was a breach of Part 6 of the SDP which provides that no more than two vehicles may become involved in a pursuit unless directed by a suitable supervisory officer. Secondly, the involvement of these vehicles created instances of "street paralleling" where vehicles were travelling parallel to the path of the pursuit. Again, such a practice is contrary to part 6 of the SDP which provides that there is to be no street paralleling unless authorised.

Thirdly, the involvement of vehicles in the pursuit without authorisation also created instances where the vehicles were travelling in convoy behind the VOI. Again, such a practice is a breach of Part 6 of the SDP unless authorisation has been given.

The breaches are relevant because they raised questions as to:

- whether either the first pursuit or the second pursuit should have been terminated at earlier points in time than what in fact occurred;
- whether the pursuits were managed appropriately by those with authority to do so; and
- whether management of the pursuits could be improved in any way.

It should be pointed out that the evidence established that the above issues did not directly cause or contribute to the fatal collision that Sergeant Richardson was involved in, and his subsequent death. As noted above, the sole contributing factor was the excessive speed that Sergeant Richardson's vehicle was travelling at. However, the issues are relevant and connected to Sergeant Richardson's death as they provide a basis to understand the reason why Sergeant Richardson was driving at a high speed, and whether earlier termination of the pursuits might have meant that Sergeant Richardson was no longer required to be involved in them.

Pursuits generally

Once a pursuit is reported, or "called", by a police officer over VKG, that communication over police radio is acknowledged, logged and coordinated by a NSW police communications officer, known as a dispatcher, working in a radio operations centre. A VKG Shift Coordinator on duty in the centre is alerted to the pursuit and attends the terminal where the dispatcher is working in order to monitor and assess the pursuit, and assume overriding control of the pursuit. For pursuits that last longer than five minutes the Duty Operations Inspector (DOI) is required to be notified so as to provide an additional level of oversight and monitoring of the pursuit.

For both pursuits on 5 March 2016, Ms Trudy Taylor was the dispatcher, Sergeant David Stevens was the VKG Shift Coordinator, and Inspector Darren Gregor was the DOI.

How many police vehicles were involved in the pursuits?

The evidence established that at least five police vehicles were involved in the first pursuit and at least three police vehicles were involved in the second pursuit. Other additional police vehicles were also involved in both pursuits although they could not subsequently be identified upon review. Apart from the primary and secondary pursuing vehicles in each pursuit, no other vehicle was authorised to take part in the pursuit. The involvement of the additional unauthorised vehicles created instances of convoying and paralleling.

It is clear from the evidence that Ms Taylor, Sergeant Stevens and Inspector Gregor were all unaware of the involvement of the unauthorised police vehicles. This is because the police vehicles did not broadcast over VKG that they had joined the pursuit, or seek authorisation to do so. This issue is important because the evidence indicates that if those in supervisory role were aware of it, consideration would have been given to earlier termination of the pursuits.

Sergeant Stevens said that he was unaware that there were four or five police vehicles following the VOI. In evidence he said that if he had been aware of this fact he probably would have terminated the first pursuit, particularly if the vehicles were not forthcoming with information and if authorisation had not been given to them. Similarly, Inspector Gregor said in evidence that if he had been aware that police vehicles were engaging in paralleling and convoying he almost certainly would have terminated the pursuits.

Sergeant Cooper was asked about these instances of unauthorised involvement in evidence. He explained that, in general, it was not unusual for unauthorised vehicles to become involved in a pursuit. He acknowledged that there is often a clear difference between understanding the terms of a policy document such as the SDP, and compliance with it. However, Sergeant Cooper explained in evidence that his Command has observed a cultural change to pursuits in general over time so as to reduce instances of unauthorised involvement. Further, Sergeant Cooper explained that the advent of in-car video, revisions to the SDP and panels constituted to review driving incidents have allowed for increased compliance.

Conclusion: The SDP clearly sets out the terms under which police vehicles can become involved in pursuits and what type of driving is prohibited unless authorisation is given. Individual non-compliance with these terms led to a situation on 5 March 2016 where the VKG Shift Coordinator and DOI were unaware of the number of vehicles involved in both pursuits. This lack of awareness resulted in further breaches of the SDP by way of convoying and paralleling of vehicles. Had these breaches been made known to those in supervisory role it is probable that both pursuits would have been terminated. Whilst it appears that such non-compliance is not unusual, generally speaking, the evidence established that there has been a reduction in the overall extent of non-compliance.

When did the first pursuit terminate?

During the course of the inquest it became apparent that there was an issue in relation to precisely when the first pursuit terminated. Once the first pursuit entered the dirt roads of Werakata National Park, both CEH102 and CEH186 ceased their involvement in the pursuit. However, both CEH14 and NTH240 continued to pursue the VOI for a short distance until NTH240 also was forced to stop pursuing due to the poor road conditions. At this time the following broadcast was made over VKG:

NTH240: *North 240 we have terminated we cannot go any further, radio.*

Dispatcher: *Copy, terminated. Last seen on this dirt track, possibly comes out at Gibsons Road at Lovedale for cars that might head in that direction.*

NTH240: *North 240, Central Hunter 14 has managed its way around so it may be able to pick up that vehicle.*

Dispatcher: *Copy that, Central Hunter 14 to advise.*

CEH14: *Yeah, radio, still on Mears Lane, just following dust at the moment, still no sight of the vehicle.*

Dispatcher: *Copy.*

The above broadcast by NTH240 seems to suggest that they had terminated their *individual* involvement in the pursuit. However, the broadcast by NTH240 seems to have been regarded by the VKG dispatcher as a termination of the pursuit *as a whole*. This is supported by the fact that the VKG dispatcher subsequently broadcasted the direction that the VOI was last seen heading. This type of broadcast as to last known direction of travel of a VOI is consistent with training provided to VKG dispatchers as to what to broadcast upon termination of a pursuit.

The VKG broadcasts also indicate that, despite the termination by NTH240, CEH14 continued to follow the dust trail left behind by the VOI. This itself suggests that the pursuit had not terminated and was still continuing, and appears to be consistent with Part 6 of the SDP which provides:

“A pursuit is deemed to continue if you FOLLOW the offending vehicle or continue to attempt to remain in contact with the offending vehicle, whether or not your police vehicle is displaying warning lights or sounding a siren”.

A short time later, the VKG dispatcher requested an update from CEH14. The following exchange took place between Acting Sergeant Blythe and the VKG dispatcher:

CEH14: *Yeah, radio at this stage no, there’s a lot of different tracks in here at the moment, um yeah no longer sight [sic] of the vehicle, or dust.*

Dispatcher: *We’ve lost all sight of the vehicle and we are not even following dust any more for those cars.*

The reference to CEH14 no longer being able to follow the dust trail of the VOI also seems to indicate that the pursuit had been terminated at that point. This is because elsewhere in Part 6 of the SDP a list of factors (such as when danger to the pursuing police or public outweighs the need for immediate apprehension) is set out which will result in the termination of a pursuit. One of the factors noted is when:

“The distance between the pursuing and fleeing vehicle is so great that further pursuit is futile”.

It should also be noted that Part 6 of the SDP also contains the following definition in relation to pursuits:

TERMINATION: *“All vehicles cease to pursue, stop following and return to the legal speed limit. Turn off all warning devices as soon as possible and when safe”.* Acting Sergeant Blythe said in evidence that whilst following the dust trail of the VOI he still considered that he was in pursuit of the VOI under the terms of the SDP. He said that at the same time he was also attempting to find a route out of the National Park. When asked at what point he considered the pursuit to be terminated, Acting Sergeant Blythe indicated it to be at the point that he lost sight of the VOI. He agreed that he did not specifically use the word “terminate” in his VKG broadcast although he said this would be his general practice (having previously taken part in between 10 and 12 pursuits).

He also said that he assumed that by telling VKG that he had lost sight of the VOI they would understand that he had terminated the pursuit. Ms Taylor was asked whether she considered Acting Sergeant Blythe to still be in pursuit when he was following the dust trail. She indicated that she did not believe that he was still in pursuit, although according to the SDP he was, technically, still in pursuit. Ms Taylor was further asked how she knew that the first pursuit had been terminated. She indicated that when Acting Sergeant Blythe informed VKG that he had lost sight of the VOI it meant that the pursuit was over. Ms Taylor was asked whether, in most circumstances, it was her experience that pursuing officers use the word “terminate” to indicate the termination of a pursuit.

Ms Taylor said that in most instances officers will say that they have terminated a pursuit, although it is not unusual for an officer to indicate that they have lost sight of a vehicle. She went on to say that when this is said it is understood that a pursuit has been terminated and that occasionally confirmation will be sought by a dispatcher. Sergeant Stevens said that he assumed that Acting Sergeant Blythe was still pursuing the VOI, including when he was only following the dust trail, until he lost sight of the VOI. He said that a pursuing officer does not always use the word “terminate” and that sometimes it is simply indicated by a pursuing officer that they have lost sight of a VOI, which is by definition a termination of the pursuit.

Conclusion: A review of the VKG recording from 5 March 2106, the relevant terms of the SDP and the evidence given during the course of the inquest gives rise to a degree of ambiguity as to when the first pursuit terminated. The broadcast made by NTH240 terminating its own involvement in the pursuit seems to have been regarded as a termination of the pursuit as a whole, given the subsequent broadcast as to the last known direction of travel of the VOI.

However, the evidence of Acting Sergeant Blythe, Ms Taylor and Sergeant Stevens is that the pursuit had not terminated due to the mere fact of Acting Sergeant Blythe’s actions in following the dust trail left by the VOI. This understanding appears to be in accordance with the SDP which regards a pursuing vehicle attempting to remain in contact with a pursued vehicle as continuation of the pursuit. However, the evidence from Ms Taylor establishes that even though Acting Sergeant Blythe’s actions met the strict definition contained in the SDP, she did not believe the pursuit to be continuing past the point that NTH240 indicated its own disengagement from the pursuit. Again, this is supported by the broadcast made by Ms Taylor as to the last known direction that the VOI was seen to travel.

Further, the SDP itself does not appear to provide a clear and precise definition as to when a pursuit ends. The “definition” of termination referred to above is more akin to an instruction given by a VKG dispatcher, following the termination of a pursuit, for all vehicles to return to driving at the legal speed limit. Interestingly, the evidence established that despite the appearance of this apparent instruction, it is not standard practice for such an instruction to be given by a VKG dispatcher at the termination of a pursuit. Instead of providing a precise definition of termination, the SDP instead sets out a list of factors that may result in the termination of a pursuit. Even though Acting Sergeant Blythe, Ms Taylor and Sergeant Stevens all referred to the loss of the VOI from sight as amounting to termination of the pursuit, losing sight of a VOI is not set out anywhere in the SDP as amounting to termination of a pursuit.

Instead, it may be inferred that loss of sight of a pursued vehicle means that the distance away from it is so great that further pursuit is futile. This is one of the factors referred to in the SDP. Having regard to all of the above, it is evidence that some degree of ambiguity surrounds precisely when a pursuit is terminated, and that there is an absence of an unequivocal definition of the term termination as it relates to pursuits. It should be noted that the current version of the SDP is in the same terms as the version which applied as at March 2016. For these reasons it is desirable that the following recommendation be made:

Recommendation 1: I recommend to the NSW Commissioner of Police that consideration be given to reviewing the current version of the NSW Police Force Safe Driving Policy to ensure that it provides (a) an unequivocal definition of the term “termination” as it relates to pursuits; (b) clear indication as to whether, and in what circumstances, losing sight of a pursued vehicle amounts to termination of a pursuit; and (c) for consistency in language and instructions to police officers in relation to when a pursuit is terminated.

What issues were identified in relation to the beginning of the second pursuit?

At 11:38pm CEH21 made a broadcast of a possible sighting of the VOI leaving the National Park from Lomas Lane, Nukulba onto Wine Country Drive. CEH38 was positioned at the intersection of Wine Country Drive and Lovedale Road. When the VOI passed CEH38 it activated all warning devices but the VOI did not stop and CEH38 broadcast at 11:39pm that it was in pursuit. CEH38 commenced pursuing the VOI, along with NTH248, NTH240 and CEH186.

A period of one minute and 25 seconds elapsed between the first pursuit and the second pursuit. Part 6 of the SDP provides that:

“A pursuit is not to be re-initiated by any other vehicle unless is approval is FIRST granted by a DOI, VKG Supervisor, DO or Supervisor in the field. It must be noted that this approval will only be considered if pertinent information is received which indicates that the circumstances of the pursuit have changed significantly”.

Neither of the police officers in CEH38 sought or obtained permission to re-initiate the pursuit; rather a broadcast was simply made by CEH38 in the following terms: *“Central Hunter 38 in pursuit”*. Ms Taylor said in evidence that she regarded the broadcast by CEH38 as amounting to the commencement of a second pursuit. However, Ms Taylor agreed that at this time she did not follow standard practice by broadcasting the start of pursuit. This standard practice, taught during training, requires a dispatcher to make the following broadcast: *“All cars standby unless urgent. [Call sign] is in pursuit. [Call sign] only go ahead, and keep your locations coming”*. Sergeant Stevens agreed that CEH38 did not seek permission to re-initiate the pursuit. In evidence he was asked how he would normally approve the re-initiation of a pursuit. He explained that it would be his practice to ask a VKG dispatcher to broadcast that no police vehicle is to re-initiate a pursuit without first seeking authority, in accordance with the terms of the SDP.

Sergeant Stevens went on to explain that this was a practice he had observed other VKG Shift Coordinators follow and had adopted it as part of his usual practice since the events of 5 March 2016. Sergeant Stevens concluded by indicating that he was unaware if other VKG Shift Coordinators were also following this practice.

Senior Sergeant Bernard Sloane, the State Coordinator for the Radio Operations Group (whose responsibilities include management the Radio Operations Training Unit), was asked about this issue in evidence. He explained that when a pursuing vehicle terminates a pursuit, VKG dispatchers are taught to acknowledge the termination. Further, he confirmed that unlike the standard broadcast made by a VKG operator at the start of pursuit, there is no equivalent standard broadcast which VKG operators are trained to make at the conclusion of a pursuit. On this basis Senior Sergeant Sloane was asked whether he thought it would be beneficial for such a standard broadcast to be made so as to ensure that there was no ambiguity as to the circumstances in which a pursuit could be re-initiated. Senior Sergeant Sloane said that as part of training provided to VKG Shift Coordinators it is recommended that such a standard broadcast be utilised; however, such a recommendation does not form part of any training provided to VKG dispatchers. Senior Sergeant Sloane acknowledged in evidence that such training would be beneficial.

Conclusion: The commencement of the second pursuit did not comply with the terms of the SDP as approval was neither sought, nor given, prior to its commencement. It is clear that on 5 March 2016 there was no broadcast made on VKG reminding the involved police officers of this requirement. It seems that the adoption of such a practice since 5 March 2016 has been the result of a combination of initiative taken by individual VKG Shift Coordinators and recommendations made to such Coordinators during relevant training.

The adoption of such a practice does not form part of any equivalent training provided to VKG dispatchers. The evidence given by Senior Sergeant Sloane supports a conclusion that such training would be of benefit to VKG dispatchers and to the operation and management of pursuits in general. Consideration of the above issues relating to clearly defining when a pursuit is terminated and what is required before a pursuit can be re-initiated is directly relevant to the manner of Sergeant Richardson's death.

This is because if on 5 March 2016 it had been clearly established over VKG that the first pursuit had ended, and if there had been consideration at that time as to whether approval ought to have been given for the re-initiation of the pursuit, it may have led to the second pursuit not commencing at all. If this had occurred, it means that it is likely that Sergeant Richardson may not have considered it necessary to drive in excess of the designated speed limit in order to reach a point in the pursuit where he was able to usefully deploy road spikes. Of course, it is impossible to know whether this would have been the case or not. The point to be made is not that if the above actions had been taken on 5 March 2016 it would have altered the eventual outcome. Rather, the point is that given that vehicles responding to requests for assistance in relation to pursuits will usually be doing so under urgent duty response (see further below), any approval for the re-initiation of a pursuit should be only be given following an opportunity for careful consideration of all relevant factors.

Having regard to all of the above, it is desirable that the following recommendation be made.

Recommendation 2: I recommend to the NSW Commissioner of Police that consideration be given to the establishment of a standard VKG broadcast at the termination of a pursuit to: (a) confirm the termination of the pursuit; (b) direct involved police officers to cease pursuing and stop following a pursued vehicle, and to return to driving at the legal speed limit; and (c) remind involved police officers of the requirement for approval to be given before a pursuit is re-initiated. I further recommend that the establishment of such a standard VKG broadcast to be incorporated into relevant training packages provided to both VKG Shift Coordinators and VKG dispatchers.

What issues were identified with the management of the pursuits?

The evidence establishes that Sergeant Richardson only had limited familiarity with the geographical area where the pursuits were taking place. At certain points it appears that this led to confusion on his part, and on the parts of the VKG Shift Coordinator and the VKG dispatcher, as to his exact location and how to best utilise him as a resource to assist the pursuit. In this regard the inquest considered issues relating to the use of GPS in police vehicles, the distance that Sergeant Richardson had to travel in response to the request for assistance, and the management of the pursuit in general.

PTS12 was fitted with the mobile Computer Aided Dispatch (**CAD**) system. CAD has its own GPS receiver and is capable of tracking and recording the movements of a vehicle. However, the evidence revealed that the CAD in PTS12 was not activated on 5 March 2016. This meant that the only means of tracking the movements of PTS12 was via radio transmissions, sightings by other police vehicles, and images captured by MANPR systems. The evidence established that applicable NSW Police Force standard operating procedure requires police officers to log in to the CAD when using vehicles fitted with the system. Ms Taylor said that in her experience general duties and highway patrol officers generally complied with these procedures, although this was not universally the case.

The evidence suggested that there was a general degree of non-compliance with these procedures although the extent of non-compliance could not be determined. However, it appears that non-compliance may be due to a number of factors, with the urgency of response to a situation often proving to be a limiting factor. It is not possible to determine the reason why Sergeant Richardson did not log into the CAD within PTS12, although it is likely that the urgency of his travel from Raymond Terrace contributed to it.

Ms Taylor said that it would be greatly beneficial to use both radio communication and GPS to monitor the movement of police vehicles during a pursuit. However she explained that she would not rely solely on GPS due to issues associated with unreliability in areas with weak or no reception and/or satellite signal. Further, Ms Taylor explained that there can sometimes be a delay (due to different refresh rates) between the actual location of a police vehicle and its GPS position shown on a monitor viewed by a VKG dispatcher. This means that radio communication is still required to confirm the location of a police vehicle.

Nonetheless, evidence given at the inquest by Senior Sergeant Terrence Brombey, the Systems Coordinator of the CAD Business Support Unit, established that there is an anticipated future roll out of up to 2,000 CAD units with GPS functionality. This is aimed at improving GPS coverage of available police resources in the field.

Clause 2-3-2 of the Standard Operating Procedures for the Deployment of Tyre Deflation Devices (**the SOP**) provides that deployment officers are to *“ensure that they are able to deploy the Tyre Deflation Device without lateral catch-up, or by travelling lengthy distances, or by overtaking the pursuit. Advise VKG communications operator of approximate time and distance from pursuit/deployment site”*. Further, the SOP requires that VKG will *“ascertain the location of the authorised vehicle and the distance that is required to be travelled to deploy the Tyre Deflation Devices”*.

The evidence established that there was some dispute as to whether the distance that Sergeant Richardson had to travel from Raymond Terrace amounted to a lengthy distance. Sergeant Stevens said that he did not consider the distance that Sergeant Richardson had to travel to be excessive. He explained that this was because the pursuit kept changing directions and that it did not follow one fixed direction. Similarly Inspector Gregor expressed the view that a vehicle travelling from a neighbouring command in a rural area would not be considered to be a lengthy distance.

However Sergeant Cooper said in evidence that the pursuit was fluid and moving in unknown directions and had doubled back on itself. He said that the pursuit was moving away from Sergeant Richardson and that he had not broadcast on VKG that he was providing an urgent duty response. This suggested to Sergeant Cooper that the distance was a lengthy one. Part 6 of the SDP defines urgent duty response as *“duty which has become pressing or demanding prompt action”*. Relevantly, it is noted that police officers providing urgent duty response *“must consider high-speed urgent duty driving as a last resort (refer to the ‘Coded System of Driving’ page 34). It will only be engaged when the gravity and seriousness of the circumstances require such action and there are no other immediate means of responding”*.

The Coded System of Driving (**CSD**) prescribes actions required of drivers engaging in urgent duty. An urgent duty response under the CSD is a *“code red”* response. It requires that officers must advise VKG of the response code and give an estimated time of arrival. It notes that *“by advising VKG of the response an officer is also informing other car crews, duty officer and supervisors of the capacity to respond. This will assist in managing the overall police response to an incident”*.

The evidence established that Sergeant Richardson did not provide VKG with his response code or estimated time and distance from a possible road spikes deployment site. Similarly, Ms Taylor said that she did not ask where Sergeant Richardson was nor seek any information as to the distance he was to travel. She said that she believed that she had not received training by March 2016 (the version of the SOP applicable at the time was published in February 2016, although the requirement had been in the SOP since its inception in 2010) and so she was unaware of this requirement at the time. Similarly, Sergeant Stevens said that at the time he was also unaware of these requirements in the SOP.

In his report, Sergeant Cooper reached the following conclusion:

“Had all the involved officers complied with their requirements it would have become readily apparent to Sergeant Stevens as the VKG Shift Coordinator, and possibly Inspector Gregor as the Duty Operations Inspector, that the response to the pursuit, rather than the pursuit itself, was becoming unmanageable and corrective action could have been taken. This in turn may have influenced the decision making processes surrounding the pursuit itself”.

This was something that Sergeant Stevens was asked about in evidence. He explained that he felt that he had a good grasp of where the pursuit was going, but possibly not as a good grasp in relation to monitoring vehicles other than the primary and secondary pursuit vehicles, and their surroundings. Sergeant Stevens said that he particularly would have liked to have known where vehicles capable of deploying road spikes were travelling from. Despite this, Sergeant Stevens said that he did not find management of the pursuits of 5 March 2016 to be any more difficult than other pursuits, and did not consider the pursuits themselves to be unmanageable.

Conclusion: As the CAD in Sergeant Richardson’s vehicle had not been activated on 5 March 2016, his GPS location was not available to communication officers monitoring the pursuits on screen. Further, the lack of information, both requested and provided, as to how far away Sergeant Richardson was (both in time and distance) from the pursuit was contrary to applicable procedures at the time. This was due in part to the lack of awareness within the radio operations centre of these procedures. However, the evidence established that there is now an increased understanding of the requirements of these procedures by those to whom they apply. Further, it also appears that since the events of March 2016, improvements have allowed for increased GPS coverage of police vehicles. Despite this, limitations with technology means that sole reliance on GPS to monitor police resources is not a feasible option, and that the technology works best in conjunction with radio communication.

It was acknowledged in evidence that greater awareness of vehicles involved in the pursuits and their precise locations, other than the primary and secondary pursuit vehicles, would have been of general assistance to those monitoring and managing the pursuits. However, it is not possible to determine to what degree such assistance might have improved management of the pursuits, nor whether such assistance might have affected Sergeant Richardson’s involvement in the pursuit in a material way. This is because even without this assistance, those monitoring the pursuits had an understanding of where Sergeant Richardson was about six minutes before the collision, and information was provided that he was behind the direction of travel of the second pursuit.

However, one important matter relating to these considerations emerged during the course of Sergeant Cooper’s evidence. He was asked about the training provided to police officers regarding the SDP, and whether such training included testimonials from families of police officers who had died during pursuits. Including such testimonials would serve as a powerful reminder of the risks involved in a pursuit, and that, in accordance with the SDP, high speed urgent duty driving should only be used as a last resort.

Sergeant Cooper referred to similar testimonials being used as part of a conference relating to police officer safety that he had attended in the United States, and expressed an intention to draw on that material in the future. Given this expressed intention, a recommendation in this regard does not appear to be necessary or desirable. To the extent that such testimonials would assist in mitigating the risk to the lives of police officers performing duties in service of the NSW community, such an intention is to be strongly endorsed and commended.

Findings

The findings I make under section 81(1) of the Act are:

Identity

The person who died was Sergeant Geoffrey Richardson.

Date of death

Sergeant Richardson died on 5 March 2016.

Place of death

Sergeant Richardson died at Allandale NSW 2320.

Cause of death

Sergeant Richardson died from multiple injuries.

Manner of death

Sergeant Richardson suffered the multiple injuries whilst on duty, in the course of a police operation, when the police vehicle that he was driving failed to negotiate a sweeping bend, causing it to leave the road and impact with a tree.

17. 87470 of 2016

Inquest into the death of KS. Finding handed down by Deputy State Coroner Lee at Ballina on the 22nd June 2018.

Introduction

On the afternoon of 16 March 2016 KS went to the house of his former partner with a plan to take his own life. Over the subsequent 39 hours KS's loving and supportive family, and a number of police officers, attempted to intervene to protect KS from the risk that he posed to himself, and preserve his life. Despite their best efforts, they were ultimately unable to prevent KS from self-harm.

Why was an inquest held?

Under the *Coroners Act 2009 (the Act)* a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions about the identity of the person who died, when and where they died, and what was the cause and the manner of their death.

At the time of KS's death, he was armed with a firearm. He had used the firearm to discharge two rounds into the floor of a residential house where his former partner lived. In the 39 hours preceding his death, KS had expressed an intention to use the firearm to cause his own death. Tragically, this is what ultimately occurred. During KS's period of crisis a number of police officers attempted to persuade KS to resolve the situation without injury or loss of life; these police officers continued to do so right up until the moment of KS's death. Due to these circumstances KS was regarded as having died in the course of a police operation. This meant that, according to the relevant section of the Act which applied at the time, an inquest into KS's death was mandatory. This mandatory requirement exists to ensure that the actions of police officers involved in operations of the kind that KS found himself in are carefully and independently examined and that the process of examination is a transparent one.

The coronial investigation into the death of a person is one that, by its very nature, occasions grief and trauma to that person's family. The emotional toll that such an investigation, and any resulting inquest, places on the family of a deceased person is enormous. A coronial investigation seeks to identify whether there have been any shortcomings, whether by an individual or an organisation, with respect to any matter connected with a person's death. It seeks to identify shortcomings not for the purpose of assigning blame or fault but, rather, so that hopefully lessons can be learnt from such shortcomings and so that, hopefully, these shortcomings are not repeated in the future. If families must re-live painful and distressing memories that an inquest brings with it then, where possible, there should be hope for some positive outcome.

KS's life

Inquests, and the coronial process, are as much about life as they are about death. Recognising the impact that the death of a person has had on their family can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that a death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge KS's too brief, but important, life.

KS was the third child of G and A. He had two older siblings, SD and KS. At a young age KS was heavily involved in the work of his family's blueberry farm in Caniaba, near South Lismore. KS was an industrious worker and well-respected within his local community. He designed and created many systems to improve the operation of the farm; systems which his father describes as remarkable and which were of great pride to him as a father of such a talented son.

KS's father fondly recalls that his son often took on responsibilities that belied his youth. At the age of 12 KS frequently helped his sister to manage the family's fruit and vegetable shop and often accompanied his father on work trips to Brisbane. At the age of 15 KS began helping to buy stock for the business' customers, something which he continued doing as the years passed. In fact, KS's father said that even many years later he would still receive calls from former customers who remembered KS as a cheeky young boy, always negotiating prices with customers.

The precociousness that KS showed at a young age meant that it came as no surprise to anyone who knew him that he was able to buy his first house at the age of 18. Despite owning his own home KS continued to live with his parents at their farm so that they would not feel alone. The devotion that KS had to his family was apparent from his close relationships with his siblings, in particular Ms D, but probably most obvious from his special bond with his two nephews, Ms D's sons, J and L. Ms D recalls that when L was 18 months old he began experiencing behavioural difficulties. It was at this time that K intervened and took over much of the responsibility for L. The impact of KS's positive influence on L was enormous as Ms D recalls that from that point on L experienced no further issues.

As a devoted uncle KS always went to his sister's house, even if he had been working all night into the early hours of the morning, to help prepare lunch for his nephews and ensure that they had a good lunch for their day ahead. This is but one example of the fact that KS always made time for his nephews even when he himself was busy and had little time. KS patiently helped his nephews with their homework, he taught J how to drive and took him to his school formal, and he taught L how to ride a mini motorcycle which he had bought for him. Indeed, L (who was 10 years old when KS died) describes the day that KS gave the motorcycle to him as the best day of his life. It is distressing to hear of L's profound sadness at the fact that KS will now never be able to take him to his first day of high school, to take him to his school formal, or to teach him how to drive.

It is equally heartbreaking to hear L say that he no longer feels strong in K's absence. L described KS as someone who had a presence that made everyone around him feel safe. In such circumstances it is heartbreaking to know that despite the best efforts of his loving family KS was unable to keep himself safe from harm.

Background to the events of March 2016

In late 2014 KS met AB who had begun working as a picker on the S family farm. After several months KS and Ms B formed a relationship. Prior to this KS had previously had only one serious relationship when he was about 25 years old and which lasted about two years.

Over time, KS have concerns regarding his relationship with Ms B. He believed that his family would not be accepting of him marrying someone who was not of Indian heritage as he was. Due to this belief KS was reluctant to disclose the full nature of his relationship with Ms B to his family and much of it was kept secret by KS. Despite this, and despite KS's concerns about the perceived non-acceptance by his family, it eventually became apparent to KS's family that he was in a relationship. However, even when KS's family enquired about the relationship, KS continued to deny its existence.

The relationship between KS and Ms B can fairly be described as a volatile one. Whilst at times the relationship was loving and affectionate, at other times it was strained. Much of the tension seems to have been caused by KS's desire to keep the relationship private, which in turn meant that he did not want to go out with Ms B and be seen with her in public together. KS would often tell his family that he was with his good friend, JF, when he was in fact with Ms B. Further tension in the relationship arose in around mid-2015 when Ms B fell pregnant to KS. Ms B later decided to terminate the pregnancy as she believed that K was not ready to have a baby. Ultimately, the strain placed on the relationship by these various factors resulted in Ms B ending the relationship in January 2016.

Despite this, KS continued to contact Ms B, usually by text message. The content of the text messages which K sent to Ms B reveals that he was unaccepting of the end of the relationship and sought to renew it on many occasions. However, Ms B maintained that the relationship had ended, that there was no opportunity for reconciliation, and that she wanted to maintain some distance from KS. Unfortunately, KS did not respond well to Ms B's views regarding the end of their relationship and he often sent her text messages conveying his anger, disappointment and frustration at the situation.

In January and February 2016 it was obvious to KS's family that he was struggling to cope with the breakdown of the relationship. Sometime in February 2016 KS spoke to Mr Farquarson about killing himself and said that he had researched different methods to do so. It was also during this time that KS spoke to his sister about the possibility of reconciliation with Ms B and, if that occurred, how that might be perceived by his family. Ms D attempted to reassure KS that his family, and in particular KS's parents, would be accepting of the relationship. Ms D attempted to comfort KS by reminding him that his happiness was of great importance to his family and that the main consideration was whether being with Ms B made KS happy.

Between Sunday, 13 March 2016 and the afternoon of Tuesday 15 March 2016 KS sent Ms B a number of lengthy messages in which he sought to discuss aspects of their past relationship and the possibility of reconciliation. Ms B was largely unresponsive to the messages apart from informing KS that she was not interested in any reconciliation. The last message sent by KS was at 5:38pm on Tuesday, 15 March which Ms B did not respond to. It was not until later that night at 10:21pm that Ms B sent KS an unexpected message which upset him, and he responded by saying, *"I'm as well as one can be about to top emselves (sic)"*. The following morning Ms B apologised to KS for sending the message. Despite the apology it was clear that KS was still struggling to cope with his feelings for Ms B.

Wednesday, 16 March 2016

Throughout the morning and early afternoon of 16 March 2016 KS continued to send a number of text messages to Ms B. The messages continued the past theme of KS seeking reconciliation and asserting that Ms B did not view their relationship with the same degree of importance that KS did. At about 1:55pm KS sent his nephews, L and J, the following group message: *"I love you buddy, thanks for being you! U r both great kids and I had (sic) any part of helping you become the people u r so far then that's something I'm proud of! The rest is up to you"*.

Sometime prior to 2:51pm KS drove to Ms B's home. On the way he actually passed Ms B in her car as she was on her way out with her sister, J. At about 2:51pm KS sent a message to Ms B asking her to come outside, indicating that he was outside her home. Ms B lived at the address with her father, J, and her sister. When Ms B did not immediately reply, KS attempted to call Ms B a number of times between 2:54pm and 2:57pm before eventually sending a message to J who replied by saying that she and Ms B were out and would return home soon.

At 2:57pm KS sent a message to Ms D in which he asked her tell everyone that he was sorry and that he hoped that they would understand how he reached this point in his life. He also thanked his sister and expressed his inability with being able to live with the fact that he had ruined his relationship with Ms B. Finally, KS said that he hated the thought of leaving his loved ones but that life had become too hard and that this was his opportunity to be free.

Ms B and J arrived home at about 3:15pm and saw that KS was standing by his parked vehicle. Ms B invited K inside and asked why he had come to talk to her. Initially Ms B did not notice that anything was amiss but as KS remained at the house he began speaking again about their past relationship. Ms B recalls that on a number of occasions KS said, *"It's really unfair that I have to feel like this and you get to go on with your life"*.

The conversation between KS and Ms B became repetitive, ventilating issues concerning their past relationship that had been raised previously in text messages. At one point Ms B told KS that she had to leave the house soon to attend a prior engagement. By this time, Ms B's sister had left the house. KS left Ms B's room (where much of the conversation had been taking place) for a short time went to his vehicle and re-entered the house.

Ms B subsequently heard some noise coming from the sun room. When she went to investigate Ms B found KS in the room, sitting down and holding a shotgun under his chin. Ms B attempted to persuade KS to put down the shotgun and attempted to take it away from him. As this was occurring KS moved from the sun room to Ms B's bedroom where he again placed the shotgun under his chin. Ms B continued to plead with KS to put the shotgun down. At one point when KS was still in Ms B's bedroom, and Ms B was just outside of her room, KS fired two rounds from the shotgun into the timber floorboards of Ms B's room. Mr B called his daughter at around this time. Ms B told her father to come home immediately and went to the kitchen to wait for him. A short time later Ms B told KS that her father had arrived home but KS remained in Ms B's bedroom and closed the door. Ms B ran from the house, got in her father's car, and they drove away from the scene.

Between 4:20pm and 4:22pm KS sent his sister a number of further messages. Ms D expressed her concern for KS and said that she would come to see him. However, KS initially said that he had not meant to send his message earlier that afternoon, that he had panicked and that he was being silly. However, in later messages KS referred to the fact that he had been mistaken about Ms B giving him a reason to live and made reference to the police arriving soon and it being too late.

The start of the siege

Subsequent events in the chronology took place over a period of some 39 hours. It is not possible to recount in complete detail the occurrences and conversations during this period of time as there were many of them. Instead, what is set out below is a summary of those events most relevant to the issues which the inquest considered. At 4:28pm Mr B called triple 0 and passed on information regarding KS as told to him by Ms B. The first police officers arrived on scene at 4:33pm and established a perimeter. Ms D arrived at the house a short time later. Further police continued to arrive on scene up to about 5:00pm as residents from neighbouring houses were evacuated, and a command post was established at an intersection near Ms B's house. During this time, at about 4:40pm, KS took a photo of himself with the barrel of the shotgun in his mouth.

Initial attending police officers attempted to make contact with KS to ensure that he was safe and well. At 5:05pm Inspector Nicole Bruce, one of the Duty Officers on shift, contacted Northern Region Operations in relation to activating and deploying a tactical and negotiation response.

Detective Senior Constables Steven Hoffman and Tracey Linton arrived on scene at about 5:15pm as members of the negotiation team. Detective Senior Constable Linton knew both KS and Ms D, having previously met them through her past personal dealings associated with the S family farm. At around this time an initial briefing was held between the Duty Officers, Inspectors Nicole Bruce and Susan Johnston, and the State Protection Support Unit (SPSU) Field Supervisor, Detective Sergeant Michael Smith who had also arrived on scene. Other SPSU operatives arrived on scene at 6:08pm and Sergeant Claude Toscan, another member of the negotiation team, arrived at 6:20pm. As Sergeant Toscan was the most senior negotiator on scene he was allocated the role of negotiation Team Leader.

It is important at this point to explain the organisational structure within the command post and regarding the police operation generally. The Duty Officer was designated the role of Forward Commander and bore the ultimate responsibility for all decisions regarding the negotiation.

The Forward Commander received advice from the Negotiation Team Leader in relation to matters concerning negotiation strategy, and from the SPSU Field Supervisor (or Tactical Commander) in relation to any possible tactical response.

The negotiation team itself is usually comprised of four members:

- a Team Leader, responsible for overall team management;
- a Primary Negotiator, responsible for the actual negotiation and intelligence gathering;
- a Secondary Negotiator, responsible for supporting and relieving the Primary Negotiator; and
- a Recorder, responsible for maintaining running sheets and recording functions, and general support.

Shortly after the initial briefing the police within the command post devised a surrender plan at about 6:40pm. This plan contained instructions for KS to leave the firearm inside the house, remove his shirt, exit the front door and walk down the front steps of the house with his hands in the air, obeying the instructions of the police. After establishing a perimeter around the house the attending police made their first attempt to contact KS. This was made at 7:04pm by Detective Senior Constable Hoffman who was acting as Primary Negotiator. After two missed calls, KS answered the third call. He and Detective Senior Constable Hoffman spoke briefly about KS's relationship with Ms B and how it had not gone well.

Detective Senior Constable Hoffman told KS that his family were at the scene however KS responded with words to the effect of, *"You want to get rid of them because they don't want to hear what I'm about to do"*.

During his conversation with Detective Senior Constable Hoffman KS made it clear that he had decided some time ago that he was going to take his own life, that he was not leaving the house, and that he was going to *"finish it off"*. KS ended the call at 7:16pm. For the next 20 minutes, there were numerous calls made to both KS's mobile phone and the landline phone at the house phone, together with a number of text messages sent to KS, as the negotiation team tried to contact him. However, all the calls and text messages went unanswered. During the course of the negotiation, the police activated sirens from a police vehicle, a loudhailer, and a long range acoustic device (**LRAD**) in an attempt gain KS's attention in order to engage him in conversation. At 11:12pm a police armoured response vehicle (**ARV**) arrived on scene.

Negotiators and SPSU operatives moved into the ARV at about 11:30pm and it was positioned in front of the house and parked so that its headlights were directly in line with Ms B's bedroom where KS had remained. The ARV was used so that negotiators and SPSU operatives were able to occupy a position of safety in close proximity to the house.

After initially being unable to make contact with KS, Detective Senior Constable Hoffman was eventually able to have a number of conversations of varying duration with him. Over time, the conversations began to take on a repetitive cycle where KS would speak about leaving the house, then saying that he needed more time, before eventually indicating that he would not be leaving the house and that he would do what he came to do. Both the police and KS recognised the cyclical nature of the conversations, with KS at one point saying, *"We're just going around in circles. We're talking about the same things. I'm not coming out of the house. I need time to think. No matter how many times you ask me to come out of the house, I'm not going to do it. I will only come out if and when I'm ready"*.

Thursday, 17 March 2016

At 12:24am on Thursday, 17 March 2016 Detective Senior Constable Linton took over as Primary Negotiator. It appears that initially Detective Senior Constable Linton was able to make some positive progress with KS as they spoke about getting KS help, KS making changes in his life and thinking about his future. However, by around 1:09am when there was further discussion about the surrender plan, KS remained adamant that he did not want to talk about, or even consider, the plan.

At around 3:30am KS ended one his calls with Detective Senior Constable Linton by saying that he wanted police to enter the house and shoot him. At around this time, Ms D asked police near the command post where she had remained whether she could speak with KS. She indicated that KS had not slept much the previous night and that he would be getting irritable due to his lack of sleep.

Ms D left the scene a short time later to return to the family farm and inform her parents of what was occurring. At around 3:37am Ms D noticed that she had a missed call from KS. She rang KS back and when KS answered he asked Ms D to return to the scene, and mentioned that the use of sirens by the police was irritating him. Ms D asked KS if he wanted to come out and if he would do so. KS indicated that he would come out when he was ready but that every time the police used the siren *"the clock starts again"*. Ms D returned to the scene and informed the police of what KS had said: that he wanted to come out on his own terms but that the clock would restart every time the police attempted to contact KS.

At 3:55am KS said that if the police continued to push him he would do something that would be regrettable. At 4:07am KS told the police that he had the shotgun in his mouth with the safety off. At around 5:00am KS began speaking again about leaving but also continued to ask for more time. By 6:50am no further progress had been made and Detective Senior Constable Linton returned to the command post and passed on duties as Primary Negotiator to a member of the relieving negotiation team.

At 6:56am enquiries were made with Telstra to isolate KS's phone. The purpose of this was to prevent outsider callers from contacting KS and to restrict any incoming calls to his phone to only those made by the negotiators. By 7:53am it was thought that isolation of KS's phone had been completed. KS later realised that there was some difficulty with his phone and the negotiators explained to him what had occurred and that if he surrendered, the isolation would be lifted.

At 7:45am police within the command post began to give consideration to changing the strategy that had been deployed up to that point. This was due to the view that the negotiation had progressed little over the previous night and had again begun to take on a cyclical nature, as referred to above. As a result, contact was made with Detective Chief Inspector Graeme Abel, the Commander of the NSW Police Negotiation Unit at the time, to seek his advice and input. At 8:40am SPSU operatives gave consideration to cutting the power and water supply to the house.

However, by 8:50am it was determined to not cut the power due to the location of the power box at the house (which made it difficult and unsafe to access) and because KS needed to keep his mobile phone charged so that the negotiators could contact him. However, the Forward Commander at the time, Inspector Douglas Connors, later made the decision to cut the water supply to the house.

At 9:19am it was apparent that KS was unhappy with the continued use of the sirens and loudspeaker as he began yelling abuse from the bedroom at the negotiators. At 9:34am DW sent KS a text message. Mr W had known KS's family for more than 15 years and had known KS personally for about 4 years. Mr W also knew Ms B and that she had previously worked on KSI's farm. Mr W, who was aware that the siege was occurring, sent the message to KS without knowledge of KS's predicament. Once Mr W came to realise what was occurring he attempted to persuade KS to relinquish the firearm and leave the house. However, KS told Mr W that whilst he wanted to leave the house, he wanted to do so on his terms and not on the terms set by the police, or because they wanted him to leave.

Mr W also asked if there was anything he could do for KS who replied by telling Mr W that he could tell the police to back off and give him some more time, as he needed to think. Following the call Mr W called Ms D and told him what KS had said regarding asking the police to back off. Ms D confirmed to Mr W that KS had said the same thing to her. When Ms D returned to the command post at around 11:00am she informed police that Mr W had spoken to KS earlier. It was then that the police came to the realisation that the isolation of KS's phone had not been completely effective. When enquiries were made with Telstra the information provided was that due to technical issues not all incoming calls, save for the ones made by negotiators, could be blocked. Rather than blocking all incoming calls, which would have left KS uncontactable to police, Inspector Connors decided to leave the partial isolation in place.

Shortly before 12:00pm the negotiators attempted to speak to KS face-to-face from the bedroom window. However, KSI refused to communicate in this manner and asked for contact to be by phone only. At around the same time KS said that he was not leaving the house and that the police would have to enter the house to reach him.

