Report by the NSW State Coroner

into deaths in custody/police operations for the year 2012.

(Coroners Act 2009, Section 23)

NSW Office of the State Coroner
NSW Department of Attorney General and Justice
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The Hon. Greg Smith SC MP
Attorney General and Minister for Justice
Level 31 Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

15th March 2013

Dear Attorney,

Pursuant to Section 37(1) of the *Coroners Act 2009* ('the Act'), I respectfully submit to you a summary of all deaths reported and inquests held by the State Coroner or a Deputy State Coroner during the year 2012 as provided by section 23 of the Act ('section 23 deaths').

Section 23 provides:

> A senior coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died (or that there is reasonable cause to suspect that the person has died):
>
> (a) while in the custody of a police officer or in other lawful custody, or
>
> (b) while escaping, or attempting to escape, from the custody of a police officer or other lawful custody, or
>
> (c) as a result of, or in the course of, police operations, or
>
> (d) while in, or temporarily absent from, any of the following institutions or places of which the person was an inmate:
>
> (i) a detention centre within the meaning of the *Children (Detention Centres) Act 1987*,
>
> (ii) a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999*,
>
> (iii) a lock-up, or
>
> (e) while proceeding to an institution or place referred to in paragraph (d), for the purpose of being admitted as an inmate of the institution or place and while in the company of a police officer or other official charged with the person's care or custody.

Section 23 deaths include deaths of persons in the custody of the NSW Police, the Department of Corrective Services, the Department of Juvenile Justice and the Federal Department of Immigration. Persons on home detention and on day leave from prison or a juvenile justice institution are subject to the same legislation.

Deaths occurring ‘in the course of police operations’ can include shootings by police officers, shootings of police officers, suicides and other unnatural deaths.

Deaths occasioned during the course of a police operation are always of concern and have been the subject of intense media scrutiny in the recent past.

These critical incidents are thoroughly investigated by independent police officers from an independent Local Area Command in accordance with the critical incident guidelines of the NSW police.

In 2012 there were forty-one Section 23 matters reported to the Coroner.

Thirty-nine matters were completed by way of inquest.

Sixty five Section 23 deaths currently await inquest and many of these matters are in the investigative stage or set down for inquest in 2013.

In many inquests constructive and far-reaching recommendations were made pursuant to Section 82 of the Act.

I submit for your consideration the State Coroner’s Report, 2012.

Yours faithfully,

Magistrate Mary Jerram
(NSW State Coroner)

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:

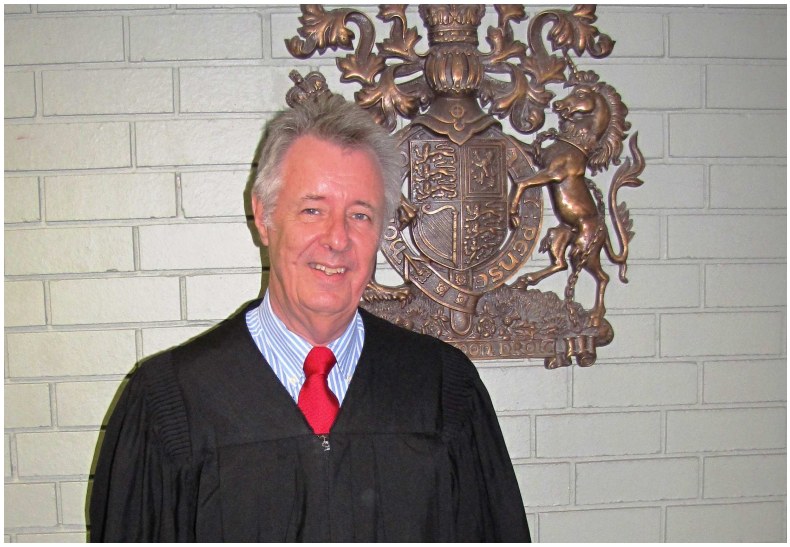
NSW State and Deputy Coroners 2012

Her Honour Magistrate MARY JERRAM

New South Wales State Coroner

1983	Admitted as a Solicitor of the Supreme Court of NSW.
1983	Industrial Legal Officer Independent Teachers Union.
1987	Solicitor and Solicitor Advocate for Legal Aid Commission.
1994	Appointed as a Magistrate for the State of NSW.
1995	Children's Court Magistrate.
1996-8	Magistrate Goulburn.
2000	Appointed Deputy Chief Magistrate.
2007	Appointed NSW State Coroner.