Shortly after 12:00pm a decision was made to contact Dr Michael Diamond, a consultant psychiatrist who had previously been consulted and provided advice to police in relation to previous incidents of a similar kind. Detective Senior Constable Tony King, the negotiation Team Leader at the time, spoke to Dr Diamond.

At 1:07pm KS dropped his mobile phone out of the window. KS became uncontactable by phone at this time as the isolation of the landline to the house required Telstra to assign the house a new phone number.

As a result there was some face-to-face communication between KS and the negotiators during this period although both sides encountered difficulties being able to hear each other whilst attempting to talk through the open bedroom window. At one point KS told the negotiators that he was not going to kill himself but that instead he would get the police to do so. At around this time, further advice was sought from both Detective Chief Inspector Abel and Dr Diamond in relation to possible ways to overcome the resistance that KS had been demonstrating. As KS appeared closed and stubborn, and did not like talking about his family, the decision was made to take what was described as a more “softly, softly” approach with KS; in other words, to speak with him in a way that would be met with less resistance and to be less direct in attempting to persuade KS to take certain actions.

Part of the advice provided by Dr Diamond was that it might be helpful to police to obtain a recording from Ms B which could then be played to KS. Arrangements were made for this to be done and it was completed by about 6:20pm. However, a decision was later made to not play the recording with Ms B to KS. Just before 8:00pm Mr F arrived at the command post with Ms D. He informed police that he wanted to talk to KS to see whether he would be able to assist the negotiations. With the approval of Sergeant Claude Toscan, the negotiation Team Leader at the time, a recorded message was taken from Mr F and completed at about 9:25pm.

By about 9:45pm Detective Senior Constable Hoffman noticed a difference in KS’s willingness to engage with police compared to when he had last spoken with KS the previous night. Detective Senior Constable Hoffman described KS as relaxed, calm and easy to engage in conversation, and happy to talk about what had happened during the day. Although engaging KS in conversation had become an easier process, the conversations themselves regarding the prospect of leaving the house still retained their cyclical nature as before.

Friday, 18 March 2016

Up to 12:06am Detective Senior Constable Hoffman had some lengthy conversations with KS (one lasting about 20 minutes and another about 50 minutes) and appeared to be making positive progress. KS himself confirmed this to Detective Senior Constable Hoffman, saying that he felt good about where things were going. Further, KS offered to throw some ammunition that he had out the window, in order to demonstrate that he was not a threat to the police.

Detective Senior Constable Hoffman attempted to have KS throw out all the ammunition in his possession but KS declined and indicated that he would throw out all the ammunition except for a single round which he said he was keeping for himself. At 1:16am KS placed four rounds of ammunition in a bag and threw it out the window.

By 2:00am Detective Senior Constable Hoffman noticed that KS was tired and that it would take eight rings before KS would answer the phone. It was Detective Senior Constable Hoffman's intention to only allow KS to have breaks of 10 to 15 minutes between phone calls and he told KS this. KS responded by saying that one of the earlier Primary Negotiators that he had spoken to had told him the same thing.

At around 2:46am KS spoke with Detective Senior Constable Hoffman about throwing his pocket knife out the window which he later did. By this time KS appeared fatigued to Detective Senior Constable Hoffman as he was complaining of being tired and finding it difficult to stand. Detective Senior Constable Hoffman repeatedly asked KS what needed to be done in order to have him leave the house. KS replied by referring to the fact that he needed a "kicker", in other words, something to push him over the edge to convince him to leave the house. Detective Senior Constable Hoffman continued to talk with KS in an attempt to identify the kicker that KS needed. However, KS did not specifically indicate what kicker he needed and continued to tell Detective Senior Constable Hoffman that he needed more time to think about the matter.

After KS initially indicated that he did not want to hear the recording made with Mr F, Detective Senior Constable Hoffman persisted and KS eventually agreed to it being played to him. However, after it was played, KS indicated that the recording did not mean anything and that it had had no effect on him. At about 6:15am a briefing was held at the command post involving, relevantly, Inspector Connors, Inspector Bruce, Sergeant Toscan, and Detective Senior Constable Hoffman. Although Detective Senior Constable Hoffman indicated that he was building rapport with KS he believed that little progress was still being made with respect to persuading KS to leave the house. It was therefore decided to adopt a change of tactics.

Whilst Detective Senior Constable Hoffman was attending the briefing, KS told Senior Constable Peta Erickson, who was acting as Primary Negotiator at the time, that he promised that he would let the police know if he was going to harm himself. He said that he had made the same promise to the other negotiators. At around 6:40am KS again repeated that if he was going to make any decision regarding the next course of events it would be the one that he intended to make when he arrived at the house on Wednesday. In a subsequent conversation, Detective Senior Constable Hoffman said to KS that sunrise was approaching and that perhaps the kicker which KS had mentioned was a number of things taken collectively; that is, the fact that a new day was beginning, that the nearby school would be beginning soon, and that there was still time to attend to paperwork to ensure that KS was brought before a court that day before the weekend.

However, KS remained resistant and said that the only way the situation was going to end was if it was done his way.

He acknowledged that the police had managed to build some rapport with him during the night but reminded them that if he was pushed to make a decision he would simply do what he came to the house to do. At around 7:15am KS indicated that he would leave the house and during a subsequent phone call Detective Senior Constable Hoffman attempted to discuss the terms of the surrender plan with KS. However, during this discussion KS again reverted back to his previous position and said that he was not coming out and that he would do what he came to the house to do. At around this time KS began to question the movements of some of the SPSU operatives. As the negotiators were only wearing light protective gear in the form of bulletproof vests and helmets, each time they moved to and from the ARV a SPSU operative was required to escort them for safety reasons. As this movement was occurring within KS's line of sight it appears that he believed that some unusual activity was occurring.

To the contrary, no order had been issued to any SPSU operative to take any deliberate action. Detective Senior Constable Hoffman attempted to reassure KS by identifying the location of the SPSU operatives and indicating that the situation up to that point had remained unchanged. However, KS remained agitated. He told Detective Senior Constable Hoffman that he had agreed to let the police know if he was going to harm himself, and that this was him letting the police know. Detective Senior Constable Hoffman repeated a number of times that KS needed to stay on the phone and that the police were there to help him and for KS to continue to talk to him. However KS instead thanked Detective Senior Constable Hoffman, told him that he had been good to him, and that he did not need to hear what was about to occur.

At 7:35am a single gunshot was heard by the police followed by a loud thud. Detective Senior Constable Hoffman attempted to ascertain KS's welfare by calling out to him and by calling his phone. However, the phone line was engaged and there was no response. Accordingly, following approval being given, SPSU operatives entered the house at 7:48am and found KS lying on his back in Ms B's bedroom with a significant gunshot wound to the head, and with the shotgun on his chest. Paramedics, who had been on standby outside, entered the house a short time later and confirmed that KS was deceased.

What was the cause of KS's death?

KS was later taken to the Department of Forensic Medicine at Newcastle where a postmortem examination was performed by Dr Rexon Tse on 22 March 2016. Dr Tse found that KS had suffered a single gunshot wound to the head, with the entry point in the mouth, causing significant craniofacial injuries including a burst skull fracture and complete disruption of the brainstem. Dr Tse concluded in his autopsy report dated 21 April 2016 that the cause of death was gunshot wound to the head.

What was the manner of KS's death?

Given the gravity of a finding that a person has intentionally inflicted their own death it is well-established that such a finding cannot be assumed, but must be proved on the available evidence.

Taking into account KS's previous suicidal ideation, the content of his text messages to Ms B, and the totality of his actions and communication with police between 16 and 18 March 2016, I conclude that the evidence is sufficiently clear, cogent and exact to allow a finding to be made that K died as a consequence of actions taken by him with the intention of ending his life.

Issues examined by the inquest

Prior to the start of the inquest a list of issues was circulated to the interested parties, KS's family and the NSW Commissioner of Police. That list identified the following issues:

The negotiation procedure adopted by NSW Police when dealing with KS;

The various negotiation strategies deployed by NSW Police including:

- choice of negotiators;
- isolation of KS's telephone;
- cutting of the water supply;
- limiting of KS's contact with his family and friends;
- the adequacy of information gathering from KS's family and friends;
- continued communication throughout the day and night to bring about a resolution;
- the impeding of KS's ability to sleep;
- decisions concerning whether the tactical team would enter the house; and
- changing tactics and/or placing of pressure on KS.
- The timing and extent to which the Police obtained and/or followed the advice of psychiatrists.

Consideration of each of these issues is set out below.

The negotiation procedure

The NSW Police Force has a principle operating strategy of resolving high risk situations by containment and negotiation. The *Australia New Zealand Guidelines for Deployment of Police to High Risk Situations 2013* identifies that one of the criteria that may be used to define a high risk situation is where there are reasonable grounds to believe that a person may use lethal force, or there is an expressed intention by a person to use lethal force. The NSW Police *Negotiation Unit Management – Operational Guidelines 2011 (the 2011 Guidelines)* provide that the Negotiation Unit is to be used in conjunction with the Tactical Operations Unit in the resolution of high risk situations and that, specifically, police negotiators should be used in any situation where a person is threatening to make an attempt to take their own life.

Negotiation is defined in the guidelines as “*a planned intervention on behalf of the Police Forward Commander to resolve an incident and to achieve a peaceful resolution through the use of skilled communication*”. Containment refers to both physical containment of a subject person, together with aspects of mental containment that may arise as part of the overall strategy.

In evidence Detective Chief Inspector Abel explained that the strategy of containment and negotiation has been used by law enforcement agencies worldwide for many years. He explained that the strategy was adopted in NSW following a number of deaths of persons who were the subjects of siege-like situations, and where more deliberate police action had been used in these situations. Detective Inspector Kirsty Hales, the current Commander of the Negotiation Unit (since December 2016), explained that development of negotiation strategy is not prescriptive and not guided by individual policy or procedures.

Instead, the development of strategy is dependent on the nature of the incident in question, situational awareness, and the aim of the negotiation which is ultimately achieving peaceful resolution of the situation. As such, phone isolation and cutting of the water supply are examples of tools or techniques that may be used to support a negotiation strategy, but are not themselves an actual negotiation strategy. Due to the large number of variables in the factors that may impact on any high-risk situation, the strategies developed are “*infinitely variable*” and there is no checklist which a negotiation team may work through. Detective Chief Inspector Abel explained it succinctly in this way: the negotiation, and any strategy developed as part of it, is focused on the subject person’s agenda, and not on any agenda held by the police.

The evidence established that the negotiation strategy is developed by the negotiation Team Leader in consultation with the negotiation team as part of the overall strategy adopted by the police. Ultimately, the decisions made and the strategy implemented are matters for the Forward Commander, who is also in receipt of advice from the Tactical Commander.

Conclusion: The negotiation strategy employed in KS’s case was one of containment and negotiation. As the incident involving KS was properly regarded as a high-risk incident, it was appropriate for the NSW police to adopt and follow such a strategy. Negotiation with KS was conducted by trained officers from the NSW Police Negotiation Unit. As part of the overall strategy KS was physically contained in the Dalley Street house by use of a cordon of SPSU operatives, and other police, surrounding the premises. It is evident from the conduct of the involved police officers that the strategy of containment and negotiation had an overall objective of achieving peaceful resolution of the incident. Within that overall objective were three aims: ensuring KS’s safety, ensuring the safety of the police officers involved, and ensuring the safety of members of the community.

Choice of primary negotiator

During the evening of 16 March 2016, when negotiations with KS began, there were two trained negotiators available to fulfil the role of Primary Negotiator: Senior Constables Hoffman and Linton.

Sergeant Toscan, the negotiation Team Leader at the time, made the decision to utilise Detective Senior Constable Hoffman as the Primary Negotiator. Sergeant Toscan's decision was examined during the inquest because of two factors: Detective Senior Constable Linton had known KS and his family for about 15 years (even though she had not had any contact with KS in recent years); and Detective Senior Constable Hoffman initially had difficulty building rapport with KS and productively advancing the negotiation; however, this situation improved following Detective Senior Constable subsequently taking the role of Primary Negotiator at 12:24am on 17 March 2016.

Ms D said that when she arrived on the scene she saw Detective Senior Constable Linton and spoke to her. Detective Senior Constable Linton asked Ms D whether she thought KS would feel embarrassed, or whether it would worsen the situation, if she (Detective Senior Constable Linton) spoke to him. Ms D told her not to let anyone who did not know KS talk to him, and that KS would trust Detective Senior Constable Linton and be willing to talk to her.

Given the above it is evident that KS's family have legitimate reasons to query the reason why Detective Senior Constable Linton, who knew KS and who Ms D believed KS would trust, was not used as the initial Primary Negotiator. Sergeant Toscan explained in evidence that his decision was based on the fact that he had worked with Detective Senior Constable Hoffman previously and formed a positive impression of his competency as a negotiator. He described Detective Senior Constable Hoffman as someone who communicated, and built rapport, well with subjects. Further, Sergeant Toscan explained that because of Senior Constable Linton's previous relationship with KS's family, he wanted her to perform the role of gathering information from KS's family. Sergeant Toscan went on to explain that this way, the option to use Senior Constable Linton as the primary negotiator would still be available at a later time. Indeed, this is what ultimately occurred.

During the inquest Detective Chief Inspector Abel was asked whether he thought it was a significant factor for a Primary Negotiator to have a pre-existing relationship with the person who was the subject of a negotiation. He said that in certain instances this might be regarded as an advantage; however, at other times, because of the emotion that may be involved, such a situation may not be beneficial to the overall negotiation. Detective Chief Inspector Abel explained that in such instances a negotiator with no previous personal relationship may be a more suitable option.

At the time of the change of Primary Negotiator, Detective Senior Constable Hoffman had been unsuccessful in building any rapport with KS. Detective Senior Constable Hoffman describes the progress in this way: *"...it felt like my efforts with him weren't, weren't going anywhere. They weren't going backwards but they weren't going forwards"*.

However, once Detective Senior Constable Linton began talking to KS she was able to engage KS into talking about why he had gone to the house and *"within the first five or ten minutes [of talking to KS] she was able to, to get well beyond a point that...[Detective Senior Constable Hoffman] got to within the first few hours"*. It appears that the use of Detective Senior Constable Linton as primary negotiator also proved to be beneficial in the sense that she was able to talk KS out of a critical point when he spoke about being close to taking his own life. At one point KS said that he had placed the firearm in his mouth and was preparing to use it.

However, Detective Senior Constable Linton was able to talk KS through the crisis; KS agreed to take the gun out of his mouth and place the safety on, although he would not agree to unload it. Nonetheless, even though talking to Detective Senior Constable Linton appeared to make KS more comfortable with the strategy utilised by the police, the same pattern that had been occurring with Detective Senior Constable Hoffman still continued until the morning; that is, KS made it very clear that he was a stubborn person and was not coming out of the house until he was ready to.

Conclusion: Detective Senior Constable Linton's previous relationship with, and knowledge of KS, and Ms D's confidence in her ability to gain K's trust, provided a sound basis to potentially consider using her as the initial Primary Negotiator. However the evidence establishes that there was an equally sound basis underlying Sergeant Toscan's decision to use Detective Senior Constable Hoffman in the role instead: he was a competent negotiator, it was thought that Detective Senior Constable Linton's pre-existing relationship with the family would facilitate in gathering information from them, and the option to utilise Detective Senior Constable Linton at a later stage remained available. Further, the evidence established that the advantages and disadvantages that may be occasioned by the use of a negotiator with a pre-existing relationship with a subject can often be finely balanced.

With the benefit of hindsight it is evident that Detective Senior Constable Linton was able to build rapport with KS more successfully than Detective Senior Constable Hoffman. However, despite this, KS maintained his resistance to leaving the house and following the surrender plan. There is no evidence to suggest that the decision to utilise Detective Senior Constable Hoffman over Detective Senior Constable Linton was unreasonable, or that it adversely contributed to the eventual outcome.

Isolation of KS's phone

Inspector Connors and Detective Senior Constable King both explained that isolation of KS's phone was a tool deployed as part of the strategy of containment and negotiation. Detective Senior Constable King explained that its purpose was to ensure that police were able to control the situation at hand and prevent any unwanted distraction.

Inspector Connors said that it was his understanding that a basic principle of any negotiation is to control who communicates with the person the subject of the negotiation. To this extent, KS's phone was isolated so as to allow the police to effectively control the negotiation process. He explained that if KS could make calls to, and receive calls from, persons other than the police this would inhibit the ability of the police to gauge his actions, and their ability to gauge the impact of such external communications.

As an example, Inspector Connors referred to the fact that he was aware that KS and spoken to Ms D in the early hours of the morning on Thursday, 17 March 2016, and following that call KS had become agitated. The command post log records that at 3:30am KS had "*hung up really agitated wants police to go in and shoot him*". During the inquest there was some debate about whether KS's agitation was a product of the call itself, or whether it was related to his reason for calling his sister. This issue will be discussed further below.

Conclusion: The available evidence indicates that the principle of containment and negotiation was a sound strategy to follow in KS's case. It follows from this that in order to fulfil the objective of containment and allow negotiation to occur, there was a need for the police to take control of the situation. One of the means by which this control was taken was to control the channels of communication that were available to KS. On this basis, it is reasonable to conclude that isolation of KS's phone was warranted.

Cutting of the water supply

Inspector Connors explained that the purpose of cutting the water supply was to make KS feel that he was in fact contained, and not merely comfortable inside the house. It was thought that this would, in turn, encourage KS's continued communication with the negotiators and enable the negotiation to work towards a resolution. Inspector Connors acknowledged that there were some safety concerns implicit in denying KS access to water. However, the evidence establishes that KS still had access to other fluids which he could drink for sustenance. Inspector Connors indicated that on one occasion KY appeared at the window drinking a bottle of lemonade.

Conclusion: The decision to cut the water supply to the house that KS was legitimately made in furtherance of the strategy of containment and negotiation.

It formed part of the principle of containment and was used as a means to attempt to focus KS's attention on the result the police were trying to achieve. Any inherent risks to KS's well-being that were associated with such a step being taken were recognised and considered by the police. There is no evidence that this action adversely affected KS's health in any way; to the contrary, it was evident that he still had access to fluids to sustain him following the restriction of water supply.

Third party intervention

KS's immediate family, and in particular Ms D, were present at the scene throughout much of the negotiation. Ms D and KS's parents all indicated that they wanted to talk to KS but were informed that this could not occur. KS's family were aware that messages had been recorded with Ms B and Mr F so that they could be potentially played to KS.

In such circumstances Ms D said that she essentially begged the police to be allowed to make a similar recording to play to KS. However, she said that she was informed that there would be no point in doing so because KS said that he did not want to talk to her. Ms D said she found this difficult to believe because she was the first person that KS rang to ask her to intercede on his behalf.

The question that arises from this evidence is whether sound reasoning was applied to the decision to not accept the offer of KS's family and utilise a member of the family to communicate with him, either directly or indirectly.

The *2011 Guidelines* applicable at the time provided that:

*“Police negotiators should be prepared for the suggestion that a third person can intervene and negotiate on behalf of the negotiating team. **Third person intervention poses considerable risk and must be carefully considered** (original emphasis). Whilst it is still an option in a lot of instances, third party intervention should only be considered and used following: Due consultation with the Commander (or Coordinator) Negotiation Unit; Advice from consulting psychiatrists where appropriate; and Effective assessment and management of potential risks”.*

Detective Chief Inspector Abel was invited to comment on the use of third party intervention generally and:

- explained that the intervention of what are termed civilian negotiators is a topic that has been discussed in crisis negotiation courses worldwide and that *“the general consensus of opinion is that it should not be done without careful consideration and in exceptional circumstances”*;
- described it as a *“high-risk proposition”* and a tactic that is *“generally unsuccessful”*;
- explained that when under stress, third parties often revert to their most comfortable behaviour which is not always conducive to good negotiation and a peaceful resolution;
- said that it should not be assumed that family members have a moderating effect on the level of anger or frustration being experienced by a subject person and explained
- that family members are often under the perception that because of their closeness to the subject they are in a better position than police to understand the problems experienced by the subject and are therefore more likely to resolve the situation;

But that if this were the case then the advice that police have received from psychiatrists and psychologists is that family members would have identified and resolve the problem prior to the subject being in a crisis situation.

In evidence Chief Inspector Abel said further that the question of third party intervention is often raised in many negotiation situations like the one involving KS, which are termed suicide interventions. He said that in general third party intervention is detrimental to an ongoing negotiation, so much so that specific training, including the use of exercises, is conducted, and the opinion of appropriate experts sought, to identify the ways in which a negotiation might be adversely affected.

Sergeant Toscan similarly explained that, from his training and experience, third party intervention can be detrimental to negotiations. He explained that any such intervention means that police do not know the relationship between the parties, have no knowledge of how the subject might feel about the third party, have no control over what is said, and on the whole it makes the situation less controlled for both negotiators and the Forward Commander.

Detective Senior Constable Hoffman was asked whether there was any discussion regarding using a member of KS's family in a recording. He said that this option was considered but he did not consider it to be appropriate because he was aware that KS was agitated after speaking to Ms D early on Thursday morning, and by that stage the negotiation had progressed enough so that the police had an understanding of the reason underlying the situation KS was in. Further, Detective Senior Constable Hoffman said that from his discussions with KS he formed the view that it was KS's perception that he would not be supported by his family and would be ostracised.

From this, Detective Senior Constable Hoffman formed the belief that KS's family were a contributing factor (this is not said critically) to the situation that KS was in and at whilst he would consider an uncomplicated intervention from a friend, he considered a family intervention to be fraught with risk.

Inspector Connors said that he was aware that KS's family were at the scene at 11:00am on Thursday, 17 March 2016 and had asked for an opportunity to speak with KS. He agreed in evidence that there was no absolute prohibition on contact and that the question of contact would always be raised with senior officers from the Negotiation Unit. However, Inspector Connors said that he advised that request made by KS's family would not be accommodated. This is because he said that based on a conversation that Detective Senior Constable Hoffman had had with KS earlier that morning he formed the view that KS was angry with his family and blamed them for the circumstances he was in and the breakdown of his relationship. On this basis, Inspector Connors said that their involvement presented too many risks and he was not prepared to introduce them into the equation.

KS's family have queried the decision not to utilise a family member to speak with KS, either directly, or indirectly via a recording. This is because in their view there was no family disharmony which would have led to any communication from them being adversely received by KS. In support of this KS's family points to:

- the fact that Ms. D had reassured KS prior to 16 March 2016 that his relationship with Ms. B would be accepted (should they reconcile); and
- that KS had intentionally reached out to Ms. D and sought her assistance in intervening on his behalf when he called her early on the morning of Thursday, 17 March 2016.

The evidence established that there was a degree of misapprehension between the police on the one hand, and KS's family, on the other, regarding the above two issues. The view held by the police was that KS's motivation in attending Ms B's house, and him remaining inside the house, was related to his belief of how his relationship with Ms B had been (and potentially would be) viewed. It appears that this view was based on information gathered by police from KS himself and also Ms B.

In relation to KS's agitation following his call to Ms D on 17 March 2016, Detective Senior Constable Hoffman said that he did not understand KS's agitation to be due to the use of sirens but rather to the call itself.

Detective Senior Constable Hoffman said that he received no direct information from the command post as to how the call to S had come about or its content. The evidence established that information between the command post and the negotiation teams in the ARV was usually shared via text message or by using a fourth negotiator. However, this created difficulties with real-time communication.

It should be noted that the negotiation teams did not have the benefit of the command post logs, and those in the command post did not have the benefit of the negotiation logs. Further, the negotiation logs were not updated on 18 March 2016 due to the unavailability of a negotiator to act as a Recorder.

Since KS's death Detective Inspector Hales referred to the fact that in the Negotiation Unit's new Standard Operating Procedures (**SOP**) there are clearer guidelines regarding the documentation and logs that are to be maintained during the course of a negotiation. Further, the SOP provides for the negotiation Team Leader to assume responsibility for accurate record-keeping and the recording of details of conversations. In evidence Commander Hales also referred to use of the police VKG radio system to assist real-time communication as well as provide a permanent record of such communication, along with a computer-based tool which can provide real-time updates (similar to a social media feed) and thereby facilitate the flow of information.

Conclusion: The relevant section of the *2011 Guidelines* applicable to the issue of third party intervention is not rigidly stated. It contemplates consideration being given to, and the actual use of, third party intervention in negotiation situations. Importantly, in KS's case, the evidence established that appropriate consideration was given to third party intervention, and it was actually utilised in the form of the recordings taken from Ms B and Mr F. What is clear from the *2011 Guidelines* is that there is potential risk associated with third party intervention and the potential benefit of intervention must be weighed against such risk.

In the case of intervention by KS's family, it was considered by police that the potential risk outweighed the potential benefit. This consideration was based on a belief that some earlier disharmony within KS's family regarding his relationship with Ms B existed and might cause any intervention to be adversely received by KS. In forming this belief, the police relied on information obtained from Ms B, and from information that Senior Constables Hoffman and Linton elicited from speaking to KS himself.

Whilst KS's family legitimately held a different view regarding such matters, there is no basis to conclude that the belief which Senior Constables Hoffman and Linton held were not genuine; Further, there is also no basis to conclude that their belief was not reasonable based on the information known to them. It appears that the disconnect between the views of KS's family and the belief of the police was due in part to obstacles associated with the facilitation of information between the command post and the negotiators speaking with KS. Due to the close proximity of the negotiators to KS, their need to remain in constant communication with him, and the difficulty associated in physically moving negotiators between the ARV and the command post, the transfer of direct information proved to be problematic.

Further, there were difficulties associated with the documentation of information gathered from KS himself and other sources and reconciling such information. However, the evidence during the inquest established that the new Negotiation Unit SOP has established improved systems for record keeping, and there have been similar technological improvements to assist with the exchange and reconciliation of information between police in the field.

There is no doubt that the desire held by KS's family to intervene and communicate with him was founded on positive intentions, their love for him, immense concern for his welfare, and a belief that such intervention might have made some difference to the eventual outcome. It is of course not possible to reach any conclusion about this and it was difficult and upsetting to hear during the inquest that KS's family feel a sense of remorse in that they believe that they could have done more for him. However it is clear that they did all that they could and supported him in every way possible during his 39 hours of crisis.

Adequacy of information gathering

Ms D said that when police spoke to her on the night of 16 March 2016 they were primarily asking questions relating to whether KS had a previous criminal history, whether he had been to Queensland, whether he had been in trouble with the police before, and where he obtained the firearm from. However Ms D said in evidence that the focus of the police questioning the following night on 17 March 2016 took on a different focus, with greater emphasis in trying to learn about KS's personality and his train of thought.

Overall, Ms D describes the police as being not very responsive to, or interested in, input from KS's family. Further, Ms D said that to her the police seemed surprised that she and her mother had remained near the command post for much of the first night. Ms D also said that she and her parents expressed difficulty in being updated on the evolving situation and that during the night of 17 March 2016 they were asked to leave the command post area.

One of the pieces of information which KS's family felt that it was important for the police to be aware of was the fact that KS had only slept for about three hours during the early hours of 16 March 2016, that is, the morning before he drove to Ms B's house. This is because he had been working late at the farm with Mr F. However, Detective Senior Constable Hoffman said in evidence that he could not recall ever being told this. It is also apparent that none of the police officers in the command post were aware of this either. This issue regarding KS's fatigue as the negotiation unfolded is discussed further below.

Conclusion: It is clear that during the initial stages of the siege the police were focused on gathering information to understand the reason the reason for KS's presence in Ms B's house. Given that the information available to police established that KS was armed with a firearm and had discharged it twice in Ms B's presence, there were legitimate reasons to be concerned about all three aspects of the overall objective of achieving a peaceful resolution of the matter; that is, ensuring the safety of KS, the police officers involved, and the community.

To this end, it is not unexpected that the police sought to gather information about any possible involvement KS may have had with the police and the origin of the firearm. Once this information was obtained and the reasons for KS's presence at the house more clearly understood, the information-gathering necessarily focused on KS's personal relationships and personality.

It has already been noted above that there were some impediments to the gathering and flow of information between the command post and the negotiators. It appears that the lack of awareness of KS's lack of sleep during the night of 15 March 2016 was a result of these impediments. However, again it should again be noted that procedural improvements have been made in this regard.

The perception by KS's family that they were being dismissed and that the police were not receptive to any input which they might have offered is regrettable. Clearly the police were confronted with a dynamic, stressful, and difficult situation and it is not possible on the available evidence to reach any firm conclusion regarding the extent to which the perception held by KS's family translated into reality. However, the mere fact that KS's family held such a perception (and the evidence does not positively confirm that it was unjustified) suggests that possibly greater attention ought to have been given to ensuring that the gathering of information from, and the imparting of updates and information to, KS's family was a more inclusive one.

As will be discussed further below, the evidence during the inquest established that aspects of the events of 16 to 18 March 2016 have been used in the training of police negotiators. Most of this training concerns application of the principles relevant to the strategy of containment and negotiation. However, it seems to me that highlighting and learning from the experience of KS's family in this case would be beneficial to the overall management of similar negotiation situations in the future. I therefore consider it desirable for the following recommendation to be made.

Recommendation: I recommend to the NSW Commissioner of Police that consideration be given to using the experience of KS's family during the events of 16 to 18 March 2016 (with appropriate anonymization, and conditional upon consent being provided by KS's family) in an appropriate case study as part future training packages provided by the NSW Police Negotiation Unit to police negotiators to address the issues of adequate and appropriate information gathering from, and impartation of information to, family members of subject persons involved in a high-risk incident.

Continued communication

During the initial stages of the negotiation KS was not interested in talking to the negotiators at all. The conversations with police were brief, KS frequently terminated the calls, and it reached a point where he stopped answering the calls entirely. This resulted in police going forward to the house and using a loudhailer in an attempt to engage KS face-to-face. In addition to the loudhailer, the evidence established that bursts of a siren from a police vehicle were frequently used to attract KS's attention when there was no response to messages sent, and calls made, by the police. The LRAD was a more extreme method of establishing contact. It appears that it was first deployed at 7:49pm when it was moved from the command post to a position under the house next door to Ms B's house before the arrival of the ARV.

The LRAD was used between 7.49pm and 11:35pm as a loudhailer to get in contact with KS. During the time that the LRAD was used Detective Senior Constable Hoffman did at times make attempts to defuse its use by sending text messages to KS as a prompter before it was used, explaining that it was his preference to speak to KS.

Detective Senior Constable Hoffman said that during the night of 16 March 2016 the conversation was one-sided with police doing most of the talking and KS giving very little back. Therefore Detective Senior Constable Hoffman explained that using the sirens placed “*a little bit of pressure*” on KS by annoying him so that he would be forced to talk to the police. Detective Senior Constable Hoffman explained that even if any eventual conversation was only about how the sirens were annoying KS and why the police were using it, his view was that at the very least its use elicited some sort of response from KS.

The use of the sirens, loudhailer and LRAD was part of the overarching strategy of containment and negotiation. As part of this strategy there was a need for constant communication with KS. Inspector Connors explained that there were three reasons for this:

- to provide for the ability of negotiators to negotiate with KS;
- to ensure that KS was safe and had not harmed himself; and
- to ensure the safety of the community by reducing the likelihood of unpredictable action.

The negotiators in this case acknowledged that constant communication can have the effect of agitating a person. But the view of the negotiators is that constant communication usually leads to resolution. Therefore there is a need to balance the risks associated with its use against the need to give a subject considerable time to reflect on their next actions. It should be noted that in other previous inquests, including the ***Inquest into the deaths arising from the Lindt Café siege*** (May 2017); adverse comment has been made against the police for not attempting to engage constantly with the subject of a siege.

The use of sirens agitated KS and he did not like them. Even though the use of the sirens annoyed KS and he asked to be left alone, the evidence establishes that each time it was used it elicited a response from KS. From there, it allowed police to talk to KS on the phone and confirm that he was well, even though KS frequently ended the call shortly afterwards.

Inspector Connors was asked about the consideration to be given to the fact that constant communication can have the effect of agitating a subject and impede rapport building. Inspector Connors acknowledged the need to strike a balance between adopting strategies to ensure constant communication that would inherently agitate a subject. When asked how those considerations are balanced he said that the critical issue for a suicide negotiation is to pay attention to the language used by a person; that is, although a person may be agitated they may not have made any reference to the fact that if the strategy continued (that is, if the use of sirens and other acoustic devices continued to be used) that this would result in them harming themselves.

Instead, Inspector Conners noted that in response to the use of the sirens, KS only made references to the clock resetting or starting again, and made no reference to being prompted to self-harm. Detective Senior Constable Hoffman was also asked in evidence about whether any consideration was given to the fact that KS was clearly agitated by the use of the sirens. Like Inspector Conners, he explained that the decision regarding when to use the siren is a balancing exercise. He said that the negotiators needed to be in contact with KS in order to progress the situation and work towards a resolution, and that the sirens were not used flippantly; they were used for good reason, depending on the situation at the time.

In this regard, Detective Chief Inspector Abel explained that negotiators are provided with specific training by the distributor of the LRAD as to its use, how to operate it, and its inherent dangers of using it in confined spaces or too close to a subject. Detective Senior Constable Hoffman said that he told KS that he would only allow 10 to 15 minute breaks between calls and explained that this was to ensure that KS was safe and that he had not done anything to harm himself. In response KS said that he was aware of this and had been told the same thing by other negotiators.

Conclusion: There is no evidence to suggest that the sirens, loudhailer and LRAD were used for any other purpose than to encourage KS to remain in communication with the negotiators. These tools were utilised in furtherance of the strategy of containment and negotiation; prompting KS to begin any type of communication created opportunities for that communication to continue with the aim of ultimately resolving the situation. The constant communication also provided confirmation that KS was safe and mitigated the possibility of unexpected and unpredictable actions which may have been detrimental to all concerned. Whilst the use of these tools irritated KS and he did not like them, the evidence establishes that they were utilised only when required. Further, appropriate consideration was given to their use and the possibility of an adverse response from KS was gauged and monitored, thereby mitigating the risk of escalation of the situation.

Impediments to KS's ability to sleep

The evidence established that the police officers involved in this matter had not experienced a protracted negotiation of this kind previously. Detective Chief Inspector Abel was asked whether he considered the duration of 39 hours to be more protracted than normal. He said that because each situation is different there is no timeframe which could be considered as "normal". However, he did indicate that there would likely be a difference of opinion between negotiators in metropolitan areas versus those working in rural areas; the former would be less likely to regard a three day negotiation situation as uncommon. Ultimately Chief Inspector Abel indicated that whilst the length of the negotiation was unusual for the involved officers in KS's case, this did not reflect the position of the NSW Police Force more generally. Nevertheless, the nature of this matter was clearly different to the ordinary experience of the police involved. This in turn raised questions regarding KS's fatigue, whether it impacted upon his decision-making ability, and whether his sleep was intentionally impeded.

It was apparent to Detective Senior Constable Hoffman that by the night of 17 March 2016 KS was very tired and showing signs of increasing fatigue. KS even told Detective Senior Constable Hoffman that he was sleeping in between their conversations. Detective Senior Constable Hoffman said that KS was always given time if he needed it or requested it. On the one hand he said that fatigue was a by-product of the strategy of containment and negotiation; on the other hand, he also said that it was part of a deliberate tactic of mental containment which he thought was a conduit to resolving the situation. When asked why fatigue formed part of such a tactic Detective Senior Constable Hoffman explained that fatigue makes a subject uncomfortable in their environment, forces a subject to talk to police and makes them realise that they need to work with police in order to resolve their current situation. However, Detective Senior Constable Hoffman acknowledged that deprivation of sleep did not form part of any deliberate strategy and that it was simply his own view that it was an element of mental containment.

Further, Detective Senior Constable Hoffman said that although KS was tired he believed that KS was still alert and making rational decisions. Detective Senior Constable Hoffman was asked in evidence whether he had any concerns about the lack of sleep carrying with it an increasing risk of KS's thought processes being impeded. Detective Senior Constable Hoffman responded by explaining that the collective decision within the negotiation team was that the best strategy to progress forward was to engage KS in conversation. Detective Senior Constable Hoffman said that on the morning of 17 March 2016 KS was positive and rational and that there was nothing about his conversations which gave Detective Senior Constable Hoffman any concern about KS's ability to think, comprehend the gravity of the situation, or comprehend what was being discussed.

The issue of KS's increasing fatigue was most relevant to the decision to change tactics on the morning of 18 March 2016. Inspector Connors said that when considering the possibility of a change in tactics he took into account KS's fatigue and sought the advice of Detective Senior Constable Hoffman, Sergeant Toscan and Detective Sergeant Smith. Inspector Connors said that based on their collective advice there was agreement that there was no increased risk to KS and that therefore he considered it worthwhile to change tactics.

Detective Chief Inspector Abel was asked whether sleep deprivation formed part of the training for negotiators. He said that he did not use words "sleep deprivation" and instead referred to the issue in terms of fatigue. He explained that fatigue is a by-product of constant communication in the sense that tiredness may make a subject more accommodating when asked to do something. Detective Chief Inspector Abel expressed the opinion that fatigue was not a contributing factor in KS's case. He referred to previous instances where a subject had given an indication that because of their fatigue there was a risk of self-harm or harm to others. In such situations negotiators would have to re-evaluate the strategy of constant communication and the overall strategy in general.

Conclusion: The evidence establishes that fatigue is a consequence of constant communication and part of the overall negotiation strategy. In KS's case, it was considered that as a by-product it contributed to an aspect of KS's containment and may have facilitated his willingness to accede to the requests from police to comply with the surrender plan and leave the house.

Whilst it is clear that KS was growing increasingly tired as the negotiation progressed, there is no evidence that KS made any request to the police that he be allowed to sleep. There is also no clear basis to conclude that any fatigue which KS was experiencing played a causative role in his decision to self-harm. It is evident that there were a number of factors at play and the evidence of Detective Senior Constable Hoffman and Inspector Connors is that KS was alert at the relevant time, and that the possibility of any increased risk to KS was appropriately considered and monitored.

It is evident that managing KS's fatigue was a balancing exercise and that there would be circumstances where re-evaluation was required if the degree of fatigue inhibited KS's ability to function. However, there is no evidence that such re-evaluation was required.

What the evidence does reveal is that there is no guideline or policy document which addresses fatigue that the subject of a negotiation may be experiencing. It is accepted that, like the overall strategy of containment and negotiation, a prescriptive guideline or policy regarding the potential impact of fatigue as a by-product of constant communication would not be a viable option. However, evidence during the inquest established that expert opinion used in negotiator training can provide guidance in relation to issues such as suicide ideation and drug and alcohol issues, which commonly form part of negotiation situations.

I have considered whether it is necessary or desirable for a recommendation to be made that consideration be given to similar expert opinion being gathered as to how a person's functioning may be affected by fatigue. However in evidence Detective Inspector Hales referred to the fact that the incident involving KS had provided the basis for a scenario which formed part of the SPSU regional training package. In using the scenario to conduct a training exercise, consideration was given to the use of third parties, maintenance of negotiation logs, and also the effects of fatigue. Accordingly, given that the issue of fatigue as a by-product of constant communication has been appropriately addressed in training packages, I conclude that a recommendation is no longer necessary or desirable.

Tactical decision-making

SPSU operatives entering the house where KS was contained would have constituted deliberate action on the part of the police. Such deliberate action could only occur following appropriate approval being given by the Regional Commander. The option to employ deliberate action always remains an available option as part of the overall strategy of containment and negotiation. The evidence established that it was an option which was continually considered. Indeed, Detective Senior Constable King discussed the possibility of exercising this option on the morning of 17 March 2016. Detective Chief Inspector Abel's advice was sought on this issue and he advised against its use.

Detective Sergeant Smith said that the police were prepared to follow the strategy of containment and negotiation for as long as it took to achieve the goal of having KS leave the house safely.

Further, Inspector Connors gave evidence that a directive was issued to the SPSU operatives that even if KS emerged from the house and discharged his firearm, there was to be no engagement if the SPSU operatives were safely in cover, for example with in the ARV. This directive was issued in order to preserve KS's life.

Conclusion: The possibility of deliberate action remained an available option to police throughout the incident. The evidence indicates that it was considered as an option on one occasion but deemed to be unwarranted. There is no evidence to suggest that the change in tactics on the morning of 18 March 2016 (discussed further below) was prompted by a need for some kind of deliberate action. Indeed, the evidence established that to the contrary the strategy of containment and negotiation was to continue for as long as was required. Further, directives had been established to minimise the possibility of deliberate action resulting in any harm to KS.

Changing tactics and/or placing pressure on KS

A briefing was conducted at 6:15am on the morning of Friday, 18 March 2016. The command post log indicates that the Forward Commander, Tactical Commander and negotiation team were present. It records: *"Pros/cons discussed @ escalating...greater emphasis on resolving matter peacefully"*. Further, it also records: *"6:17am Consult Graham Able (sic) in regard to placing emphasis on resolution. GA agreed that tactic to be adopted"*.

Inspector Connors explained that in his view there had been little progress in the negotiation and therefore he sought advice about using the start of a new day as providing the impetus for KS to leave the house. Inspector Connors explained that the change was not so much a change in pressure but a change in emphasis, and said that both Detective Senior Constable Hoffman and Sergeant Toscan agreed with this change. Inspector Connors described it as *"just a slight variation"* of the strategy that had been adopted for the previous 36 hours of the negotiation. He explained that the intention going forward was for the police to be less accommodating to any request that KS might make, and that any request would not be accommodated unless KS indicated his willingness to comply with the surrender plan.

Inspector Connors said it was raised during the briefing whether a change of tactics was likely to increase the risk of self-harm by KS, or harm to the involved police. It was agreed amongst those present that no additional risk was created and Inspector Connors said that Sergeant Toscan had sought advice from Chief Inspector Abel who agreed that it was a suitable tactic to adopt.

Inspector Connors agreed that Dr Diamond was not consulted about the change of tactic. When asked whether any consideration was given to consulting Dr Diamond, Inspector Connors indicated that he was content with the advice he received from Detective Chief Inspector Abel, Detective Senior Constable Hoffman, Sergeant Toscan and Detective Sergeant Smith; he said that their collective wealth of experience was sufficient for him to make an informed judgment regarding what he termed as a slight adjustment in the strategy. Finally, Inspector Connors said that there was no feeling on Friday morning that the matter had to be brought to some resolution.

He said that the surrounding cordon was in place, the nearby school had been closed and that, indeed, additional police resources were making their way to the scene.

Detective Senior Constable Hoffman said in evidence that following the meeting there was not much difference to the strategy that had been used up to that point. He explained that instead of asking KS what the police could do to have him leave the house, the intention was to be more direct by pointing out the collective reasons for him to leave: that it was new day, it was early so that members of the public would not see him leave, that if he left the school could still be opened that day, and that he could be brought before a court and not be bail refused by police over the weekend. Detective Senior Constable Hoffman said that it was thought that the change in tactic probably would not accomplish anything. However, at the same time, it was considered worth trying as it was still felt that despite the rapport that had been built with KS, the negotiation was not progressing in the sense that KS was not leaving the house.

In contrast to some of the above, Detective Chief Inspector Abel said in evidence that he had no recollection of his advice being sought in relation to the proposed change in emphasis on Friday morning. He said that if it had been sought he would have advised that further advice be sought from Dr Diamond. However, ultimately Chief Inspector Abel said that with the benefit of hindsight he would not have done anything differently, nor would he have suggested that anything be done differently.