His Honour Magistrate SCOTT MITCHELL



Deputy State Coroner

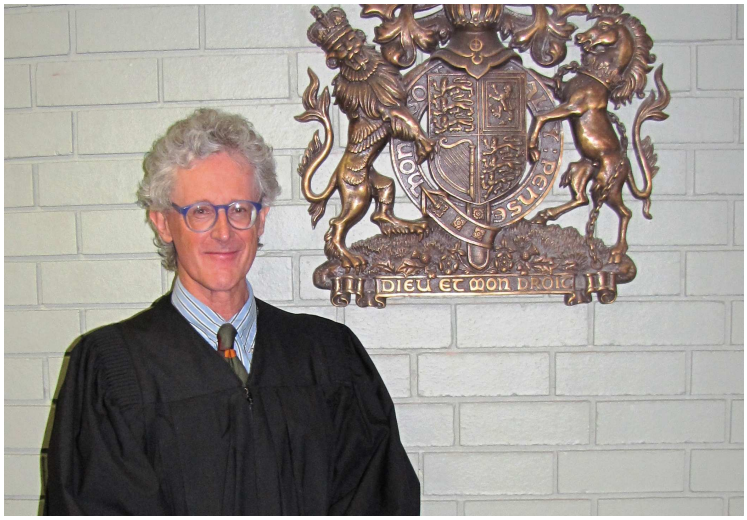
1972	Admitted as Solicitor of the Supreme Court of NSW.
1975	Admitted to the NSW Bar.
1993	Appointed a Magistrate.
2001	Appointed a Children's Magistrate.
2004	Appointed Acting Senior Children's Magistrate.
2005	Appointed Senior Children's Magistrate and Deputy Chief Magistrate.
2010	Appointed Deputy State Coroner.

His Honour Magistrate PAUL MACMAHON

Deputy State Coroner

1973	Admitted as a Solicitor of the Supreme Court of New South Wales and Barrister and Solicitor of the Supreme Court of the Australian Capital Territory and the High Court of Australia.
1973-79	Solicitor employed in Government and Corporate organisations.
1979-02	Solicitor in private practice.
1993	Accredited as Specialist in Criminal Law, Law Society of NSW.
2002	Appointed a Magistrate under the *Local Court Act 1982*.
2003	Appointed Industrial Magistrate under the *Industrial Relations Act, 1996*.
2007	Appointed NSW Deputy State Coroner.

His Honour Magistrate HUGH DILLON



Deputy State Coroner

1983	Admitted as Solicitor.
1984	Legal Projects Officer, NSW Council of Social Service.
1986-1996	Worked as Lawyer in government practice, principally with NSW Ombudsman Office and Commonwealth Director of Public Prosecutions.
1996	Appointed as a Magistrate of the NSW Local Court.
2007	Appointed Visiting Fellow, Faculty of Law, UNSW. Appointed a part time President of Chief of Defence Force Commissions of Inquiry (Defence Force Inquests).
2008	Appointed NSW Deputy State Coroner.

His Honour Magistrate MALCOLM MACPHERSON

Deputy State Coroner

1965	Department of the Attorney General (Petty Sessions Branch).
1972	Appointed a Coroner for the State of New South Wales.
1986	Bachelor of Legal Studies Macquarie University.
1987	Admitted as a Solicitor of the Supreme Court of NSW.
1991	Appointed as a Magistrate for the state of New South Wales.
2006	Appointed as New South Wales Deputy State Coroner.

Her Honour Magistrate CARMEL FORBES

Deputy State Coroner

1983	Admitted as Solicitor of the Supreme Court of NSW
1986-87	Solicitor for Department of Motor Transport.
1987-92	Solicitor in private practice.
1992-98	Solicitor for Legal Aid Commission.
1998-2001	Solicitor in private practice.
2001	Appointed a Magistrate.
2011	Appointed a Deputy State Coroner.

Her Honour Magistrate SHARON FREUND

Deputy State Coroner

1991	Admitted as Solicitor of the Supreme Court of NSW.
1993-97	Solicitor in private practice.
1997-2006	Litigator Partner/ Consultant Diamond Peisah Solicitors.
2003	Appointed Arbitrator of District Court of NSW.
2004	Appointed Arbitrator of Local Court of NSW.
2006	Appointed Magistrate of Local Court of NSW.
2011	Appointed Deputy State Coroner.

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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.

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

Intensive Correction Orders

I have advised Corrective Services NSW that 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.

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. I intend to re-visit State Coroners Circular No 24 to ensure that it adequately covers all possible scenarios of a death in custody or police operation.

The Deputy State Coroners and I have tended to interpret the subsection broadly. We have done this 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 investigated*[2]*.*

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.*

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

> *It is entirely proper that any death in custody, from whatever cause, must be meticulously examined*[3]*.*

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.

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.

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

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 Glebe or Newcastle conduct examinations.