Conclusion: The difference between Detective Chief Inspector Abel's recollection, on the one hand, and the command post log along with the recollection of Inspector Connors, on the other, cannot be resolved on the available evidence. However, notwithstanding Detective Chief Inspector Abel's opinion, it is clear that the ultimate decision regarding any change in tactics rested with the Forward Commander and not a consulting psychiatrist. That decision appears to have been made following appropriate consideration. There is no evidence to suggest that it was made based on some motivation to resolve the situation according to a defined timeframe. To the contrary it appears to have arisen following the collection of appropriate advice in circumstances where the change to the "softly, softly" approach had yielded little progress (despite the rapport that had been built with him) in the previous 15 hours in terms of persuading KS to leave the house. The evidence indicates that the change in tactics was subtle and involved a shift in emphasis rather than overt pressure being applied to KS and his circumstances. Although neither the command post log nor the negotiator's log contain precise details regarding this shift in emphasis, this deficit in the documentation appears to have been now addressed by the introduction of the new Negotiation Unit SOP.

Advice from psychiatrists

Detective Senior Constable Tony King spoke to Dr Diamond at around 3:05pm on 17 March 2016. He said that the advice from Dr Diamond was that KS had a stubborn personality and that it would be no use pushing him. This correlated with the feedback that the negotiators had provided up until that point in time which indicated that KS was very closed and did not like talking about many topics, particularly about his family.

Therefore the decision was made to take a “softly, softly” approach and to attempt to allow the progress of the matter to appear to be KS’s idea. Dr Diamond had no direct recollection of the events of March 2016. In order to prepare a statement as part of the coronial investigation, Dr Diamond spoke to both Detective Chief Inspector Abel and Detective Senior Constable King, and relied on information provided by them. At the time of the first call from Detective Senior Constable King, Dr Diamond was involved in a patient consultation. He advised the police to back off from the position of suggesting that KS should do something, and to instead broaden the content of the dialogue with him. This was suggested to allow for more open ended dialogue rather than allowing KS to refuse each suggestion made by the negotiators. Secondly, Dr Diamond suggested that a recording could be made with Ms Bancroft in an attempt to encourage KS to resolve the situation peacefully. Later that same afternoon Dr Diamond received a second call from the police during which there was some further discussion regarding the content of the recording with Ms B.

Detective Chief Inspector Abel explained in evidence that over time the Negotiation Unit saw value in using mental health professionals to provide advice regarding negotiation scenarios. Used in this way, advice is obtained from a psychiatrist in relation to aspects of human behaviour. This advice is provided to negotiators, and ultimately the Forward Commander, for their consideration. However, the negotiation remains a police operation and so decisions made regarding it rest ultimately with the Forward Commander and not any psychiatrist.

In evidence Detective Inspector Hales referred to recommendations made following the *Inquest into the deaths arising from the Lindt Café siege* provided for the development of the new SOP to provide guidance regarding the use of psychiatrists in negotiation situations. As part of these changes advice received from psychiatrists is to be clearly documented. Detective Inspector Hales also indicated that the incident involving KS had been reviewed (along with other similar incidents) and it provided the foundation for scenario-based training provided to negotiators during reaccreditation training to ensure that such training is both realistic and relevant.

Conclusion: It is difficult to reach any conclusion regarding the nature of Dr Diamond’s advice on the afternoon of 17 March 2016 due to the paucity of evidence regarding the specifics of what advice was actually given. Similarly it is not possible to speculate as to whether the change in tactics on 18 March 2016 might have been pursued if Dr Diamond’s further opinion had been sought at that time. What is clear is that in each instance the advice provided by Dr Diamond could only be given in his capacity as an expert in the field of human behaviour. He could not give advice regarding the strategy to be deployed by the police; that was always a matter for the Forward Commander on advice from Dr Diamond and others with experience and training in negotiation and tactical operations. What is also clear is that changes that have been made since March 2016 now provide for increased and more informative documentation of advice received from psychiatrists in negotiation situations, and the manner in which such advice is applied to an overall strategy. Such improvements should allow for a clearer and more transparent review of the conduct of such negotiations as a whole.

Findings

Identity

The person who died was KS.

Date of death

KS died on 18 March 2016.

Place of death

KS died at East Lismore NSW 2480.

Cause of death

The cause of KS's death was gunshot wound to the head.

Manner of death

Ks died as a consequence of actions taken by him with the intention of ending life, during the course of a police operation.

18. 94829 of 2016

Inquest into the death Richard John O'Connor. Finding handed down by Deputy State Coroner Grahame at Glebe on the 27th April 2018.

Mr O'Connor died at Prince of Wales Hospital on 27 March 2016, at the age of 76. At that time he was a sentenced prisoner and had been brought to hospital from the Metropolitan Special Programs Centre (MSPC) at Long Bay Correctional Complex for medical treatment and observation. He had a lengthy medical history and was known to have significant and chronic health problems. No issues have been raised in relation to his care or medical treatment.

The role of the coroner

The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death. In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future. This occurs when opportunities for improvement arise in the evidence.

In this case there is no dispute in relation to the identity of Mr O'Connor, or to the date and place of his death. No outstanding questions have been raised in relation to the medical cause of death or in relation to the circumstances surrounding Mr O'Connor's death. However, where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner.

There are sound reasons for holding an inquest in relation to the death of each prisoner who dies in custody in NSW. When a person is detained in custody the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice, it is especially important that the care they receive is of an appropriate standard. Even where the death appears to have been naturally caused, it is essential that any medical treatment provided is reviewed independently and that its quality is carefully assessed. This is particularly true in circumstances such as this where it appears that Mr O'Connor had little or no family support after his entry into custody. At the time of his death Mr O'Connor's level of care should have resembled the care any citizen would expect within the public system in the community.

Section 81 (1) of the *Coroner's Act* (2009) NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of Richard O'Connor.

The inquest

A short inquest was held on 27 April 2018. The officer in charge of the investigation, Detective Senior Constable Joseph Coorey gave evidence and the court considered numerous statements, medical records, photographs and reports.

Background

Mr O'Connor was born on 12 October 1939. He was a high school teacher for about 35 years, working within the Catholic system. He joined the Patrician Brothers for a few years, later marrying and having a family. His marriage broke down and at the time of his arrest in 2014 he was single and living in the Lismore area. It appears that since his arrest he had no contact with his children or grandchildren. His sister was noted as his official next of kin on records held by Corrective Services NSW. However, she did not visit him or know of any family member who did.

In 2014, Mr O'Connor was charged with 55 offences relating to child sexual and indecent assault. He was convicted of a number of offences at Lismore District Court on 9 October 2015 and sentenced to ten years imprisonment, backdated to his entry into custody on 5 August 2014. There was a non parole period of six years and six months.

Medical history

Mr O'Connor had a long history of cardiac issues. In the 1980s he had suffered infective endocarditis and had required a valve replacement. He had ongoing atrial fibrillation and was managed in the community with medication.

Mr O'Connor had attempted suicide after being charged with the sexual offences and had been briefly admitted to the Lismore Base Hospital. He was later diagnosed with having an adjustment disorder with mixed anxiety and depression.

On his entry into custody, Mr O'Connor's health needs were fully assessed. I have had the opportunity to review his contact with Justice Health and have had access to their records. Mr O'Connor's pre-existing conditions were well documented and medications he had commenced in the community were continued. During his time in custody Mr O'Connor was seen regularly by medical staff for minor injuries, medication review and monitoring. He required and received a variety of mobility aids and age related equipment. He received attention in relation to his mental health issues.

It is clear that Mr O'Connor's health deteriorated over time and that his mobility was further impaired. Mr O'Connor's respiratory function decreased towards the end of 2015. He had significant weight loss and decreased tolerance for exercise. In 2015 he was seen by both a respiratory specialist and a cardiologist for review.

Admission to Prince of Wales

On 17 March 2016, Mr O'Connor suffered an unwitnessed fall in his cell resulting in a grazed elbow. He presented himself the following day to the Aged Care Clinic with shortness of breath and an increased heart rate. He declined to go to hospital.

On 20 March 2016, he was found to be suffering from significant respiratory difficulties and he was conveyed to the Prince of Wales Hospital.

On 26 March 2016, Mr O'Connor entered a palliative pathway and his next of kin was notified. A non-resuscitation direction was discussed and signed. Just before midnight on 27 March 2016, Mr O'Connor was observed to have stopped breathing. A doctor attended and he was certified as deceased in the early hours of 28 March 2016. His death was not unexpected by medical staff who had already diagnosed severe heart failure.

The autopsy

A limited autopsy was conducted on 30 March 2016 by Dr Bernard l'Ons at the Department of Forensic Medicine, Sydney. Records obtained from the Prince of Wales Hospital indicated that Mr O'Connor had a history of congestive cardiac failure, aortic valve replacement, atrial fibrillation, asthma, chronic venous insufficiency, hypercholesterolaemia, hypertension, depression and lymphoedema. A whole body CT scan revealed significant coronary artery calcification and an aortic valve replacement, which was consistent with the medical notes provided. The forensic pathologist found that the cause of death was consistent with congestive cardiac failure. The forensic pathologist noted a background of previous aortic valve replacement, atrial fibrillation, and hypercholesterolaemia.

Findings

The findings I make under section 81(1) of the Act are,

Identity

The person who died was Richard John O'Connor

Date of death

He died on 28 March 2016

Place of death

He died at the Prince of Wales Hospital, Randwick, NSW.

Cause of death

He died as a result of congestive cardiac failure.

Manner of death

Mr O'Connor died of natural causes. No issues were raised in relation to the quality of his medical care.

19. 149781 of 2016

Inquest into the death of Ian Douglas Davidson. Finding handed down by Deputy State Coroner O’Sullivan at Glebe on the 18th July 2018.

Introduction

Mr. Ian Davidson was 84 years old at the time of his death on 14 May 2016. He was an inmate at the Metropolitan Remand and Reception Centre, Silverwater. At the time of his death, Mr. Davidson was awaiting transport to the Aged Care Rehabilitation Unit at Long Bay Gaol Hospital.

As Mr Davidson was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the *Coroners Act 2009* (NSW).

The role of the Coroner

When a person’s death is reported to the coroner, there is an obligation on the coroner to investigate the death. The role of a coroner, as set out in s81 of the *Coroner’s Act 2009* (NSW), is to make findings as to the identity of the person who died, when they died, where they died, and the cause and manner of their death. If any of these questions cannot be answered then a coroner must hold an inquest.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the *Coroners Act 2009* (NSW) makes an inquest mandatory in cases where a person dies whilst in lawful custody. A coronial investigation and inquest seeks to examine the circumstances surrounding that person’s death to ensure that the State adequately discharges its responsibility. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

The Inquest

A short inquest was held on 18 July 2018. The officer in charge of the investigation, Detective Sergeant Andrew Tesoriero, gave evidence and the brief of evidence was tendered.

The Evidence

Background:

There is little information regarding Mr Davidson’s life. It is known he was born in 1931, never married and had no children. A friend advised Police he may have had an estranged sister living in Brisbane, however Police were not able to locate her. It is known that Mr Davidson worked as a school teacher during the 1950’ and 60’s. Around 1957 he was employed as a school teacher in

Armidale NSW. He then went on to be employed as the Resident Master of the Sydney Grammar Preparatory School at St Ives around 1962.

Mr Davidson's power of attorney advised Mr Davidson had a brief period of employment at Dunlop, though there are no details about this. Mr Davidson was convicted of serious child sex offences committed against young boys in his care whilst he was a school teacher. In 1956, he was charged with 6 counts of indecent assault on a male at Armidale. He received a 5-year good behaviour bond.

In 1987, he was charged with stealing and fraud offences. He received a fine. In 1990 he was charged with numerous further fraud related offences. He was sentenced to 12 months periodic detention at Malabar Periodic Detention Centre and ordered to pay compensation of just over \$20,000.

In January 2015, Mr Davidson was charged with a range of child sex offences dating from 1962-1963 when he was employed at Sydney Grammar Preparatory School. The offences included Buggery and Indecent Assault on young boys under his care. Mr Davidson was elderly and in poor health at the time of this arrest and charge. He was not remanded in custody whilst he awaited his trial. He was residing in an aged care facility at Surry Hills at the time.

Mr Davidson faced trial in April 2016 at the Downing Centre District Court. He was ultimately convicted on 1 count of buggery and 8 counts of indecent assault. He was sentenced to imprisonment for 7 years commencing 29 April 2016. He was due for release on parole in April 2019. After being sentenced on 29 April 2016, Mr Davidson was immediately taken from the court into the custody of Corrective Services NSW to serve his term of imprisonment. He was taken to the Downing Centre Court Cells where an initial assessment was undertaken by Correctives Services staff.

The New Inmate Lodgement & Special Instruction Sheet dated 29 April 2016 notes that Mr. Davidson had "Hepatitis B, Diabetes, [and] Bowel Cancer". The lodgement sheet also states that these issues required review by Justice Health on reception. Other observations recorded were that Mr. Davidson "[could] not walk well, needs nappies and constant meds".

Justice Health Registered Nurse Anna Grigore assessed Mr Davidson, and indicated Mr Davidson required attention at the medical clinic prior to review by a general practitioner within the prison network. Mr Davidson's insulin and medications were administered and he was transferred to the Metropolitan Remand and Reception Centre (MRRRC). It was noted Mr Davidson's medications included medication for previous heart failure. Mr Davidson was seen at the MRRRC by Justice Health nurses where Mr Davidson's extensive health issues were documented. Given his frailty and health issues, Mr Davidson was housed in a cell within the medical clinic area of the gaol.

Whilst housed at the MRRRC clinic, Mr. Davidson was assessed for admission to the Aged Care Rehabilitation Unit (ACRU), located within Long Bay Gaol Hospital. The assessment also included a Basic Aged Care Assessment.

On 12 May 2016, the Corrective Services Aged Care Bed Demand Committee (ACBDC) met and determined that a bed would be made available for Mr. Davidson at the ACRU, Long Bay Hospital.

An application for a Medical Certificate Consideration for Special Transport was approved by the Executive Director of Clinical Operations, Custodial Health and faxed to the Nursing Unit Manager at the MRRC clinic. On 13 May 2016, the Executive Director of Clinical Operations, Custodial Health emailed the medical certificate to officers attached to the Court Escort Security Unit (CESU) who are responsible for the transport of prisoners. The medical certificate recommended Mr. Davidson be transported by van, rather than the standard prison truck. There was a breakdown in communication, as staff from the Court Escort Unit provided statements indicated they were not aware of the email from Executive Director of Clinical Operations. In any event, Correctives Officer's made attempts to have Mr. Davidson transferred by van, to be told that no vans were available at the time. The decision was made to transfer Mr. Davidson to Long Bay Gaol Hospital via the standard prison truck.

The Fatal Incident:

About 12:30pm on 13 May 2016, Mr. Davidson was being escorted from the clinic at the MRRC to the intake area where he was placed into a cell to await transport. Correctional officers escorting Mr. Davidson stated that he appeared to be having no difficulties with his mobility, only that his movements were slow. About 8.30pm, Mr. Davidson, was removed from the intake cell and escorted to the prison truck which had arrived to transport him and other prisoners to various correctional facilities.

It was apparent Correctional Officers appreciated the fragility of Mr. Davidson. He was given access to his wheeled walking frame and given assistance in entering the prison truck. There is no evidence Mr. Davidson objected. CCTV footage showed another inmate using a walking stick to enter the truck prior to Mr. Davidson. Mr. Davidson attempted to board the truck. However, due to his frailty, Mr. Davidson could not step up the 44cm required to enter the truck. Correctives officers and other inmates already on the truck tried to assist Mr. Davidson.

Mr. Davidson sat on the top step of the truck which led to the holding area on the truck. Correctives Officers instructed Mr. Davidson to place his hands by his sides, his feet on the step below then to shuffle backwards using his legs and arms at the same time. Mr. Davidson could do this for a short distance. He tried to repeat the process, however complained of not feeling well. Almost immediately, his face lost colour, his head rolled back and he lost consciousness.

Medical assistance and an ambulance was immediately call for. First aid was rendered by Correctives staff. Justice Health staff arrived, and assisted with first aid. Mr. Davidson was lifted from the rear of the prison truck and placed on the ground. First aid was continued. A pulse could not be detected and a defibrillator was used to restart Mr. Davidson's heart. CPR was performed by Correctives and Justice Health staff prior to the arrival of NSW Ambulance. About 8.55pm an Ambulance arrived and paramedics treated Mr. Davidson. He was eventually stabilised and taken to Westmead Hospital. Ambulance officers described Mr. Davidson as being blue in colour with ineffective breathing.

Mr. Davidson arrived at Westmead Hospital at 9.35pm and had an irregular heart rhythm. Defibrillation and medication was used to rectify this. Mr. Davidson underwent blood tests, a chest X ray and a brain CT scan.

All investigations suggested a cardiac arrest. A likely diagnosis of cardiogenic shock due to ischaemic cardiomyopathy was made and he was admitted under the care of the on-call cardiologist, Dr David Tannous. Dr Tannous and Senior Staff Specialist in Emergency Medicine, Dr Dayamathy Jeganathan determined that a heart operation was unlikely to be beneficial given Mr. Davidson's history of cardiac disease, and prolonged CPR. The decision was made that if Mr. Davidson's medical condition was to decline further, medical intervention was not appropriate.

Mr. Davidson did not recover and his condition declined. He died around 3.35am on the 14th May. He was formally declared deceased by Dr Prabeen Dulal.

Autopsy:

Forensic Pathologist, Rebecca Irvine conducted the autopsy. She found the direct cause of death to be "Complications of hypertensive and atherosclerotic cardiovascular disease".

Police and CSNSW Investigation

Police were notified of the death and attended shortly after. Specialist investigators from the NSW Police Corrective Service Investigative Unit investigated. Specialist forensic police attended the hospital and examined Mr Davidson. No evidence was found suggesting foul play. Staff from Corrective Services, Justice Health and NSW Ambulance were spoken to. CCTV footage of Mr Davidson's collapse was reviewed and tendered as part of the brief of evidence. Medical, health and prison records were reviewed which revealed nothing untoward. Corrective Services NSW also conducted its own internal investigation and review, which highlighted a number of areas for improvement. The suitability of Mr Davidson's planned transport to Long Bay.

Questions arose as to the suitability of Mr Davidson being transported via the regular prison truck, rather than a van, to Long Bay. A critical review of this and other issues was undertaken by Corrective Services NSW. A statement from Terry Murrell, General Manager, State-wide Operations, Custodial Corrections Branch of Corrective Services NSW was tendered as part of the brief. Mr Murrell outlines new protocols have been put in place for prisoners, such as Mr Davidson, who require special transport needs due to their frailty, ill health or disability. These protocols outline that where Justice Health assesses an inmate to be transported as having special medical needs and requiring special transport needs, a medical certificate outlining alternate transport needs will be issued.

The medical certificate is then provided to the Coordinator of the CSNSW Court Escort Security Unit (CESU) who is required to update the computerised Offender Integrated Management System with the details of the certificate. A computerised 'alert' for the specific inmate is also required to be created. Further, the Coordinator of the Court Escort Unit is also required to complete a 'Special Transport Package', consisting of a 'Special Transport Arrangements Form, a 'Special Arrangements

Checklist', a copy of the Justice Health issued medical certificate and a copy of the OIMS alert which gives the special transport advice.

The Correctives Officer in Charge of transporting a group of prisoners is required to check the OIMS for any alert or special instructions prior to transporting any inmates. If a van or car is required to transport an inmate, Justice Health of State-wide Disability Services is then contacted for authorisation and advice. I am satisfied that the requirement for the Coordinator of CESU to be notified and for the Coordinator to update OIMS with an alert for an inmates' special transport needs will help address the communication breakdown which occurred in Mr Davidson's case.

The removal of medical equipment used to administer medication to Mr. Davidson whilst in Westmead Hospital

Two matters became apparent upon post mortem examination of Mr Davidson's body. Pathologists at the Department of Forensic Medicine require all medical equipment on the body of a deceased person to be left in place when that person is transported to the morgue. This is for evidentiary reasons and can assist pathologists in determining a cause of death. In Mr Davidson's case, medical equipment used at Westmead Hospital had been removed prior to his body being delivered to the morgue. This equipment included containers of medicine which had been attached to intravenous lines inserted into Mr Davidson. The intravenous lines had been left in situ, however the associated containers of medicine had been discarded by nurses at Westmead Hospital.

Kate Hackett, the Director of Nursing and Midwifery at Westmead Hospital provided a statement which forms part of the brief. Ms Hackett indicated that the nurses in question thought that the medication within these containers needed to be disposed of prior to the body leaving the hospital. Certain medications are required to be disposed of after someone dies. The exceptions are deaths reported to the Coroner.

This misunderstanding has since been rectified by Westmead Hospital. The nurses involved have been counselled regarding this issue and an Emergency Department Newsletter distributed in February 2018 included a reminder of the requirements to leave medical equipment in situ where deaths are to be reported to the Coroner. Further, Ms Hackett indicates that Westmead Hospital Emergency Department and Hospital training resources have been updated to cover this issue. I am satisfied that these actions address the breakdown in procedure which occurred in this case.

The fentanyl syringe

A syringe used to administer fentanyl was attached to Mr Davidson upon his delivery to Glebe morgue. The syringe did not contain the amount of fentanyl expected to be left, given the dosage and frequency prescribed to Mr Davidson. The pathologist expected to find about 8mls of fentanyl left in the syringe attached to his body, however the syringe was empty. Ms Hackett explained that upon Mr Davidson's death, nurses at Westmead Hospital discarded the fentanyl due to the misunderstanding of protocol described earlier. Ms Hackett stated that the nurses in question have been counselled.

Further, Ms Hackett provided that Westmead Hospital "Care of the Deceased" Resource Folders have been updated to reflect the requirement for medical apparatus to be left in situ upon a deceased persons body for matters which are to be reported to the coroner. These folders have been distributed to units throughout the hospital. I am satisfied that these actions address the breakdown in procedure which occurred in Mr Davidson's case.

Are there any other issues to investigate?

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility. CCTV footage, records from Justice Health and Corrective Services have been reviewed. There is no evidence to suggest Mr Davidson was assaulted or deliberately injured prior to his death. There is no evidence to suggest that any person directly contributed to his collapse and cardiac arrest at the MRRC or his subsequent death at Westmead Hospital.

The gaol and health records reveal Mr Davidson's care and treatment was appropriate.

Conclusion

Mr Davidson's death is not suspicious and he died of a natural cause process. Mr Davidson received health care of an appropriate standard whilst in custody. I do not find that any action or inaction by Corrective Services or Justice Health contributed to Mr Davidson's death. Given Mr Davidson's age and health issues and his deterioration whilst in hospital, it does not appear that anything could have reasonably been done to prevent Mr Davidson's death.

Findings required by s81(1)

After considering all the documentary evidence and the oral evidence heard at the inquest, I make the following findings under s81(1) of the Act:

The identity of the deceased:

The deceased person was Ian Davidson.

Date of death:

He died on 14 May 2016.

Place of death:

He died at Westmead Hospital, Westmead, NSW.

Cause of death:

He died as a result of complications of hypertensive and atherosclerotic cardiovascular disease.

Manner of death:

Mr Davidson died of natural causes whilst serving a custodial sentence.

20. 151275 of 2016

Inquest into the death of Scott Bowden. Finding handed down by Deputy State Coroner Ryan at Glebe on the 19th July 2018

Introduction

Shortly after midnight on 17 May 2016 Scott Bowden aged 51 years died on the road between Casino and Coraki in northern NSW. Mr Bowden was riding his motor cycle home from work when it collided with a cow which had escaped onto the road. Mr Bowden lost control of his motor cycle and was thrown onto the road, then impacted with the front of a stationary police vehicle. Police immediately rendered assistance and called an ambulance, but Mr Bowden died on the way to hospital.

Because Mr Bowden's death occurred in the course of a police operation, an inquest must be held, pursuant to sections 23 and 27 of the Act.

The role of the Coroner

Pursuant to section 81 of the Act, the Coroner must make findings as to the date and place of a person's death, and the cause and manner of death. In addition the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Mr. Bowden's life

Mr Bowden was born on 31 May 1964. He is survived by his adult son and daughter, Patterson and Shylah. At the time of his death Mr Bowden had just commenced a new job as a night cleaner at the Northern Co-operative Meat Company Ltd at Casino. His supervisor, Cory Cameron, said he was doing a good job and seemed to be enjoying his work.

The autopsy report

The autopsy performed by forensic pathologist Dr Brian Beer found Mr Bowden had died from multiple injuries which were mainly in his chest region. He had suffered fractures to his ribs, sternum, clavicle and scapula, collapsed left and right lungs, and a haemothorax.

The accident site

The fatal collision took place on the Casino-Coraki Road, about 21 km from Mr Bowden's workplace in Casino and 10kms from his home in Coraki. The Casino-Coraki Road is the main road between the two towns. It runs roughly east-west, with a single carriageway each way and a posted speed limit of 100 kmh. Mr Bowden was travelling eastwards towards his home in Coraki. Not far to the west of the accident site there is a small bridge called Willox Bridge. The road rises to a crest at this point, then descends eastwards in a straight line for about 680m. It was on the straight section that the accident occurred. Near the collision site on the northern side of the road is a farm property which had been owned for many years by Mrs Joan Monaghan.

The property is about 300 acres and is bordered on its southern side by the Casino-Coraki Road and on its northern side by the Richmond River. Since 2011 Mrs Monaghan had agisted her land to Jasen Somerville for the use of his Hereford brand cattle. Mr Somerville is a stock and station agent and auctioneer, who also has his own business buying, breeding and selling cattle. Under their agistment agreement Mr Somerville was responsible for keeping all boundary fences in a reasonable state of repair. Mrs Monaghan's property was fenced along its boundary with the Casino-Coraki Road, with the exception of a rectangular area at its eastern end which contained cattleyards. The cattleyard was fenced on its three sides which adjoined Mrs Monaghan's property, but not on its side which fronted the road. At the time, Mrs Monaghan employed Christopher Mortimer on a casual basis to carry out farm work, building and lawn mowing.

The accident

At about 11.45pm on the night of the accident a member of the public reported to police that cattle were wandering on a stretch of the road near Willox Bridge. There had been other reports of straying cattle in this area, as will be seen below. Senior Constable Daniel Tagg and Senior Constable Matthew Bailey, both stationed at Casino Police Station, were tasked with going to the site and making it safe for the public. SC Tagg drove them there in a marked four wheel drive police vehicle. That night it was dry, with moderate to heavy fog blanketing sections of the road. Witnesses described the fog as so thick in parts that visibility was restricted to just fifty metres.

At about 12.02am the two police officers encountered a group of cows on the side of the road, heading slowly eastward. This was on the straight section of road to the east of the crest of Willox Bridge. SC Bailey recalled the cows were brown with cream markings. As the police vehicle approached, one cow broke away from the group and ran eastwards. SC Tagg drove slowly in its wake. The police officers saw the lights of a small house off the road about 100 metres ahead, and decided to enquire if the cattle belonged to that property. A young woman at the house told them she thought they belonged to someone in town. The police officers then drove back onto the Casino-Coraki Road, turning right in the direction of Casino. SC Tagg re-activated a number of sets of lights on their vehicle. These were the headlights, a set of red and blue lights which flashed at the front of the car, a set of lights mounted on the car's roof which flashed in 360 degrees, and the car's alley lights which illuminated the two sides of the car.

Almost immediately they re-encountered the group of cows, now moving westward on the northern side of the road. SC Tagg drove very slowly after them, keeping them off the road, while he and SC Tagg searched for a suitable place in which to pen them. While still on the straight section of the road the officers saw the glow of a single light advancing eastwards from the other side of the crest. Once over the crest it materialised into the single headlight of a motor cycle. SC Tagg flashed their highbeam lights to warn the rider to slow down, but the motor cycle did not appear to do so. SC Tagg did not activate their siren for fear of startling the cattle.

Suddenly one of the cows stepped out onto the roadway. Almost immediately the rider and motor cycle collided with the cow's head or neck area. The rider, Mr Bowden, was thrown into the air and fell heavily onto the roadway, sliding forward before impacting the front driver's wheel of the stationary police vehicle.

The motor cycle continued to skid past the police car and came to a halt 20-25 metres behind it. SC Tagg immediately radioed for an ambulance while SC Bailey got out and tried to give assistance to Mr Bowden. In order for SC Bailey to access him, SC Tagg had to reverse the police vehicle half a metre. SC Tagg then got out with a torch to warn any approaching traffic.

At this time Mr Bowden was breathing but unconscious, recovering consciousness only for brief periods while they waited for the ambulance. On route to Lismore Base Hospital Mr Bowden suffered a cardiac arrest as a result of his injuries. He failed to respond to CPR and on arrival at the hospital he was declared deceased. Very soon afterwards officers of the Ballina Crash Investigation Unit attended the accident scene. Mr Paul Cowles, a Regulation Ranger employed by Richmond Shire Council, also attended. About 30-40 metres east of the site he encountered six brown and white cows on the northern side of the road. Using his vehicle Mr Cowles herded them into a paddock about 20 metres further east.

The next morning Mr Cowles inspected the boundary fences along the roadway. He saw flattened grass and cow manure near the road outside the cattleyards, at the eastern end of Mrs Monaghan's property. He concluded the escaped cattle had got out from that area. He also noted damage to the fence between the cattleyards and the paddock immediately to the west of it, which also fronts the road. This is part of the property agisted to Mr Somerville. I will refer to this paddock as 'the front paddock'.

Reports of cattle on the road

Prior to the fatal accident there had been persistent reports of cattle on sections of the road close to the accident site. On the morning of 16 May at about 8.00am Mrs Monaghan's casual employee Chris Mortimer saw five Hereford cows on the road outside the cattleyards. He checked the fences of the nearest paddock, which is the one I have called 'the front paddock'. Mr Mortimer saw damage to the front paddock's fence bordering the roadway, as well as damage to the front paddock's western fence. He also noticed that a gate to a paddock behind the front paddock, which he called 'the lagoon paddock', was bent and was not closing properly.

Mr Mortimer herded the five Herefords into the lagoon paddock and did his best to close the bent gate. He then fixed the wire on the western fence of the front paddock, so the cows could not get into the front paddock and from there onto the road via its broken roadside fence. When he finished work at about 1pm he saw the Herefords were still in the lagoon paddock. The next morning, which was the morning after the accident, Mr Mortimer noticed further damage to the fence between the front paddock and the lagoon paddock. In addition to Mr Mortimer's sighting of cows on the road, the farm owner across the road from Mrs Monaghan told Mr Cowles he had seen cattle on the road on the days prior to the accident. He had not reported this to police or to the Council.

At 6.45pm on 16 May, just hours before the fatal accident, Mr Cowles had himself spent time patrolling the area, following another report of cattle on the road about ten minutes west of Coraki. It was very foggy and Mr Cowles did not see any cows on the road. The following night there was yet another report of cattle on the road near the accident site.

The cow found in Mr. McCormack's herd

Mr James McCormack and his brother run cattle on a property located approximately 500 metres west of the accident site. Like Mrs Monaghan's, their property fronts onto the Casino-Coraki Road.

On the morning of 18 May 2016 Mr McCormack noticed a section of their boundary fence which was damaged, with flattened grass in front. He then saw a cow in their paddocks which did not belong to their herd. It was a Hereford cow with a yellow ear tag, and it was injured with a bleeding nose. The McCormacks do not keep Hereford cattle.

Mr McCormack notified the police and then rang Mr Jasen Somerville, who as I have mentioned keeps his herd of Hereford cows on Mrs Monaghan's property. Mr McCormack said: *'They tell me you own the cattle that was involved in the accident'*. Mr Somerville replied: *'That's what they're telling me'*. Mr McCormack then said: *'I have found a Hereford with a yellow tag in with mine'*. Mr Somerville said he would come over later that day after the cattle sales and have a look. Mr McCormack put the Hereford cow into a small yard on his property.

Later that day Mr McCormack learnt that the cow was still in his yard, and rang Mr Somerville again. Mr Somerville told him he'd been held up at work and would come the following day. The next day Mr McCormack's brother informed him the cow was no longer on their property. Neither of the McCormacks are aware of how the cow came to leave or be removed.

Prior to the removal of the injured cow, SC Gerry Kemp came to the McCormack property and examined it as part of the police investigation into the fatal accident. SC Kemp noted the cow was brown and cream in colouring. There was congealed blood on its nostrils and bloodstains on both sides of its face. In addition it had suffered a large laceration on its upper lip and several teeth had been dislodged. The cow had no other injuries and SC Kemp observed it was able to jump over a 1.8m fence to rejoin the McCormack herd.

At the inquest Mr Somerville denied that the cow found in Mr McCormack's herd belonged to him. He also denied collecting it from Mr McCormack, or arranging for anyone else to do so. Mr Somerville told the Court he recalled Mr McCormack ringing him to say he had one of his cows on his property, and that he himself *'might have said'* he would come and sort it out after work. He thought it possible Mr McCormack rang him again the following day to ask why he hadn't come as arranged.

In his evidence Mr Somerville acknowledged he had never told Mr McCormack the cow was not his. He also claimed that he took no steps at all to establish if in fact it was his. The only explanation he could offer for his inactivity was that he assumed the cow would make its own way back to his herd.

Issues at the inquest

The evidence establishes that Mr Scott Bowden died soon after midnight on 17 May 2016 on the way to Lismore Base Hospital. His death was caused by multiple injuries mainly to his chest, which he received when the motor cycle he was riding collided with a cow on the road.

The inquest focused on questions related to the manner of Mr Bowden's death. These were:

- -who owned the cow involved in the accident?
- -how did the cow come to be on the roadway?
- -was Mr. Bowden travelling at excessive speed for the road conditions?
- -did the police take appropriate action in response to the report that cows were on the road, including steps to warn Mr. Bowden and other road users about the risk?

Who owned the cow involved in the accident?

The evidence enables a finding on the balance of probabilities that the injured Hereford cow found in Mr McCormack's herd was the cow with which Mr Bowden's motor cycle collided.

SC Bailey recalled that the cow involved in the accident was brown with cream markings, as was the injured cow. The injured cow was found at a place and time proximate to that of the accident: that is, on a property about half a kilometre from the accident site, accessible via the Casino-Coraki Road, and on the day following the accident. Furthermore its injuries are not inconsistent with those which might be expected from the collision: both police officers described the motor cycle impacting with the cow's head and neck area.

The evidence enables the further finding on the balance of probabilities that the injured cow belonged to Mr Somerville's herd. Counsel Assisting acknowledged it could not be stated with complete certainty that this was the case: there was no direct evidence of ownership of the injured cow, as its yellow ear tag could only be traced to a sale which had occurred several years prior the accident, and in a different part of NSW.

Nevertheless, and for the reasons given below, I accept the submissions of Counsel Assisting and those made on behalf of the family, that the evidence is sufficient to find on the balance of probabilities that the injured cow did belong to Mr Somerville.

The injured cow is of the same breed as those kept by Mr Somerville. In addition Mr McCormack's property is geographically proximate to the property on which Mr Somerville kept his herd. There is also ample evidence that around the time of the accident Mrs Monaghan's boundary fences were damaged enabling livestock to escape onto the roadway. Mr Somerville's evidence that so far as he was aware the boundary fences were stock-proof is contradicted by the careful observations of Mr Mortimer and Mr Cowles, who each found sections of damage in areas that would enable Mr Somerville's cattle to get onto the roadway.

Mr Somerville's evidence at the inquest denying ownership of the injured cow was confused and frankly implausible.

He gave contradictory evidence as to whether or not his cattle had yellow ear tags, at first stating they did not and then modifying this to say that his cattle's yellow ear tags had the initials 'JAS' on them. He could not offer any credible explanation to support his assertion that he had taken no action to recover the cow from Mr McCormack. One explanation may have been that he did not believe the cow to have been his, yet he did not assert this to Mr McCormack at the time, nor did he offer this to the Court when pressed for an explanation for his inactivity. Instead he stated that he had got too busy at work to make time to examine the cow; and later in his evidence, that he presumed the cow would make its own way back to his herd. The latter explanation undercuts his assertion that the cow did not belong to him, while the former is implausible in light of his acknowledgement that its value would have been at least \$800.

In submissions on behalf of Mr Somerville, Mr Cochrane suggested a further explanation for Mr Somerville's inactivity in relation to the injured cow: that inspecting the cow might have been construed as an implied admission of ownership. This submission is rejected as pure speculation in circumstances where Mr Somerville himself gave no evidence of this as an explanation.

What are the circumstances that led to the cow being on the road?

There is ample evidence of damage to the boundary fences and gates on Mrs Monaghan's property, of a kind which would have allowed cattle to escape from the property. Furthermore there is ample evidence that cattle had escaped onto the roadway in the period before and after the fatal accident. The sightings of straying cattle all occurred in areas geographically proximate to the Monaghan property. I note further the observations of Mr Cowles of a damaged fence line, flattened grass and cow manure at the eastern end of the Monaghan property, causing him to conclude that cattle had escaped from that point.

The above evidence enables a finding on the balance of probabilities that the cow involved in the fatal accident had escaped onto the road as a result of damage to the fences of the property on which it was kept. An issue was raised at the inquest as to who was responsible for maintaining the fences at the Monaghan property. The agreement between Mrs Monaghan and Mr Somerville states that Mr Somerville was responsible for maintaining the boundary fences '*in a reasonable state of repair*'.

However this issue is of marginal relevance to the inquest, which so far as the circumstances of Mr Bowden's death is concerned, has established that the cow involved in the accident most likely escaped onto the road as a result of damaged fences. It is no part of the coronial function to inquire into issues of civil liability and whether Mr Somerville's maintenance of his fences had exposed him to such liability.

Was Mr. Bowden travelling at excessive speed for the conditions?

In their evidence to the inquest Senior Constables Tagg and Bailey both described the motor cycle as approaching them '*at speed*'. In his interview SC Tagg stated he thought Mr Bowden had been travelling in excess of 100 kph, but he acknowledged he couldn't be accurate about this.

The Court had the benefit of an expert statement from SC Mark Fogarty, who is attached to the Far North Coast Crash Investigation Unit. He and his team attended the accident site and among other investigations, attempted to provide an estimate of the speed at which Mr Bowden's motor cycle had been travelling at the time of its impact with the cow. SC Fogarty was able to conclude only that it would have been moving at a speed above, but not less than 71 kph.

The Court did not have the benefit of any expert evidence that travelling at a speed of at least 71 kph in the conditions that prevailed was excessive. I make no finding as to whether at the time of the impact Mr Bowden was travelling at excessive speed for the conditions.

- **Did the police officers take appropriate action in response to the report that cows were on the road, including steps to warn Mr. Bowden and other road users about the risk?**

Counsel for the NSW Commissioner of Police informed the Court that no specific policies exist regarding police procedures for managing strayed livestock. The Court was however directed to a draft set of Straying Stock Procedures, which was authorised by Assistant Commissioner Geoff McKechnie in February 2015. The procedures remain in draft form only and have not been ratified. As such they can provide only limited guidance to the inquest on this issue.

According to its foreword, this document is designed to assist officers in clarifying their roles and responsibilities when they are tasked with managing escaped livestock. Police are to take initial responsibility for controlling traffic and locating the owner of the stock so that vehicles do not collide with the animals. Among other steps, attending police are to manage traffic and remain at the scene until an Impounding Authority (in this case the Richmond Shire Council, whose Regulation Rangers have the power to impound cattle) has secured or removed the stock from the roadway.

Having carefully considered the evidence I am of the view that the police response and conduct in relation to the strayed stock cannot be criticised. Officers Tagg and Bailey were faced with a difficult situation. The hazard to road users represented by the moving stock was a dynamic one which would have been very difficult for two police officers to contain. In the circumstances they were required to use initiative and remain flexible in their response.

Counsel representing Mr Somerville suggested to officers Tagg and Bailey that they might have done more to warn Mr Bowden and other road users of the presence of the cattle. In my view however the measures taken by the officers were reasonable. Fog and darkness reduced the capacity for oncoming traffic to see the cows ahead. Officers Tagg and Bailey utilised all available resources to alert approaching traffic, ensuring that the headlights, roof mounted lights and alley lights of their police vehicle were activated. SC Tagg also flashed his highbeam lights as soon as he became aware of Mr Bowden's approach. He was perplexed when the motor cycle did not appear to slow down.

Counsel for Mr Somerville also suggested that by going to the farmhouse to make enquiries about the cows' ownership, the officers may not have complied with the draft document's injunctive not to leave the scene until Council rangers had secured the stock. I note however that the draft document also requires police to take steps to locate the owner of strayed stock.

In the circumstances of there being only one police vehicle, it is difficult to see how they could have complied with this step without temporarily leaving the cattle's location. With the benefit of hindsight it is usually possible to identify other steps that might have been taken in an emergency situation. In the present case however I am satisfied that the conduct of officers Tagg and Bailey was reasonable and appropriate, and that they did all they could in the circumstances to prevent this tragic death.

Conclusion

I accept the submission of Counsel Assisting that this is not a matter where any recommendations in relation to public health and safety would be appropriate. It was suggested by Counsel for the Bowden family that increased Regulation Ranger resources in the area may reduce the risk of further such fatal accidents. While this may be the case, I did not hear any evidence on this question and therefore am not in a position to consider it as a recommendation.

I hope that this inquest has provided Mr Bowden's son and daughter with some answers to their questions about their father's death, and that they will accept the sincere sympathy of all at the NSW Coroner's Court.

Identity

The person who died was Scott John Bowden, born on 31 May 1964.

Date of death

Scott Bowden died on 17 May 2016.

Place of death

Scott Bowden died at Coraki NSW on the way to Lismore Base Hospital.

Cause of death

Scott Bowden died of multiple injuries mainly to the chest.

Manner of death

Scott Bowden died in the course of a police operation, after his motor cycle accidentally collided with a cow.

21. 199540 of 2016

Inquest into the death of Peter Woodcroft. Finding handed down by Deputy State Coroner O’Sullivan at Glebe on 2nd May 2018

Introduction

Peter Bernard Woodcroft was born on 6 September 1937, and he was 78 when he died on 30 June 2016. He was at his home at 4.32am that morning when he suffered a medical emergency and called Triple Zero. Although police were notified of the call, it took them almost 4 hours to attend Mr Woodcroft’s property, where they found him deceased.

As Mr Woodcroft died in the course of police operations, an inquest is required to be held pursuant to ss. 23(c) and 27(1)(b) of the *Coroners Act 2009* (NSW) (“the Act”).

- **The nature of an inquest;**
- **The role of a Coroner, as set out in s.81 of the Act, is to make findings as to:**
 - **the identity of the deceased;**
 - **the date and place of the person’s death;**
 - **the physical or medical cause of death; and**
- **the manner of death, in other words, the circumstances surrounding the death.**

There is no controversy about Mr Woodcroft’s identity, or about the date and place of his death. As to the cause of death, the available medical evidence suggests that the most likely causes were either sudden heart failure or an arrhythmia. Accordingly, the focus of the inquest was on the manner of death, and in particular the actions taken by emergency services following Mr Woodcroft’s call to Triple Zero.

A secondary purpose of an inquest is to determine whether it is necessary or desirable to make any recommendations in relation to any matter connected with the death, including in relation to matters of public health and safety.

The Facts

Background

Mr Woodcroft was born and raised in Randwick. He was a twin, although his brother died aged 40 of a heart attack. During his working life he was employed by Trans Australia Airlines.

He was also a keen sportsman. As a young man in the 1950s he played for Coogee Rugby League Football Club and he later became an official with the NSW Professional Runners Association.