Responsibility of the Coroner

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

> **81 Findings of Coroner or jury verdict to be recorded**
>
> (cf *Coroners Act 1980*, s 22)
>
> (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**
> (cf *Coroner's Act 1980*, s 19)
>
> (1) 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.

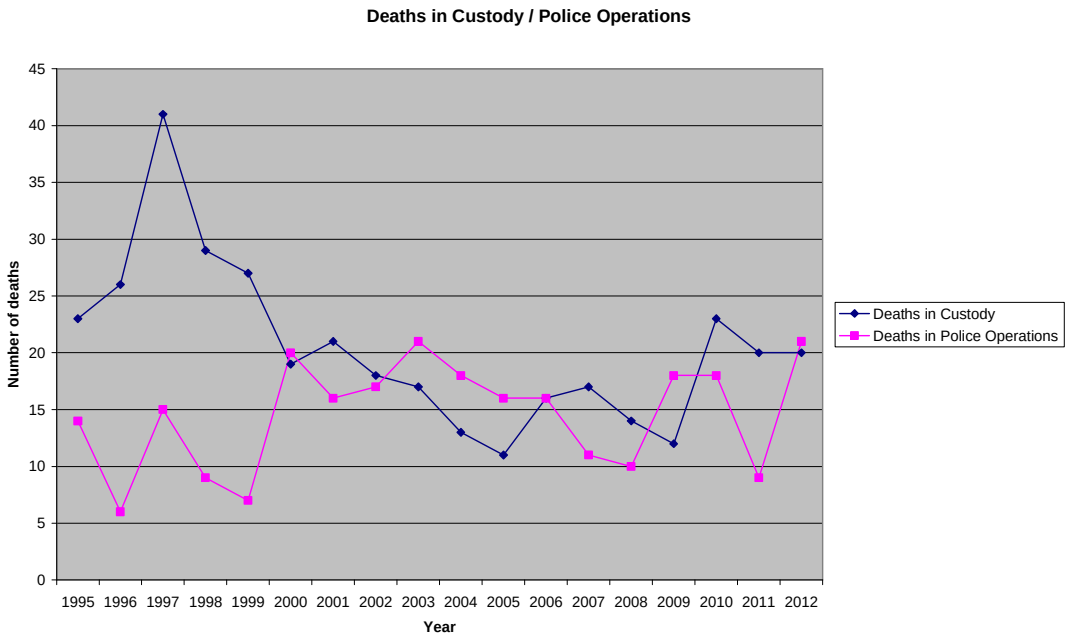
Any statutory recommendations made following an inquest should arise from the facts of the enquiry and be designed to prevent, if possible, a recurrence of the circumstances of the death in question. The Coroner requires, in due course, a reply from the person or body to whom a recommendation is made.

Acknowledgment of receipt of the recommendations made by a Coroner is received from Ministers of the Crown and other authorities promptly.

AN OVERVIEW OF DEATHS IN CUSTODY/POLICE OPERATIONS REPORTED TO THE NEW SOUTH WALES STATE CORONER DURING 2012.

Table 1: Deaths in Custody/Police Operations, for the period to 2012.

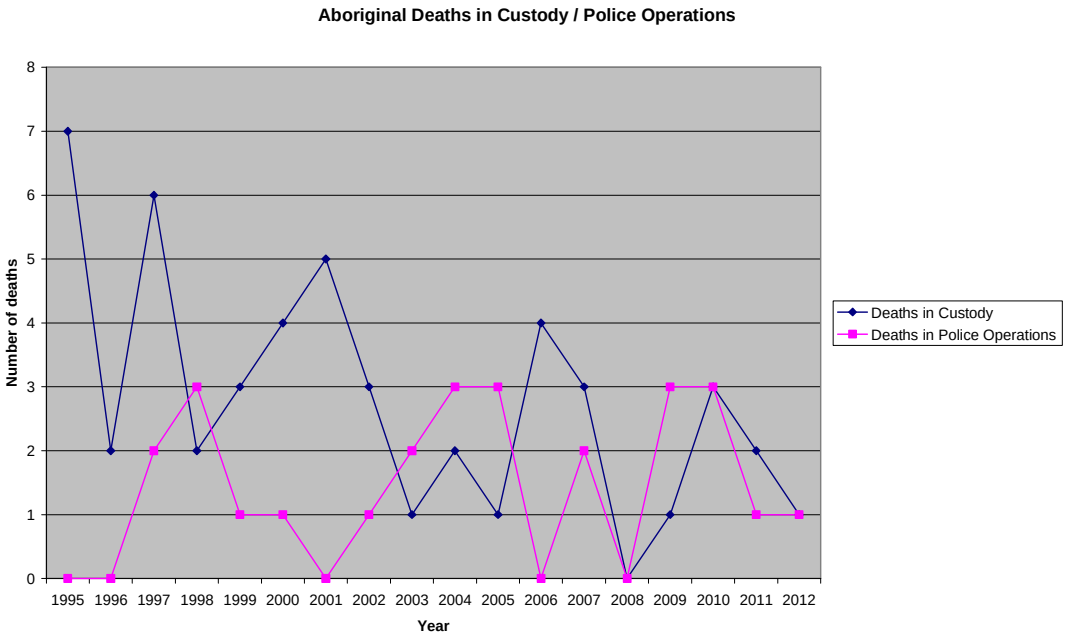
Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	37
1996	26	6	32
1997	41	15	56
1998	29	9	38
1999	27	7	34
2000	19	20	39
2001	21	16	37
2002	18	17	35
2003	17	21	38
2004	13	18	31
2005	11	16	27
2006	16	16	32
2007	17	11	28
2008	14	10	24
2009	12	18	30
2010	23	18	41
2011	20	9	29
2012	20	21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



Aboriginal deaths which occurred in 2012

Table 2: Aboriginal deaths in custody/police operations 2012.

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



Circumstances of deaths of persons who died in Custody/Police Operations in 2012:

15 x natural causes
7 x motor vehicle accident
6 x gun shot wounds
3 x hanging
2 x drugs/alcohol
2 x drowning
1 x undetermined
2 x stabbing/knife
1 x jump/fall
2 x suffocate/strangle

Unavoidable delays in hearing cases

In 2012 the State Coroner and the Deputy State Coroners completed 39 inquests of deaths reportable by Section 23.

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.

Summaries of Individual Cases Completed in 2012

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 in **2012.** 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 will be referred to as **AA.**

SECTION 23 INQUESTS UNDERTAKEN IN 2012

	Case No.	Year	Name	Coroner
1	2977	2009	AA	DSC Mitchell
2	174	2009	Johnson Graham	DSC Dillon
3	1949	2009	AA	DSC Mitchell
4	2539	2009	Taufalema, David	DSC Mitchell
5	3605	2009	Holman, Warren	DSC Mitchell
6	3716	2009	Cowie, Ian	DSC Freund
7	485	2010	Stewart, Geoffrey	DSC Mitchell
8	520	2010	Urgic, Dragan	DSC Mitchell
9	778	2010	Ashin, Paul	DSC Freund
10	1564	2010	AA	DSC MacMahon
11	1576	2010	Klum, Ian	DSC MacPherson
12	1809	2010	AA	DSC Mitchell
13	1889	2010	Worall, Kathleen	DSC Mitchell
14	2076	2010	Rennex, Alan	DSC Mitchell
15	2209	2010	Jones, Peter	DSC Forbes
16	2222	2010	Crews, William	SC Jerram
17	2325	2010	AA	SC Jerram
18	2804	2010	BB	SC Jerram
19	2877	2010	AA	DSC Freund
20	2924	2010	AA	DSC Freund
21	2980	2010	CC	SC Jerram
22	3036	2010	Clarke, Reg	SC Jerram
23	3037	2010	AA	DSC MacPherson
24	3159	2010	Fulton, Roy	DSC Freund
25	339	2011	Harman, Gillian	SC Jerram
26	473	2011	McGregor, Frederick	SC Jerram
27	746	2011	Iglesias, Isidro	SC Jerram
28	965	2011	Dowley, Floyd	DSC Dillon
29	1197	2011	Lisita, Gheorghe	SC Jerram
30	1308	2011	AA	SC Jerram
31	1659	2011	Dunn, John	DSC MacMahon
32	1761	2011	Hong, Son Le	SC Jerram

33	1922	2011	Kostovski, Dusko	DSC Forbes
34	2133	2011	Richards, Gary	DSC Freund
35	2161	2011	Desantis, Amedo	DSC Mitchell
36	2334	2011	EL-Kass, Rodney	DSC Dillon
37	2406	2011	Bond, James	DSC MacMahon
38	866603	2012	Curti, Roberto	SC Jerram
39	100939	2012	Kaniappa, Raju	DSC MacMahon

1. 2977 of 2009

Inquest into the death of AA on 28th May 2008 at Westmead. Finding handed down by Deputy State Coroner Mitchell.

This is an inquest into the death of AA who was born on 29 July, 1984 and died at Ward B3b, Westmead Hospital, Westmead, NSW in the early hours of 28 May, 2008. As this inquest opened, his *cause of death* was unknown.

The inquest is mandatory because at the time of his death, AA was a serving prisoner at the *Metropolitan Reception and Remand Centre (MRRC)*, Silverwater. AA had been in custody since 21 October 2002 when he was just 18 years of age. His sentence was due to expire on 20 October 2010.