In the early 1960s he married Maria Eirth and they had three children, Anthony, Victoria and James. The couple divorced in the 1970s although Mr Woodcroft continued to live with the family off and on over the years. In the 1990s he moved to a unit at 1707, 1 Phillip Street, Waterloo. That property is also known as Turanga, it is a high-rise block housing mostly elderly public housing tenants.

Mr Woodcroft suffered from poor health. He had been exposed to asbestos during his life and had also smoked and drank heavily from his teens through to his fifties. The family also report a downturn in his health following an assault he suffered in his early 70s. His GP records that he had Chronic Obstructive Pulmonary Disease, emphysema, pulmonary fibrosis, atrial fibrillation, congestive heart failure (leading to non-ST elevation myocardial infarction and angioplasty in 2013), hypertension, peptic ulcer disease, anaemia and benign prostatic hyperplasia, osteoporosis and chronic renal failure.

From about 2014 Mr Woodcroft's health was reviewed by Dr Jankelson, a respiratory specialist, A/Professor Holloway, a cardiologist, and Dr Yuen, an urologist. He also had home visits from Clinical Nurse Specialist Cate McClary, a respiratory specialist. Her role was to support patients to manage their conditions at home and to try to minimise the presentations to hospital. She visited him about 4 times from November 2015.

As a result of his poor health, Mr Woodcroft made 11 calls to Triple Zero in the three years to March 2016.

During each of those 11 previous calls, Mr Woodcroft stated he was having chest pains or breathing problems. Each of those calls was diverted to NSW Ambulance Service and Mr Woodcroft was taken by ambulance to St Vincent's Hospital. On six occasions, including the penultimate time he called Triple Zero in March 2016, it was also recorded that he had "difficulty speaking between breaths".

These previous calls were not known to any of the people who responded to Mr Woodcroft's final call to Triple Zero. The information was held by NSW Ambulance, which was not contacted until after Mr Woodcroft's body had been discovered. As will be discussed, they are a striking feature of this case, and one that was explored in the evidence. This was in particular to discover what impact this information might have had on the course of events, if it had been known to those involved in the response.

Contact with Mr Woodcroft prior to his death

On 21 June 2016 Nurse McClary visited Mr Woodcroft for the final time. He told her he was feeling well, and she confirmed this in her observations that day and by weighing him and testing his respiratory function. However, Mr Woodcroft admitted to her that he had not been taking his Frusemide or Lasix medication. This is a diuretic medication used to reduce fluid retention. A build-up of fluid was likely to exacerbate Mr Woodcroft's heart condition and cause breathlessness. Mr Woodcroft did not want to take this medication, because it made him urinate more frequently and this was painful for him. Instead, he preferred to control the quantity of fluid he drank, including by reducing his alcohol intake. Nonetheless, Nurse McClary advised him strongly to take the medication. She planned to visit him again in 6 weeks.

On Saturday 25 June 2016 Mr Woodcroft went on a social outing to Ettalong Beach with Chelsea Old Mates, which is a social/welfare group associated with the Men of League Foundation. He had been a loyal member of the group for some time. During that outing he drank an unknown quantity of alcohol, probably light beer, over the course of a couple of hours.

On Tuesday 28 June his daughter Victoria visited him at home. He told her he felt good and he appeared to her to be in good health.

The following day, Wednesday 29 June, Mr Woodcroft's son Anthony collected him and took him to vote at Botany Road. Again, he appeared to be well. After voting, Anthony dropped Mr Woodcroft at a podiatrist called "Great Feets" (sic.) in Redfern. The podiatrist Anna Crawford reviewed him and, although she found him to have an irregular pulse, she was not concerned about his health. In particular, she did not record him to have any problems with his breathing.

During the evening Mr Woodcroft spoke with Patricia Weekes on the telephone. They had dated in their teens and had recently reconnected with each other. Mr Woodcroft called Mrs Weekes at 6.51pm and again at 8.02pm. She says they spoke about football and about the goings on at his block. He told her he was feeling good. This was the last contact anyone is known to have made with Mr Woodcroft prior to his call to Triple Zero.

Also during that evening, at 7.43pm, Mr Woodcroft phoned his friend Neville Woods. Mr Woods told police that Mr Woodcroft always said his health wasn't good, although he didn't make any specific comment during that conversation.

The process of handling Triple Zero calls

When a person calls Triple Zero, the call is received by Telstra, which is the "Emergency Call Person" for all Triple Zero calls made in Australia. Its obligations are governed by a federal regulatory scheme, in particular the *Telecommunications (Emergency Call Service) Determination 2009 (Cth)* ("Determination") made by the Australian Communications and Media Authority ("ACMA")

Under the Determination, Telstra must transfer Triple Zero calls to an Emergency Service Organisation (i.e. Police, Fire or Ambulance) where: the caller asks to be transferred to one of those services; or the caller indicates in another way that he or she wants to be transferred; or when information is given that may reasonably be relied on as indicating that the caller should contact an emergency service.

Telstra must then provide the emergency service with the location of the caller, the identity of the customer and the telephone number. For landlines, at least, this information is obtained automatically and is referred to as "Caller Line Identification" or CLI. It is sent electronically to the emergency service. Telstra must also provide other information about the call where the emergency service requests it.

Unfortunately, there are a large number of calls made to Triple Zero that do not require an emergency service. Telstra estimates that these make up 25% of the 23,000 Triple Zero calls it receives nationally each day. Sometimes there is no response at all by the caller, often because the call was made in error, but also for other reasons including nuisance calls.

Where the caller does not respond at all to the operator, and there are no suspicious circumstances associated with the call and there is no indication that assistance is required, there is a procedure called the "Caller No Response Call". The Determination requires these calls be transferred to an automatic message system, called "Interactive Voice Response" or IVR.

At this point a message is played three times, prompting the caller to dial 55, and if the caller does not do so the call will be disconnected automatically.

However, where a caller does respond to the operator, but cannot articulate where they are and what they want, such calls are diverted to police. This is because of all the emergency service organisations, police are considered to be best equipped to respond to such calls. Where such a call is transferred to police, Telstra will provide police with the customer, telephone number and location of the service, that is, the CLI information.

Once a Triple Zero call is transferred to police, the call is received by PoliceLink command. The Telstra operator remains on the line until contact is established and then the call is released, leaving only the caller and PoliceLink connected. The role of PoliceLink is to speak with the caller, triage the call and then summarise the information provided in a CAD incident message. That message is then relayed electronically to the relevant Local Area Command on the Police CAD system. PoliceLink also ascribes a priority rating for each incident, with priority 1 and 2 requiring an immediate response and priority 3 a non-urgent response. A non-urgent response means “respond when there are no priority one or priority two matters outstanding ... police to attend as soon as possible”.

Where there is no response from the caller to PoliceLink, the Standard Operating Procedures (“SOPs”) state that the call should be terminated and the person called back to establish whether an emergency exists. If there is still no response, a CAD incident is to be created with the category “Check bona fides”, and a police unit is sent to check the circumstances. There are a large number of such calls received by police each week.

Once the CAD incident is created, it is picked up by Police Radio Operations Group. Dispatchers will broadcast the message over VKG radio to the appropriate Local Area Command. They obtain and broadcast available background information about the call, such as warnings or other information known about the person or location involved. Dispatchers can also change the priority of the CAD message, or request other resources, including an ambulance.

The Radio Operations Group’s Dispatch Broadcast Procedures require priority 3 incidents to be broadcast within 150 seconds of being received, and thereafter every 300 seconds or 5 minutes, or less if possible. In the event that the incident is not acknowledged by the Local Area Command within 30 minutes, there is a procedure where the Radio Operations Group Dispatcher alerts their supervisor, and the supervisor contacts the Local Area Command to escalate the matter.

From here, local police units will acknowledge the job and respond to it, according to the priority of the job and any competing priorities.

The action taken in response to Mr Woodcroft’s call

At 4.32am Mr Woodcroft called Triple Zero. The call was answered by an Emergency Operator for Telstra, Gerard Cogley, who was based in Melbourne. This call was recorded and it and other recordings were played during the inquest.

Mr Cogley said “*Emergency, Police, Fire or Ambulance?*” and he heard Mr Woodcroft say “*I can’t hear you*”.

Mr Cogley repeated his question and he then heard Mr Woodcroft moan but make no other response. Approximately 27 seconds after receiving the call, Mr Cogley transferred it to police in NSW.

At PoliceLink, the call was answered by Dominic Sirone. Mr Cogley told Mr Sirone *“I’ve got a caller on the line but I’m not exactly sure what they’re after, I’m not sure if they can hear properly.”* Mr Cogley did not say Mr Woodcroft had said the words *“I can’t hear you”*, nor did he mention the fact that Mr Woodcroft had moaned. This was explored in evidence.

Mr Sirone asked if the caller needed the police, to which there was no response. Mr Sirone indicated to Mr Cogley that he would take the call, and accordingly Mr Cogley disconnected. After asking repeatedly for a response, Mr Sirone disconnected the call, although before doing so he believed he could hear a moan. Mr Sirone attempted to call Mr Woodcroft back, but the line was open.

A further call was made to Mr Woodcroft’s phone shortly afterwards, which was not answered; this was probably also made by police.

Mr Sirone then created a CAD incident. Although he had not spoken, the CLI information (Mr Woodcroft’s name, telephone number and address) was known, having been provided electronically by Telstra. Mr Sirone gave the incident a priority 3 rating, meaning a non-urgent response, and described it as a *“concern for welfare”*.

The CAD message was sent to Radio Operations Group. Patricia Kudric was the Dispatcher at Radio Operations Group for the relevant area that evening. She viewed the CAD message at 4.36am and shortly afterwards also viewed information about the location, provided by Mr Sirone, Ms Kudric broadcast the incident promptly at 4.37am.

Ms Kudric went on to broadcast that message again three more times, at 5.09am, 5.46am and 6.04am.

However, these broadcasts were not performed as frequently as is required by the Radio Operations Group Dispatch Broadcast Procedures, and nor were they escalated after 30 minutes, as was then required. Her reasons for this were explored in evidence.

There were two police units available at Redfern Local Area Command that morning. One of these, Redfern 16 (Leading Senior Constable Welch and Constable Brennan) responded to an Aggravated Break and Enter at about 4am and was occupied in relation to that incident over the course of the morning. I am informed that incidents of that nature are considered to be an operational policing priority. In those circumstances, it appears reasonable for those officers to have continued to focus on that incident, rather than respond to the job relating to Mr Woodcroft’s call.

The other unit, Redfern 17 (Senior Constable Morony and Constable Katsogiannis) was available at Redfern police station when the initial broadcast was made. They heard the broadcast and they discussed attending it. They did not consider the incident to be urgent, and they did not acknowledge the job. Their actions were explored in evidence.

At 4.56am a second priority 3 job was broadcast, involving a female with possible mental health problems being abusive towards security staff, and the Redfern supervisor on duty at the time (Sergeant Botha) asked Redfern 17 to respond to that job, which they did at about 5.10am. They returned to the station 15 minutes later at 5.25am. Shortly afterwards, they encountered the oncoming shift, being Redfern 15 (Senior Constable Botha and Probationary Constable Field).

They did not mention the outstanding job relating to Mr Woodcroft's call, and neither did the supervisor Sergeant Botha mention it to his replacement, Sergeant Hill, and nor was it mentioned in any documents handover.

Nonetheless, Senior Constable Botha noticed the outstanding CAD message on starting his shift and he acknowledged the job at 6.11am. Unfortunately, before attending Mr Woodcroft's home, another urgent priority 2 job relating to a "road rage" incident was broadcast. Both available police units and the supervisor attended this incident. While Redfern 16 (Welch/Brennan) became available soon afterwards, they returned to their investigation of the Aggravated Break and Enter. Redfern 15 (Botha/Field) did not become available until 6.46am. After returning to the police station, they completed COPS entries and then attended a morning intelligence meeting for about 15 minutes at 7.30am. Accordingly, they did not respond to Mr Woodcroft's call until 8.05am, arriving on scene at 8.14am.

By this stage, it had taken approximately 3 ¾ hours for police at Redfern Local Area Command to respond to Mr Woodcroft's Triple Zero call.

Police arrive at Mr Woodcroft's unit

On arrival at the Turanga block, Senior Constable Botha and Constable Field spoke with security, discovering that Mr Woodcroft had last used his key fob to enter the building on Saturday 25 June 2016. As I have noted above, this was not the last occasion he left his unit. Police made their way up to the 17th floor and knocked on Mr Woodcroft's door and announced their presence. After getting no response, Senior Constable Botha tried the handle and found the door was unlocked.

Police immediately saw Mr Woodcroft lying on the floor of his unit. They checked for signs of life, and finding none they commenced CPR. They contacted the supervisor Sergeant Hill and called for an ambulance, which arrived a short time later.

Sadly, it was not possible to resuscitate Mr Woodcroft and he was pronounced deceased.

Paramedics who attended observed that Mr Woodcroft appeared cold to the touch, and also that hypostasis or livor mortis was present, suggesting he had been dead for some time.

When police had first attended Mr Woodcroft the phone receiver was located underneath him, which suggests he became incapacitated at the time of his phone call. Police also noted that the radio was switched on, which explains the background talking that had been heard by Mr Sirone.

Autopsy

A limited autopsy was performed, which stated the cause of death as ischaemic heart disease.

Further enquiries with A/Prof Holloway, Mr Woodcroft's treating cardiologist, and his respiratory specialist, Dr Jankelson, suggest that the most likely causes of death were either sudden heart failure or arrhythmia. A/Prof Holloway estimates that Mr Woodcroft was unlikely to have survived without receiving medical assistance within 30 minutes, in the case of heart failure, or as little as 10 minutes in the case of arrhythmia. In that event, Mr Woodcroft's chance of survival would have been "exceptionally slim".

Issues explored at the inquest

A list of issues was circulated to the interested parties, outlining the broad areas of interest for the inquest as follows:

In particular, the following matters as to the manner of death:

- *Was adequate information regarding Mr. Woodcroft's 000 call on 30 June 2016 conveyed by Telstra to PoliceLink?*
- *Was the CAD message created by PoliceLink appropriate and in accordance with NSW Police Force policy, in light of the information known?*
- *Was the incident broadcast and monitored by NSW Police Force Radio Operations Group adequately and in accordance with NSW Police Force policy?*
- *Was there a reasonable opportunity for police to attend Mr. Woodcroft's home prior to 8.14am, and if so, why was there no attendance prior to that point?*
- *Was the response by Redfern Local Area Command adequate and appropriate in all the circumstances?*

Is it necessary or desirable to make recommendations in relation to any matter connected with the death?

I will deal with these issues in turn.

Was adequate information conveyed by Telstra to PoliceLink?

Mr Cogley heard Mr Woodcroft say "I can't hear you". He said he formed an impression "that they were having trouble hearing me" and that "they obviously need some service but whether its police, fire or ambulance I couldn't tell".

Mr Cogley said it was not the role of Triple Zero operators to make assessments of calls.

Nonetheless, he formed the impression was that it was a *“genuine call for help”*. He said that, as Mr. Woodcroft had not identified which service he required he technically could have diverted the call to the automated system as a no response call, but he decided to *“err on the side of caution”* and transfer the call to NSW Police. This evidence was unconvincing. Having formed an impression that Mr. Woodcroft needed help, it would not have been appropriate to treat the call as a “no response” call. It clearly did require a response.

Mr Cogley did not tell Mr Sirone that Mr Woodcroft had said *“I can’t hear you”* but instead told him *“I’m not sure if they can hear properly”*. Mr Cogley did not accept the distinction between the two. He said *“I think I communicated that appropriately when I told the police that the caller could not hear me properly, so there’s obviously been some communication”* and *“I don’t think the meaning is different than what was conveyed”*. I do not accept this evidence. If Mr Cogley had told Mr Sirone that Mr Woodcroft had actually spoken to him, it would have been clear that a person was on the line who was unable to communicate; the words that Mr Cogley said did not give that impression.

Similarly, Mr Cogley did not tell Mr Sirone that Mr Woodcroft had moaned during the early part of the call. When asked why he did not do so, he said he did not consider it to be relevant at the time. He further explained *“Yeah, it’s policy ... Only to state the facts and not presume that the moaning means anything – it could – the moaning could have meant anything. I didn’t want to bias the police into anything ... It’s only in retrospect now that we hear the phone call, hear what has happened, that the moaning does take on a different aspect, but at the time it meant nothing”*.

Mr Cogley did not have an independent recollection of the call, and so he gave his evidence in retrospect, after having listened to the recording in order to prepare his statement. He said it was only in hindsight that he formed the view that the noise he heard sounded like a moan. However, it seems likely that Mr Cogley would have formed a similar impression at the time of the original call. Listening to the audio recording, with the words Mr Woodcroft said followed shortly thereafter by his moaning, gives an impression that he was unable to communicate.

Mr Cogley also pointed out that, as Mr Woodcroft was still on the line, then the police would be able to find out what he needed. This, in his view, lessened the need for him to provide such information to police. However, he accepted that he couldn’t be confident that Mr Woodcroft would have been able to communicate with the police operator once the call was transferred.

After all, he had been unable to get further information from Mr Woodcroft. Nonetheless, he maintained *“I handled it the way I would have handled any other call in the same situation”*.

Telstra’s Triple Zero Policy, as Mr. Cogley correctly identified, requires its operators to “clearly and simply state the facts” and not to offer judgments or opinions.

However, Mr. Cogley did not do what the policy required. He did not state the fact that Mr. Woodcroft had spoken during the call, or the fact that Mr. Woodcroft had moaned. In considering the appropriateness of Mr. Cogley’s actions, I bear in mind three significant matters. First is that Mr. Cogley was dealing with the call in real time, as the events were occurring. He had just 27 seconds to make a

The recording of the call was played several times during the inquest, which also had the benefit of background information about Mr. Woodcroft; Mr. Cogley did not have that advantage.

Second is that Mr. Sirone says he heard Mr Woodcroft moan at the end of the call, which led him to think that there was a concern. This cannot be heard on the audio recording, although he was confident he heard it.

In that light, Mr Cogley's failure to mention this fact is of less significance.

Third is that Telstra has, in light of matters raised during this inquest, prepared a draft amendment to its Triple Zero Policy. This draws attention to the situation where a caller is unable to speak, and prompts an operator as to what information should be provided to Police, including any words said by the caller and other noises such as moaning. This provides greater guidance to operators than was available to Mr. Cogley at the time.

However, Mr. Cogley's omissions contributed to a dilution of the information, as it passed along the chain of communication from Telstra to the responding officers.

While the information he conveyed to Police was adequate, not all of the important details were communicated. This, in my view, contributed to the fact that police officers responding to the call treated it with less urgency than they otherwise would, if they had known all relevant details.

- **Was the CAD message appropriate?**

Although Mr Woodcroft did not speak to Mr Sirone, the CLI information (Mr Woodcroft's name, telephone number and address) was known, having been provided electronically by Telstra. After Mr Sirone attempted to call Mr Woodcroft back, he completed the CAD message, as follows

Priority 3 - Concern for Welfare (017)

FROM CLI - TURANGA,, LOT UN 1707/1 PHILLIP ST, COPE ST, WATERLOO, SYDNEY (LGA) 2017

NIL REQ FOR POL - TELSTRA COULD HEAR NOISE IN THE BACKGROUND - ON TRANSFER NIL RESPONSE BUT COULD HEAR TALKING IN THE BACKGROUND - JUST B4 TERMINATED CALL COULD HEAR A MOAN - UNABLE TO CALL BACK AS LAND LINE OPEN - NFI - CHKS OTW.

Three aspects of this CAD message are significant. First, the message stated "nil req for pol" (nil request for police) although it required a priority 3 response.

Mr Sirone did not accept that there was any contradiction between saying there was a concern for welfare on the one hand, but there was nil request for police on the other. However, the description "nil req for pol" contributed to an impression that the incident was of low importance.

Second, the reference to "talking in the background" does not reflect what Mr Sirone heard, which he believed to be a television in the background and which turned out to be a radio. As Mr Sirone agreed, the reference to talking suggests that another person was present, albeit unaware of the call, and it again tends to lessen the seriousness of the incident.

Third, the reference to a "moan" was, to some extent, ambiguous. Mr Sirone said that he thought the person on the line was unable to communicate, he was concerned for their welfare and they needed assistance. This impression was not conveyed.

Ms Kudric thought it could be a couple engaged in an intimate moment; Senior Constable Moroney thought it could be an intoxicated or drug-affected person, which was a frequent occurrence.

As a whole, while the details of the CAD message were accurate, the three matters referred to above were potentially misleading. The terms of the CAD message also contributed to a dilution of the information communicated to the responding police, and gave the impression that it was of less urgency, as was reflected in Ms. Kudric's evidence.

Was the incident broadcast and monitored adequately?

Ms Kudric initially broadcast the incident message promptly at 4.37:50am, which was about 90 seconds after she first received it. However, as she accepted in evidence, she did not continue to broadcast the message as frequently as she was required pursuant to the SOPs.

Her computer screen did provide a visual prompt, displaying messages in yellow where they have not been broadcast as frequently as required. Despite that prompt, she did not re-broadcast the message until 5.09am, some 30 minutes after the first broadcast, by which time the SOPs (as then in force) required her to escalate the incident to the supervisor at the Local Area Command.

By way of explanation, Ms Kudric recalled that she was busy with another job at Leichhardt, and was attempting to find an address. However, a close examination of the timeline of broadcasts provided by Police shows that a request was not made to check this address until 4.51am, almost 15 minutes after the broadcast. The SOPs required Ms Kudric to broadcast the message two further times over that period. The evidence revealed no reason why Ms Kudric was unable to re-broadcast the message. It is likely that at least part of her reason for not doing so was because she formed the impression that the incident was of lower priority.

It is probable that Ms Kudric's failure to broadcast the incident as frequently as required also contributed to the responding officers considering it to be of less importance.

Had they been reminded of the outstanding job more frequently, it seems likely they would have responded. To her credit, Ms Kudric frankly admitted that she had not done what the policy required of her.

Was the response by Redfern Local Area Command appropriate?

As noted above, it took approximately 3 $\frac{3}{4}$ hours for police at Redfern Local Area Command to respond to Mr Woodcroft's call. This was an inadequate response.

Senior Constable Morony and Senior Constable Sanders were at Redfern station when the incident relating to Mr Woodcroft was broadcast by Ms Kudric. They had previously attended an urgent job, but were updating information on the COPS computer system at the time the job came in. Senior Constable Morony asked her colleague if she wanted to attend the job, and Senior Constable Sanders said yes. However, Senior Constable Sanders continued to work on the computer and so eventually Senior Constable Morony logged back on. This is supported by an audit of the COPS computer.

Both officers had attended similar CLI jobs numerous times in the past, and on each occasion these had been a “false alarm”. The impression that the job was of low importance was fortified by the reference to talking and other noises in the background. This influenced their approach to this incident, and led to a degree of complacency.

The incident was given a priority 3. This required a non-urgent response, but it still required officers to attend as soon as possible, if no priority 1 or 2 jobs were outstanding. They did not do so.

Unfortunately, as noted above, a second priority 3 job was broadcast at 4.56am, relating to a woman shouting at security in Walker Street, Redfern. Officers Morony and Sanders did not immediately respond to that job either, but their supervisor Sergeant Botha asked them to attend that job, which they did at 5.10am.

Walker Street bisects Phillip Street, where Mr Woodcroft’s home was situated. It would clearly have been possible for the officers to attend both jobs, given their proximity. They did not do so. They returned to Redfern police station at about 5.25am.

At that point they were approaching the end of their shift, and they prioritised other tasks they needed to complete. They did not draw the attention of the oncoming shift to the outstanding job. This is not something they would ordinarily do, given that outstanding CAD messages are displayed on a monitor in the station and also on computers used by police.

I find that there was an opportunity for Senior Constable Morony and Senior Constable Sanders to attend Mr Woodcroft’s home, either before or after attending the Walker Street job. It was remiss of them not to do so. To their credit, however, they each frankly accepted that it would have been possible for them to attend the job, and they expressed regret for this.

Senior Constable Botha and Probationary Constable Field were the oncoming shift. Senior Constable Botha acknowledged the outstanding job relating to Mr Woodcroft shortly after his arrival, at 6.11am. Senior Constable Botha felt it was not of an urgent nature due to the nature of the CAD message, but he intended to attend the job in any event. As noted above, he was unable to attend the job due to an urgent priority 2 job that was broadcast at 6.20am. There was an opportunity for them to attend after returning from that job at 7am, which Senior Constable Botha accepted. Instead, they decided to attend the morning meeting at 7.25am. That meeting was one which police are expected to attend. I accept that that decision was not unreasonable in the circumstances.

Accordingly, I find that there was an opportunity for police from Redfern Local Area Command to attend the incident before they eventually did at about 8.14am. The fact that the call was described as a CLI call lead to an impression that it was of low importance, and this was compounded by the missing information and the terminology used in the CAD which I have described above. Another factor that contributed to this impression was the fact that the involved officers’ experience of CLI calls was that they were never “genuine” calls.

I find that the response of Redfern Local Area Command to this incident was not adequate.

Is it necessary or desirable to make a recommendation?

Two potential areas for recommendations arose in the course of the inquest. The first was the fact that the information received by Telstra and PoliceLink was “diluted” as it passed through the hands of Mr Cogley, Mr Sirone and Ms Kudric en route to the responding police. Each of the responding police said they were misled by the information in the message, and would have viewed the incident differently if they had known details such as the fact that Mr Woodcroft had spoken or that the talking was believed to be a television rather than a person.

This is supportive of recommendations relating to the policy about what information should be supplied by Telstra to emergency services, and also of the possibility of making audio recordings available to the emergency services. These are discussed below.

A second issue was the potential use of a Triple Zero caller’s call history. Mr Woodcroft’s previous 11 calls to the emergency services were not known to any of the people who responded to Mr Woodcroft’s final call. When asked whether this knowledge would have had any impact on the way that they responded to the incident, almost every witness stated that they would have responded differently.

Mr Sirone would have been concerned Mr Woodcroft was having another medical emergency, and would have linked in NSW Ambulance. Ms Kudric would have changed the priority and would also have contacted NSW Ambulance. Officers Morony, Sanders and Botha all stated they would have attended the job urgently if they had known this information. Only Mr Cogley believed he would have handled the call in the same way, which is perhaps reflective of his understanding of his employer’s policy, to treat every call on its merits.

In my view, the responses of the other witnesses were compelling. Their evidence is supportive of a recommendation that, in an appropriate case, information as to a caller’s previous history should be made available to responding police. This is explored further below.

The inquest had the benefit of evidence from three senior witnesses, who between them have a substantial experience and expertise in the handling of Triple Zero calls in NSW. Christopher Beatson is the Director of PoliceLink Command within NSW Police Force. Jamie Vernon is Assistant Commissioner of NSW Ambulance, with responsibility for the management of Triple Zero and 131 emergency calls in NSW. Jane Elkington is the Emergency Answer Point General Manager for Telstra. Their evidence was extremely helpful in crystallising the issues and identifying the competing considerations.

After the conclusion of the factual evidence, those witnesses were posed a series of questions regarding possible areas for recommendation.

They convened a joint conference to discuss those questions, and the minutes of that conference were tendered at the inquest. They also gave oral evidence to the inquest on 8 March 2018. Following that evidence, the interested parties were given an opportunity to respond to possible recommendations. The following issues were canvassed.

Information provided by Telstra to the police

Mr Beatson confirmed that the expectation was that Telstra would provide Policelink with an accurate account of what was heard during the call. Ms Elkington believed that Telstra's policies already provided for this, and in her view Telstra was doing this already. However, as I have noted above, the information Mr Cogley told police was not complete. Ms Elkington explained that Telstra advises their operators not to offer opinions or judgments about the call, due to the risk that an operator may mislead emergency services about whether a call is genuine.

Mr Beatson identified a "grey area", where background noises or things said cannot be communicated verbatim. In those circumstances, the operator would need to give their impression of what was heard.

Prior to giving her evidence, Ms Elkington had reviewed the relevant policy and produced a draft revised policy concerning information that Telstra operators should provide to the emergency services. It provides more specific guidance on what information should be provided to the emergency service organisation, underlines the need of accuracy, and picks up on some of the details that were missed in Mr Woodcroft's call.

Furthermore, a draft work instruction has been produced, which, will form the basis of training that can be provided to operators very quickly if adopted.

In light of this, in my view it is not necessary or desirable for me to make a formal recommendation about the information that Telstra should provide to the emergency services. I do, however, endorse the draft policy, and I would expect Telstra to bring the policy into effect, with appropriate training, at the earliest opportunity.

Transfer of the audio recording

A central issue in the inquest was the "dilution" of information. Mr Sirone and Ms Kudric did not hear what Mr Cogley heard. Had they done so, it is probable that their responses would have been different, which in turn may have affected the actions of responding police.

A possible solution that avoids dilution of information would be for the audio recording itself, during which only Telstra and the caller are on the line, to be made available to the emergency services. Such an option would only be exercised where appropriate, for example where the caller cannot themselves communicate, where there are indistinct background noises or the words said by the caller are unclear.

It was pointed out by Mr Beatson and Mr Vernon that, in the vast majority of cases, this option is not necessary. In that respect, the circumstances of Mr Woodcroft's case is an "outlier" and does not reflect the requirements of most Triple Zero calls. Mr Vernon said that NSW Ambulance does sometimes contact Telstra, to clarify what was said, but this was rare; NSW Ambulance have high degree of confidence in the information provided to them by Telstra.

Mr Beatson also raised a concern that this option would inject delay into the process, where the priority was to get police to respond to the incident. It was also unnecessary if Telstra provided sufficient information.

Submissions from NSW Police Force further raised a concern that this option would create a situation where police operators would have to make a “judgment call”, whether or not to listen to the audio, the implication being that it would expose police to criticism or liability if the option was not exercised.

Ms Elkington explained that the current technology would not allow for transmission of audio recordings in real time. Audio recordings of Telstra calls are all stored in the ECLIPS database. However, that recording does not complete until the call is wholly transferred to an emergency service.

At present, audio could not be transferred until after that time, and at present this would require a manual request. Ms Elkington noted that there was an existing “workaround”, whereby if an emergency service wanted access to the audio recording, a specific request could be made and it could be either reviewed by the supervisor or played via the phone line. There are similar policies and practices already in place which allow for transfer of sound files between NSW Ambulance and NSW Police Force.

Telstra, in closing submissions, noted that as an organisation it is open and committed to improving the Triple Zero service. NSW Ambulance made a similar submission, and I have no doubt NSW Police Force adopt a similar approach. Telstra itself maintains a “roadmap” of possible future technological advances. Ms Elkington in evidence suggested this option might be added to that roadmap.

However, there are barriers to introducing new technologies. One obvious barrier is funding, which on Telstra’s part is determined at a Federal level. I cannot make a recommendation as to funding, but nor should funding considerations preclude a recommendation where it is necessary or desirable to be made.

Another is the fact that, as Triple Zero is a national service, any changes or improvements must be nationally coordinated, to ensure viability and consistency between the States. For those reasons, Telstra urged that any recommendation be framed as an issue to be raised at the National Emergency Communications Working Group. I accept that submission.

In my view, despite the concerns and barriers raised, this is an improvement which is supported by the evidence and which should be explored further.

Sharing a caller’s Triple Zero history

As noted above, the response of the witnesses in this case to the information that Mr Woodcroft had frequently phoned Triple Zero was striking. Had they known this fact, it is probable that they would have behaved differently. Accordingly, the inquest explored whether such information could be made available to the emergency services.

I should note that NSW Ambulance already has a project that deals with people who frequently call Triple Zero, called the Frequent User Management program.

That provides casework assistance to individuals to frequently call Triple Zero, with the intention of putting in place services that will reduce the reliance on ambulances. Mr Woodcroft did not meet the definition of a “frequent user”, being a person who calls 10 times in 6 months.

There were five considerations raised by the interested parties that weigh against sharing information about a caller's Triple Zero history. The first is the fact that it would not be of any use for an emergency service to know a caller's history in the vast majority of cases. Mr Beatson doubted that it would change the way police respond to an incident in any event. This was in contrast to the balance of the witness evidence. He was also concerned that requiring emergency services to review such information could delay the response. Of course, it is not suggested that such information must be reviewed in every case, but only where the caller does not communicate and there is uncertainty about the need for attendance.

The second is the current incompatibility between the information held by the different organisations. Telstra holds information about all calls received via Triple Zero on its ECLIPS database. It records information according to the CLI information, being the phone number and the owner of the service, and also records the emergency service to which the call was diverted. NSW Police Force records names and locations of interest, and also warnings or firearms information. NSW Ambulance is concerned with locations only, as the identity of the caller is of less significance. In addition, NSW Ambulance records are held in an accessible form for only 2 months.

NSW Ambulance pointed out that information it has about a location may not be of any use if supplied to police. For example, some locations - such as nursing homes or sporting venues - make a large number of Triple Zero calls, most of which would be irrelevant to police. However, in the present case, the records relating to Mr Woodcroft's address, which was known to NSW Ambulance, would have been very significant to police.

The third is that providing a caller's history has the potential to mislead. For example a caller calls Triple Zero 10 times for an ambulance, and then on the 11th occasion calls Triple Zero because there has been a burglary; or a caller who calls 10 times accidentally and then makes a genuine emergency call on the 11th occasion. This is a clear risk, but it is not suggested that a caller's previous history alone should determine the response by emergency services. Instead, it should inform the responding emergency service of a known history where the caller is unable to articulate why they need help. A careful development of policy would be required to ensure the information is used only where necessary.

The fourth is privacy, which would also potentially affect the sharing of audio recordings. In helpful submissions, NSW Ambulance and Telstra have described the impact of privacy considerations on this proposal. Sharing a caller's medical history between different services would inevitably risk exposing their private health information. There could be highly undesirable consequences, for example: disclosing health information about a location that is not about that caller, but about another person; or disclosing health information about a person to police that could affect the manner in which the police deal with that person in the future.

The *Health Records and Information Privacy Act 2002 (NSW)*, and equivalent Commonwealth legislation, operate to restrict the use of private health records.

However, NSW Ambulance submits that the Privacy Commissioner may in an appropriate case issue a guideline (with the approval of the Minister) to determine the use of private health information. It may be therefore be possible to overcome the privacy concerns, and devise policy on sharing a Triple Zero call history in circumstances where it is required.

The fifth is the fact that current technology does not exist to allow ready sharing of information. Any change would encounter the problems I have described above.

In all, I accept that there are significant barriers to progressing this option. The considerations raised above demonstrate that any change in policy must be carefully calibrated to avoid undesirable consequences, and should only progress if it can be justified. While the circumstances of Mr Woodcroft's death are not ordinary, I am not satisfied that they are so unique that they will not be replicated. It is clear to me that it is worth exploring this option further. I therefore intend to make a recommendation that the interested parties raise the option of sharing a Triple Zero caller's history in the appropriate forum.

Conclusion

Mr Woodcroft's death occurred in circumstances where the response by the emergency services was not adequate. In light of the seriousness of his medical condition, it is not known whether an earlier response would have prevented his death. However, areas for improvement can be identified, and should be explored, to ensure that people who contact emergency services in similar circumstances in the future are provided an optimal response.

I thank the office in charge of the investigation, Detective Sergeant David Gates. I thank my counsel assisting Mr Jake Harris for the enormous amount of work he put into assisting me aided by his instructing solicitors, Ms Joanna Mooney and Ms Clare Skinner. I offer my heartfelt condolences to Mr Woodcroft's family. They obviously cared for him and loved him very much. Despite how painful it must have been, I hope that this inquest has answered some of their questions.

Findings

The identity of the deceased

The person who died was Peter Bernard Woodcroft

Date of death

Mr Woodcroft died on 30 June 2016

Place of death

Mr Woodcroft died at Waterloo, NSW

Cause of death

Heart failure or arrhythmia, secondary to ischaemic heart disease.

Manner of death

Mr. Woodcroft suffered a medical emergency and phoned Triple Zero. He was unable to tell the operator what he needed. Mr. Woodcroft died before police attended his home. His death was from natural causes in the course of police operations.

Recommendations

To the Commissioner of NSW Police Force, the Commissioner of NSW Ambulance and Telstra Corporation Limited:

I recommend tabling for consideration at the next National Emergency Communications Working Group (scheduled for 23 May 2018) the following agenda item:

The development of a system that would allow the following information to be readily accessed by, or provided to, the relevant Emergency Services Operator (ESO), where this is permitted by privacy legislation:

- (a) the audio recording of Triple Zero calls that is captured by Telstra;*
- (b) a caller's Triple Zero call history, as held by Telstra; and*
- (c) a location's previous Triple Zero call history, as held by each ESO.*

22. 231300 of 2016

Inquest into the death of JM. Finding handed down by Deputy State Coroner Lee at Glebe on the 8th May 2018.

Introduction

JM was last seen alive on the evening of 31 July 2016 whilst he was being held in lawful custody at Bathurst Correctional Complex where he was serving a custodial sentence. Tragically, the following morning JM was found in his cell, deceased, after having apparently taken his own life.

Why was an inquest held?

When a person's death is reported to a Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the *Coroners Act 2009* (the Act) makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure that the State discharges its responsibility appropriately and adequately. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

JM's life

Before going on to set out the findings from the inquest it is appropriate at this point to recognise, and say a few brief words about, JM's life. Much of the evidence that is gathered in a coronial investigation relates to the final period of a person's life. That final period is often measured in hours, minutes and, sometimes, seconds. That final period is often intensely scrutinised during an inquest. These circumstances rarely allow for much consideration to be given to the (usually) years of life that preceded a person's death, who that person was, and how their death has impacted their family and loved ones. Therefore it is important to recognise the life of that person in some small, but hopefully meaningful, way.

JM was born in 1970 in Sydney and grew up in the suburb of Daceyville. JM was one of three children to M and BM, with the others being an older brother, K, and an older sister, K. After spending some years in Daceyville, JM and his mother later moved to Belfield and then Hammondville.

In his youth JM enjoyed playing football and motorbike riding. JM later found a job as a delivery driver, and also met his former partner, VA. They moved to Condell Park and had two children together: K and C.

Unfortunately, from the age of about 20, JM began having trouble with the law and was in and out of custody over the course of a number of years. JM also spent some time in custody in Queensland. When he was released in 2013 he went to see his mother in Hammondville who was at that time in poor health. Sadly, JM's mother later passed away in July 2014. JM was particularly close to his mother and her death profoundly affected him.

JM received an inheritance from the sale of his mother's house and later moved to the Central Coast with his new partner at the time, ES. JM's brother, K, and Ms S's son, C, also accompanied JM and Ms S in their move. Regrettably JM and K later had a disagreement which resulted in K leaving the Central Coast area. However, JM and Ms S remained in the area and Jason developed a close relationship with C.

Custodial history

In 2011 JM was convicted of an offence in Queensland that resulted in him being sentenced to five years imprisonment expiring on 15 November 2016, with a non-parole period that expired on 17 July 2013. JM was released on parole on that date with one of the conditions of his parole that he be of good behaviour. On 16 February 2016 JM's parole was revoked by virtue of him allegedly breaching his parole. As a result, on 26 February 2016 a warrant was issued for JM's arrest.

JM was later apprehended and refused bail on 10 March 2016. He was taken into custody at Cessnock Correctional Centre (**Cessnock**) the following day on a revocation of parole warrant. On 19 April 2016 JM was convicted and sentenced to eight months imprisonment at Newcastle Local Court (in relation to new offences that had been committed on 7 March 2016) with the sentence due to expire on 9 December 2016. On 3 June 2016 the State Parole Authority determined that, in view of JM's conviction that his parole was to remain revoked.

At Cessnock JM was initially placed in a two-out cell on 11 March 2016 after it was noted on a Health Problem Notification Form that he presented with low mood, anxiety and agitation. On 23 March 2016 JM was reviewed and assessed as being suitable for normal cell placement as no acute concerns were noted.

On 23 April 2016 JM was transferred to the Metropolitan Special Programs Centre at Long Bay Correctional Centre. Upon review by a nurse at reception JM guaranteed his own safety. On 20 June 2016 nursing staff noted that JM's mental health was stable. On 19 July 2016 JM was reviewed by a mental health nurse. JM reported being content with his medication (quetiapine and mirtazapine) and was positive when speaking about his plans for the future upon release from custody. JM reported that he had not experienced any psychotic symptoms and that he had no thoughts of suicide or self-harm.

On 21 July 2016 JM was transferred to Bathurst Correctional Complex (**Bathurst**). On arrival JM took part in a routine Reception Screening Assessment. During this assessment JM reported that he had previously been diagnosed with schizophrenia and that he had a history of daily cannabis use, infrequent methamphetamine use, and alcohol abuse. JM also reported that he had experienced suicidal ideation some 18 months earlier following the death of his mother, but denied any current suicidal thought or intent.

Events leading up to 31 July 2016

Barry Nikolovski, another person in lawful custody, met JM around 21 July 2016 after he was transferred to Bathurst from another correctional centre. JM and Mr Nikolovski were initially housed together for several days. JM was later temporarily moved to a different cell but upon his transfer to a different wing at Bathurst he was placed in the same cell as Mr Nikolovski again.

On or about 29 July 2016 JM asked Mr Nikolovski to help him plait together some torn bed sheets. When Mr Nikolovski asked what he was doing, JM said that he was making a clothesline. At some stage Mr Nikolovski saw JM attempt to thread the makeshift clothesline of plaited sheets through a vent above the cell door. Mr Nikolovski told JM that the correctional officers were likely to tear it down and so JM removed it himself. At around the same time JM told Mr Nikolovski that he had had an argument with Ms S over the phone and that this had angered Ms S.

Mr Nikolovski recalls that JM made three or four “clotheslines” using a loose razor blade to cut the sheets and then plait them together. Each line was about 1 to 1.5 metres in length. Mr Nikolovski said that he thought nothing of JM’s activities and said that he never suspected that JM was going to harm himself.

What happened on 31 July 2016?

JM called Ms S at 3:40pm on 31 July 2016. After speaking for only a short time Ms S told JM that she could not “*do this anymore*”. JM asked Ms S if she had “*found someone else*” to which Ms S replied, “*Maybe*” and “*I don’t know*”. JM said, “*Well I will neck myself if I have to lose you again, I can’t do it babe. I love you too much*”. JM again asked Ms S whether she had met someone else. Ms S was initially equivocal in her response but later denied that she had. Ms S went on to tell JM that she had had enough and ended the call.

JM attempted to call Ms S again at 4:02pm but the call was unanswered. JM left a voicemail message in which he said, “*Tell C I love him forever. I love you forever, and I’ll join my mum tonight. I love you, bye. I promise, Correctives will ring you tomorrow*”.

JM called Ms S a third time at 4:23pm. Ms S answered the call and there was a brief argument about her having ended the first call. At one point JM said, “*I’m going to neck*”. There was some further discussion about Ms S ending the relationship with JM again asking if she was seeing someone else before the call ended.

Following the phone calls JM was returned to his cell. During the evening JM and Mr Nikolovski spent some time watching TV and at some stage JM wrote a letter and asked Mr Nikolovski to remind him in the morning to post it.

Mr Nikolovski went to sleep at about 10:30pm. At the time JM was in his bunk above Mr Nikolovski, listening to the radio. At one stage during the night Mr Nikolovski got up to turn off the radio. At another time, Mr Nikolovski got up to use the toilet. Mr Nikolovski did not notice anything amiss on either occasion.