The family background

Mr. AA'S adoptive parents are AA and his natural mother is AA. Mrs. AA provided a written statement for the inquest and she supplemented that statement when addressing the inquest. It is plain that she had great love and affection for him and that Mr. AA was brought up in a close and loving family. Mrs. AA appears not blind to Mr. AA's difficulties and problems but she described him as an affectionate and caring young man.

AA came to live with the AA family, as a foster family, when he was only about 6 months of age. His natural father was unknown and his natural mother, AA, had problems of her own and was unable to care for him. AA did well with the AA family and Mr. and Mrs. AA decided to adopt him, which they did about twelve months later. AA proved to be a loving son and brother to the three AA children, the youngest of whom was about nine years AA's senior and he was greatly loved in return.

When he commenced at school, some problems emerged and, after a while, it was decided that he would benefit from home schooling. According to Mrs. AA, AA did very well in that situation and he passed his Year 10 exams, gaining a credit in each subject.

AA grew up on his parents' farm in the New England district. Overall, he seemed an affectionate and happy boy who loved the farm and idolised his older brothers and sister and it was not until he turned sixteen or seventeen years of age that his problems and difficulties manifested themselves.

Self-harm

Sadly, by the time of his death, AA had a long history of serious self-harm as was well known to prison authorities in New South Wales. He may have suffered from *Munchausen Syndrome*. His habit was to swallow or to insert into his body via his urethra, rectum or nostrils or, sometimes, into wounds on various parts of his body various foreign objects such as plastic bags, light globes, pins, a spoon, pens, foam cups and other objects. In addition, he more than once lacerated his scrotum and expelled the testes.

Further, AA made many allegations of sexual abuse at the hands of prison officers. It is reported that he admitted that his reports of sexual abuse, like his acts of self-harm were often *"strategic"* and that he had admitted a desire to cause difficulties for staff to whom he had taken a dislike and sometimes to gain admission to hospital to relieve boredom and, his treating psychiatrist suspected, to gain access to opiate analgesia and anaesthesia which, evidently, he enjoyed.

Care in prison

In October 2002 while an inmate at Tamworth Correctional Centre, he was placed on *mandatory notification* and on 5 November 2002, as a result of his continuing self-harming behaviour, he was transferred to the Metropolitan Special Programmes Centre at Long Bay. Between October 2002 and May 2008 when he died, he was transferred from custody to hospital on 112 occasions as a result of self-harming behaviours.

In August 2006, Mr. AA was refused parole due to the high risk of re-offending and because no suitable release plans were available. His accommodation as at 22 May 2008 was cell 598 in the *Mental Health Screening Unit (MHSU)* of the *MRRCP.* This was a modern, single cell with an attached lavatory, kept locked when not in use. There appear to be no *hanging points* in the cell and the only furniture was a *built-in* platform on which a thin mattress was placed together with a *built-in* corner desk and a *built-in* pilar for sitting at the desk. There were notices at the entrance to the cell reading: -

"ATTENTION OFFICERS; KNOW WHAT STAGE HE IS ON!!! WHEN YOU ENTER AA'S CELL LEAVE NOTHING BEHIND YOU OR WITHIN HIS REACH!! HIS MATTRESS MUST REMAIN ON HIS BED!! HE MUST NOT BE OUT OF HIS BED WITHOUT DIRECT SUPERVISION!! HE MUST BE SEARCHED ON RETURN TO HIS CELL!!" and "ATTENTION OFFICERS NO SHARPES NO CUTLERY NO FOAM CUPS LIQUID SOAP ONLY" And" NIGHTLIGHTS MUST STAY ON!!"

A series of very detailed, extremely restrictive but no doubt necessary *Management Plans* was devised for him. Dr. Murray McKay, forensic psychiatrist with *Justice Health*, describes the latest such plan, dated 9 April 2008, as *"probably the most complex plan that has been developed for a male inmate."* Dr. Andrew Dakin, the Nursing Manager at *MRRCP* was of the opinion, he told Police, *"that no other inmate received the care and treatment the Deceased had received."*

A copy of the final plan is contained in the Coronial Brief. Highlights include the requirement of supervision in the lavatory, the requirement that night-lights in the cell not be extinguished and that he be tied into his overalls. Furniture was kept to a bare minimum and there was no free standing furniture and the TV set was kept securely being the Perspex shield. Further, Mr. AA's activities in the safe cell were to be monitored, 24 hrs per day, via closed circuit *TV*.

According to Dr. Murray McKay, Mr. AA had been receiving on going – indeed, he described it as *"constant,"* psychiatric treatment from the Forensic Psychiatric Service and, specifically, from Dr. Gordon Elliott during his period of incarceration. He was on a programme of psychotropic medication designed *"to lower his level of anxiety and dysthymia… …and to increase his quality of life"* and *"would generally speak with a psychiatrist in a weekly basis but that would change when (his) behaviour lapsed."*

When speaking to Police, Dr. McKay observed that Mr. AA's was *"an extremely severe personality disorder"* while Dr. Elliott diagnosed *"a severe personality disorder with pronounced Cluster B characteristics of a borderline and antisocial nature"* perhaps accompanied by *pyromania*. It is hard to know what somebody with such pronounced difficulties was doing in gaol.

The events of 21 May, 2008

On 21 May, 2008, Mr. AA, while in his *safe cell* at *MRRCP*, swallowed approximately 900 millimetres of electrical cable from the television set. The *TV* set had been encased in a unit embedded in the cell wall and was covered by a Perspex shield with small opening, 30cm x 3cm, to facilitate changing channels. Detective Senior Constable viewed *CCTV footage* showing Mr. AA in his cell 2130 hrs to 2400 hours on 21 May 2008. He describes Mr. AA, sitting, apparently watching *TV* until 2153 when he stood close to the secure casing and began manipulating the *TV* set through the 30cm x 3cm opening in the Perspex shield. Then, one minute later, the *TV* set is turned off and Mr. AA is seen apparently pulling the cable through the small opening. At 2158 hrs, Mr. AA is seen in bed *"active under the covers"* and apparently swallowing the cable. He is seen at 2234 and 2317 hrs speaking with staff and, on the second occasion, a prison officer is seen inspecting the *TV* area. Then, at 2348 hrs a *Justice Health* nurse is seen in the cell.

The *Justice Health* nurse was Hellal Hussein. He had no previous dealings with Mr. AA but came to cell 598 as soon as the prison officers called him. AA told him *"I swallowed the television cord"* and Mr. Hussein examined his mouth and throat but was unable to see any foreign objects there.

His assessment of Mr. AA was that he was not short of breath and had no respiratory distress so that urgent medical attention was not required. He completed a request for Mr. AA to undergo X-rays next morning and made a phone call to the on-call medical officer, Dr. Yee, *"who was satisfied that the Deceased was not in need of urgent medical treatment"* and, later than evening, he returned to the cell to administer 200mg of *Seroquil* which, he recalls, Mr AA *"swallowed easily."*

The Correctional Officers with particular responsibility for Mr. AA's care on 21/22 May, 2008 were First Class Correctional Officer O'Meley and Correctional Officer Fitzpatrick, the former with 12 years experience and the latter with each was aware of Mr. AA's particular needs and peculiarities of behaviour and his *high risk* status as a *Risk Intervention Team (RIT)* prisoner. Their duties, though, included monitoring and supervising many other inmates of the *MHSU* as well as AA*,* responding to any cell alarms and monitoring cameras for the *safe cells*.

Officers O'Meley and Fitzpatrick reported that they entered Mr. AA's cell at 2200 hrs. On 21 May 2008 in response to his intercom request to be allowed go to the lavatory. They unlocked the lavatory door, removed the cable ties from his overalls and waited until he had finished before once again securing him in his overalls. Both officers recall that, at this time, the TV was on although, at 2235 hrs when they gave Mr. AA a drink of water, he complained that the *TV* was not working. Both officers inspected the *TV* set and confirmed that it was *off* but neither saw any indication that it had been tampered with.

Neither Mr. O'Meley nor Mr. Fitzgerald saw Mr. AA manipulating the TV set or pulling the cable through the gap in the Perspex shield, much less swallowing it and they next noticed him at 2130 hrs when he called for corrections staff to attend his cell and announced, *"I need to vomit straight away. I have swallowed something… …My power cord to the TV. I ripped some off and swallowed it."* As a result of what seem to have been very detailed internal inquiries within the Department of Corrective Services conducted by Senior Investigator Sandra Steel whose report is contained in the Coronial Brief, Exhibit 5, findings, of which I have no criticism, were made against Officers O'Meley and Fitzpatrick that *"on or about 21 May, 2008 while supervising inmate AA in Pod 21m Block you neglected to devote the whole of your attention to the performance of your duties by failing to notice that Inmate AA was removing the television cable from the television set in his cell and swallowing it."*

Westmead Hospital

Mr. AA was transferred to Westmead Hospital at 1400 hrs on 22 May 2008 where he remained, under guard, until his death. His guards on the evening of 27 May and early morning of 28 May were 1st.Class Corrections Officer James Cobden and Corrections Officer Lawrenz Whitaker. Mr. AA underwent two surgical procedures. In the first, a small spring from a pen, which was unexpectedly encountered in Mr. AA's intestines, were successfully retrieved. Next day, 23 May, he underwent a *laparotomy*. The electrical cable was retrieved and the patient seemed to be making a recovery.