What happened on 1 August 2016?

Mr Nikolovski woke up the following morning, got out of bed and tripped over a milk crate that had been left in the middle of the floor. Mr Nikolovski also heard that the radio had been turned up to a loud volume. As he called out to JM to ask why the milk crate was in the middle of the floor, he noticed that JM was suspended in the doorway from the plaited sheet that had been tied around his neck.

At the same time a Corrective Services NSW (**CSNSW**) officer who was conducting a morning check of the cells opened the door to the cell where JM and Mr Nikolovski were housed and saw JM. Another CSNSW officer was alerted and together they cut the sheet in order to release JM and assist him to the ground. JM was found to have no pulse and no signs of life. CPR was commenced and a call was made for emergency services to attend. Paramedics arrived on scene at about 6:23am and continued to perform CPR with no signs of life established. JM was later pronounced life extinct at 6:30am.

During a subsequent search of JM's cell four letters were located. Two of the letters were addressed to Ms S; one to JM's brother, K; and one to a police officer in Victoria which contained a number of allegations. In his letters to Ms S, JM wrote, *"I can't live without you, I miss my mum so bad and you, C so bad I'm not lieing [sic] I want to knock myself"*. In his letter to his brother, J wrote, *"I have thought about suicide a couple of times but you only get one life so as bad as it has got I'm trying my best"*.

A further letter was also located in the pocket of JM's pants. The letter was dated 1 August 2016, addressed to Ms S, and bore a heading which read, *"My last words"*. In the letter JM expressed his love for Ms S and left instructions for the disbursement of his property and where he wished to be buried.

What was the cause of JM's death?

JM was later taken to the Department of Forensic Medicine at Newcastle. Dr Jane Vuletic, senior staff specialist in forensic pathology, performed the post-mortem examination on 3 August 2016 and later prepared an autopsy report dated 30 August 2016. Dr Vuletic noted that JM had sustained fractures of the hyoid bone and thyroid cartilages, and abrasions on the neck, which were consistent the application of pressure on the neck with a ligature. Dr Vuletic found no other bodily markings to indicate the involvement of another person in JM's death and ultimately concluded that the cause of death was hanging.

What was the manner of JM's death?

Given the gravity of a finding that a person has intentionally inflicted their own death it is well-established that such a finding cannot be assumed, but must be proved on the available evidence. I have had regard to JM's history of previous suicidal ideation, the lasting adverse effect that the passing of JM's mother had on JM's mental well-being, JM's suicidal ideation which he voiced to Ms S during the phone calls on 31 July 2016, JM's preparatory actions in constructing a ligature from plaited bed sheets several days prior to his death, and the content of the letter dated 1 August 2016 which was found in JM's pocket.

Taking all of these matters into account, together with the circumstances in which JM's was found, I conclude that the evidence is sufficiently clear, cogent and exact to allow a finding to be made that JM died as a consequence of actions taken by him with the intention of ending his life.

Was JM's care appropriately and adequately managed whilst in custody?

JM's death raises two questions concerning his care whilst in custody:

- Firstly, was JM housed in an appropriate cell?
- Secondly, was there any way to predict JM's actions during the evening of 31 July 2016 and therefore prevent them from occurring?

In relation to the first question the evidence establishes that JM was housed in a section of Bathurst known as X-Wing. This wing houses minimum security inmates who are deemed to be not at risk of suicide or self-harm. As a result of this classification no structural or physical modifications had been made to the cells in X-Wing to, for example, remove possible hanging points. The evidence establishes that no cell searches were conducted from the time that JM arrived in X-Wing on 26 July 2016. Therefore, there was no opportunity for any CSNSW officer to discover the plaited sheet that JM had been making from about 29 July 2016.

The evidence described above raises a further question: namely, whether it was appropriate for JM to be housed in X-Wing. The records from both CSNSW and Justice Health & Forensic Mental Health Network (**Justice Health**) indicate that between 10 March 2016 and 31 July 2016 there was no evidence to indicate that JM posed a risk to himself. During his initial reception screening assessment upon entering custody and during subsequent reviews conducted by Justice Health staff, JM denied any thoughts of self-harm or suicidal intent. On 19 July 2016, during the most recent mental health assessment conducted prior to his death, JM again denied any thoughts of suicide or self-harm and instead expressed positive plans for the future.

Conclusion: Having regard to the totality of the records available there is no evidence to indicate that, in the period between 10 March 2016 to 31 July 2016, JM was at risk of suicide or self-harm. Accordingly, it was appropriate for JM to have been housed in the minimum security X-Wing upon his transfer to Bathurst.

In relation to the second question it is evident that JM had expressed suicidal ideation to Ms S during the series of phone calls on 31 July 2016. However, although these calls were recorded (in accordance with standard procedures at a correctional centre) they were not monitored by any CSNSW staff at the time the calls were taking place. The content of the conversations between JM and Ms S only became known during the police investigation after JM's death. Importantly, this meant that what was said by JM during these phone calls was never brought to the attention of any CSNSW or Justice Health staff before JM's death.

The evidence gathered during the coronial investigation established that as at 2017 there were over 14,000 persons detained in NSW correctional centres. It would therefore be impossible to monitor every phone call of every person held in custody. More specifically, the evidence established that monitoring of specific calls usually only occurs when CSNSW, or an investigative agency, possesses information that suggests that unauthorised or illegal activity is being discussed during a call. There was no basis for the calls between JM and Ms S on 31 July 2016 to be monitored.

Mr Nikolovski was aware that JM had been plaiting the sheets together to form what JM explained would be a "clothesline". Mr Nikolovski was also aware that JM had been involved in an argument with Ms S around the time he began plaiting the sheets. In hindsight, it is perhaps easy to draw a logical connection between what was known to Mr Nikolovski around this time and JM's subsequent actions. However, reaching such an inference without the benefit of hindsight is a more difficult task.

Conclusion: Ultimately it is unnecessary to speculate about whether the drawing of such an inference by Mr Nikolovski was possible. The fact remains that by 31 July 2016 no information had been communicated to CSNSW or Justice Health staff by any third party which raised the possibility that JM was at risk of suicide or self-harm. I therefore conclude that there was no basis upon which any CSNSW or Justice Health staff could have predicted JM's actions and taken possible preventative measures. I also therefore conclude that the care provided to JM whilst in custody, in the period from 10 March 2016 to 1 August 2016, was adequate and appropriate. There is no evidence to suggest that any inaction by CSNSW or Justice Health or staff contributed to JM's death.

Findings:

I find that JM died on 31 July 2016 or 1 August 2016 whilst in lawful custody at Bathurst Correctional Complex, Bathurst NSW 2795 where he was serving a custodial sentence. The cause of JM's death was neck compression due to hanging. JM died as a consequence of actions taken by him with the intention of ending life.

23. 280295 of 2016

Inquest into the death of Laurence O'Connor. Finding handed down by Deputy State Coroner Russell at Glebe on the 6th March 2018

At the time of his death Laurence O'Connor was in custody serving a sentence of 21 years imprisonment for the murder of his wife. The earliest date on which he would have been eligible for release on parole was 6 September 2023.

He was, then, within the meaning of section 23 of the *Coroners Act 2009*, in lawful custody. An inquest in such circumstances is mandatory pursuant to section 27(1) of that Act.

Background

In 1985 Mr. O'Connor travelled to the Philippines where he met a Filipino national. He arranged for her to follow him to Australia where they married and had 2 children.

On 7 July 2007 Mr. O'Connor murdered his wife and buried her body in a relatively isolated location on their property, Quandilli near Tooraweenah. He was sentenced for that offence on 5 December 2008.

Mr. O'Connor was a heavy drinker. In 1977, after he was involved in a motor accident causing the death of a motorcyclist for which he was convicted of culpable driving causing death, he gave up drinking for some 15 years. He then took up drinking again and drank heavily.

Health while in custody

On 8 September 2007 a Reception Risk Assessment was conducted when Mr. O'Connor was received into custody at the Dubbo Court cells. Mr. O'Connor reported, *inter alia*, that he experienced respiratory problems, that he drank excessive amounts of alcohol daily and was a heavy cigarette smoker. A chest x-ray conducted on 11 September revealed Chronic Obstructive Pulmonary Disease.

Mr. O'Connor also suffered from Asthma and Benign Prostatic Hyperplasia. He had high cholesterol and regularly experienced chest infections. He was prescribed a number of medications including Warfarin. He suffered gum disease which necessitated the removal of his teeth. He had a number of skin lesions removed while in custody. On 15 March 2013 Mr. O'Connor's health deteriorated and he was rushed to Wellington Hospital. He was diagnosed, *inter alia*, with emphysema. His condition was life-threatening and he was transferred to the Prince of Wales Hospital by air for cardiac surgery. A successful repair of the aortic wall was performed. He remained in hospital until September 2013. On 3 October 2013 Mr. O'Connor experienced an exacerbation of chronic obstructive pulmonary disease and was again transferred to the Prince of Wales Hospital. There he was diagnosed with endocarditis.

Mr. O'Connor was, subsequently, transported for annual transthoracic echocardiograms at Prince of Wales Hospital. He continued to have breathing difficulties in 2015 and 2016 and received regular medical reviews and instruction in the use of inhalers. In 2016 he was awaiting cataract surgery and had a basal cell carcinoma removed.

Wing 13 Long Bay Hospital Correctional Centre

Wings 12 and 13 of the Long Bay Hospital Correctional Centre are outpatient wings for inmates who require medical treatment but not hospitalisation. Mr. O'Connor had been transferred to Wing 13 on 16 May 2016. In August and September of that year he was sharing cell 9.

Hours leading up to death

At about 5:30pm on 16 September 2016 Mr. O'Connor was retching phlegm. He complained to his cell mate of a sore throat and said it was hard for him to talk. Following the routine visit of the nurse to his cell at about 6pm he was taken to the clinic and assessed. His blood pressure, pulse, temperature and oxygen saturation level were taken. The clinic nurses gave him cough medication and a new Ventolin inhaler and advised him to press the cell call activation button if he felt unwell. He returned to his cell.

When he returned to his cell he told his cell mate that he was feeling better and lay down on his bed at about 8:30pm watching television. Mr. O'Connor did not press the cell call activation button on the night of 16/17 September. On the morning of 17 September his cell mate could not rouse Mr. O'Connor and at 6:23 am pressed the emergency call button to inform the staff. Prison officers immediately responded and called Justice Health staff for assistance.

On arrival at the cell they found Mr. O'Connor stiff to touch and could not discern a pulse. Nonetheless Mr. O'Connor was moved out of the cell to allow room for cardiopulmonary resuscitation (CPR) which was commenced. Nurses arrived with a defibrillator, the use of which, together with CPR, continued until New South Wales ambulance paramedics arrived at 6:40am. Mr. O'Connor could not be revived.

The cause of death

An autopsy was performed by forensic pathologist, Dr Elsie Burger who determined that the cause of his death was the combined effects of ischaemic heart disease and chronic obstructive pulmonary disease.

Mr. O'Connor was 73 years old at the time of his death.

Findings required by s81(1)

Laurence Bede O'Connor died at Long Bay Hospital Correctional Centre, 1300 Anzac Parade, Malabar, New South Wales on 17 September 2016. Mr. O'Connor died as a result of the combined effects of ischaemic heart disease and chronic obstructive pulmonary disease. He died of natural causes.

24. 291951 of 2016

Inquest into the death of Caille Scott-Lewis. Finding handed down by Deputy State Coroner O’Sullivan at Glebe on the 26th June 2018.

These are the findings of an inquest into the death of Caillie Scott-Lewis.

Introduction

This was an inquest into the death of Caillie Scott-Lewis. Ms Scott-Lewis was aged 23 at the time of her death shortly after 11.04 p.m. on 27 September 2016. She died when a car in which she was a passenger ran off Ophir Road in Orange and collided with fences and a tree on properties adjacent to the road.

The Inquest

An inquest is conducted pursuant to provisions of the *Coroners Act 2009*. Section 81 the Act requires a Coroner to make a written record of the fact that a person has died and also record:

- **the person's identity;**
- **the date and place of the person's death; and**
- **the manner and cause of death.**

In addition, s. 27(1) and s. 23(b) of the Act, in the version applicable at the time this matter came to be considered by the Court, made the holding of this inquest mandatory. This is because Ms Scott-Lewis appears to have died either “as a result of” or “in the course of” a police operation, since the car in which she was a passenger came to the attention of a NSW Police car in the minutes before the accident. The police car commenced to turn to follow after it for a short distance, while the driver of Ms Scott-Lewis’ vehicle appears to have driven away to evade it, running off the road some time later.

It is the appropriateness of the actions of those police actions which must be scrutinised as part of this inquest. In mandating that Coroners conduct (and not dispense with) inquests in circumstances where a death appears to have had some relation to police actions, Parliament has attached considerable importance to a review by Coroners of those actions. That said, the holding of such an inquest itself does not imply that any wrongdoing has occurred on the part of any police officer, or that any view has been formed that the actions of police officers have ultimately contributed to the death of a person.

Caillie Scott-Lewis

As I have stated, Ms Scott-Lewis was only 23 years old when she died. The death of a person so young, with their life ahead of them is a great tragedy and loss for their family and the community. Her family’s grief can only have been horrific, and I express my condolences to them.

I understand that Ms Scott-Lewis had three young children and that, after having apparently experienced some difficulties in life, she had expressed to others just shortly before her death that she was getting her life together and looking forward to spending time with her young ones.

History of the proceedings

Ms Scott-Lewis' death occurred almost two years ago. The time taken to hold an inquest has been a consequence of criminal proceedings that were instituted against Matthew Borghero, who was charged on 28 September 2016 on the basis that he was alleged to be the driver of the vehicle carrying Ms Scott-Lewis. Mr Borghero pleaded guilty to those offences on 5 September 2017. Now that those matters have been finalised, this inquest has been able to be resumed under s.79 of the Act.

Mr Borghero was notified of his sufficient interest in these proceedings but did not seek leave to appear or be represented in the proceedings.

The evidence

At some time between 10:00pm and 11:00pm on 27 September 2016, Matthew Borghero drove a silver Ford Futura (registration no. CI 90 NO) with his friends Quinton Nydegger and Duane Blandford as passengers to pick up Ms Scott-Lewis, a friend of Mr Borghero's, from an address at Lone Pine Avenue, in Orange. Mr Borghero was unlicensed and on bail in relation to drug offences with which he had been charged some five days before. Accounts of events before this vary between the witnesses who have provided statements, but those events and discrepancies need not be explored for the purposes of this inquest.

Mr Borghero then stopped at a house in Spring Street, where he went inside for two or three minutes. He returned to the car and proceeded to drive from Spring Street onto Algona Crescent. He then turned right and proceeded south along Calang Street toward Bletchington Street. On Calang Street, the Ford Futura driven by Mr Borghero passed Orange 35, a fully-marked police sedan which was being driven by Constable Elizabeth Johns. Constable Johns was accompanied by Senior Constable Annette Tindall. At the time, the two officers were conducting a general patrol of the area, and were heading north along Calang Street (that is, in the opposite direction to the Ford).

SC Tindall recognised the number plates of the Ford Futura as belonging to a vehicle known to be used by Duane Blandford. SC Tindall understood Mr Blandford was on bail at the time and that, if he were in the car, he would be in breach of his bail curfew conditions. The officers then decided that they would turn their vehicle around and stop the Ford Futura in order to perform a random breath test and check the occupants of the vehicle. It appears that Constable Johns activated her vehicle's turning signals to indicate that she was about to perform a U-turn. This was observed by the occupants of the Ford Futura, prompting Mr Borghero to begin to speed away from Orange 35.

Constable Johns performed a U-turn and saw the lights of the Ford Futura turn left toward Dalton Street. Constable Johns proceeded to turn from Calang Street onto Bletchington Street, then onto Carramar Avenue and then onto Dalton Street. Constable Johns stated that she lost sight of the Ford Futura by this stage, as the Futura had gone over the crest of a hill on Dalton Street. SC Tindall notified VKG (police radio) of the situation. The Futura turned left from Dalton Street onto Ophir Road. At this time, Constable Johns had reached the crest of the hill on Dalton Street. From this viewpoint, Constable Johns and SC Tindall could see the Futura turn left from Dalton Street onto Ophir Road. SC Tindall radioed VKG to state that:

The Futura had taken-off before they had a chance to stop it;

They were not in pursuit; and other police vehicles in the area should keep a look-out as they believed Duane Blandford was in the car, and that he was in breach of the curfew conditions of his bail.

The Ford Futura proceeded through a roundabout at the intersection of Ophir Road and the Northern Distributor. It appears that Mr Borghero may have turned off the car's lights around this time. It appears that shortly after driving through the intersection and after a right-hand bend, Mr Borghero began to lose control of the vehicle, and it left the road. In the vicinity of 133 Ophir Road, the vehicle collided with fences and trees, ultimately stopping in the front yard of 145 Ophir Road.

Events following the collision

After the collision, Mr Borghero and Mr Blandford fled the scene. It appears that neither Mr Borghero nor Mr Blandford checked on the welfare of the other occupants of the vehicle. Ms Scott-Lewis suffered head injuries and died during the collision. She remained in the car.

Isha Deep, a resident in a granny flat at the back of 145 Ophir Road, recalled hearing the sound of a speeding car, followed by a "loud crashing sound" and "what sounded like wood snapping and metal smashing together". She immediately phoned 000 to request assistance. According to her phone records, she made this call at 11:04pm.

Having heard the collision, Joel Taylor, a resident in the main property of 145 Ophir Road, opened the door to his house and was approached by Mr Nydegger, who asked Mr Taylor to call an ambulance as there had been an accident and there was a deceased person. Mr Taylor's fiancée, phoned 000.

It appears that Orange 35 initially drove past the crash site, not seeing what had happened, and continued to drive along Ophir Road, possibly as far north as Banjo Patterson Way. When they could not locate the Ford Futura, SC Tindall and Constable Johns decided to drive back toward Orange in order to perform a bail compliance check at the property where Mr Blandford was supposed to reside during his curfew.

After turning around, SC Tindall and Constable Johns received a VKG broadcast that there had been an accident on Ophir Road. SC Tindall and Constable Johns arrived at the crash site a couple of minutes later. They were the first officers on scene.

On arriving at the accident site, Senior Constable Tindall got out of the police vehicle and ran straight to the Ford Fortura. She found Ms Scott-Lewis' body in the vehicle. Both Constable Johns and Senior Constable Tindall spoke with Quinton Nydegger, who remained at the scene. Mr Nydegger informed Constable Johns that he had been a passenger in the car, and that Duane Blandford, another passenger, had fled the scene together with the driver, whom he identified to the officers as Matthew Borghero.

Senior Constable Tindall appears to have been very concerned to establish the identity of the person in the car, and thought it may have been Ms Scott-Lewis. Coincidentally, Senior Constable Tindall had been providing support to Ms Scott-Lewis in the weeks prior with a court matter that Ms Scott-Lewis was involved in.

Ms Scott-Lewis was declared deceased at Orange Hospital at 6:58 a.m. on 28 September 2016. Her identity was confirmed by subsequent fingerprint analysis.

On 28 September 2016, investigating police conducted recorded interviews with Mr Nydegger and Mr Blandford (who made contact with police that morning and presented himself to Orange Police Station). Both men identified Matthew Borghero as the driver of the car. Neither stated that the police car was in pursuit of their vehicle. They describe the manner of Mr Borghero's driving as, among other things, "erratic".

At around 9 a.m., police attended premises in Algona Crescent, Orange, and arrested Mr Borghero. An officer noted Mr Borghero had scratches to his face and knuckles. He appeared visibly upset and stated to one of the officers "I can't believe I hurt my friend." Mr Borghero was taken to Orange Police Station and later Orange Base Hospital for treatment of injuries he sustained in the accident. At 11:25 a.m., Mr Borghero was subjected to a blood test for drugs and alcohol at Orange Hospital. He was returned to the station and charged with criminal offences in relation to the accident. He was interviewed by police around 2 p.m. In his interview, Mr Borghero denied being the driver of the car and stated Duane Blandford was driving. Further, he made various statements suggesting that the police vehicle was pursuing the vehicle in which he was traveling. Those statements warrant careful scrutiny given the purpose of this inquest.

Amphetamine and methylamphetamine were found upon toxicological analysis of the sample of Mr Borghero's blood that was taken after his arrest at 11.25 a.m.

In parallel to the criminal investigation police were undertaking into the cause of the accident, a Critical Incident Investigation, led by Detective Inspector Jason Pietruszka of the Orana Local Area Command, was commenced. A Critical Incident Investigation is a review conducted by police officers from a different Local Area Command of deaths or serious injuries that occur in the context of police operations. As part of this investigation, both Constable Johns and Senior Constable Tindall were required to undergo alcohol testing (no alcohol was detected). They were also required to participate in recorded interviews about the circumstances of Ms Scott-Lewis' death. Those interviews are contained in the brief of evidence.

An autopsy was performed by Dr Brian Beer, Senior Staff Specialist in Forensic Pathology, at Newcastle on 4 October 2016. Dr Beer ascertained the cause of Ms Scott-Lewis' death to have been head injuries.

As I have noted, Mr Borghero pleaded guilty in the NSW District Court at Orange on 5 September 2017 to the offences of dangerous driving occasioning death (s. 52A(1)(c) *Crimes Act 1900*) and fail to stop and assist after vehicle impact causing death (s. 52AB(1)). The facts tendered as part of his plea are contained in the brief of evidence. In his plea, Mr Borghero admitted being the driver of the car.

Issues at inquest

The particular issue that was considered at the inquest, beyond consideration of the statutory findings that were required to be made, were:

Whether Constable Johns and SC Tindall on 27 September 2016:

- engaged in a pursuit of the vehicle in which Ms Scott-Lewis was a passenger;
- acted in compliance with the requirements of the NSW Police Fore Safe Driving Policy.

A brief of evidence was tendered at the hearing (Exhibit 1), which comprised various witness statements, other documentary evidence and the audio of police radio broadcasts made on the night of 27 September 2016. The Court also heard oral evidence from Inspector Pietruszka. In addition, a view of the route driven by Orange 35 and the vehicle carrying Ms Scott-Lewis was conducted, to allow the Court to consider the physical aspects of the roads involved.

Cause of the accident

On the basis of Mr Borghero's plea of guilty to the offence of dangerous driving in relation to the crash, it can be found to the requisite standard that he was the driver of the Ford Futura at the time of the collision. Additional support, should any be required for this conclusion, is found in the accounts of Mr Nydegger and Mr Blandford, who both nominated Mr Borghero as the driver of the car. Mr Borghero was the owner of the vehicle, although it was not registered in his name. Further, he was homeless at the time, and living out of the vehicle. He had been seen driving the vehicle by police on the day of the accident. Those officers made efforts to locate him that afternoon, without success.

Mr Borghero had been charged with criminal offences on 22 September 2016, five days before the collision, and was on bail at the time of the accident. He was unlicensed. It appears clear that Mr Borghero understood that, if he were to be found by police driving a car, unlicensed, he would be in breach of his bail conditions, and that he feared being imprisoned if he were found. This prompted Mr Borghero to seek to evade the police car he encountered.

It is clear from the available evidence that Mr Borghero's decision to drive at a high speed and erratically in order to evade police detection caused the collision which resulted in Ms Scott-Lewis' death. While the exact speeds that the Ford Futura was travelling are not known, witnesses have made the following statements:

Mr Nydegger estimates the car was travelling at between 100km/h and 120km/h on Dalton Street, between 60km/h and 80km/h as it went through the roundabout, and he states that Mr Borghero "was going too fast the whole way along";

SC Tindall states the vehicle was travelling "extremely fast" and she "wasn't comfortable chasing after the vehicle once I saw the speed it was reaching".

Adding to the dangerousness of his driving, Mr Borghero turned off the headlights of the Ford Futura on an unlit road in order to reduce his visibility to police.

Both Mr Nydegger and Ms Scott-Lewis repeatedly asked Mr Borghero to stop so that they could exit the vehicle.

In relation to the cause of the collision, Mr Nydegger makes the following statement in his interview:

"Q416 In your opinion, is there anything that could have prevented the crash occurring tonight?

A Yes. Matt not taking off, driving, taking off, basically, just staying, not panicking. Basically I think he's just panicked and it's gone from one thing to another. Yes. Tragic."

Similarly, Mr Blandford makes the following statement in his interview:

“Q72 Do you know what caused the accident?

A Matt speeding and no lights on.”

Whether a police pursuit took place

In his recorded interview, Mr Borghero maintained that the police officers were closely following behind the Fort Futura, in pursuit:

A The car was being chased.

Q39 I’m sorry?

A The car was being chased.

Q40 The car was being chased. So tell me what happened.

A Um, yeah. The car was chased.

Q41 By who?

A Police

Q42 Tell me about that.

A It was chased. It was chased. There were police headlights and - - -

Q43 I’m sorry, I can’t hear you.

A Police headlights in the car.

Q44 Police headlights in the car?

A They were like, they were right behind the car. They were trying - - -

Q45 I’m sorry, I can’t, I need to be able to hear you correctly. It’s quite... so.

A They were right behind the car the whole time.”

The evidence I have considered in this matter does not support the statements made by Mr Borghero. It must be noted that Mr Borghero denied being the driver of the vehicle in his interview with police, but later accepted in his guilty plea that he was driving the car. Given this, the credibility of his account, generally, must be questioned. The presence of what Dr Perl determined was a “significant level” of methylamphetamine in a sample of his blood taken at 11:25 a.m. also raises the possibility that he may have still been under the effect of the drug at the time of the interview, at around 2:08 p.m. In any event, he provides very little detail to bear out his claims and his recollection of events appears vague. Given these matters, and considering the other evidence in this inquest, his version of events that night cannot be accepted.

In contrast, Mr Nydegger gives the following account (with emphasis added):

“Q196 So you’re heading towards Dalton Street.

A Yes.

Q197 And as you turned the corner you saw the indicator come on the police vehicle.

A Yes.

Q198 And they indicated to turn around.

A Yes. But they didn’t seem to chase us or follow us through here.

Q199 Right.

A And we never saw them after that, basically, as we drove up Dalton Street. We couldn’t see them behind us.” The account given by Mr Nydegger in his interview is to be preferred. He provides a detailed description of events, including of the route taken by the Ford Futura that is consistent with the accounts given by the officers. He appears certain that the Ford Futura quickly lost sight of Orange 35, at a point when the vehicle entered Dalton Road. As the only person to remain at the scene of the accident, I infer that he is a credible witness.

Mr Blandford’s account is that he was asleep in the vehicle until shortly before the collision and is not generally of assistance, save to say that he did not notice any police sirens or the presence of a police car when he woke at a time shortly before the crash. The evidence of SC Tindall and Constable Johns is that they decided not to pursue the Ford Futura. In her interview, SC Tindall gives the following account of her decision not to initiate a pursuit:

“Q Can you like estimate the speed of the vehicle as it was approaching or as it was getting away from you?

A I have no idea. It was extremely fast. There was something that alerted me to the manner of driving that prompted me to straightaway say that we were not in pursuit. I wasn’t, I wasn’t happy with the speed that it was going, you know,

I know it was in excess of the speed limit. To what that extent was, it was only a matter of seconds before we lost sight of it.”

Later in her interview, SC Tindall states that she “wasn’t comfortable chasing after the vehicle once I saw the speed it was reaching.”

A fact upon which it appears all witnesses (including Mr Borghero) agree, is that the sirens and flashing lights of Orange 35 were not activated at any stage between the time Orange 35 passed the Ford Futura on Calang Street and the time the Ford Futura crashed on Orphir Road.

The VKG audio contained within the brief hearing confirms that Orange 35 made a radio broadcast stating that the Ford Futura had sped away from the officers and that they were not in pursuit.

After that broadcast is heard, there follows a further four-and-a-half minutes of broadcasts by Orange 35 and other units about looking for the Futura before a broadcast is made by the operator reporting that the accident had occurred. That is a significant period of time and the discussion heard on the audio during it is inconsistent with an idea that the police officers in Orange 35 were simultaneously engaging in a high-speed pursuit of the Futura.

After a broadcast is made of the accident at Ophir Road, it is a further two minutes before Orange 35 arrives at the accident scene. This is also consistent with Orange 35 having lost contact with, and being some distance from the Ford Futura after it had sped away.

Whether the NSW Police Safe Driving Policy was adhered to

The officers' actions in not engaging in a pursuit were consistent with what is required under the NSW Police Safe Driving Policy. In particular, the reasons given by Senior Constable Tindall in her interview (at p. 12) for not engaging in a pursuit correspond with the matters to be considered at 7.2.2 of the policy, relevant parts of which were tendered as an exhibit in the proceedings. There can be no criticisms of the actions taken by S/C Tindall and Constable Johns.

I find that the officers initially turned to follow after the Ford Futura on Calang St, losing sight of it by the time the Futura sped away on the uphill portion of Dalton St. During the view, it was evident that this portion of Dalton St features a significant incline leading to a crest, such that a vehicle traveling up the hill cannot see anything of the road beyond it. The officers regained sight of the taillights of the Futura once they reached the crest the hill on Dalton St, when the Futura had already turned left from Dalton St onto Ophir Rd, by which time it was a distance of some 500-600 metres away and traveling at significant speed. The officers did not engage in a pursuit at this point or otherwise attempt to catch up with the vehicle.

The officers' attendance at the collision must have been distressing, in particular given Senior Constable Tindall's recent involvement in assisting Ms Scott-Lewis. Her clear concern for Ms Scott-Lewis at this time should be noted. I would like to thank the officer in charge, Detective Inspector Pietruszka, for his thorough investigation. I would also like to thank my Counsel Assisting, Mr James Herrington from the Crown Solicitor's Office for his excellent assistance before and during the inquest.

Finally, I offer my sincere condolences to Ms Scott-Lewis's family for the tragic loss of Caillie.

Findings required by s. 81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased The deceased person was Caillie Scott-Lewis.

Date of death She died on 27 September 2016.

Place of death She died at 145 Ophir Road, Orange, NSW.

Cause of death The death was caused by head injuries.

Manner of death

Ms Scott-Lewis died when a car in which she was a passenger ran off the road and collided with fence posts and a tree. The driver of the car was attempting to evade a NSW Police car, but not in the course of a police pursuit.

25. 347726 of 2016

Inquest into the death of MB. Finding handed down by Deputy State Coroner Lee at Glebe on the 28th August 2018.

Introduction

Mr MB was a much-loved husband and father of three adult children. During the last 18 months of his life, MB experienced a gradual deterioration in his mental health that made him distant and almost unrecognisable to those that loved him the most.

On 20 November 2016 MB found himself in crisis and placed his own life in danger. A number of police officers responded to this crisis and attempted to bring MB to safety. Tragically, despite their best efforts, the danger that MB was in could not be averted and he took actions to end his own life.

Why was an inquest held?

Under the *Coroners Act 2009 (the Act)* a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner fulfil their statutory responsibility to answer questions that they are required to be answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

Due to the circumstances surrounding the events of 20 November 2016, MB was regarded as having died in the course of a police operation. This meant that, according to the relevant section of the Act which applied at the time, it was mandatory to hold an inquest into MB's death. This does not suggest that there was any action taken by any police officer that should be subject to scrutiny or criticism. In fact, the evidence is to the contrary; it establishes that the police officers who were directly interacting with MB on 20 November 2016 did so in a professional and compassionate manner, with the goal of preserving MB's life.

MB's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important at this point to recognise and acknowledge MB's life in a brief, but hopefully meaningful, way.

MB was born in India in 1952 and moved to England with his family when he was around 7 years old. M B later met his first wife, M, and together they had three children: A, A, and D. In 1995, shortly after his mother's death, MB moved to Australia in 1995 with his then wife and three children.

At this time, MB was working as a computer engineer and he continued in this capacity until 2001 when he changed jobs and took on a role in sales for a solar company. At around the same time, MB's marriage came to an end and he and his wife separated. In 2006 MB began a relationship with his second wife, R. They later married in 2006 and in 2013 they moved to a home in the Kellyville area. By around this time MB had left his sales role and had become involved in property development.

By all accounts, MB was an intelligent and articulate man as evidenced by his successful professional careers over many years which earned him the respect of his professional peers. He was also a loving husband and a caring and loyal friend.

Most importantly, MB was also a devoted father who, when his children were younger, took an active and involved role in their upbringing. No doubt MB's children have very fond memories of the time spent with their father and the great interest and pride that he took in their sporting, and other, activities. When MB's children grew older, they left Australia to pursue their own careers and other endeavours overseas. Despite this, MB remained in frequent contact with his children and the distance between them in no way diminished his love and affection for them.

It is most upsetting to know that the life of such a much-loved and well-respected gentleman has ended prematurely and that he will be greatly missed.

MB's medical history

According to his wife, R, MB was in good health up until about 18 months before his death. In June 2015 Mrs B noticed that her husband appeared to be under some stress after returning from a business trip to India. The following month Mr and Mrs B travelled to England to attend a wedding but they returned to Australia earlier than planned after Mr B complained of experiencing shortness of breath whilst overseas. Mrs B also noticed that her husband appeared agitated and unsettled during the trip.

Upon their return MB went to see a GP for a routine health check where nothing adverse was noted. Despite this, MB's apparent general malaise persisted and he saw a number of doctors (including a gastroenterologist, and a respiratory and sleep physician) in an attempt to resolve his issues. During this time, MB first began to make references to a belief that features of his home were making him sick. MB spoke of a chemical that was emanating from the floorboards, and the air conditioning system which was circulating fibreglass particles throughout the house, causing him to inhale them. During this period Mrs B also noticed that her husband became socially withdrawn; as an example, where MB would previously go out to play golf, he instead preferred to remain at home.

At around this time one of MB's closest friends of many years, JH, noticed what he described as a real change in his friend.

He observed that MB had begun to question his own self-confidence and decision-making, and that this behaviour was a stark contrast to the strong, confident friend that he had known for many years.

MB was eventually referred to see Dr Jaspreet Singh, a consultant psychiatrist. Dr Singh first saw M B on 25 November 2015. At the time Dr Singh noted that MB was displaying symptoms of low mood, lack of motivation, poor sleep and appetite, and negative ideas about himself and his future. Dr Singh diagnosed MB as suffering from major depression of moderate severity, prescribed him with antidepressant medication (mirtazapine) and referred him to a psychologist. Dr Singh noted that some recent financial difficulties that MB had experienced, prolonged grief from the breakdown of his first marriage, and increasing isolation from his family were all stressors contributing to his depressive illness.

Mr B saw Dr Singh a further three times between December 2015 and March 2016. On these occasions Dr Singh noted that MB continued to experience low mood whilst feeling unmotivated, and was concerned about issues relating to his physical health and financial situation. On 23 March 2016 Dr Singh ceased the prescription of mirtazapine and trialled a new medication regime consisting of another SSRI (selective serotonin reuptake inhibitor) antidepressant (venlafaxine) and an antipsychotic (quetiapine) in an attempt to treat MB's symptoms.

In the period between December 2015 and March 2016 MB attended four counselling sessions with a psychologist. During these sessions MB expressed concern about his financial situation and was reported to be experiencing general negativity at this time.

An extended period passed before MB's next appointment with Dr Singh. According to Mrs B this was due to her husband's preoccupation with renovations needed for their home in order to address MB's concerns regarding the floorboards and air conditioning, combined with MB's reluctance to continue the appointments. Eventually, MB saw Dr Singh again on 1 June 2016 where it was noted that MB continued to experience stress and depression related to his home renovations and financial issues, and that the change in medication had had little positive effect. Dr Singh increased the dose of venlafaxine and scheduled a further appointment in three weeks.

When MB next saw Dr Singh on 23 June 2016 he reported some improvement in his mood, anxiety level, and sleep. Dr Singh also noted that MB denied any suicidal ideation or intent and that he was motivated to resolve his various issues. Dr Singh increased the dose of venlafaxine and made arrangements to see MB again.

This occurred next on 21 July 2016 when Dr Singh noted that MB *"continued to be poorly motivated and was at a pre-motivational stage in terms of making changes to his lifestyle and implementing suggestions about rehabilitation"*. Dr Singh encouraged MB to engage with his treatment and provided a second referral to a different psychologist.

MB later attended a single appointment with this psychologist on 4 August 2016 when it was noted that MB avoided discussion about his psychological symptoms, preferring to instead concentrate on his physical symptoms related to his perceived living conditions at home.

MB saw Dr Singh for an eighth and final time on 18 August 2016. During this consultation MB reported improvements in his mood, appetite and sleep, but remained preoccupied with his home and its air conditioning system. Dr Singh discussed the possibility of a voluntary admission to hospital but MB was resistant, indicating that he wanted to continue treatment as an outpatient and to address his physical issues first; however, he agreed to discuss the idea of an admission with his wife. Dr Singh made plans to review MB again in two or three weeks, if he decided not to agree to a hospital admission.

On 2 November 2016 MB went to see a GP at a local medical centre when he again reported his concerns that the air conditioning system in his home was causing him respiratory issues. Further, MB expressed the view that fibreglass particles circulated by the air conditioning system were causing irritation to his skin, and he expressed the view that he should be seen by a dermatologist.

Dr Singh noted that during his consultations MB *“would occasionally voice a passive ‘wish to die’ on questioning but on further exploration, would deny any clear ideas or intent or suicide or self-harm”*. Dr Singh also formed the view that MB’s concerns about his physical health *“were best conceptualised as ‘hypochondriacal ideas’”* as part of his depressive condition. In this sense, Dr Singh noted it is common for patients with depression to have concerns about their physical well-being.

Events of early November 2016

On Thursday, 10 November 2016 Mrs B returned home and saw that there was a rope lying on an internal staircase. When she asked MB about this discovery he said that it was nothing and that he was not going to do anything with the rope. Due to concerns for her husband’s welfare, Mrs B contacted Mr H and asked for his assistance. When Mr H later attended MB’s home he was shocked at MB’s appearance, describing him almost unrecognisable from the friend that he knew and a shell of his former self. Mr H attempted to elicit from MB what was troubling him and MB again referred to perceived issues relating to the floorboards and air conditioning system in his home.

After meeting with MB, Mr H later asked his son to contact MB’s son, D, in order to advise him of his father’s condition and ask that he return home to see him. At the time, D was living in London and, upon hearing that his father was not well, sought further information from both Mrs B and Mr H. After speaking with them, D learned that his father seemed to be socially withdrawn and staying at home more often than he had previously.

Several days after discovering the rope at home, Mrs B found a recorded video message that MB had left on his Facebook account for his family to access. The message was about three minutes in duration and in it MB bade farewell to his family, expressed his love for them, asked Mrs B to forgive him, and referred to the house which was damaging his health. MB concluded by saying, *“And again I’m very sorry to do this to you, but at the moment I’m just not even surviving, I’m just barely getting up I’m so weak, no energy, and it’s all cause [sic] by the gas from the laminated floorboards”*. After viewing the message, Mrs B spoke to her husband about it. MB expressed great reluctance in going to what he referred to as an *“institution”* and assured his wife that he was not going to hurt himself. After this conversation, Mrs B decided not to speak to her husband about the message again as he had guaranteed his own safety and because she did not want to upset him.

D arrived in Sydney unannounced on Sunday, 13 November 2016 and went to see his father, hoping to surprise him. However, when he saw his father D noticed that he appeared to be emotionless and described him as being in a “*dark place*”, with a lifeless expression and appearing to be “*empty*”. Whereas D had previously known his father to be a decisive person he now seemed hesitant and listless.

On Tuesday, 16 November 2016 D contacted Mr H in an attempt to arrange a meeting so that he and MB could catch up and socialise. Despite encouragement from his son, MB was non-committal and ambivalent. Two days later on Thursday, 18 November 2016 D spoke to Mrs B about his father’s condition and enquired whether he had been seeing any health care professionals. Mrs B told D about his father’s past medical appointments and mentioned her discovery of the rope at home a week earlier.

D saw his father later that day and again encouraged him to contact Mr H. Again, MB remained hesitant and non-committal. D attempted to persuade his father to leave the house more often and offered to take him to an outdoor event which he thought he would enjoy, but his father showed little interest in doing so. D attempted to engage his father in conversation about his welfare and told his father that he loved him and that his family would never judge him no matter how he was feeling. MB acknowledged this but otherwise was reticent to continue the conversation. Eventually D managed to persuade his father to accompany him to visit Mr H but during the visit MB appeared to be mentally absent. After the visit D and his father went to Bondi to go for a walk along the coast but D noticed again that his father appeared to be “*mentally slow*” during the walk and afterwards, and that he was “*zoning in and out, not really there*”. On their way home from Bondi D attempted to ask his father about the rope which Mrs B had found but MB said very little in response and dismissed the incident.

When D went to visit his father the following day, Friday, 19 November 2016, MB again referred to the floorboards in the house releasing formaldehyde and that the air conditioning system in the house was not being maintained causing fibreglass particles in the roof to be circulated throughout the house and causing damage to his lungs. D spoke to his father about seeking professional mental health assistance and noted that there was a referral at his father’s house for Dr Singh, and for another clinic in the Kellyville area.

D subsequently called Dr Singh’s office to make an appointment and was advised that his father could not be seen until 15 December 2016. When he called the other clinic he was told that because his father would be a new patient he could not be seen until January 2017. D conveyed during both phone calls that he believed his father’s condition to be poor and that he needed to be seen earlier than the dates that were being offered. After D spoke to his father about the results of the enquiries MB eventually made an appointment to see Dr Singh on 15 December 2016.

D later took his father out to a hardware store in order to buy some equipment so that his father could engage in some gardening activities. Whilst at the store, MB noticed some floorboards and again made reference to his dissatisfaction with the floorboards in his own home.

After they returned home and had lunch, they had a conversation with Mrs B during which MB expressed a desire to move homes because of his unhappiness concerning the floorboards and air conditioning system.

What happened on 19 and 20 November 2016?

On Saturday 19 November 2016 Mrs B suggested to her husband that they should go for a short trip to the Central Coast in order to spend some time away from the house that was causing MB a great deal of anxiety and distress. They left home at about 11:30am intending to drive to The Entrance but stopped at Terrigal along the way. They decided to stay overnight there and checked into the Crowne Plaza Hotel. After walking around Terrigal, they had dinner and otherwise enjoyed a pleasant evening out. Although she had observed MB to be happy during the evening Mrs B found her husband to be restless later that night. She noticed that he turned the air conditioning off and on in their room, and also took the doona off their bed.

The following morning, Sunday 20 November 2016, Mr and Mrs B went out for breakfast and then returned to the hotel to pack before their departure. They left the hotel and drove to the nearby Skillion, a narrow section of headland near Terrigal beach and well-known local attraction. After sitting on a blanket underneath a tree Mr and Mrs B decided to go for lunch at a restaurant close by in the area. Following lunch MB returned to the blanket to lie down in a shaded area whilst Mrs B went for a walk. When she returned MB decided that he wanted to go for a walk as well and so they both made their way up a hill to the top of the Skillion where there is fenced lookout area with views out to the ocean, at a height of about 150 metres above sea level. Mr and Mrs B remained in the area for a while and Mrs B noticed that her husband was quiet. As the weather was hot, Mrs B decided to walk back down and sat on a bench at the base of the Skillion.

After about 10 minutes Mrs B saw MB walking around the lookout area. She called him on his mobile phone but he did not answer, so she began walking back up the hill. As she approached the top of the Skillion Mrs B saw that MB was standing on the incorrect side of the fence surrounding the lookout and near the edge of the cliff. Mrs B called out to her husband, asking him what he was doing and to return back to the correct side of the fence. MB asked to be given a minute and Mrs B saw what she described as a "lost look" in his eyes. She told MB to come out and that she loved him. He responded by saying, "I know", and then took his wallet out of his pocket and threw it on the ground. Mrs B asked her husband to pick up the wallet and hand it to her, in an attempt to bring him closer to the fence, but he instead picked it up and threw it towards her. At this time, there were some members of the public in the lookout area who had observed what was occurring. One of the persons asked Mrs B if MB was not well and Mrs B confirmed that was the case, whilst another person asked Mrs B if she wanted the police to be called, to which Mrs B agreed.

One of the bystanders called triple zero and a broadcast was made over police radio for any available officers to respond. Senior Constable Bernadette Difford was performing general duties in the nearby area at the time and heard the broadcast at 4.49pm. She acknowledged the job and made her way to the Skillion, arriving at 4.52pm.

After making her way to the top of the Skillion Senior Constable Difford saw that MB was still standing on the incorrect side of the fence, about five metres away from it, and still near the cliff edge.

Senior Constable Difford identified Mrs B and asked her what had caused her husband to be on the incorrect side of the fence. Mrs B explained that she and her husband had been looking at the view from the top of the Skillion, and that she had left and returned a short time later to find her husband on the incorrect side of the fence. Senior Constable Difford moved Mrs B and some other members of the public who were at the scene to one side and introduced herself to MB. Senior Constable Difford asked MB to step back from the ledge and to move closer to the fence so that she could speak with him. MB took a step back and Senior Constable Difford asked if she could do anything for him, and again requested that he move closer to the fence.

By this time, other police officers who had acknowledged the radio broadcast had also arrived on scene and were making their way to the top of the Skillion. One of the police officers was Senior Constable Craig Tonks. After Mrs B moved away from the scene Senior Constable Tonks spoke to her. Mrs B indicated that MB had been suffering from depression, had not seen his doctor for several weeks and was not taking his medication. She told Senior Constable Tonks that she and her husband had enjoyed a very pleasant day when they arrived in Terrigal the previous day, but that she had noticed that he had been acting somewhat unusually that day.

Meanwhile, Senior Constable Difford began to engage MB in conversation and asked him if he was happy to speak with her; MB indicated that he was. After asking MB some introductory questions about where he lived and what sporting teams he followed, Senior Constable Difford asked him why he was there. MB replied, *"Because of my health"*, and when Senior Constable Difford asked what was wrong with his health, MB replied, *"My chest"*. Senior Constable Difford continued to engage MB in conversation, asking him questions about his background, his employment and his children. As this was occurring, further police officers arrived at the scene.

The activity and movement of people away from the summit appeared to unsettle MB, causing him to move closer to the cliff edge. However, Senior Constable Difford continued to reassure MB by advising him that other first responders and emergency personnel would also be arriving at the scene shortly, so that their appearance would not come as a surprise to him. Senior Constable Difford also continued to ask MB if he could move closer to the fence. A short time later Senior Constable Difford was joined by a paramedic who also engaged MB in some introductory conversation. At some stage MB began eating berries from a small tree that was located near a small chicken wire fence close to the cliff edge. Senior Constable Difford asked MB if he could bring her some berries so that he would move closer to the fence surrounding the viewing area that she was standing behind.

She also asked MB if he wanted some water and he indicated that he did. Senior Constable Difford obtained a bottle of water from the paramedic and asked MB to approach the fence to collect it. MB asked if Senior Constable Difford could throw the bottle to him but she declined and so MB walked over and Senior Constable Difford handed the bottle to him.

Senior Constable Difford asked MB to remain close to the fence and engaged him in further conversation about his children and other members of his family. As this conversation continued Senior Constable Difford saw MB step closer to the edge and each time this occurred Senior Constable Difford asked him to step back, and MB complied.

At some point in their conversation Senior Constable Difford asked MB if he wanted to hurt himself. When MB said that he did not, Senior Constable Difford asked why he had placed himself in danger. MB replied, *"Because I'm in a bit of a jam"*. When Senior Constable Difford enquired further about this, MB said that the floor boards in his house were toxic. After speaking about some other topics, Senior Constable Difford returned to the topic of MB's health issues. She asked MB to tell her about his chest pain and he indicated that he had difficulty with indigestion and heart burn. At one stage MB asked Senior Constable Difford if she had a phone. Senior Constable Difford asked MB if he wanted a phone and if he wanted to call anyone, and MB answered no on both counts. Senior Constable Difford asked MB if he would like to speak to his wife and he responded by asking Senior Constable Difford to tell her that he loved her. Senior Constable Difford attempted to reassure MB that he could do so himself and asked him again to move back to the correct side of the fence.

Senior Constable Gerrard Ivins, an officer from the NSW Police Negotiation Unit, later joined Senior Constable Difford at the lookout area. He had arrived on scene at around 5:50pm after receiving a call at about 5:10pm. Senior Constable Difford introduced Senior Constable Ivins to MB and both officers engaged MB in further conversation about topics that had been discussed previously: MB's health, his family, his job, and the toxic floorboards.

During the conversation Senior Constable Ivins asked MB if he could move away from the edge and stand near the fence. Although MB said that he would, he did not actually do so. Senior Constable Ivins left a short time later to call his supervisor whilst Senior Constable Difford continued to engage MB in conversation, reassuring him that he was not in any trouble, that she was there to help, and that she would not leave until they could walk back down from the top of the Skillion together. Senior Constable Ivins returned at around 6:15pm and noticed that MB appeared tired. Senior Constable Ivins asked MB what had upset him and why he was at the location, and MB again referred to the fact that the house he was living in was causing him health problems. During this conversation Senior Constable Ivins continued to ask MB to step away from the edge. Both he and Senior Constable Difford asked MB if he wanted anything to eat or drink but MB said that he did not.

As he was having some difficulty hearing MB, Senior Constable Ivins positioned himself closer to him, along the fence line and about four metres away. He reassured MB that the police were not going to attempt to approach MB and that he was simply moving so that he could better hear him. At this time further police officers were arriving on the scene, including officers from the Rescue Unit, and Senior Constable Ivins explained to MB who they were and that their task was to ensure the safety of all persons involved.

At around 6:55pm, Senior Constable Ivins saw that other police negotiators had arrived on the scene. He told MB that he was going to speak with them and asked MB to sit down on the grass near the edge so that he knew that he was safe.

After speaking with the negotiators who had arrived Senior Constable Ivins made his way back to the top of the Skillion at around 6:58pm, accompanied by Sergeant Joseph Caruso, another officer from the Negotiation Unit. As the officers approached, Senior Constable Ivins saw that MB was no longer sitting down and had stood up near the cliff edge. After returning to his previous position where he had been speaking with MB, Senior Constable Ivins introduced Sergeant Caruso and told MB that they were there because they were concerned about him.

As this was occurring arrangements were being made for other police officers, including Senior Constable Difford, and emergency personnel to move away from the top of the Skillion and to a command post at the base of the hill. This was to allow the police negotiators to speak to MB without interruption or distraction. As the police and other personnel moved away, Senior Constable Ivins again asked MB to move away from the edge so that he and Sergeant Caruso could talk to him about what was troubling him. MB looked in their direction and then turned and jumped off the edge of the cliff.

Emergency personnel were immediately despatched to the rocks at the base of the cliff where MB was found. They discovered that MB had sustained significant traumatic injuries and showed no signs of life.

What was the cause and manner of MB's death?

MB was later taken to the Department of Forensic Medicine at Newcastle where a postmortem examination was performed by Dr Brian Beer, forensic pathologist, on 24 November 2016. MB was found to have extensive head injuries, including skull and facial fractures, and extensive fractures of the ribs. Dr Beer concluded in his autopsy report dated 23 December 2016 that MB died from multiple injuries.

Given the gravity of a finding that a person has intentionally inflicted their own death it is well-established that such a finding cannot be assumed, but must be proved on the available evidence. Taking into account MB's history of declining mental health in the 18 months preceding his death, the discovery of the rope at his home and his video recorded message to his family, and his witnessed actions on 20 November 2016, I conclude that the evidence is sufficiently clear, cogent and exact to allow a finding to be made that MB died as a consequence of actions taken by him with the intention of ending his life.

Issues considered by the inquest

Prior to the inquest, a thorough coronial investigation was performed in order to identify whether there were any factors contributing to MB's death which warranted specific examination at inquest. No such factors were identified. On this basis it was indicated to MB's family and to the NSW Commissioner of Police (the only other sufficiently interested party) prior to the inquest that:

An inquest was only required to be held because of the mandatory provision contained in the Act which applied at the time of MB's death, and not because it was expected that any aspect of MB's death and the circumstances leading up to it would be the subject of critical comment;

and it was expected that the only issues which the inquest would consider would be the statutory requirements under sections 27(1)(c) and 27(1)(d) of the Act – in other words, MB’s identity, the date and place of his death, and the cause and manner of his death – and that that none of these issues were controversial or in dispute. However, given the events leading up to MB’s death and the events of 20 November 2016, some comment should be made about two specific matters which are set out below.

Attempts to seek treatment for MB

The first matter concerns the attempts made by D on 18 November 2016 to make arrangements to have his father seen by a mental health care professional. As noted above, when this attempt was made with Dr Singh’s office on that day D was advised that the first available appointment would not be until 15 December 2016. The circumstances surrounding D’s attempts to seek assistance for his father were considered during the course of the coronial investigation.

Although the investigation was unable to identify who D spoke to, it is likely that it was a secretary who was employed at Dr Singh’s medical practice (but who was no longer so employed by the time of the inquest). It is unclear whether the severity of MB’s condition was made clear at the time of the call or, if it was, whether it was appreciated by the person who received the call.

In any event, what is of importance is that the nature of D’s enquiry was not communicated to Dr Singh. Had this occurred, Dr Singh explained that *“it is standard practice for acutely unwell patients to be offered the earliest possible appointment, which is generally the same day if clinically indicated. If this cannot be done secretaries are trained to direct patients to their general practitioner immediately, or to contact emergency services if the situation is really urgent”*. Dr Singh went on to explain that if had known of the severity of MB’s condition, he would have made himself available to urgently review MB on 18 November 2016, or made alternative suggestions for treatment if this could not occur.

Conclusion: The coronial investigation did not identify any systemic issue associated with the enquiries made by D with Dr Singh’s practice on 18 November 2016. It appears that the appointment date of 15 December 2016, almost a month later, was offered because the severity of MB’s clinical condition was not fully appreciated at the time. The evidence establishes that relevant procedures and training are in place to ensure that patients referred to the practice in need of acute care are triaged adequately and appropriately. The evidence also establishes that if this had been communicated to Dr Singh it is likely that MB would have been offered a consultation with Dr Singh that same day, or been referred to a more timely consultation with a different mental health care professional.

Due to several unknown variables, it is of course not possible to know whether a consultation between MB and a mental health care professional on 18 November 2016 might have resulted in a different outcome two days later. By 18 November 2016 MB had not seen Dr Singh for exactly three months and his history of consultations indicated that he was somewhat reticent to engage in treatment. Further, MB’s was in a more positive mental state by the evening of Saturday 19 November 2016, but his mental state had worsened during the course of the following day. The totality of evidence does not establish a causal or contributory link between the events of 18 November 2016 and the events of 20 November 2016.

Conduct of the police operation

The second issue concerns the actions of the police officers who directly spoke with MB on 20 November 2016. It should be recognised at the outset that Senior Constable Difford dealt with MB in a professional, caring and compassionate manner. It is evident that Senior Constable Difford established a rapport with MB and that her actions kept him safe from harm many times for over two hours. At all times Senior Constable Difford's ultimate goal was the preservation of MB's life. For that she ought to be warmly commended.

Beyond the individual involvement of Senior Constable Difford it is also evident that the overall police response was timely and also focused on achieving the same goal. A number of officers from different units specifically trained to respond to the crisis that MB found himself in, together with local police officers, were deployed in an attempt to bring about a safe resolution of the incident. The decision to transition Senior Constable Difford out of direct communication with MB was made in order to allow officers from the Negotiation Unit to take on this role. To allow them to do so effectively, and to engage MB in a meaningful way, it was necessary to remove any external distractions. There is no NSW Police Force policy that dictates whether a general duties police officer, like Senior Constable Difford, should be substituted by trained negotiators once they arrive at the scene of a suicide intervention incident such as the one involving MB.

However, the evidence established that it is usually best practice to do so and in MB's case Senior Constable Difford was replaced by two experienced and highly trained officers from the Negotiation Unit. Whilst Senior Constable Difford had successfully managed to keep MB engaged and away from potential harm, the arrival of officers from the Negotiation Unit signalled the need to transition to the next phase of the police operation. This phase was directed to understanding why MB had placed himself at risk by commencing a planned and structured conversation with him. This in turn would allow for a strategy to be devised, and then executed, in order to bring MB back to a position of safety. This required the use of trained negotiators employing a specific skill set suited to such a task. Such a skill set could not be readily imparted to a general duties officer such as Senior Constable Difford given the pressures of time and the situation itself.

Conclusion: Given the need to involve police officers specifically trained to respond to the crisis that MB faced it was both appropriate and necessary to transition Senior Constable Difford away from further continued interaction with MB. Up until this point Senior Constable Difford had empathetically kept MB engaged and more importantly, safe from harm. There is no evidence to suggest that the transition to the use of trained negotiators to continue a dialogue with MB precipitated, or contributed to, the tragic events that were to follow. At all times, the actions of all the police officers involved on 20 November 2016 were motivated by the goal of preserving MB's life.

Findings**Identity**

The person who died was M B.

Date of death

MB died on 20 November 2016.

Place of death

MB died at Terrigal NSW 2260.

Cause of death

MB died from multiple injuries which were sustained after he jumped from a height.

Manner of death

MB died as a consequence of actions taken by him with the intention of ending life.

26. 371530 of 2016

Inquest into the death of HP. Finding handed down by State Coroner Mabbutt at Glebe on the 13th December 2018.

Introduction

HP was born on 7 November 1964 and died on 9 December 2016. At the time of his death HP was subject to a Community Treatment Order (CTO) issued under the *Mental Health Act 2007*. Shortly after 12.50pm HP was being taken from his third floor unit at a residential complex in Camperdown to Concord Hospital for mental health treatment by police and mental health workers. HP was in breach of the CTO and had refused to allow mental health workers to enter his unit and administer medication. Whilst being escorted along the landing on the 3rd floor, HP jumped over the balcony railing. HP fell three floors landing on a grassed area.

Immediate attempts were made to resuscitate HP at the scene and he was conveyed to Royal Prince Alfred Hospital by ambulance. Tragically HP was pronounced deceased at 1.40pm. HP was 52 years of age.

Why was an inquest held?

The role of the Coroner pursuant to s 81 of the *Coroners Act 2009* is to make findings regarding:

- The identity of the deceased
- The date and place of that person's death
- The cause and manner of that person's death

An inquest is mandatory where the death occurred in the course or as a result of a police operation in accordance with s 23 and 27 of the *Coroners Act 2009*. HP's death occurred whilst police were conveying him to a mental health facility in accordance with s 59 of the *Mental Health Act 2007*.

Pursuant to s 82 of the *Coroners Act 2009*, a Coroner has the power to make recommendations concerning any public health or safety issue arising out of the death in question.

Background

HP was born in Vietnam in 1964. He was one of four children. In 1987 HP left Vietnam with his younger brother VP arriving in Hong Kong. Whilst in Hong Kong HP met and married NN. They had a child together, QP. In 1990 the family emigrated to Australia. HP separated from his wife in 1991. QP remained with his mother.

From 2011 onwards HP had contact with the Camperdown Community Mental Health Service. HP was commenced on antipsychotic medication "paliperidone" but was resistant to mental health treatment. In 2012 he was referred to the service again with depression, in the context of illicit drug use.

In April 2014 police attended HP's address where he made remarks about jumping from the top floor of the building. Police took HP to Royal Prince Alfred Hospital for a mental health assessment.

HP was not admitted for treatment as a mentally ill person and was referred back to Camperdown Community Mental Health Service.

In November 2014 HP was referred to the Service but was not considered psychotic on assessment. In December HP was referred again to the Service by Centrelink but was not found to be a mentally ill person. He declined a follow up doctor's appointment.

In July 2015 HP was referred to the Service by his GP. A home assessment was conducted. HP presented as psychotic with other thought disorders. He was treated in the community with risperidone and his condition improved but he disengaged with the Service within a short period of time.

In 27 September 2016 HP self presented to the Service with paranoia, delusional thoughts and psychosis. He believed a computer chip had been inserted during surgery and there was a conspiracy with Centrelink, Police and medical staff to control him. HP did not accept he had a mental illness.

That same day Mr Matthew Douglass a social worker with the Service and Registered Nurse (RN) Vella attended HP's unit in company with police officers. HP presented as illogical, irrational and with delusional thoughts. A decision was taken to detain HP under the *Mental Health Act 2007* and convey him to Concord Hospital for assessment by a psychiatrist. Eventually HP agreed to be transported to hospital without the need for a police escort.

At Concord Hospital HP was assessed as a mentally ill person and detained involuntarily for mental health treatment. Upon receiving oral paliperidone HP's condition improved. HP was discharged on 5 October. Further follow up was conducted by the Service but on 10 October HP declined to take any further medication.

Dr Trenaman a psychiatrist conducted a home visit to HP's Camperdown unit on 14 October 2016. HP reported delusional beliefs involving persons in his unit block jumping off balconies and disappearing. HP stated he did not have a mental illness and was unwilling to take any medication. Following that visit on 21 October Dr Trenaman submitted a report supporting an application for a CTO that would require HP to receive depot (injections) of paliperidone. HP's case manager on 17 November made an application to the Mental Health Review Tribunal for a CTO.

On 1 December the Mental Health Review Tribunal held a telephone hearing at Camperdown Health Centre. HP was present represented by a solicitor. During the course of the hearing HP threatened that if he was forced to have the injection he would jump off the balcony. However, later in the hearing he retracted those words. The Mental Health Review Tribunal made a CTO for a six month period requiring HP to comply with medications as prescribed (depot paliperidone). Further, HP was to attend an appointment with Dr Crawford on 6 December to receive that medication. However, the CTO issued contained an error, HP's name was spelt incorrectly. HP was very upset and stated he wanted to appeal the CTO.

On 6 December HP attended upon Dr Crawford (late) as required under the CTO. Dr Crawford was of the opinion HP was suffering from paranoid schizophrenia, had no insight into his illness and refused to accept the depot injection despite the CTO. Dr Crawford explained a failure to accept his medication could result in breach action. HP stated there was an error on the CTO and he wished to contest the CTO.

HP discussed the threats he had made during the hearing but adamantly denied any thoughts of self-harm. He spoke about his close connection with his son and that he was looking forward to the birth of a grandchild. HP stated he was a good person, had not hurt anyone and did not think he was mentally ill. Dr Crawford considered in those circumstances HP's risk of self-harm as low. HP left without receiving his medication. On 7 December the director of community treatment issued a breach order requiring HP to be taken to the Professor Marie Bashir centre at Camperdown for treatment. On the same date the Mental Health Review Tribunal corrected the error on the original CTO regarding the misspelling of HP's name.

At 8.50am on 8 December RN Benfield, the Care Team Coordinator attended HP's unit and provided him with the amended CTO order. HP said it was not him and would be seeing his solicitor on the 19th of December. He challenged RN Benfield to call the police. RN Benfield then left the premises. That afternoon RN Benfield referred the breach to the Acute Care Service (ACS) for the breach of the CTO to be actioned. That evening (RN) Olivia De Dear and another member of the Acute Care Service attended HP's unit to administer the medication. The unit was in darkness and HP could not be raised.

Events of 9 December 2016 leading up to the death of HP

On 9 December 2016 at 10.20am two members of the Acute Care Service (RN) De Dear and Mr Douglass a social worker attended HP's unit on the third floor of the unit complex. They planned to administer HP with paliperidone at his unit. If that occurred without incident, the plan was HP would not be taken to a hospital for assessment.

HP refused access to his unit. For the next 45 minutes attempts were made through the locked screen door to persuade HP to let them in and receive the injection. HP contended the wrong name was on the order. At 10.58am HP contacted 000 requesting police assistance. He informed the operator someone was trying to give him medicine that the paperwork was wrong and he was very scared. The operator recorded HP as hard to understand (English was not HP's first language) and disorientated. A message was broadcast for police to attend the address.

By chance two police officers, Constables Beau Wolfenden and Adam Williams from Glebe Police Station were at the unit complex to serve court process on another resident. They informed police radio they were nearby and would attend HP's unit. Around the same time Mr Douglass called Glebe Police Station requesting police assistance to enter the premises. It was noted both calls related to the one incident and the two calls were "merged" into the one Computer Aided Dispatch (CAD) message. At approximately 11.10am the two Constables met up with the two ACS staff at HP's unit. An ongoing negotiation continued between the police and HP through the closed screen door. Constable Williams informed HP they were there to help.

Constable Williams considered HP was on a verbal loop and was fixated on the name on the order being wrong. The order was sighted and it was explained to the police the order been amended. After some time Constable Williams advised HP that if he did not let them in they would have to force entry for the injection to be administered. HP responded to this by taking a chair onto the small balcony of this unit (on the opposite side of the lounge room to the front door) and placing his leg up on it. Constable Williams and ACS staff called out to HP, words similar to “*don’t do it, it’s not worth it, [H] ... no.*” HP then came back to the front door and stated he was only joking and continued with the same conversation about the wrong name on the order and that he was appealing the CTO.

Mr Douglass viewed HP’s actions as risky and an attempt by HP to make the ACS team go away. RN De Dear was shocked and concerned. Around that time the ACS team decided HP would have to be taken to a hospital in accordance with the CTO breach notice, simply giving the injection and leaving HP was no longer considered appropriate. It was proposed that HP would be taken to RPAH for his medication to be administered and an assessment by a psychiatrist. Constable Williams also become concerned regarding HP’s actions and made a phone call to his supervising officer Acting Sergeant (AS) Tsougranis requesting his attendance and assistance. That phone conversation took place via speaker phone in the police car with Constable Williams and AS Tsougranis. Constable Low was also in the police vehicle. Whilst driving to the location Constable Low checked the police computer system which indicated HP had previous entries for drug use and mental health, but no current warnings.

AS Tsougranis attended the location with Constable Low at 11.28am. AS Tsougranis recognized HP having seen and spoken to him previously in the general area. AS Tsougranis spoke to the ACS team. AS Tsougranis thought HP also recognized him and he attempted to establish a friendly dialogue with HP through the door. It was clear to the police that HP did not wish to speak to the ACS team. By this point HP was now closing the main wooden door for periods of time but always returned to open the wooden door and speak to the police again through the still closed and locked screen door. AS Tsougranis reinforced to HP that he had called the police, they were there to help him, he needed to let police in to see the paper work he was taking about and he was not in trouble.

In the periods when the wooden door was closed police could hear HP making phone calls on his mobile phone and speaking in Vietnamese. By standing on a portion of the external stairway or the balcony railing of the landing, police or the ACS team could see partly through a window on top of the main door. They saw HP walking in his unit and approach the balcony several times. Police were unable to persuade HP to open the front door, the situation remained unresolved.

At some point during this period there was a discussion between AS Tsougranis and Mr Douglass about whether police could leave to allow things to calm down and the ACS team return later in the afternoon to try to administer the medication again. Mr Douglass contacted his supervisor who directed in the circumstances the breach notice was to be enforced and HP was to be scheduled. Mr Douglass advised the ACS team could not leave without HP and police assistance was still required. Further phone calls were made regarding bed availability and it was decided by the ACS that HP would be taken and admitted for treatment at Concord Hospital.

Phone contact by HP with his son QP

At 11.44am HP rang his son QP. The conversation was in Vietnamese. HP told QP that persons were at his door forcing him to go with them to take a needle. He told QP that his name was misspelt and he didn't want to go with them. QP considered his father was agitated and frustrated. HP told QP that if he had to go with them to have the needle "*I am going to jump*". QP tried to tell his father to go with the workers and have the needle, but HP was adamant he didn't want to take it. HP asked QP to call the police and have them remove the mental health workers (at the time of this phone call police had already been at HP's front door speaking with him for over half an hour).

Around this time HP told police through the door he was speaking with his son and provided police with QP's phone number. It was the wrong number. Attempts by police at the scene to ring QP were unsuccessful. HP also advised he was trying to contact the Mental Health Advocacy Service.

QP was seriously concerned regarding what his father had said about jumping and rang 000 at 12.03pm. QP spoke to Senior Constable Lambert who was acting as the 000 operator at the time. QP advised SC Lambert "*there's people outside his door from the hospital.. and he's locked the door. He's saying that they have the wrong name on the... And he said if they do take him he will definitely jump*". SC Lambert recorded a Computer Aided Dispatch (CAD) message including the following information: "*INFT RECEIVED CALL FROM HIS DAD THREATENING TO LOC*".

SC Lambert did not type the word "jump" in the CAD message. The message was forwarded to the radio dispatcher Ms Crowther. Ms Crowther did not consider there was any new information contained in the message as police were already on the scene and other CAD messages related to the same incident. No radio broadcast to the police at HP's unit was made. Accordingly police at the unit did not receive any information that HP was threatening to jump if he was taken to hospital. At 12.25pm HP called QP again, He asked if QP had rung the lawyer and the police. QP advised he had called the police. QP considered HP calmed down a little after hearing this but still refused to leave the unit. (By this stage police had been outside the unit for well over an hour speaking to HP. For some reason HP did not communicate this to his son).

Entry gained by police to HP's Unit

Police Rescue were called to attend to gain entry. Prior to the Rescue Squad attending Constable Wolfenden managed to manipulate the lock on the inside of the screen door with a stick unlocking the screen door. It was decided the next time HP opened the main wooden door police would enter and restrain him. Shortly after 12.30pm HP opened the main door again and police gained entry to the unit. HP was restrained and sat in a chair. Police promptly closed the door to the balcony, removed a knife and other articles from the table and searched HP. HP was immediately compliant with police and made it clear he did not want the mental health workers in his unit. Mr Douglass remained for some period and recalled HP being calm, focused and denied he was suicidal. HP requested his shoes and keys, asked that his rice cooker be turned off and agreed he would go to hospital but with the police.

When asked about the balcony he said he wasn't going to harm himself. In Mr Douglass's opinion HP was "future focused". He did not consider at that time HP was an immediate risk of self harm given his presentation. RN De Dear recalled HP made a joke along the lines of "you got me" and made a comment that he wouldn't do that (referring to balcony). Constable Williams stated HP was calm, he appeared fine and was talking normally not aggressively. In his view HP's whole demeanour had changed and he displayed no self harm risks at that point. Constable Wolfenden was of the same view. AS Tsougranis stated HP showed no signs of resistance once police entered and he was calm.

Constable Low recalls HP denying intending to do anything whilst on the balcony previously and said "no no, you've got it wrong, I wasn't doing anything out there".

Exit from the unit

HP's shoe laces and belt were removed and he was escorted out of the unit by police at about 12.52pm. HP was not handcuffed or restrained in anyway. The group walked along the 3rd floor landing to the right side towards the lifts. A flight of stairs were immediately to the left hand side. RN De Dear was first, followed by Mr Douglass, then Constable Wolfenden, HP, Constable Low, AS Tsougranis and Constable Williams (who was securing HP's unit and front door).

After walking along the landing for a short distance HP without any warning placed his hands on the balcony railing that is approximately 1.4 metres high and swung up his right leg jumping over the railing. Constable Low attempted to restrain HP but was unable to hold him. HP fell three floors to the ground. The ACS team and police ran to the ground floor and commenced resuscitation. An ambulance was called and HP was taken to RPAH but was pronounced deceased at 1.40pm.

Police investigation

Inspector Anthony Agnew from the Eastern Beaches Local Area Command was appointed as the officer in charge of the critical incident investigation. An extensive investigation took place and a large number of witnesses were interviewed, the coronial scene was examined, a large number of documents were obtained including health records, 000 transcripts and CAD messages.

Cause of death.

A post-mortem examination was conducted at the Department of Forensic Medicine at Glebe on 13 December 2016 by forensic pathologist Dr Jennifer Pokorny. The cause of death was found to be multiple blunt force injuries from a fall from height. Toxicology revealed a therapeutic level of irbesartan (prescribed for hypertension) in the blood. No psychiatric medications were detected.

Was the action taken by Camperdown Acute Care Service appropriate?

The CTO issued by the Mental Health Review Tribunal (subsequently amended) and the breach notice issued in accordance with s 58 of the *Mental Health Act* 2007 provided the statutory power for the ACS team to take HP directly to a declared mental health facility. Mr Douglass was involved in scheduling HP for mental health treatment on 27 September. He indicated HP was compliant with police in attendance on that occasion and attended hospital with the ACS team without incident.

In the intervening period at the CTO hearing, unknown to Mr Douglass, HP had made threats to jump off the building if forced to have an injection again.

Mr Douglass and RN De Dear were not provided with a recent risk assessment regarding HP. This was critical information that should have been provided to any persons enforcing a CTO breach order. The initial decision to attempt to administer the medication without detaining and conveying HP to a hospital was proper. Once HP refused to let ACS team enter his unit, the incident escalated over the following two and a half hours. The decision to enforce the CTO breach, especially in light of the chair on the balcony incident, was also appropriate.

Likewise the decision to request police assistance in accordance with s 59 of the Act was also necessary. Mr Douglass was of the view that police involvement (successfully) on 27 September would mean HP may respond to better to police requests. That was a reasonable assessment. Following entry into the unit, Mr Douglass and RN De Dear made observations of HP to gauge any risk he presented at that time. On all the evidence, given the substantial change in HP's demeanour; requesting his belongings, asking the rice cooker be turned off and his denial of self harm thoughts, the assessment that HP was not an immediate risk of self harm at that time was appropriate in the circumstances.

I find the actions of the ACS team appropriate in the decision to enforce the CTO and transport HP to Concord Hospital. I find in the circumstances of the information Mr Douglass and RN De Dear were in possession of at the time of their attendance at the unit, they acted appropriately.

Was the action taken by police officers who attended HP's home appropriate and in accordance with NSWPF policy?

Police have a duty to action CTO breaches in accordance with s 59 of the *Mental Health Act 2007*:

"59 Police assistance

A police officer to whose notice a breach order is brought must, if practicable:

apprehend and take or assist in taking the person the subject of the order to the mental health facility,

or

cause or make arrangements for some other police officer to do so.

A police officer may enter premises to apprehend a person under this section, and may apprehend any such person, without a warrant and may exercise any powers conferred by section 81 on a person who is authorised under that section to take a person to a mental health facility or another health facility.

Note. *Section 81 sets out the persons who may take a person to a mental health facility and their powers when doing so."*

"81 Transport of persons to and from mental health facilities and other health facilities

The persons listed below may take to or from a mental health facility or another health facility any person who is authorised by this Act to be taken, or transferred, to or from the facility:

a member of staff of the NSW Health Service,

an ambulance officer,

*a police officer,
a person prescribed by the regulations.*

A person authorised by this Act to take a person to or from a mental health facility or other health facility may:

use reasonable force in exercising functions under this section or any other provision of this Act applying this section, and

restrain the person in any way that is reasonably necessary in the circumstances.....”

Once called by the ACS team the attending police officers had a responsibility to provide assistance to enforce the breach of the CTO. Police appropriately conveyed to HP through the front door that he was not in trouble, he had called the police for assistance and they were there to help him. Whilst all four officers indicated they were of the view (correctly) they had the statutory power to enter HP’s premises, detain and convey him to a hospital, none could state precisely the source of that statutory power.

I am satisfied Constables Williams and Wolfenden appropriately both viewed the CTO prior to taking any action. The evidence of all four police officers established they had a clear understanding of the need to treat HP with dignity and respect balanced against the need to detain him for mental health treatment. As Tsougranis did not recall being informed of the balcony incident by Constable Williams in the first instance prior to his arrival at the scene. Both Constable Williams and Constable Low have a clear recollection of it being discussed. I find it was discussed and was clearly the main reason Constable Williams sought guidance and assistance from a more senior officer. I am satisfied AS Tsougranis’s recollection has been affected by the period of time that has elapsed following what was understandably a traumatic incident.

Given the concerns regarding HP’s access to the balcony and the period of time the stand off continued, the decision to force access in the manner it was accomplished was proper and appropriate. As Tsougranis had attended the unit block on multiple occasions prior. He had an overriding concern regarding HP’s access to the balcony whilst police were remaining outside. AS Tsougranis as the senior officer considered escorting a person down a stair way less safe than using a lift. None of the witnesses now recall any decision being communicated regarding this issue. The evidence does not allow for a finding whether a decision was made and if so by whom, regarding the use of the lifts rather than the stairway which was closer.

Would it have been appropriate to restrain HP in order to convey him to Concord Hospital?

Once inside the unit the actions of the police in securing the balcony, removing any sharp items and searching HP was appropriate and necessary. At that point of time the attending officers were not aware of HP’s threat to jump that had been conveyed by QP and then to 000. All officers gave evidence of HP’s rapid change in demeanour once they entered the unit and that he had calmed down.

I am satisfied HP’s change in demeanour was a proper basis in the circumstances to reassess and conclude HP’s risk of self harm was lowered. That lowering of risk was also consistent with the views of the ACS team.

It is a fundamental requirement for police officers and mental health workers to make on the spot assessments and continually reassess the risk of persons who are required to be detained/arrested and transported.

The evidence also supports the view that HP was less agitated and more compliant with the police officers than the ACS team. Whilst there were differing versions from all witnesses regarding what transport was to be used to convey HP to Concord that is consistent with multiple witnesses recalling events that took place nearly two years ago and the lengthy period of time at the scene. No ambulance had been called for the purpose of transportation. The evidence that HP was willing to go with police but not the ACS team members satisfies me the plan for transport was in the ACS vehicle with a police officer (most likely Constable Williams) seated next to HP.

Restraint guidelines for police officers when dealing with mental health patients

In July 2007 a memorandum of understanding (MOU) was entered into by New South Wales Health, the New South Wales police force and the New South Wales ambulance service regarding policy and procedures applied relating to mental health emergency response. That MOU was operative at the time of this incident. That MOU has now been superseded by a MOU entered into in 2018.

The 2007 MOU outlines the following principles regarding restraint of patients: “7.3 Restraint

The principle of least restrictive environment requires a restraint (physical or mechanical) only be used where less restrictive alternatives are ineffective.

The practice of restraint should be viewed as a last line of patient management in response to significant risk to the safety of patients or others and used only where less restrictive alternatives are ineffective or are not appropriate to meet the specific needs of the patient.

When restraint is used, three key issues need to be considered:

- *treating the patient with dignity and respect at all times is imperative*
- *restraint is a temporary intervention. The main aim is to treat the underlying condition*
- *restraint is used for the welfare of the patient and not for staff operational convenience.*

Restraint is to be used consistent with the policies and procedures applied to the respective agencies.

In general police use of restraint is to prevent a breach of the peace or to prevent injury to the patient, service providers, or the public.”

AS Tsougranis was of the view if he had handcuffed HP all the trust he had attempted to build in his dialogue with HP over the lengthy period he was at the scene would have been broken. HP gave no signs of harming anyone or breaking away, he had not been aggressive.

AS Tsougranis did not consider given HP's presentation once police entered the unit and HP's clear preference to deal with the police not the ACS team, that handcuffing HP was in any way appropriate or necessary to transport him to a hospital. Constable Wolfenden did not consider handcuffing HP was appropriate and that HP was compliant and would go with police. Constable Williams was of the view HP's whole demeanour had changed and handcuffing HP was not necessary. Constable Low also saw no need to restrain HP given his change of behaviour once police entered the unit.

The need for police officers to effectively communicate with persons who may be suffering a mental illness is an important component of any interaction. The ability to establish a level of rapport and trust, an appropriate de-escalation technique, is not always possible. Having got to the point where HP was willing to talk to police but not the ACS team and HP's compliance with police once they entered his unit, I find any decision to handcuff HP may well have been detrimental to any ongoing communication and/or escalate HP's behaviour. I find the decision not to handcuff or restrain HP based on the information available to the attending police at the time was in accordance with existing police policy.

Was the information provided by Mr QP to 000 that his father had made a threat to jump if he was taken to hospital accurately recorded?

Senior Constable Lambert was performing duty as Police Liaison operator at the Police Communication Centre. SC Lambert had four years experience in that role. Her primary role was to assist radio operators/dispatcher with police computer checks and other information required in the course of dispatching/receiving police radio messages. SC Lambert also performed the role of the police radio rescue coordinator for a considerable portion of her shifts.

Infrequently, due to overload on the system or when not tasked with conducting computer or other inquires SC Lambert received direct 000 calls from the public. That would occur infrequently perhaps once in every two shifts.

The Computer Aided Dispatch (CAD) System

When a call is received the 000 operator opens a new message and records the details on screen. Certain prompts will appear if a computer field is missed or not completed properly. The operator must listen very carefully to the caller who is often distressed, ascertain the nature of the call, obtain the relevant and necessary information, record it (often at the same time as listening to the caller), determine the priority of the message and what specific information must be contained in the CAD message. The CAD is then reviewed by the operator prior to being electronically forwarded and allocated to a dispatcher.

SC Lambert made an error in not recording the word "jump" in the CAD message. SC Lambert agrees the message "INFT RECEIVED CALL FROM HIS DAD THREATENING TO LOC" did not make sense and when she reviewed the message prior to forwarding it to the dispatcher she must have missed that error. In addition, in hindsight, SC Lambert considered the information in the 000 call required an upgrade of priority from Category 3 "Concern for Welfare" to Category 2 "Self Harm".

SC Lambert described her error as a serious mistake. I find as a result, information received that a threat of self harm was made was not recorded or actioned appropriately.

Why was this information not broadcast or otherwise communicated to police at the scene?

Ms Crowther was the civilian radio operator/dispatcher for Channel F on duty at the time and received SC Lambert's CAD message. Ms Crowther had 11 years' experience as a radio dispatcher and commenced duty at midday. Prior to her commencing the shift the two separate CAD messages (one from HP and the other from Mr Douglass) had been received, actioned and merged as they related to the same incident. Ms Crowther received SC Lambert's message at 12.07pm. Ms Crowther's recollection is it was obvious the message related to the same incident. The message remained at Category 3, concern for welfare. In Ms Crowther's experience it is a common situation that multiple calls are received for the one incident, such as a serious motor vehicle accident. The information she had to hand was the police were already on the scene.

Ms Crowther was of the view the message as sent by SC Lambert provided no new relevant information that required a decision to broadcast a message to police who had been at the scene for some considerable time. Accordingly no radio message was sent. Ms Crowther merged the new message into the existing entry. Ms Crowther stated if the message had contained information that a person was threatening to "jump" she would have broadcast the message to the attending police at the scene immediately. I find Ms Crowther's decision not to broadcast the message based on the information she had to hand was appropriate.

Should any recommendations be made pursuant to s 82 of the Coroners Act 2009? Failure by SC Lambert to record on the CAD message the threat of HP to jump

I am satisfied that the evidence demonstrates the failure to record and action HP's threat to jump occurred due to human error on SC Lambert's part. I do not find there was any systemic error that contributed to critical information not being provided to police at the scene. In those circumstances no recommendation is necessary or desirable.

Police training regarding specific powers under the Mental Health Act 2007

On the basis all attending police were not specifically aware of their statutory powers under ss 59 & 81 of the *Mental Health Act 2007*, I direct a copy of these findings be forwarded to the Commander, Leichhardt Local Area Command. Appropriate education and training of police officers in that Command should take place regarding this issue. On that basis I make no formal recommendation in this regard.

The failure to provide the ACS team with a recent risk assessment regarding HP prior to their attendance at the unit.

The important and difficult role fulfilled by ACS staff must be acknowledged. The facilitation of community based treatment for persons with mental illness presents many challenges to staff. That Mr Douglass and RN De Dear attended the address without all relevant information is a matter of concern.

Information was received during the course of the inquest from the Sydney Local Health District (SLHD) advising of the following: In November 2015 the SLHD published a guideline document regarding procedures for *“Intake/ACS Transfer of Care Procedure for SLHD Eastern Sector Community Mental Health”* Part 1 of the guidelines state:

“All efforts should be made by Care Coordinators to enact breach proceeding in working hours. If unable to breach, verbal handover to ACS in evening/weekend with complete recent assessment and breach paper (and medication if required)”

The tragic circumstances of HP’s death have highlighted the need for clarification between the various teams of what information a *“recent assessment document”* should contain. It is not defined in the SLHD guidelines. The SLHD is currently in the process of updating those procedures to clarify exactly what documentation is required on handover to the ACS team for breach actions. A Home Visit Safety Checklist is a mandatory form to be completed for all community based mental health consumers. It is a centralised document available via the electronic medical records system. It is updated every 13 weeks or earlier if there are significant changes. The current checklist is being reviewed and updated to ensure additional risk factors are appropriately recorded to include the inclusion of historical risk events. I am satisfied that the SLHD is taking appropriate and active steps to address the failings identified in this matter to ensure the provision of relevant information to field staff. Accordingly I do not consider the making of any recommendations necessary or desirable.

Conclusion

HP’s death occurred where mental health workers and police in difficult circumstances were attempting to ensure HP received necessary mental health treatment. In accordance with the principles of s 3 (a)&(b) of the *Mental Health Act 2007* HP was receiving treatment in the community for his mental illness. The ACS team and the attending police dealt appropriately with HP whilst in possession of an order that required HP’s detention and transfer to a mental health facility for treatment. The sudden actions of HP jumping over the balcony railing have deeply affected HP’s family and all persons present at the scene. HP’s mental state at the time must be closely examined. HP was non compliant with medication and treatment. The last review of HP on 6 December resulted in Dr Crawford expressing an opinion HP was suffering from paranoid schizophrenia. A finding of suicide should only be made if the evidence is clear, cogent and exact, *Briginshaw v Briginshaw (1938) 60 CLR 336*.

That HP was suffering delusional thoughts at the time of his death is supported by the two phone calls to QP asking him to call the police to remove the mental health workers. The evidence clearly demonstrates police had been there and speaking with HP for some time. Accordingly I find HP’s thought processes were overborne by the mental illness he was suffering. I find HP was incapable of forming an intention to end his own life at the time of his death.

Identity

The person who died was HP

Place of death

Royal Prince Alfred Hospital Camperdown

Date of death

9 December 2016

Cause of death

Multiple blunt force injuries

Manner of Death

HP whilst suffering from a mental illness jumped over a balcony railing on the third floor of his unit block during the course of a police operation. HP fell to the ground receiving fatal injuries.

27. 5348 of 2017

Inquest into the death of Solomon Te Kohekohe Shortland. Finding handed down by State Coroner Mabbutt on the 31st October 2018.

On Thursday 5 January 2017 at 10.09am Mr Solomon Te Kohekohe Shortland was driving an Isuzu 6.2 tonne light rigid truck travelling east on Vardys Road, Kings Park. The rear tray was loaded with various flooring material Solomon was delivering to Westmead Hospital. Solomon had just driven a short distance from his place of employment at General Flooring, 1/8 Turbo Road, Kings Park.

Senior Constable Shane Heron was driving a fully marked highway patrol vehicle in the area. He noticed Solomon's truck and the load in the rear. Senior Constable Heron considered the load was not properly secured and pulled the truck over to the side of the road. Vardys Road at that point has two lanes of traffic in each direction separated by a large median strip. Both vehicles stopped in the kerbside lane (lane 1).