He was allowed *Patient Controlled Analgesia* (PCA) being *Fentanyl 20 micrograms intravenously per 5 minutes if needed*, which was to be self-administered by means of a *Baxter 11 PCA* machine. According to Suzanne Pagett, Clinical Nurse Consultant, *"the machine took a 60 ml syringe of fentanyl, that contains 1200 micrograms and is loaded into a locked compartment from which ran a thin tube known as an "intravenous line" and this is attached to the cannula inserted into the patient's vein.*

The amount of fentanyl to be administered by the PCA machine was programmed into the machine as per the prescription in the PCA orders by a member of the Adult Pain Service." The *Autopsy Report* of 28 November, 2008 prepared by Dr. Neil Langlois, then of the Department of Forensic Medicine at Westmead, records that *"in the absence of an anatomical cause for death, the cause of death is attributed to the toxic effects of Fentanyl."*

Cause of Death

In his original *Autopsy Report* of 28 November 2008, Dr. Langlois certified *Fentanyl Toxicity* as the cause of Mr. AA's death but was moved to revisit the matter after reading and considering the reports of Dr. Ross MacPherson and Dr. Michael Kennedy. As a result, Dr. Langlois issued a further report, which was received by the Crown Solicitor on 7 December 2011 when he speculated on *"the combined toxic effects of fentanyl, Oxychodone and quetiapine"* but, in the end, preferred to find the *cause of death* as *undetermined*.

In doing so, Dr. Langlois saw at least three possibilities, none of which he felt able to dismiss. It was because these three possibilities remained open that Dr. Langlois reached the decision he did. One such possibility was that Mr. AA was the victim of sudden cardiac death due to *arrhythmia* arising out of some anatomical cause although there was no such family history and no sign that he had been predisposed to such an event.

A second possibility, according to Dr. Langlois, was that Mr. AA had experienced sudden and fatal *cardiac arrhythmia* due to his psychotic illness or, more probably, to anti-psychotic medication. Like Dr. Elliott, Dr. Langlois admitted that it is far from clear that Mr. AA suffered from a psychotic illness, his dysfunction being referable not to mental illness but to a personality disorder not usually associated with cardiac reaction.

Nevertheless Dr. Langlois thought that there was some, though perhaps not very compelling, reason to associate *quetiapine* which is in a class of medications thought to interfere with *QT* intervals, with sudden cardiac death. He did admit, though, that Dr. Kennedy's finding that *QT* intervals were normal would, if correct, diminish the likelihood of *quetiapine* having played any part in Mr. AA's death.

Or, finally, Dr. Langlois thought the death might have been caused by a *respiratory depression* due to the combined toxic effects of *fentanyl, Oxychodone* and *quetiapine,* the presence of the latter two medications having been unknown to him at the time of the original *Autopsy Report.*

Dr. Langlois, who reminded the inquest of the need, in determining *cause of death*, to take into account not only toxicological findings but also the history and the accounts of observers, was prepared to say that this is the most likely of the three possibilities.

Except perhaps as regards *quetiapine*, it is also the view of the three experts, Dr. Michael Kennedy, Dr. Ross MacPherson and Dr. John Paul Seale as to the cause of Mr. AA's death and I think it is the view to be preferred.

Dr. Kennedy prepared both a report and a supplementary report for the inquest. It appeared that, inadvertently, he may have been misinformed with regard to *antemortem* bloods which were taken on 26 May, 2008, much earlier than is ideal, and *post-mortem* bloods taken on 30 May and about a possible cardiac history in AA's family of origin, something which is now acknowledged to be unknown, and Dr. Kennedy reconsidered but ultimately confirmed his original opinion.

Given the lack of familiar cardiac history and the absence of any relevant recognisable pattern, there is nothing, he told the inquest, to recommend Dr. Langlois' *sudden cardiac death due to arrhythmia arising out of some unspecified anatomical cause* proposal. Dr. Kennedy regarded that as *"a very, very, very low probability."* Professor Seale added that, in this case, *"it is pretty hard to contemplate any other cause of fatality other than the combined effects of fentanyl and Oxychodone."*

Dr's. Kennedy and MacPherson and, to a lesser degree, Professor Seale were questioned about the likely time of the *peak concentration* of opiate in AA's system and, if there is one issue which might have cast some doubt on the experts' view, it was that. Consideration was given, in that context, to the possibility that AA was a slow metaboliser, to the significance of an *oxycontin* pill having been found at *post-mortem*, undigested, in his stomach, to the likelihood of *fentanyl* surviving longer in the tissues than in the blood stream and, perhaps most importantly, to the *"enormous variations"* between people in their rate of drug absorption having in mind the multiplicity of factors likely to be influential in that matter.