Senior Constable Heron got out of his vehicle, approached the truck and spoke to Solomon who got out of the truck. A discussion took place about the load on the truck. During this discussion both persons moved from the offside to the nearside of the vehicle and back. Traffic continued to pass in the adjacent lane (lane 2).

Senior Constable Heron told Solomon to secure the load and then went back to the police car for several minutes. Solomon used a tarpaulin and a webbing strap in an attempt to secure the pallet of cement bags in the tray of the truck.

After several minutes Senior Constable Heron returned to Solomon who was on the offside of the truck at the front portion of the load tray with his back to lane 2. Solomon was informed he would be issued an infringement notice. Solomon became frustrated and upset and the tone of the conversation changed. Senior Constable Heron turned to return to the police car but then turned around again to speak to Solomon. The time was 10.18am.

At that point Solomon pulled with some force on the tie down strap that he had placed over the tarpaulin and pallet. Solomon had not secured the strap to the near side of the truck and the strap was loose offering no resistance. The momentum used to pull the strap caused Solomon to lose his balance and fall/stumble backwards into lane 2. Solomon's head and shoulders landed in the middle of the lane.

A semi-trailer was traveling in lane 2 and struck Solomon. The nearside front of the semi-trailer impacted Solomon's head and shoulders. Solomon went under the truck. The driving wheels of the prime mover ran over Solomon's body and the nearside trailer wheels over his legs.

Senior Constable Heron called for urgent immediate medical assistance and attended as best he could to Solomon. Paramedics attended the scene at 10.30am.

Dr Weatherall via the Careflight helicopter attended Solomon at 10.41am. Solomon had sustained a critical head injury and major blood loss. Tragically, despite the best efforts of the emergency and medical personnel, Solomon died at the scene at 11.09am. Solomon was 56 years of age.

Why was an inquest held?

The role of the Coroner pursuant to s. 81 of the *Coroners Act 2009* is to make findings regarding:

- The identity of the deceased;
- The date and place of that person's death; and
- The cause and manner of that person's death.

An inquest must be held where a death occurred as result of, or in the course of police operations in accordance with s. 23 (as it was prior to amendment on 1 July 2017) and s. 27 of the *Coroners Act 2009*. The stopping of Solomon's truck by Senior Constable Heron was a police operation.

Pursuant to s. 82 of the Act, a Coroner has the power to make recommendations, including any public health or safety issue arising out of the death in question.

Background

Solomon was born on 11 February 1960 in Hamilton, New Zealand. He came from a large family of 10 children and attended high school leaving at 16 years of age to begin working to support the family. Solomon was a deeply devout person and dedicated two years of his life whilst a young man to serve as a missionary in the Church of Jesus Christ of Latter-day Saints.

Solomon married Rayva Fleming in 1984 and had six children. In 1991 Solomon and his family emigrated to Australia to reside in West Pennant Hills. Solomon and Rayva divorced in 1994. All six children lived with Solomon who supported his children as a single parent. Solomon dedicated his life to providing for and raising his children. In 2003 Solomon married Ms Connie Westergard. Sadly Connie passed away in 2005 due to a rare heart condition.

In 2010 Solomon met and married Mercia Ann Kavanagh and they moved into the premises at 6/142 Glossop Street, St Mary's. In November 2011 a daughter Nevaeh was born.

Solomon had been employed at General Flooring for 17 years and was very well regarded by his employer Mr Richard Hooker. General Flooring supplies and installs commercial flooring. Solomon had held a heavy vehicle licence since 1997. Mr Hooker described Solomon as a fantastic employee, hard-working, reliable, very good at his job and throughout the entire time he worked for Mr Hooker not one person complained about Solomon's conduct.

Solomon was the only person who drove the truck owned by the business and was responsible for deliveries and loading the truck. Whilst Solomon had been employed initially as a truck driver, his role changed over the years ultimately to a contracted supervisor, jack of all trades and delivery driver.

Events leading up to the death of Solomon

On Thursday 5 January 2017, Mr Hooker was overseas and Solomon was entrusted with running the business and other duties. No other employees were working on that day. A list of jobs and deliveries had been left for Solomon to attend to in Mr Hooker's absence. Solomon left home at 5.30am and arrived at General Flooring at 1/8 Turbo Road, Kings Park at 6.55am. A delivery of flooring material was due to leave the warehouse on Friday 6 January 2017 and be delivered to a jobsite at Westmead Hospital.

For reasons that remain unclear, Solomon decided to undertake that delivery on the morning of Thursday 5 January 2017, despite the flooring contractor at Westmead Hospital indicating he did not want the delivery made on the Thursday. It is unknown if Solomon loaded the truck that morning or on a date prior.

Solomon loaded the truck with a pallet of 48 bags of cement adhesive, four rolls of vinyl flooring material and four drums of flooring adhesive. The evidence is that prior to Mr Hooker going on leave, pallets of cement adhesive had been delivered wrapped in plastic wrap in the usual way to prevent individual bags being dislodged in transit. For an unknown reason Solomon had removed that plastic wrapping from the pallet. The pallet was not rewrapped.

Solomon drove out of the premises of General Flooring around 10am. Having travelled on only a short distance Solomon's truck came under notice of Senior Constable Heron. Senior Constable Heron prior to joining the police had several years of experience loading heavy vehicles and driving medium rigid trucks.

The vehicle stop

The location chosen by Senior Constable Heron was a position nearly opposite a 7/11 service station. The position was just before the crest of a slight rise on a straight piece of roadway. The speed limit is 60 km an hour. The roadway was dry. The police vehicle was placed in an offset position. That is the driver's side of the police car was against the right edge of lane 1. Solomon's truck was pulled over in front of the police car near the gutter. In that offset position the police car provided a corridor of safety that allowed Senior Constable Heron to approach down the driver's side of the truck and remain wholly within lane 1 without the danger of being struck by a vehicle in lane 2.

The entire incident is captured on an In Car Video camera (ICV) operating from the highway patrol vehicle. Background noise prevented every word spoken being audible on the ICV footage. Senior Constable Heron advised Solomon he had stopped him as his load appeared unsecured and for a random breath test. A full viewing of the ICV footage illustrates the following:

After the random breath test, which was negative Senior Constable Heron said "*Lets have a look at this load together*". Solomon got out and with Senior Constable Heron inspected the back tray of the light truck. Both persons did this standing on the offside of the vehicle in the small corridor provided by the offset positioning of the police car behind the truck.

Traffic continued to pass in the adjacent lane Senior Constable Heron removed one bag of adhesive cement from the top of the pallet and placed it on the roadway next to the truck to demonstrate the lack of restraint for the load.

Both persons move to the nearside of the truck and stand on the nature strip where a further discussion and a demonstration by Senior Constable Heron takes place of items in the truck that are loose and could fall from the truck. Senior Constable Heron followed by Solomon then walks back to the offside of the truck. Senior Constable Heron picks up the bag of adhesive from the roadway and sits it back on top of the pallet in the back of the truck.

A further conversation takes place about securing the load properly and Senior Constable Heron walks back to the police car and Solomon walks around the nearside of the truck. Solomon obtains a tarpaulin in the back of the truck and starts to place it over the pallet and other items. He walks around to the offside of the truck again.

Solomon spent some time with the tarpaulin and again walked back the nearside further attending to securing the load. Solomon then walked around to the offside of the truck once more and starts to place a webbing strap over the pallet that is now covered by the tarpaulin. That process takes just under four minutes. Senior Constable Heron remained in the police car during this time.

Solomon secures the ratchet of the webbing strap to the offside of the truck and throws the loose end of the webbing strap across the tray to the nearside of the truck. The strap on the nearside of the truck tray is not secured by Solomon. Senior Constable Heron leaves the police car and approaches Solomon.

A further conversation takes place. Solomon is informed he will be issued with an infringement notice for \$433 with three demerit points. Up to this point the conversation had been amicable. The conversation now changes. Solomon becomes frustrated and upset:

Solomon: *"is that what you do, mate? you just go around making other people's life hard... so..."*

SC Heron: *"no I go around and make the road safe".*

Solomon: *"yeah....yeah....why don't you just give me a chance mate. You don't really care. Everybody's going to work, mate, to make a living".*

SC Heron: *"you haven't made an effort. You've made no effort.... dumped it on and you've driven. No effort....You're a professional driver. This is not professional".*

Solomon: *"thanks for this, thanks for making my day, mate, like you've made everybody else's... no consideration".*

SC Heron: *"my consideration is to make the road safe".*

Solomon: *"no, really, I hope it comes back on you too, mate, like a big broom... eh a big broom...."*

SC Heron: *"all right, well.... I'm, I'm going to leave before you say anything more stupid than that".*

Solomon: *"no you're the one who is stupid...."*

SC Heron: *"I'm not the one driven around with a pallet of...."*

Senior Constable Heron had begun to go back to the police car but turned around and walked a few steps back to Solomon. At that point Solomon pulled on the webbing strap. The ICV captures the webbing strap on the nearside of the vehicle coming up as it is not secured to anything. Solomon loses his balance and the momentum of his action causes him to fall/stumble backwards landing in the active traffic lane, lane 2. Solomon's head and shoulders land in the middle of the lane.

Travelling in lane 2 at that time was an empty Mack prime mover (semi-trailer) driven by Mr Robert Cruise. The trailer was empty. Mr Cruise had noticed the police vehicle ahead in lane 1 and slowed down as lanes 1 and 2 merged into lane 2. Mr Cruise estimated his speed at that time around 47 to 48 km an hour. As Solomon fell into lane 2 in front of Mr Cruise, he attempted to avoid Solomon.

Despite Mr Cruise's best efforts the front left corner of the truck struck Solomon, who fell under the vehicle and was run over by the wheels of the truck.

An inspection of the prime mover by Roads and Maritime Service officers revealed a fault with a brake 'travel' indicator on the third axle, however this would not have affected the braking ability of the vehicle as the trailer was empty. Given the suddenness of Solomon stumbling/falling into lane 2 Mr Cruise could not avoid him. Mr Cruise sadly passed away in 2017.

Cause of death

A post mortem was conducted at the Department of Forensic Medicine on 9 January 2017 by Forensic Pathologist Dr Lorraine Du Toit-Prinsloo. Dr Du Toit-Prinsloo determined the cause of death was multiple injuries. Toxicology detected no drugs or alcohol.

Detective Sergeant Doug Allen of the Region Enforcement Squad - Penrith was appointed the Senior Critical Incident Investigator to investigate the circumstances of Solomon's death. Senior Constable Heron was interviewed later that day. An extensive brief of evidence was prepared, witnesses interviewed and other evidence obtained.

Was the stopping of Solomon's vehicle conducted appropriately considering: The reason for conducting the stop, was the load properly restrained on the truck?

Mr Mike Robertson an engineer who specialises in safety and efficiency of road transport was engaged by the Court to provide an expert report on the loading and restraint available on the truck on the date of the incident.

Standards are set for the restraint of loads on heavy vehicles (such as Solomon's truck) in accordance with the Load Restraint Guide. As at 5 January 2017, the current edition of the Load Restraint Guide was the 2nd edition. That is prepared by the National Transport Commission and gazetted. A driver operating a heavy vehicle was responsible for ensuring the load on the heavy vehicle was appropriately secured to the performance requirements.

Mr Robinson's evidence was there were three separate loads on the truck. The heaviest being the pallet of cement bags weighing approximately 1000 kg. That pallet was unrestrained and carried the risk of bags dislodging from the top of the pallet. Many of these bags were stacked higher than the tray sides of the truck. Mr Robinson was of the opinion that the pallet needed to be wrapped with stretch wrap plastic or similar to prevent bags dislodging. Further the pallet was not blocked or strapped properly in the rear of the truck to stop it moving in the tray. In addition, in this case it may have been advisable to have two pallet angles under the webbing straps to prevent the straps cutting into the bags. No angles were in place and the pallet had not been strapped down. No plastic wrapping was in place.

Senior Constable Heron stopped the truck on the basis he considered the load was unsecured. Mr Robinson's opinion was the decision to stop the vehicle by Senior Constable Heron was appropriate. The load on the truck was not secured and constituted a clear risk to public safety including a risk to Solomon in the event of a motor vehicle accident.

I find on the evidence there was a proper reason (aside from conducting a random breath test) to stop the truck due to the unsecured load. That Senior Constable Heron was tasked to undertake speed enforcement that morning in no way affected that decision.

Was the location where the truck was stopped safe taking into account the reasonable likelihood Solomon would have to step out of the vehicle?

Senior Constable Heron is a Highway Patrol officer with 10 years of experience. He has worked in the general area of Quakers Hill for that period of time and has conducted numerous vehicle stops on Vardys Road.

Senior Constable Heron considered the location he selected for the stop a good location. The roadway is straight, slightly elevated and provides a good view to approaching vehicles to see the police car in plenty of time. Positioning the police car in the kerbside lane forces approaching traffic in both lanes to slow down and merge (which he described as "traffic calming"). He was aware given the nature of the traffic stop he was about to conduct involving an unsecured load on a heavy vehicle that he would ask Solomon to get out of the vehicle at that location.

Approximately 40-50 metres beyond the location where Solomon's truck was stopped is another area also used by the Highway Patrol to stop vehicles. It is a slip lane which branches off the kerbside lane to turn into a private commercial business, BOC Gas and Gear. The slip lane allows vehicles to diverge off the road in preparation to enter the commercial premises as opposed to braking and slowing traffic to the rear as they turn directly off lane 1. The slip lane is not a designated parking area, a lay-by lane or a stopping zone. It is designed to facilitate entry into private premises.

Between the two sites there is a slight crest on the road. Senior Constable Heron in the past had utilised the slip lane location to stop vehicles. His evidence was he no longer uses it to stop heavy vehicles. It has advantages and disadvantages. He had been requested previously by BOC Gas and Gear to no longer take vehicles into their private premises in the course of conducting a vehicle stop.

Senior Sergeant Scott Walker, the Senior Supervisor of the Hawkesbury Highway Patrol Cluster, and an experienced highway patrol officer, undertook a drive past which was recorded on ICV of both locations. The footage demonstrated a clear line of sight approaching east on Vardys Road to the first location. Past that point there is a slight crest. For the purpose of Senior Sergeant Walker's demonstration video a police vehicle was parked in the slip lane to recreate what an approaching motorist would see when a traffic stop was being conducted. There is some obstruction to vision given the crest of the hill. The roof bars on the top of the highway patrol vehicle still remain visible, but not both vehicles. With vehicles stopped in the slip lane two lanes of traffic continue unrestricted past the point where the vehicles are stopped.

Senior Sergeant Walker's opinion is using the slip lane does not provide approaching drivers a clear unobstructed view of the stopped vehicles and has the disadvantages of traffic that has not been slowed down, or "calmed" passing the stopped vehicles adjacent to the slip lane. Both vehicles in that situation are off the roadway but stopped in the slip lane. Sergeant Walker provided evidence that the slip lane is 3.2 metres wide. At the spot where Solomon was stopped lane 1 is 3.3 metres wide and lane 2 is 3.4 metres wide.

Senior Sergeant Walker also preferred the first site over the slip lane due to the forced merger of lanes 1 and 2 by a police car parked in lane 1 that slows and calms traffic. He indicated his preference is for a good clear view to the rear of a stopped police vehicle to allow approaching drivers to be aware that vehicles are stopped ahead.

Mr Robertson considered the narrow corridor on the offside of the truck was not ideal but the task of securing the load was possible in the circumstances. He did not consider standing close to passing traffic was suitable if there was a safer practical alternative. His opinion was the slip lane was also not ideal but a safer location. Whilst I accept Mr Robertson's expertise in road transport safety and efficiency (in particular in relation to load restraint safety), I note that this expertise does not extend to traffic management, nor does he have any experience in selecting locations for or conducting traffic stops.

Motor Vehicle Stopping Techniques and Procedures

"Motor Vehicle Stopping Techniques and Procedures" (MVSTP) is an educational manual prepared and used by the NSW Police Force to outline practice and procedure for the stopping of motor vehicles in a variety of different operational policing scenarios. It is the only document that guides and provides advice to police officers regarding procedures to be adopted for vehicle stops. The document expressly focuses on the safety of police officers whilst undertaking vehicle stops.

Whilst the manual does contain a section devoted to particular considerations relevant to stopping heavy vehicles, no specific reference is made to stopping heavy vehicles for the purpose of unsecure loads or any procedures to ensure loads are secured by a driver with safety. This document does not impose any mandatory policies, guidelines or requirements upon police officers in undertaking vehicle stops.

It offers a number of relevant factors to be taken into account by police officers when determining an appropriate location to stop a vehicle. It informs police officers that often the ideal location is not achievable and police officers must adjust their procedures to suit. Sergeant William Watt is a Senior Operational Safety Instructor with the NSW Police Force. His evidence was no two traffic stops are the same and stopping vehicles is dangerous. Further there is a difficulty in formulating any policy that must encompass so many different variables.

For instance, it was suggested, in evidence, to Sergeant Watt that a policy mandating that heavy vehicles should be directed off the roadway in the circumstances of an unsecure load could be formulated. In response, Sergeant Watt gave a straightforward example of such a situation occurring on a country road where directing a heavy vehicle off the road after rain might result in the vehicle becoming bogged on the verge, or due to the nature of the road, there is simply no available or safe location for a heavy vehicle to be taken off the roadway. Sergeant Watt also cited the circumstances where the serious danger presented by an unsecure load may require the vehicle to be stopped immediately where no ideal location is available.

The MVSTP must encompass all weather conditions, all roadway types, all vehicle types, the reason for stopping the vehicle, the number of persons in the vehicle and all other variable circumstances. Police officers must make a decision to stop a vehicle and the circumstances under which that stop may occur. Traffic stops can be unpredictable. A driver may pull to the side of the road immediately leaving a police officer with the choice of conducting the stop right there or trying by various means to communicate to the driver to move the vehicle to a more appropriate location, if one is available. Or a driver may continue on past a preferred location to stop further up the road in a location not of choice by the police officer.

To ensure the safety of police officers is not compromised whilst conducting a vehicle stop the procedure of providing a "corridor of safety" is set out. Senior Constable Heron followed that procedure when he stopped Solomon. Nothing in the MVSTP informs police officers about procedures to ensure the safety of drivers and passengers who may elect to get out of the vehicle, are required to get out of the vehicle or may be arrested and removed from the offside of the vehicle during a traffic stop.

Conclusion

The fact another stopping location was a short distance from where Solomon was stopped resulted in Solomon's family submitting it was a safer and better location than the site that was selected and should have been used. Senior Constable Heron knew of both and had used them previously. As set out above both sites have advantages and disadvantages. The slight crest prior to the slip lane partially obstructs the view of a vehicle stopped in the slip lane and traffic is not slowed by the forced merging of two lanes into one. I find that had the vehicle stop occurred in the slip lane in the same circumstances, this would still have resulted in Solomon falling into an active traffic lane (lane 1). I do not find in those circumstances the slip lane was a safer location.

The safety of the location used by Senior Constable Heron I find was appropriate in the circumstances that Solomon was reasonably likely to exit the vehicle.

The site had an unobstructed clear view to approaching traffic up a slight rise with the use of the police car to slow and merge traffic. Mr Cruise's statement confirms this. The ICV footage illustrates the positioning of the police vehicle provided safety to both persons whilst they remained within lane 1.

Was the manner and method in which the stop was conducted appropriate including the general road conditions at the time?

Vardys Road, Kings Park at the point where the stop was conducted ran east/west with a large median strip separating two trafficable lanes in the eastbound direction and two trafficable lanes in the westbound direction. Commercial and industrial premises are set back from the roadway at some distance. A viewing of the ICV footage indicates the traffic flow was not light. However, probably due to the phasing of traffic lights at the intersection to the west, passing traffic was not a continual unbroken heavy stream and there are breaks in the flow. I find the traffic conditions at the time involved moderate traffic. The roadway was dry. The speed limit was 60km an hour. There was a clear unobstructed view up to the stopping point for approaching traffic.

Solomon got out of the vehicle and inspected the load with Senior Constable Heron. The ICV footage illustrates the first discussions between the two persons as amicable and friendly. Senior Constable Heron tells Solomon what needed to be secured in the tray and returned to the police car. In the next approximately four minutes Solomon attempted to properly secure the load and Senior Constable Heron remained in the police car doing checks and entered details of an infringement notice. Just prior to leaving the car again Senior Constable Heron stated it became apparent to him that Solomon did not have the proper equipment or know how to properly secure the load.

After informing Solomon about the infringement notice, Solomon became very upset. Senior Constable Heron decided he just wanted to leave at that point as Solomon had become angry and emotional. He did not want to leave on a bad note and realised as the load was not secured properly he had not given Solomon a final instruction about the load. Senior Constable Heron turned back to Solomon to do that. At that point Solomon pulled on the unsecured strap and fell into lane 2.

Mr Robertson's opinion was for the purpose of properly securing the pallet in the position it was on the truck, the ratchet should have been fitted on the near side to allow for greater tension on the strap.

In examining the manner of Solomon's death I find that Senior Constable Heron's conduct up to the point where Solomon fell into lane 2 is the relevant conduct to examine. What direction or directions Senior Constable Heron was about to give Solomon does not impact on the circumstances that resulted in Solomon being struck by the semi-trailer in lane 2.

However, submissions were made on behalf of Solomon's family critical of Senior Constable Heron's decision-making process on the side of the road. It was submitted Senior Constable Heron's decision to stop the truck because the load was dangerous and unsecure and then subsequently deciding the truck should be moved as Solomon could not secure the load impacted upon his credit as a witness. It was submitted in reacting to Solomon's change of demeanour Senior Constable Heron did not exercise clear judgement on the day in exercising his duty.

Senior Constable Heron in his initial interview said he directed Solomon to get out of the truck. In evidence, Senior Constable Heron stated he had requested or asked Solomon to leave the truck. It was put this variance was consistent with him tailoring his evidence during the course of the proceedings. This point is resolved by reference to the ICV footage. What Senior Constable Heron actually said was recorded. It was: *"Lets have a look at this load together"*. I find a request was made to Solomon to get out of the truck. Solomon did so. It was not a formal direction. I do not find Senior Constable Heron's recollection of that part of his conversation with Solomon impacts on his credit as a witness. Overall I found Senior Constable Heron a credible witness.

Senior Constable Heron had decided just before Solomon fell to direct Solomon to move the truck off the roadway as Solomon could not secure the load. He was not going to allow Solomon to complete his journey. The nearest location where the truck could be taken off the road and the load properly and fully secured was a McDonalds carpark about 2km away. I find given the inability of the load to be secured and the choices available to Senior Constable Heron at that point in time, that this was an appropriate decision. The alternative was to direct Solomon to abandon the truck on the side of the road.

It was also submitted on behalf the family that Senior Constable Heron should have stopped/prevented Solomon using the offside of the truck in his attempts to secure the load and should have terminated Solomon's efforts earlier. Senior Constable Heron had no statutory power once Solomon was out of the truck to specifically direct him where to stand or where to walk unless he placed him under arrest. The only direction he could give Solomon at that time was to secure the load, drive on to another place or leave the vehicle where it was.

A viewing of the ICV footage once again illustrates that the decisions of how and in what manner to properly secure the load were made by Solomon. The responsibility for the initial loading and then addressing any deficiencies in the restraint of the load were Solomon's. Solomon made the decision to place the ratchet of the webbing strap on the offside of the vehicle.

Whilst on the offside of the vehicle Solomon remained entirely in lane 1 where by default he was protected by the corridor of safety provided by Senior Constable Heron's police vehicle. The situation evolved and it was only after approximately seven and a half minutes just before Senior Constable Heron got out of the car again that it became apparent Solomon was unable to properly secure the load with the equipment he had. I do not find that Senior Constable Heron should have intervened at an earlier stage and stopped Solomon's attempts to secure the load in those circumstances.

Whilst remaining within the boundaries of lane 1, which was what occurred just prior to Solomon pulling on the strap, Solomon was safely protected from passing traffic in lane 2 to the same degree Senior Constable Heron was. I find there was no requirement for Senior Constable Heron to advise Solomon about the "corridor of safety" in the circumstances. The manner and method used during the stop I find appropriate in all the circumstances and in accordance with the procedures and practices Senior Constable Heron was required to consider.

Solomon's response to receiving the infringement notice illustrates how quickly the dynamics of a vehicle stop can change. This is not a criticism of Solomon. All the evidence heard at the inquest demonstrates it was totally out of character. His reputation as an honest, hard-working, reliable and trustworthy person stands out. The \$433 fine probably negated any monetary benefit Solomon may have obtained for working that day. Solomon had gone to work on a day of the year when most people in the community are on holidays which accorded with his strong commitment to provide for and support his family.

I find on the evidence that once Solomon was made aware that he would receive a fine he simply forgot he had not secured the webbing strap on the near side of the truck. Throughout the stop Senior Constable Heron spoke and acted in my view in a professional manner. The ICV footage captures most of what was said and importantly the tone in which it was said. Senior Constable Heron's decision to walk away to de-escalate the situation I find entirely appropriate. I find in the circumstances there was no warning to Senior Constable Heron of what was about to happen.

I find the manner and method used by Senior Constable Heron for the stopping of Solomon's truck taking into account the purpose of the stop and the road conditions were appropriate and in accordance with procedures utilised by the NSW Police Force at that time.

Where police policies, guidelines and training regarding roadside stops of heavy vehicles adequate to ensure the safety needs of officers, drivers and the community, as well as the need for effective enforcement of road rules and regulations?

The evidence confirmed that the primary purpose of the "corridor of safety" and other information provided to police in the MVSTP is to ensure the safety of police officers during the course of vehicle stops. The corridor of safety, by default also provides a degree of safety for drivers and/or passengers of stopped vehicles. In circumstances where a driver is arrested, for instance after failing a breath test the arrested person is removed from the vehicle and the offset of the police car provides safety to both police and the person in custody.

The MVSTP does not provide any specific guidance to police to ensure the safety of drivers and their passengers who alight from stopped vehicles, or specific advice when loads will be required to be secured by the side of the roadway. Given the particular circumstances of Solomon's death I am satisfied the MVSTP is deficient in this regard.

Was the load restraint equipment available to Solomon on the truck fit for purpose?

Mr Robertson's opinion was that, because the pallet of cement bags was not against the headboard of the truck, it would have required three webbing straps to secure it properly. Solomon only had three in the truck and one (that was not fit for purpose) was already in use at the rear of the truck. Mr Robertson did not consider the tarpaulin offered adequate restraint in all the circumstances. In his opinion the equipment available in the truck would not have allowed the load to be properly secured.

There were no pallet angles in the truck. For some reason Solomon had removed the plastic wrapping from the pallet. I find the restraint equipment on the truck at that time was not sufficient to secure the load.

Mr Hooker stated any restraint equipment considered necessary was purchased by Solomon and reimbursed by the company. I accept his evidence there were additional webbing straps, approximately 8, available for use at the warehouse. Some of the webbing straps were in the company utility that Solomon drove or were in the warehouse. Plastic wrapping was available as were angles to place on top of pallets. I am satisfied there was sufficient and appropriate restraint equipment available for Solomon to use on that day. Despite his extensive experience, a good record of safe loading and his excellent professional reputation Solomon did not use the necessary equipment that was available to him. The ICV footage also illustrates he was not wearing a high visibility vest that day which was his usual practice at work.

Did the equipment or Solomon's use of it contribute to the fall?

Mr Robertson stated industry practice is the ratchet winch is placed on the kerb or nearside of the vehicle. This is specifically to allow the driver to check and adjust the straps whilst standing on the footpath. Roadway camber also results in the movement of loads to the nearside. After travelling some distance from a depot webbings straps or load restraints should be checked and tightened. However there is no legal requirement that load restraint adjustors be positioned on the nearside of a vehicle.

Mr Robertson also stated given the location of the pallet closer to the offside of the truck the proper positioning of the strap for the appropriate tension and downforce required the ratchet to be put on the nearside of the vehicle. Solomon placed the ratchet on the offside. Taking into account all the evidence received at this inquest I find Solomon's decision to place the ratchet on the offside of the truck combined with the obvious and tragic oversight of forgetting to secure the strap to the nearside before pulling on the strap is what caused him to over balance and fall/stumble out of the corridor of safety in lane 1 and into lane 2.

Did the stopping of Solomon's vehicle for the purposes of rectifying an unsecured/dangerous load and for random breath testing have any causal relationship with Solomon falling into the path of an oncoming truck?

The determination of this issue requires close consideration of whether Senior Constable Heron in performance of his duties undertook any actions that contributed to Solomon's death. The role of a Coroner is not to determine criminal responsibility, civil liability or negligence. For the reasons set out above, I find Senior Constable Heron acted appropriately and in the proper execution of his duties as a police officer in deciding to stop Solomon's truck. Solomon had not restrained the load on the truck properly. It was unsecure and potentially dangerous to other road users and Solomon, particularly in the event of an accident.

For the reasons set out above I find the location selected and the actions of Senior Constable Heron appropriate in the circumstances of that particular vehicle stop.

The load was not properly secured. I do not find Senior Constable Heron's actions caused Solomon to fall into the path of the truck. How to rectify the load was Solomon's responsibility. What occurred was a tragic accident. I find Solomon placing the ratchet on the offside of the truck and pulling on the unsecured strap having forgotten to secure it is what caused him to fall into the path of the oncoming truck.

The nature of the police investigation into Solomon's death and media reports on various news websites.

A number of contemporaneous reports of the incident from various media outlets (The Sydney Morning Herald; Yahoo 7; Channel 9; and Skynews) were provided to the inquest. These reports were seen by a friend of the family on the day of Solomon's death. Attention was specifically drawn to a comment attributed to a NSW Police Assistant Commissioner to the effect that there was nothing to indicate that the site was an inappropriate place to stop the vehicle. One report carries a timestamp of 8:22pm on 5 January 2017. Another, 1:54pm which was notably, before Detective Sergeant Allen had even interviewed Senior Constable Heron.

This issue was raised by Solomon's family with Detective Sergeant Allen during the course of Detective Sergeant Allen's evidence. I accept Detective Sergeant Allen's evidence that the first he became aware of these media reports was during the course of the inquest and that these reports in no way influenced the course of his investigation. Solomon's family take no issue with that.

There is no evidence before this inquest that the officer to whom the comment was attributed attended the scene or was in any way involved in the investigation. There is also no evidence as to what contributed to the formation of that opinion. Consequently, I am unable to make any findings regarding these media reports, nor have they affected any assessment of the issues on the evidence received.

It was submitted by Solomon's family that Detective Sergeant Allen failed to consider the alternate slip lane location in the course of his investigation. In the circumstances of what had actually occurred and where it had occurred, I consider the investigation focusing on the actual site used for the vehicle stop was appropriate. I am satisfied the investigation conducted by Detective Sergeant Allen was thorough and undertaken in a professional manner.

Recommendations:

To the New South Wales Commissioner of Police, I recommend the Commissioner consider inserting the following information in the Motor Vehicle Stopping Techniques and Procedures:

On Page 2:

In addition to your own safety, and that of any colleague working with you, consideration needs to be given to the safety of any driver, or passenger should they leave the vehicle. Such persons may become upset simply because they have been stopped or by action you may take. They may move outside the "corridor of safety" you have created and place themselves at risk by being struck by passing traffic.

Whilst you have no specific power to direct these persons to a particular place (unless you have placed them under arrest for a specific offence) it is recommended you suggest that they either remain within the vehicle or stand on its nearside until the stop has been completed.

On Page 3:

In circumstances where it is envisaged that the driver of the vehicle you have decided to stop will be requested to exit the vehicle for example, to inspect or rectify an unsecured load, a stopping location off the roadway where possible, should be selected.

Conclusion

Solomon's death was a tragic accident. Throughout the inquest Solomon's large and close-knit family attended every day. His sudden death has and will continue to affect the family enormously. I cannot adequately describe in words the level of their grief. Their love and respect for Solomon and the cherishing of his memory shone out throughout the hearing. Solomon's devotion to his family and the dedication to his faith illustrate the person he was.

Identity

Solomon Te Kohekohe Shortland

Place of death

Vardys Road, Kings Park, NSW

Date of death

5 January 2017

Cause of death

Multiple injuries

Manner of Death

Solomon Te Kohekohe Shortland died in the course of a police operation, accidentally falling into an adjacent lane of moving traffic, and was struck by a truck whilst attempting to restrain a load on a vehicle.

28. 39999 of 2017

Inquest into the death of Michael Clark. Finding handed down by Deputy State Coroner O’Sullivan at Glebe on the 31st January 2018.

Introduction:

Michael Rex Clark died on 7 February 2017, aged 53 years. As he was serving a custodial sentence at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the *Coroners Act 2009 (NSW)*.

The Inquest:

The Coroner must make findings as to the date and place of a person’s death, and the cause and manner of death: Section 81 of the Act. In addition, the Coroner may make recommendations in relation to matters that may improve public health and safety in the future arising out of the death in question: Section 82 of the Act.

As Mr Clark was in custody at the time of his death, the responsibility for ensuring he received adequate care and treatment rests with the State. For this reason, whenever a person dies in custody, an inquest is required to be held to assess whether the State has discharged its responsibilities.

The Evidence:

Background:

Mr Michael Rex Clark grew up in Stockton NSW. He worked as a landscape gardener and handyman and settled with his wife Jennifer Clark in Faulconbridge NSW. He has an extensive family including 6 children and 10 grandchildren who cared for him greatly during his life. He’d been married twice.

At 18 years of age he was involved in a motor vehicle accident and suffered a head injury. He had a colourful criminal history which included a conviction for armed robbery and the discharge of a firearm. He was convicted and sentenced on 11 August 2008 to a period of 30 years imprisonment for being complicit in the murder of his father, who was shot and killed by Michael Clark’s son, Ben Clark, in April 2005. His sentence commenced on 21 July 2005.

During his time in prison Mr Clark assisted troubled younger inmates come to terms with being incarcerated and took many of them under his wing. He was well respected by both Corrective Services NSW and Justice Health NSW staff. During his time in custody Mr Clark was granted compassionate release to attend his mother in law’s funeral on 24 August 2016, though applications for a further compassionate release reliant on his dire medical circumstances in November and December 2016 were rejected by the State Parole Authority.

Medical History:

Whilst in custody Mr Clark was treated for Hepatitis C. On 25 May 2012 Mr Clark began a Pegatron and Ribavirin treatment. On 17 October 2013, a triple therapy to combat Hepatitis C was used and the drug Boceprivir was added. Nearly 12 months later, on 14 October 2014 Mr Clark's treatment notes state his body was no longer responding to the therapies.

Between 3 July 2015 and 2 February 2016, Mr Clark received the ABBVIE treatment. By 15 May 2016 the Hepatitis C had been cleared from his body; however several lesions were discovered on his liver that were later confirmed to be carcinomas. He was referred to the Oncology department and was informed on 1 September 2016 that without treatment he would have a life expectancy of 6 months, though, his life expectancy could be extended if he was suitable for chemotherapy.

On 8 September 2016, he was deemed unsuitable for chemotherapy and was recommended for palliative care. Mr Clark's treating doctor, Professor Lloyd wrote on 24 November 2016, 'Clark has incurable hepatocellular carcinoma on a background of cirrhosis, liver failure and hepato-pulmonary syndrome'. His life expectancy was several weeks at most.

On 4 February 2017 Mr Clark's condition was deteriorating however he refused a transfer to the Prince of Wales secure annex and was instead transferred to the Medical Surgical Unit at the Long Bay hospital. A no resuscitation order was in place and he was pronounced life extinct on 7 February 2017.

Custodial History:

Mr Clark received an A2 maximum security classification and began serving his sentence at Lithgow Correctional Facility. He remained at the centre until May 2012 and was transferred to the Prince of Wales secure Annex after an unsuccessful attempt at suicide.

In May 2012, he commenced a program to treat his Hepatitis C and was transferred to the Long Bay Hospital and the Metropolitan Special Programs Centres, Long Bay Correctional Complex due to its proximity to health treatment facilities. He remained at that location until he died.

Care and Treatment:

The treatments and therapies in the above medical history occurred within Long Bay Hospital and the Metropolitan Special Programs Centres, Long Bay Correctional Complex.

In 2012 when Corrective Services NSW became aware of his deteriorating mental health, he was transferred to this facility for his own safety and because of its proximity to health services. There were no issues raised during the investigation of Mr Clark's death as to the adequacy of the medical treatment provided to him whilst in custody. Similarly, no issues were raised at inquest.

Autopsy Report:

The autopsy report confirmed the diagnosis of his treating Doctors and listed Mr Clark's cause of death as Complications of Hepatocellular Carcinoma. It found therapeutic levels of pain relief medication in keeping with palliative care treatment and there were no signs of recent trauma which could explain his rapid deterioration.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity of the deceased: The deceased person was Michael Rex Clark

Date of death: 7 February 2017

Place of death: Long Bay Hospital NSW

Cause of death: The death was caused by complications of Hepatocellular Carcinoma with significant contributing pathology of Cirrhosis of the Liver and Hepatitis C.

Manner of death: The manner of death was of natural causes whilst serving a sentence in custody.

29. 63039 of 2017

Inquest into the death of Neville Betteridge. Finding handed down by State Coroner Mabbutt at Glebe on the 18th July 2018

Introduction

Mr Neville Betteridge died on 27 February 2017 at Prince of Wales Hospital at 72 years of age. At the time of his death Mr Betteridge was undergoing treatment at the Prince of Wales Hospital, Randwick whilst in corrective service custody.

Why was an inquest held?

Mr Betteridge was in lawful custody at the time of his death. An inquest is required to be held pursuant to sections 23 and 27 of the *Coroners Act 2009*.

The role of the Coroner pursuant to s 81 of the *Coroners Act 2009* is to make findings regarding:

- The identity of the deceased
- The date and place of that person's death
- The cause and manner of that person's death

A Coroner may also make recommendations in accordance with s 82 of the Act concerning any public health or safety issues arising out of the death.

Mr Betteridge's background

Mr Betteridge was born in Beecroft, Sydney and grew up in Epping. Mr Betteridge's parents separated when he was five. He and his brother were raised by their mother and grandmother. Mr Betteridge attended high school at Trinity Grammar, Summer Hill and Epping Boys High. Upon finishing high school, he gained employment as a teacher at Blue Mountains Grammar school, before teaching at St Patricks, Sutherland and later Trinity Grammar.

Mr Betteridge eventually left teaching and became a bus tour operator, moving to Queensland. He returned to teaching in 1989 and took a position as housemaster at Ipswich Grammar before moving on to teaching positions in Alice Springs and then Charters Towers, Queensland. Mr Betteridge never married and had no children. He was a heavy smoker and drinker for most of his life.

Mr Betteridge's criminal and custodial history

In 2004, Mr Betteridge was charged with 2 counts of indecent assault dating back to his time at Blue Mountains Grammar. He was convicted of these offences in late 2004 and received a 3 year good behaviour bond. In May 2016, Mr Betteridge was arrested in Queensland and extradited to NSW to face child sexual assault charges, related to his time at Blue Mountains Grammar.

He appeared at Central Local Court on 12 May 2016 and was remanded into the custody of Corrective Services. At the time of his death Mr Betteridge was due to appear before Penrith Local Court on 17 March 2017 on 128 historical sexual offences. Mr Betteridge was in custody at MRRC Silverwater before being moved to the Metropolitan Special Programs Centre in June 2016. He was transferred to the Prince of Wales Hospital on 25 January 2017, after a minor fall and deterioration in his health.

Mr Betteridge's medical history

Mr Betteridge suffered mobility problems relating to spinal disability. He relied on the use of a walker for mobility and suffered from chronic foot ulcers. Mr Betteridge had smoked and suffered from vascular disease, severe cardio obstructive pulmonary disease amongst other medical ailments.

Whilst in custody, Justice Health staff noted Mr Betteridge:

- had a history of heart problems
- had poor circulation
- was easily short of breath and required a walker
- had a history of depression, for which he was treated with medication

Mr Betteridge was provided with appropriate mobility aids and medication whilst in custody. Mr Betteridge was seen by vascular and respiratory specialists and was prescribed a nasal spray and inhaler. Mr Betteridge attended the health clinic at least weekly, for regular dressings to both feet and for regular observations.

Events leading up to Mr Betteridge's death

Mr Betteridge's cell mate informed Police that Mr Betteridge had been feeling unwell in the weeks leading up to his hospitalisation. About 10.30pm 24 February 2017, Mr Betteridge used the toilet in his cell but had trouble getting up from a seated position. Mr Betteridge lost balance and fell, though the impact was lessened by his cellmate who had grabbed him as he was falling.

Mr Betteridge suffered a cut to his elbow, and remained sitting on the floor until Correctives Officers attended a short time later. He was taken to the correctional centre clinic and seen by nursing staff. Mr Betteridge complained of light headedness and tunnel vision. A decision was made at 2.00am on 25 February to transfer Mr Betteridge to the Prince of Wales Hospital. Mr Betteridge was admitted at the Emergency Department at Prince of Wales Hospital and later transferred to the geriatrics ward. Tests revealed Mr Betteridge was suffering from a urinary tract infection along with a chest infection, suspected of being either influenza or pneumonia. Mr Betteridge was treated with antibiotics and given oxygen. Further tests revealed concerns with the electrical impulses from Mr Betteridge's heart. It was thought he was also suffering from an artery blockage near his lungs.

About 9.00am, on the morning of the 27th February, Mr Betteridge's oxygen levels dropped. Mr Betteridge was given more oxygen and monitored. Mr Betteridge became agitated and delirious. Treating physician, Dr Perreira discussed Mr Betteridge's condition with Professor Billeri. The decision was made to transfer Mr Betteridge to the Intensive Care Unit.

Upon arriving at the ICU, Mr Betteridge was in respiratory distress and his blood pressure had decreased. Invasive exploratory surgery in a catheterization laboratory was considered, however cardiac experts, including Professor Allen advised that Mr Betteridge was not a suitable candidate for this procedure. Mr Betteridge's condition deteriorated and urgent medical intervention was initiated, including intubation and the administration of adrenaline. Mr Betteridge failed to respond to treatment and clinician Dr Collins and Professor Billeri were consulted. Mr Betteridge's condition was such that he was considered not likely to recover. The decision was made to provide palliative care only. Mr Betteridge's died at 1.30pm.

Police Investigation

Police were notified of the death and attended shortly after. Specialist investigators from the NSW Police Corrective Service Investigative Unit conducted the investigation. Specialist forensic police attended the hospital and examined Mr Betteridge. Detective Sergeant TESORIERO the officer in charge of the investigation gave evidence at the inquest. Mr Betteridge's cellmate, correctional and health staff were interviewed. Medical, health and prison records were obtained and reviewed regarding Mr Betteridge's care and medical treatment whilst in custody.

What caused Mr Betteridge's death?

Forensic Pathologist Dr Du Toit-Prinsloo conducted an external post mortem examination at the Department of Forensic Medicine at Glebe on 1 March 2017. Dr Du Toit-Prinsloo determined Mr Betteridge's cause of death was a ruptured abdominal aortic aneurysm.

Conclusion

When the death of a person in custody occurs, even of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility to provide adequately care and treatment to the person detained. There is no evidence to suggest Mr Betteridge was assaulted or deliberately injured prior to his death. There is no evidence to suggest that any person directly contributed to Mr Betteridge's death. I am satisfied Mr Betteridge's death was not suspicious.

Records from Justice Health and Corrective Services have been reviewed. Mr Betteridge's care and treatment in custody was appropriate taking into account Mr Betteridge's existing health issues upon his reception into custody in New South Wales following his extradition from Queensland. Mr Betteridge was transferred to Prince of Wales Hospital when treatment was required beyond the capacity Corrective Services medical services. Mr Betteridge's family has not raised any care and treatment issues.

I find that Mr Betteridge received health care and treatment of an appropriate standard whilst in custody. Having considered all of the evidence both oral and documentary tendered at the inquest I find that that Mr Betteridge died of natural causes whilst in lawful custody.

Findings Pursuant to s 81 of the *Coroners Act 2009*

Identity

The person who died was Neville Betteridge.

Date of death

27 February 2017.

Place of death

Prince of Wales Hospital, Randwick, New South Wales.

Cause of death

Ruptured aortic aneurysm.

Manner of death

Mr Betteridge died of natural causes whilst in lawful custody.

30. 76969 of 2017

Inquest into the death of Michael Joyce. Finding handed down by Deputy State Coroner O’Sullivan at Glebe on the 24th October 2018.

Introduction:

This is a mandatory inquest into the tragic death of Mr Michael Joyce. Mr Joyce’s death is a huge loss to his family, friends and colleagues. I would like to extend my condolences to them for their loss. This is a mandatory inquest by operation of s23 of the *Coroners Act 2009*, as in force at the relevant time. The role of the coroner

My role, as set out in s81 of the *Coroners Act 2009* (“the Act”), is to make findings as to the:

- identity of the deceased;
- date and place of the person’s death;
- physical or medical cause of death; and
- manner of death, that is, the circumstances surrounding the death.

Pursuant to s82 of the Act, I have the power to make recommendations, including concerning any public health or safety issue arising out of the death in question. For the reasons set out below, I do not consider there is any need for me to make recommendations arising out of the present inquest.

Background

Mr Joyce was born on 12 December 1988. He was still a young man, of 28, at the time of his death. His mother is Ms Jennifer Joyce. He has two sisters, Danielle and Kathleen. Statements provided by Ms Jennifer Joyce and Ms Danielle Joyce and, in addition, the tone of the text messages between Ms Danielle Joyce and her brother which are attached to Ms Danielle Joyce’s statement, indicate that the relationship between Mr Joyce and his family was a particularly close, loving and supportive one.

Although it risks getting lost given the focus of the inquest, the material before me also says a lot about Mr Joyce and the person who he was. In particular, his family members and their partners, who reside in Brisbane, recall the many attractive elements of Mr Joyce’s personality; particularly his intelligence, sense of humour, and larrikin nature.

Mr Joyce was actively pursuing his business opportunities (he was developing an App) and, not long before his death, seemed to have had some considerable successes in this regard, in particular, obtaining a lucrative contract from a client).

Indeed, Mr Joyce had moved to Sydney from Brisbane in early 2017 to pursue these business opportunities further. He was living with Mr Tang at a flat in Coogee, a location that he liked. During the time that he knew him, Mr Tang records Mr Joyce as having an active social life and as pursuing various interests and hobbies.

Although the focus of my reasons will be on the events leading to Mr Joyce's death, I do think it important to record these positive and happy aspects of Mr Joyce's life.

The Evidence:

At the hearing of the inquest, a brief of evidence, being a one volume folder containing the written, photographic and video material obtained by the officer in charge of this investigation, A/Inspector Christine McDonald, was tendered.

I have referred above to what that evidence in that brief says about who Mr Joyce was and his relationship with his family. I will now deal with what it says about the manner and cause of his death.

The background to the events of 12 March 2017

The account of members of his family is that Mr Joyce had been experiencing some mental health issues over a long period of time. In her statement, Ms Jennifer Joyce refers to her son having suffered for a number of years from a sleeping disorder, exacerbated by stress. In 2010, while he was still living in Brisbane with his family, Mr Joyce had been hospitalised at the Royal Brisbane Hospital for a period of around 3 months after suffering psychosis. In 2016, he was admitted to the Princess Alexandra Hospital at Brisbane for sleep deprivation.

Medical records obtained through the Randwick Medical Centre record that Mr Joyce had been prescribed Temazepam as a sleeping aid. However, approximately 2 weeks prior to his death, Mr Tang records Mr Joyce saying to him that his sleeping pills were no longer working.

During the last few weeks of his life, Ms Jennifer Joyce had a number of conversations with her son. From them, she took the view that her son was troubled and may have been "slipping in and out of reality". I am satisfied that, in the weeks leading to his death, Mr Joyce had experienced an unfortunate relapse of the chronic insomnia which had precipitated his mental health issues in the past.

The events of 12 March 2017:

Relevantly for present purposes, the material in the brief indicates that, on 12 March 2017, Mr Joyce had made his way to Dunningham Reserve, located in Coogee. The reserve adjoins a cliff overlooking the sea. There is a look out area at the top of the cliff and a small path leading to the look out. A fence separates the lookout from the cliff's edge. Records from the NSW Ambulance Service indicate that Mr Joyce requested an ambulance from that location. In a conversation which took place at 13:17 Mr Joyce indicated to the telephonist that he was "feeling a little insane". The telephonist asked Mr Joyce whether he was feeling violent towards anybody at which point Mr Joyce said no and hung up.

As is explained in the statement provided by Mr Gately (an employee of the NSW Ambulance Service), the telephonist was asking a question that had been prompted to her by a software program (the ProQA system) deployed by the NSW Ambulance Service to assist in triaging and prioritising the available resources to respond. In light of this explanation, I am satisfied that the telephonist's response to Mr Joyce was appropriate.

As Mr Gately explains, based on the information Mr Joyce had provided, the ProQA system allocated a response code of a priority 2 immediate response. Ambulance unit 1446 was assigned to that job and was dispatched at 13:18. It was cancelled, however, to attend to a higher priority case (a patient who experiencing breathing difficulties, a case which, as Mr Gately says, would generally be classified as at least a 1C urgent response). I am satisfied that this course was necessary and that it was appropriate for the finite resources of the NSW Ambulance Service to be deployed to prioritise a patient experiencing urgent symptoms such as breathing difficulties.

At 13:22, a further unit, Ambulance 1536, was assigned to the job and was similarly re-assigned due to a higher priority incident (again, a case involving breathing difficulties). Again, I am satisfied that this course was necessary and appropriate.

The NSW Police Force was copied in on the calls that had been received at 13:18.

Mr Joyce telephoned his mother Ms Jennifer Joyce at around 13:20 that day (in her statement, Ms Joyce says that this occurred at 12:20 but that is easily explained due to daylight savings being in operation in New South Wales and not in Queensland). As a result of this conversation, Ms Joyce expressed the opinion that her son was "not in reality" at that time because he was afraid of heights and would never contemplate going near a cliff's edge if he had been in a well state of mind.

Computer Aided dispatch records obtained by the NSW Police Force indicate that Ms Jennifer Joyce then telephoned Police at 13:29 because she was concerned for her son's welfare. Based on what the information that Ms Jennifer Joyce provided, the matter was appropriately treated by Police as requiring an urgent response. Three police units responded: EB 10 (Inspector Wunderlich); EB 14 (Sergeant Badger) and EB 17 (Senior Constable Belinda Jones and Constable Rainin).

Meanwhile, Ambulance unit 1423 continued proceeding to the scene but became delayed by heavy traffic. Consistently with usual procedure, a supervisor unit, unit 1049, was allocated at 13:35. Neither ambulance was ultimately able to arrive at Dunningham reserve before Mr Joyce's death. Sergeant Badger was the first of the police to arrive at Dunningham reserve (at 13:38) followed a minute later by Inspector Wunderlich. Sergeant Badger proceeded directly to the footpath leading to the lookout area. He called Polair to assist in locating Mr Joyce.

Inspector Wunderlich went past the path leading to the lookout area with the intention of continuing to move south to clear the area. Once he was in a position to see over the fence line separating the reserve from the edge of the cliff he saw a man (now known to be Mr Joyce) on the far side of the fence and called out to him.

Mr Joyce moved away from Inspector Wunderlich, heading north, towards the lookout area where Sergeant Badger was. Inspector Wunderlich called for specialist resources including negotiators and water police. Inspector Wunderlich was not, apparently, a trained negotiator.

Sergeant Badger had meanwhile had some dealings with another group of people who were standing on the cliff side of the fence at the lookout area. Sergeant Badger asked them to return to the reserve side of the fence. One of that group pointed out Mr Joyce to him. Sergeant Badger attempted to engage Mr Joyce telling him to come to the reserve side of the fence, not to jump and that he (Sergeant Badger) was going to back off. Sergeant Badger remained at all times on the reserve side of the fence (the opposite side from Mr Joyce). According to his own directed interview and that of Inspector Wunderlich, Sergeant Badger at no time was closer than 10 metres to where Mr Joyce was standing. Like Inspector Wunderlich, Sergeant Badger was also not apparently a trained negotiator.

Inspector Wunderlich then arrived at the lookout area. He too remained on the reserve side of the fence. Senior Constable Jones and Constable Rainin then arrived, in a position out of Mr Joyce's view and on the reserve side of the fence. The period of time Sergeant Badger had to engage with Mr Joyce before his death was extremely limited (estimated by Inspector Wunderlich to be 30 seconds). From the above, I am satisfied that those police who attended acted in an appropriate and professional manner and did everything in their power to prevent Mr Joyce's death. Their actions displayed an appropriate sensitivity to and awareness of the delicacy of the situation. The final moments of Mr Joyce's life are captured on two video recordings taken by civilian witnesses. They record Mr Joyce approaching the cliff's edge on a number of occasions before he finally went over the edge.

In addition, witnesses to the final moments of Mr Joyce's life record him as being "visibly distressed and agitated" and "sweating profusely". More relevantly, they describe Mr Joyce as being unsteady on his feet. Inspector Wunderlich says of the fall: "It almost seemed like he stumbled as he got towards the edge... [I]t just didn't look very co-ordinated when [Mr Joyce]... went off the cliff edge. I wouldn't be prepared to say he slipped but it wasn't a clean jump from the cliff edge." In a similar vein, Mr Woodward (one of the group of people located on the cliff side of the fence with whom Sergeant Badger had had dealings with and who witnessed the final moments of Mr Joyce's life) says that as Mr Joyce approached the cliff edge he "hesitated and fell off the cliff edge" (my emphasis).

I am satisfied from the above that Mr Joyce did in fact ultimately stumble and fall over the edge of the cliff at Dunningham reserve. This is perhaps as a result of the disorientation and confusion he was suffering as a result of him experiencing an episode of mental disturbance.

Autopsy Report

Dr Istvan Szentmariay, Forensic Pathologist, performed an autopsy on Mr Joyce on 14 March 2017. He concluded that Mr Joyce died as a result of multiple injuries.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was Mr Michael Joyce.

Date of death

Mr Joyce died on 12 March 2017.

Place of death

Mr Joyce died at Dunningham Reserve, Coogee in NSW.

Cause of death

The medical cause of his death was multiple injuries.

Manner of death

Mr Joyce died when he stumbled and fell from a cliff when he was experiencing an episode of mental disturbance.

31. 95138 of 2017

Inquest into the death of Ian Turnbull. Finding handed down by Deputy State Coroner Lee at Glebe on the 10th October 2018.

Introduction

Mr Ian Turnbull died on 27 March 2017 in hospital, but whilst in lawful custody. He had been held in custody after being arrested, and then convicted and sentenced, in relation to a criminal offence committed on 29 July 2014. In November 2016 Mr Turnbull suffered a serious medical event and made a partial recovery. However, Mr Turnbull was later admitted to hospital on 20 March 2017 in a serious condition, which did not improve and ultimately resulted in his death six days later.

Why was an inquest held?

Under the *Coroners Act 2009 (the Act)* a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This is so even when the death of a person in lawful custody believed to be due to natural causes. It should be noted at the outset that there is no evidence to suggest that in this case the State has not discharged its responsibility in anything other than an appropriate and adequate manner.

Mr. Turnbull's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most.

Therefore it is extremely important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way. Unfortunately, in this case, very little is known about Mr Turnbull's personal life. Mr Turnbull was born in Moree, in northern NSW, in 1934. He was married to his wife, Robeena, and together they had four children. At the time of his death, Mr Turnbull also had 13 grandchildren.

Mr Turnbull previously worked as a carpenter and joiner. In the early 1960s he and his wife bought their first farm in the Croppa Creek area outside of Moree. Mr Turnbull and his wife originally farmed stock and grain, but later changed focused on grain farming only. The success of the farm allowed Mr and Mrs Turnbull to expand their farming operations, and over time they acquired a number of other farms with members of their family. Prior to the events which resulted in his incarceration Mr Turnbull had been, by all accounts, an industrious farmer of many years. He had also gained a positive reputation as a member of the local community in the Moree region.

Throughout his life, Mr Turnbull enjoyed the love and support of his wife, children, and grandchildren. There is no doubt that Mr Turnbull's passing has caused them great sadness and grief, and that he is enormously missed by them, and his close friends.

Mr. Turnbull's custodial and medical history

On 29 July 2014 Mr Turnbull, then aged 79 years old, was arrested and charged in relation to an offence of murder involving the discharge of a firearm. He was later convicted of this offence and on 23 June 2016 Mr Turnbull was sentenced to a term of imprisonment of 35 years with a non-parole period of 24 years, commencing on 29 July 2014 (the date when Mr Turnbull was taken into police custody) and due to expire on 28 July 2038.

Following his transfer from police custody to the custody of Corrective Services NSW (**CSNSW**), Mr Turnbull was initially housed at Cessnock Correctional Centre before later being transferred to Mid North Coast Correctional Centre. This was the first time in his life that Mr Turnbull had been incarcerated. Upon entering into custody it was noted that Mr Turnbull had a relevant history of hypertension, ischaemic heart disease, angina, gastroesophageal reflux disease, basal cell carcinoma on his nose, peripheral neuropathy and osteoporosis.

Between July 2014 and June 2016 Mr Turnbull was referred by Justice Health and Forensic Mental Health Network (**Justice Health**) staff for a number of diagnostic tests and consultations with external specialists. This was done so that his chronic and complex health issues could be adequately managed, and involved Mr Turnbull's transfer to Long Bay Correctional Complex (**Long Bay**) so that he could attend appointments at Prince of Wales Hospital (**POWH**).

On 6 November 2016 Mr Turnbull was transferred to Port Macquarie Hospital where he was subsequently diagnosed with a right-sided cerebrovascular accident (**CVA**). He was later transferred from Port Macquarie to POWH for continued rehabilitation. On 3 January 2017 Mr Turnbull was transferred from POWH to the Medical Surgical Unit at Long Bay.

Mr Turnbull was referred back to POWH for review in February 2017. It was noted that Mr Turnbull had been reporting some breathlessness since suffering his CVA. On examination it was found that he had a mild reduction in lung volume since his last examination (in December 2016). It was also noted that it was likely that Mr Turnbull had asbestos-related pleural disease given his past significant asbestos exposure while having previously worked as a carpenter and joiner for many years.

Later in the same month, upon review in the POWH rehabilitation clinic, it was noted that Mr Turnbull had recovered well from his CVA but had minor residual impairments of left-sided facial droop, paraesthesia, mild dysphagia, and decreased balance and lower limb strength. Plans were made for Mr Turnbull to continue with physiotherapy to increase strength and balance.

On 20 March 2017 Mr Turnbull attended a consultation with Justice Health staff where it was noted that he had difficulty swallowing and dyspnoea. He was subsequently transferred to the POWH emergency department for further investigation. On examination it was found that Mr Turnbull had an abnormal breathing pattern (Cheyne-Stokes respiration), bilateral oedema to his mid-shins, and raised white cell count, lactate and creatinine levels. Mr Turnbull was subsequently admitted to POWH Secure Annex with septic shock and renal failure.

The following day, 21 March 2017, Mr Turnbull's condition deteriorated and it was noted that he had hypotension and bradycardia, requiring cardiac rhythm resynchronization therapy. Due to his multiple comorbidities and poor prognosis, a clinical decision was made to place Mr Turnbull on a palliative care pathway. Mr Turnbull's condition continued to decline over the following days. On 22 March 2017 Mr Turnbull's family were advised of his prognosis and that his life expectancy was limited to the next few days. On 25 March 2017 it was noted that Mr Turnbull was no longer verbally communicating, nor eating and drinking.

On 27 March 2017 arrangements were made to allow Mr Turnbull's family to visit him. During the visit Mr Turnbull ceased breathing and became unresponsive. In accordance with existing advanced care directives that were in place, no resuscitation measures were taken. Mr Turnbull was later pronounced deceased at 3:42pm.

What was the cause and manner of Mr. Turnbull's death?

Following the death, Mr Turnbull was taken to the Department of Forensic Medicine at Glebe where a post-mortem examination was performed by Dr Lorraine Du Toit-Prinsloo on 29 March 2017. Dr Du Toit-Prinsloo reviewed Mr Turnbull's medical records and performed a limited autopsy by way of external examination only. Dr Du Toit-Prinsloo concluded that the cause of Mr Turnbull's death was acute kidney injury due to possible sepsis or cardiogenic shock, with congestive cardiac failure being a significant condition contributing to the death. There is no evidence to indicate that any external factor contributed to Mr Turnbull's death. Therefore, his death was due to natural causes.

What conclusions can be reached regarding Mr. Turnbull's care and treatment whilst in custody?

Having considered the available records held by both CSNSW and Justice Health in relation to Mr Turnbull, I cannot identify any matter associated with his care and treatment whilst in custody that contributed to his death. Following diagnosis of Mr Turnbull's CVA in November 2016, it is clear that appropriate treatment in the form of clinical management and rehabilitation therapy was provided. It is equally clear that in March 2017 Mr Turnbull's condition rapidly deteriorated over a number of days and that appropriate palliative care was provided.

There is no evidence to suggest that the health care provided to Mr Turnbull whilst in custody was not within an expected standard of care. There is no evidence to suggest that any act or omission by either CSNSW or Justice Health contributed to Mr Turnbull's death in any way. Evidence given by the police officer in charge, Detective Sergeant Joseph Coorey, confirms that Mr Turnbull's family have raised no concerns about the care and treatment provided to Mr Turnbull whilst in custody. Mr Turnbull's deterioration due to natural disease process is well documented in the available medical records. The evidence indicates that appropriate clinical and administrative steps were taken to manage Mr Turnbull's declining condition in accordance with his palliative care pathway.

Findings

The findings I make under section 81(1) of the Act are:

Identity

The person who died was Ian Turnbull.

Date of death

Mr Turnbull died on 27 March 2017.

Place of death

Mr Turnbull died at Prince of Wales Hospital, Randwick NSW 2031.

Cause of death

The cause of Mr Turnbull's death was acute kidney failure due to possible sepsis or cardiogenic shock, with congestive cardiac failure being a significant condition contributing to the death.

Manner of death

Mr Turnbull died from natural causes whilst in lawful custody.

32. 199884 of 2017

Inquest into the death of Zaydoun Al Qaser. Inquest suspended by State Coroner Mabbutt on the 15th June 2018.

Having been informed a known person has been charged with an indictable offence connected to the death of Zaydoun Al Qaser. The State Coroner in accordance with the Coroners Act suspended the inquest.

33. 312005 of 2017

Inquest into the Jaland Small. Inquest suspended by Deputy State Coroner Russell on the 9th February 2018.

Having been informed a known person has been charged with an indictable offence connected to the death of Jaland Small. The Deputy State Coroner in accordance with the Coroners Act suspended the inquest

34. 327738 of 2017

Inquest into the death of Kenneth Johnstone. Finding handed down by Deputy State Coroner Russell on the 15th November 2018 at Glebe.

Background

Kenneth Johnstone died at the Long Bay Correctional Complex at Malabar on 29 October 2017. He was 79 years old, having been born on 20 May 1938.

On 2 June 1975 Mr. Johnstone was sentenced by the Supreme Court of New South Wales to life imprisonment for the offence of murder. That sentence dated from 6 November 1974. Mr. Johnstone had sexually assaulted and murdered a 13-year-old victim, whose body he burnt and dumped in a shallow grave.

On 20 December 1991, it was determined that a term during which Mr. Johnstone may be released on parole was to commence on 5 November 1993 and to continue for the term of Mr. Johnstone's natural life. The State Parole Authority declined, on a number of occasions in subsequent years, to release Mr. Johnstone to parole.

He was, then, at the time of his death, within the meaning of section 23 of the *Coroners Act 2009*, in lawful custody. An inquest in such circumstances is mandatory, pursuant to section 27(1) of that Act.

Functions of the Coroner

Section 81 of the *Coroners Act 2009* sets out the principal functions of a coroner conducting an inquest. Those are to record the identity of the person who has died, the date and place of his death and the manner and cause of his death.

Classification in custody

Mr. Johnstone was classified as a Special Management and Placement inmate. That classification reflected the protection concerns associated with Mr. Johnstone's status as a child sex offender.

Medical history

Mr. Johnstone had been incarcerated for more than 40 years and, during that time, had been diagnosed with, and treated for, a wide range of medical conditions. That extensive medical history included metastatic colorectal carcinoma (adenocarcinoma), diabetes mellitus type II (insulin dependent), stage 4 chronic kidney disease (diabetic nephropathy), glaucoma, peripheral vascular disease with sepsis amputation and osteomyelitis of the right foot, transient ischaemic attacks, cerebrovascular disease, osteoarthritis, hypertension, coronary ischaemic syndrome (coronary stents), gastro oesophageal reflux disease and sleep apnoea.

In early 2017, Mr. Johnstone underwent colorectal surgery following the diagnosis of metastatic colorectal carcinoma. He was an unsuitable candidate for chemotherapy. His cancer recurred in July 2017 and he received ongoing palliative care involving both the Prince of Wales Hospital and the Long Bay Hospital.

Cause of death

A post-mortem investigation was undertaken by Dr Sairita Maistry, forensic pathologist. Dr Maistry found that Mr. Johnstone died as a result of the complications associated with metastatic colorectal carcinoma and diabetes mellitus with osteomyelitis. She found that other significant conditions contributing to his death but not relating to the disease or condition which caused it were peripheral vascular disease, ischaemic cardiovascular disease and hypertension.

Period leading up to Mr. Johnstone's death

Some weeks before his death, Mr. Johnstone was admitted to Long Bay Hospital for the treatment for his osteomyelitis. The underlying colorectal cancer meant that his health deteriorated and he agreed to be placed in palliative care and that he should not be resuscitated in the event that his heart stopped or that he stopped breathing. He was moved to Palliative Care Cell 32 within the Long Bay Hospital complex.

On 28 and 29 October 2017 Mr. Johnstone's health declined rapidly. He was administered morphine for pain management and observed on 15 to 30 minute observations. He was bedridden and unconscious. He was nursed and cleaned by staff. He died late in the morning of 29 October 2017.

The evidence establishes that Mr. Johnstone received appropriate attention for his medical conditions and that his final illness was managed with proper care.

Findings

Kenneth Johnstone died on 29 October 2017 at Long Bay Hospital, Malabar, New South Wales, as a result of complications associated with metastatic colorectal carcinoma and diabetes mellitus with osteomyelitis. Other significant conditions contributing to his death were peripheral vascular disease, ischaemic cardiovascular disease and hypertension.

He died of natural causes.

35. 350282 of 2017

Inquest into the death of Jamie Walker. Finding handed down by State Coroner Mabbutt at Glebe on the 20th July 2018

Introduction

Mr Jamie Walker died on the 19 November 2017 at Prince of Wales Hospital, Randwick. At the time of his death Mr Walker was in lawful custody and under guard of Corrective Services. Mr Walker was 49 years of age.

Why was an inquest held?

The role of the Coroner pursuant to s 81 of the *Coroners Act* 2009 is to make findings regarding:

- The identity of the deceased
- The date and place of that person's death
- The cause and manner of that person's death

A Coroner may also make recommendations in accordance with s 82 of the Act concerning any public health or safety issues arising out of the death. In accordance with s 23 and s 27 of the *Coroners Act* 2009, an inquest is mandatory where a person's death occurs whilst in lawful custody

Background

Mr Walker was born in 1968. His family moved to Lethbridge Park when Mr Walker was young. They lived there until 1993. Mr Walker attended Shalvey High School. He left school prior to completing his High School Certificate, eventually taking up employment with State Rail. Mr Walker worked with State Rail for about 11 years, before leaving due to a workplace injury. He then worked odd jobs, often with his father who was a cabinet maker. When he was 28 Mr Walker suffered a fall and as a result developed epilepsy. He was eventually placed on a pension due to the epilepsy.

Mr Walker had one child. The mother of the child left Mr Walker taking the child with her. Mr Walker only saw his son twice, the last time when the baby was 6 weeks old. They never reconnected. Mr Walker then commenced a 25 year relationship with Ms Linda Lock. Ms Lock also suffered from epilepsy and they resided in Quakers Hill.

Mr Walker's custodial history

Mr Walker taken into custody on 27 April 2015 and subsequently charged with the murder of Ms Lock. Mr Walker was found guilty of murder at trial on 18 August 2017 and was due to be sentenced on 23 November 2017. Upon admission into Corrective Services custody a health review of Mr Walker disclosed cannabis and benzodiazepines use and he was on the methadone program.

Mr Walker was placed in a monitored cell due to his epilepsy and concerns regarding drug withdrawal. He was continued on the methadone program. His medications were continued in custody.

A health management plan involving access to specialists and medical services outside the custodial health system was implemented to ensure Mr Walker's health treatment was continued at an appropriate level whilst in custody. Mr Walker was transferred to Long Bay Prison hospital in December 2016 where he remained until 27 October 2017 when he was transferred to Prince of Wales Hospital where he remained under guard until his death.

Mr Walker's medical history

Records reveal Mr Walker's past medical history included epilepsy and cirrhosis and that he suffered from Hepatitis C. Mr Walker had a history of drug and alcohol abuse. Mr Walker was receiving treatment for his epilepsy, with his last seizure about 2 years prior to his death. He was also receiving treatment from a liver specialist for his cirrhosis, as well as receiving regular medication for his hepatitis. Mr Walker was provided with appropriate medication for the duration of his time in custody.

The events leading to Mr Walker's death

On 19 October 2017, Mr Walker was taken to the Prince of Wales Hospital complaining of pain to his abdomen and swelling to his leg. He was seen in the emergency department by the consulting physician Dr Davis and also the emergency department medical officer Dr Perry. Consultation took place with the gastroenterology registrar and the surgical registrar regarding the possibility of gallbladder disease. Mr Walker's pain had subsided and he was not showing specific symptoms of gallbladder disease. Mr Walker was discharged back to Long Bay Gaol Hospital. Liver function tests were ordered.

At Long Bay hospital, Mr Walker was seen by Professor Lloyd. Mr Walker's liver function tests produced abnormal results and it was noted that Mr Walker was extremely jaundiced. Mr Walker had lost weight in the preceding four months and was suffering from increased fatigue and nausea. On 27 October 2017, Professor Lloyd referred Mr Walker to Prince of Wales Hospital advising Mr Walker was suffering obstructive jaundice on a background of liver cirrhosis.

Upon admission to Prince of Wales Hospital, Mr Walker was assessed then transferred to the Gastrointestinal and Liver Unit for ongoing care. Mr Walker came under the care and management of a team of doctors headed by Professor Stephen O'Riordan and including Dr Brennan and Dr Matthew Kim.

Hospital tests showed Mr Walker was suffering gallstones and inflammation of his gallbladder. Chronic liver disease and hypertension in his veins was also found. On 3 November 2017, Mr Walker underwent exploratory surgery which revealed an obstructed bile duct, kidney damage and severe liver dysfunction. On 8 November 2017, a liver biopsy and other scans revealed cancerous nodules in his liver as well as his upper abdomen and right lung. This suggested that cancer was spreading through his body.

Dr Kim reviewed these results in consultation with Professor O'Riordan. Given the extent of the disease and Mr Walker's background of poor health, specialist surgical and oncological opinions deemed the cancer was not suitable for surgical or chemotherapy treatment. Over the ensuing days, Dr Kim discussed the results with Mr Walker and his mother, informing them that the clinical focus would be on symptom control rather than curative intent. On 10 November, Mr Walker and his mother agreed that he would be given a 'not for resuscitation status'.

On 13 November, consideration was given to returning Mr Walker to Long Bay Gaol Hospital, however this did not occur as a palliative consultant could only see Mr Walker on a weekly basis at Long Bay. On 13 November, Dr Kim had phone discussions with Mr Walker's mother and informed her that Mr Walker was to be transferred into palliative care at Prince of Wales Hospital. By 17 November, Mr Walker's condition had continued to deteriorate. Dr Kim consulted with Dr Hertz in palliative care and the decision was made to place Mr Walker onto a terminal pathway treatment, where he was issued pain medication to make him comfortable and ease sporadic convulsions. By this stage, Mr Walker was mostly unconscious, could not communicate and could only be roused by touch.

Mr Walker's condition continued to deteriorate and on 19 November 2017 he died. He was declared deceased by Dr Dominic Vickers at 1.55pm that day. During his hospital admission, Mr Walker was managed in close collaboration with specialists in Interventional Hepatobiliary Endoscopy, Intensive Care Medicine, Surgery, Oncology, Radiology and Anatomical Pathology. Police were notified of the death and attended the Hospital. Staff from Corrective Services, Justice Health and Prince of Wales Hospital were spoken to. Medical and health records were reviewed.

At the inquest Detective Senior Constable Cambridge the officer in charge of the investigation gave evidence and the brief of evidence was tendered which contained statements, medical records, photographs, the post mortem report and other material.

The cause of Mr Walker's death

Forensic Pathologist Dr Irvine conducted an external post mortem examination of Mr Walker at the Department of Forensic Medicine Glebe on 21 November 2017. The direct cause of death was found to be metastatic cholangiocarcinoma.

Conclusion

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility.

Records from Justice Health, Corrective Services and Prince of Wales Hospital have been reviewed. There is no evidence to suggest Mr Walker was assaulted or deliberately injured prior to his death. There is no evidence to suggest that any person directly contributed to Mr Walker's death. I am satisfied Mr Walker's death was not suspicious.

Mr Walker's family have not raised any issues regarding the care and treatment received by Mr Walker in custody. Having considered all of the evidence both oral and documentary tendered at the inquest I find Mr Walker received care and treatment to an appropriate standard whilst in custody.

I find that that Mr Walker died of natural causes whilst in lawful custody.

Findings pursuant to s 81 of the *Coroners Act 2009*

Identity

The person who died was Jamie Walker.

Date of death

19 November 2017.

Place of death

Prince of Wales Hospital, Randwick.

Cause of death

Metastatic cholangiocarcinoma.

Manner of death

Mr Walker died of natural causes whilst in lawful custody.

36. 358109 of 2017

Inquest into the death of Stephen John. Finding handed down by State Coroner Mabbutt at Glebe on the 10th July 2018.

Introduction

Mr Stephen John died at Fairfield Nursing Home on 26 November 2017. Mr John was 68 years old. At the time of his death Mr John was detained in the lawful custody of the Department of Home Affairs at the nursing home.

Why was an inquest held?

In accordance with s 23 and s 27 of the *Coroners Act 2009*, an inquest is mandatory where a person's death occurs whilst in lawful custody. Mr John was in lawful custody of the Department of Home Affairs at the time of his death

The role of the Coroner pursuant to s 81 of the *Coroners Act 2009* is to make findings regarding:

- The identity of the deceased
- The date and place of that person's death
- The cause and manner of that person's death

A Coroner may also make recommendations in accordance with s 82 of the Act concerning any public health or safety issues arising out of the death.

Background

Mr John was born in England in 1949, and arrived with his family in Australia at the age of nine. He became a permanent resident of Australia. Mr John married and raised three children however he was separated at the time of his death. Mr John joined the railways at age 18 and worked in south west Sydney for 47 years before retiring. Despite spending most of his life in Australia, Mr John never became an Australian citizen. At the time of his death he was detained by the Department of Home Affairs, awaiting deportation to his birth country of England.

The imprisonment of Mr John on criminal charges

In June 2012, Mr John was charged with multiple child sex and child pornography offences. Mr John was sentenced at the Downing Centre District Court on 6 December 2013 and received several terms of full time imprisonment in excess of 12 months.

The detention of Mr John under the *Migration Act 1958* (Cth)

Whilst in Corrective Services custody and as result of his convictions, Mr John's residency was reviewed and Mr John's permanent residency visa was cancelled by the then Department of Immigration and Border Protection. That decision was on character grounds and due to his criminal convictions. Accordingly Mr John was classified as an unlawful non-citizen.

On 18 December 2016, Mr John was released from corrective services custody and detained in the custody of Immigration and Border Force officials in accordance with s189 of the *Migration Act 1958*. Mr John was detained initially in Villawood Detention Centre, pending his deportation to England. However, Mr John's medical condition prevented his deportation from Australia. Mr John's health declined to the extent he was transferred for medical treatment to Liverpool Hospital on 10 July 2017 and on 24 July 2017 he was transferred to Fairfield Nursing Home, where he remained until his death.

Mr John's medical history and the events leading to his death

Mr John was already frail upon entering into Corrective Services Custody in 2012, suffering diabetes and breathing difficulties from Chronic Obstructive Pulmonary Disease. Mr John was ultimately placed within a unit specifically for older inmates with a disability. Mr John was given a nebuliser in his cell. Mr John was seen by Justice Health staff daily prescribed medication and received treatment when health issues arose.

In January 2013, he was admitted to the Prince of Wales Hospital suffering from shortness of breath and respiratory distress. Upon discharge back into corrective services custody, Mr John was provided access to oxygen to assist with his breathing difficulties. Mr John's overall condition did not improve. Upon his release from Corrective Services Custody and entering Immigration Detention on 18 December 2016 Mr John's Chronic Obstructive Pulmonary Disease had advanced to the point where he required aids for mobility, constant oxygen, and could only walk for a maximum of 10 metres at a time.

Whilst in Immigration detention, Mr John had access to care to assist with his showering, mobility and toileting and was supplied with oxygen and medication for his illnesses. Mr John's condition deteriorated whilst in detention. Whilst at Villawood Detention Centre Mr John was referred to Dr Keller a respiratory specialist. Dr Keller reviewed Mr John at Villawood Detention Centre on 3 July 2017. Dr Keller determined Mr John was in end stage Chronic Obstructive Pulmonary Disease and emphysema and had been on long term oxygen therapy for a number of years. Dr Keller discussed palliative care treatment with Mr John who agreed to a "not for resuscitation" status.

On 4 July 2017 the medical director at Villawood requested Mr John to be transferred to palliative care outside the Detention Centre. That request was approved on 6 July. Mr John was transferred on 10 July to Liverpool Hospital under the care of the Community Palliative Care Team. On 24 July Mr John was transferred to a placement at Fairfield Nursing Home. Dr Peter Tieuw was Mr John's treating practitioner upon his admission to Fairfield Nursing Home. Dr Tieuw stated Mr John illness was at a severe stage. Mr John was confused due to a lack of oxygen to his body and brain and spent most of his time in bed. Mr John needed assistance with all his activities of daily living.

By Saturday, 25th November 2017, Mr John's condition had declined to the point where his breathing became shallow and laboured and he fell into unconsciousness. His illnesses had reached end stage respiratory failure. Medical staff were notified and attempted to assist Mr John and make him comfortable. Dr Chiwara attended and pronounced that Mr John had died about 12.35am on 26 November 2017. Police were notified of the death and attended shortly after. Constable Elise Ryan from Fairfield Local Area Command conducted the investigation.

Cause of death

A post mortem examination was conducted by Forensic Pathologist Dr Rebecca Irvine. Dr Irvine determined the cause of Mr John's death was chronic lung disease.

Was Mr John provided appropriate care and treatment whilst in custody?

When a person is detained in lawful custody, it is essential that person receives appropriate care and treatment. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess that adequate care and treatment was provided to the person detained.

Records from Corrective Services NSW, Villawood Detention Centre and Fairfield nursing home have been reviewed. There is no evidence to suggest Mr John was assaulted or deliberately injured prior to his death. I am satisfied there are no suspicious circumstances. Mr John was transferred from Villawood Detention Centre to Liverpool hospital then to Fairfield nursing home when his medical condition required care above that available at Villawood Detention Centre. The medical records reviewed reveal Mr John's care and treatment were appropriate. Mr John's family have raised no issues with his care and treatment.

Conclusion

I find that Mr John died of natural causes. I find Mr John received care and treatment of an appropriate standard whilst in lawful custody of the Department of Home Affairs. I find that Mr John died at Fairfield Nursing Home on 26 November 2017.

Findings Pursuant to s 81 of the *Coroners Act 2009*:

Identity

The person who died was Stephen John.

Date of death

26 November 2017.

Place of death

Fairfield Nursing Home, Fairfield, New South Wales.

Cause of death

Chronic lung disease.

Manner of death

Mr John died of natural causes whilst detained in lawful custody of the Department of Home Affairs.

Appendix 1: Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed as at 31 December 2018

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	435610/10	24/04/10	Silverwater	18	In Custody
2	273783/12	01/09/12	Silverwater	49	In Custody
3	343092/14	20/11/14	Hurstville	18	Police Op
4	124745/15	27/04/15	Camden	43	Police Op
5	141693/15	12/05/15	Silverwater	31	In Custody
6	208086/15	15/07/15	Maryvale	18	Police Op
7	289369/15	02/10/15	Parramatta	15	Police Op
8	323840/15	03/11/15	Malabar	74	In Custody
9	323811/15	03/11/15	Wellington	34	In Custody
10	329568/15	09/11/15	Camperdown	25	In Custody
11	373099/15	19/12/15	Penrith	54	In Custody
12	381722/15	29/12/15	Malabar	26	In Custody
13	18089/16	18/01/16	Lismore	23	Police Op
14	19119/16	19/01/16	Quakers Hill	46	Police Op
15	24535/16	22/01/16	Malabar	19	In Custody
16	56536/16	20/02/16	Marayong	37	Police Op
17	56558/16	20/02/16	Marayong	35	Police Op
18	56518/16	20/02/16	Westmead	36	Police Op
19	73098/16	07/03/16	Ingleburn	33	Police Op
20	82254/16	15/03/16	Concord	51	In Custody
21	88742/16	21/03/16	Bradbury	36	Police Op
22	107266/16	07/04/16	Parklea	58	In Custody
23	110830/16	11/04/16	Malabar	37	In Custody
24	186812/16	19/06/16	Westmead	28	In Custody
25	214323/16	14/07/16	Parklea	43	In Custody
26	218940/16	19/07/16	Maitland	36	Police Op
27	273191/16	11/09/16	Parklea	44	In Custody

28	290240/16	27/09/16	Sth Windsor	46	Police Op
29	329687/16	03/11/16	Bonville	36	Police Op
30	334771/16	08/11/16	Narromine	22	Police Op
31	350477/16	22/11/16	Westmead	22	Police Op
32	361528/16	01/12/16	Appin	62	Police Op
33	24726/17	24/01/17	Malabar	74	Police Op
34	39421/17	06/02/17	Westmead	67	In Custody
35	43731/17	10/02/17	Macksville	15	Police Op
36	76874/17	10/03/17	Londonderry	18	Police Op
37	81862/17	15/03/17	Girrards Hill	58	Police Op
38	96394/17	29/03/17	Bathurst	35	Police Op
39	99958/17	02/04/17	Silverwater	32	In Custody
40	100899/17	03/04/17	Parklea	38	In Custody
41	121886/17	24/04/17	Malabar	72	In Custody
42	136779/17	05/05/17	Parklea	52	In Custody
43	142803/17	09/05/17	Blacktown	20	In Custody
44	157550/17	25/05/17	Goulburn	49	In Custody
45	185430/17	20/06/17	Camperdown	47	In Custody
46	188495/17	23/06/17	Goulburn	21	In Custody
47	202885/17	04/07/17	Westmead	35	In Custody
48	225703/17	23/07/17	Malabar	67	In Custody
49	225920/17	22/07/17	Lithgow	56	In Custody
50	228552/17	26/07/17	Sydney	30	Police Op
51	256295/17	22/08/17	Malabar	57	In Custody
52	256693/17	06/08/17	Grafton	44	Police Op
53	264782/17	30/08/17	Kelso	47	Police Op
54	266269/17	31/08/17	Bendeneer	29	Police Op
55	272539/17	04/09/17	Albury	19	Police Op
56	275511/17	08/09/17	Parklea	81	In Custody
57	275550/17	10/09/17	Randwick	49	In Custody

58	286401/17	20/09/17	St Leonards	64	Police Op
59	288854/17	22/09/17	Tamworth	22	In Custody
60	297414/17	29/09/17	Silverwater	34	In Custody
61	311913/17	15/10/17	Randwick	49	In Custody
62	343689/17	13/11/17	Nth Narrabeen	27	Police Op
63	344706/17	14/11/17	Coffs Harbour	27	Police Op
64	371691/17	07/12/17	Parklea	37	In Custody
65	373943/17	10/12/17	Penrith	35	Police Op
66	381497/17	17/12/17	Westead	18	Police Op
67	387508/17	20/12/17	Watsons Bay	40	Police Op
68	15741/18	15/01/18	Malabar	57	In Custody
69	28682/18	26/01/18	Maroubra	33	Police Op
70	37983/18	03/02/18	Junee	23	In Custody
71	39867/18	06/02/18	Malabar	70	In Custody
72	40544/18	06/02/18	Darlinghurst	55	In Custody
73	41984/18	07/02/18	Waterloo	31	Police Op
74	46266/18	09/02/18	Westmead	55	In Custody
75	54603/18	15/02/18	Westmead	44	In Custody
76	54392/18	18/02/18	Camperdown	30	Police Op
77	60363/18	20/02/18	Goulburn	67	In Custody
78	63185/18	24/02/18	Liverpool	26	Police Op
79	79469/18	11/03/18	Malabar	60	In Custody
80	80723/18	12/03/18	Emu Plains	23	In Custody
81	109796/18	08/04/18	Randwick	82	In Custody
82	14791/18	11/04/18	Collingullie	42	Police Op
83	119731/18	14/04/18	Westmead	84	In Custody
84	123983/18	18/04/18	Kogarah	54	In Custody
85	136203/18	30/04/18	Randwick	44	In Custody
86	142510/18	06/05/18	Bomaderry	24	Police Op
87	150088/18	11/05/18	Mt Druitt	29	Police Op

88	150097/18	13/05/18	Randwick	53	In Custody
89	166031/18	25/05/18	Surry Hills	48	In Custody
90	194750/18	23/06/18	Malabar	86	In Custody
91	199143/18	27/06/18	Randwick	52	In Custody
92	206773/18	04/07/18	Randwick	69	In Custody
93	209734/18	07/07/18	Silverwater	30	In Custody
94	269824/18	01/09/18	Bershire Park	36	In Custody
95	279370/18	11/09/18	Silverwater	48	In Custody
96	281398/18	12/09/18	Goulburn	43	In Custody
97	283647/18	15/09/18	Malabar	68	In Custody
98	287982/18	19/09/18	Malabar	68	In Custody
99	291962/18	23/09/18	Brocklehurst	51	Police Op
100	297261/18	27/09/18	Tweed Heads	22	Police Op
101	314209/18	12/10/18	Randwick	85	In Custody
102	328285/18	25/10/18	Berkshire Park	30	In Custody
103	338690/18	03/11/18	Ryde	26	Police Op
104	3622445/18	23/11/18	Engadine	81	Police Op
105	369349/18	29/11/18	Richmond Vale	55	Police Op
106	372498/18	03/12/18	Silverwater	30	In Custody
107	391439/18	19/12/18	St Leonards	23	Police Op
108	392964/18	20/12/18	Malabar	34	In Custody