But, as Ms. Stern submitted, at the end of the day, the experts agreed that there were just too many factors and too many unknowns to tell and each agreed that the overwhelming likelihood is that AA died of a cardiac arrest occasioned by respiratory depression as a consequence of *PCA fentanyl* and *oxycontin* toxicity while a patient at Westmead Hospital, Westmead, NSW.

Analgesia

It is important to enquire how and in what circumstances it could be that, in a large teaching hospital and while under constant supervision of corrections staff, Mr. AA could have died of what, in layman's language, amounts to a drug overdose.

According to Mr. Dakin who had known him throughout his lengthy career in gaol during which there were so many instances of self-harm, there was never any suggestion that Mr. AA was seeking to kill himself and Mr. Dakin does not believe that he sought to do so on 21 May, 2008 when he swallowed the power lead from

his television set or later when, recovering from surgery, he sought pain relief. Secondly, Mr. Dakin told the inquest that Mr. AA's self-harming behaviours seemed to be motivated, at least in part, by a desire to have general anaesthesia but not, he thought, by a desire for opiates.

In that sense, Mr. Dakin thought that he was not a *drug chaser* but, rather, seemed to be seeking relief from his own unhappiness. Dr. Elliott, on the other hand, does not see AA as having been so discriminating and expressed the view that his self-harming behaviours were linked to a desire to access analgesia as well as anaesthesia. But Dr. Elliott agrees, too, that, probably, AA was not seeking to end his own life.

A close examination of the hospital's drug records, chiefly contained in Exhibit 2, provide some indication of the quantum of *fentanyl* injected into Mr. AA during his hospitalisation.

He was provided with a *Patient Controlled Analgesia Machine (PAC)*, which allowed him to self-administer, *fentanyl* on an *as needs* basis by way of intravenous injection. The machine which, when fully loaded, holds a 60ml syringe of *fentanyl* at a concentration of mcg/ml to be replaced from time to time by nursing staff, was sealed to prevent tampering and over-use and was fitted with a devise which imposed a *lock-out* interval of five minutes. The result was that, once a dose had been delivered, no further dose was available for a further five minutes.

Otherwise, a dose was made available by the patient depressing a button attached to the machine. Given Mr. AA's obvious skill and dexterity as exemplified by his retrieval of the *TV* lead from the secure unit in his cell at the *MRRCP*, it was a brave decision on the part of the hospital to provide him with a *PAC* machine but, in the event, there is no evidence that it was tampered with or improperly used. The machine contained a small computer to record the total dosage released from the machine and injected into the patient.

The *PCA order form*, part of Exhibit 3, contains *standing orders* regarding the use of the *PCA* machine including the following: -

Observations are to be recorded hourly for the first six hours and then 2 hourly; The PCA settings should be checked at the commencement of each shift and on patient transfer; No other opioid or sedatives to be administered unless ordered by the Acute Pain Service or equivalent Medical Officer. Management Complications: increasing sedation (score >=2;ensure oxygen therapy in progress…Contact Acute Pain Service or equivalent medical Officer. -Respiratory depression <=10: ensure oxygen therapy in progress. Contact Acute Pain Service or equivalent medical Officer.

These *standing orders* deal with a number of other matters including a *sedation score* for reference by those supervising the use of the *PCA* machine, indicating categories ranging from "*unresponsive,"* through "*often drowsy*," *"rarely drowsy"* and *"alert"* to *"asleep (rousable)."*

The score for *often drowsy* is 2 and for *unresponsive* is 3. It is clear from a reading of the standing orders as a whole that the *Acute Pain Service* or an equivalent medical officer is to be called whenever a patient using a *PAC* machine is either *often drowsy* or *unresponsive*. Clearly the hospital, in publishing these standing orders and instructions is signalling its awareness of the risk of both increasing sedation and respiratory depression by way of *PCA* administered *fentanyl.*

Early in the course of the inquiry into this matter, it might have been thought that Mr. AA had exceeded the amount of *fentanyl* he was permitted to have and that this might have been responsible for his death. But an examination of the drug records and some simply arithmetic (for which I am indebted to learned Senior Counsel assisting), taking into account the drug supplied and the drug discarded, seemed to demonstrate that such was not the case. The records indicate that between 24 May and 10pm on 27 May, the last time *fentanyl* was injected, AA was entitled to 4 syringes totalling 240 mls of which 211 mls were had been consumed and 29 mls were apparently missing. But according to Exhibit 2, on 28 May, 2008 at 0200 hrs 15 mls of *fentanyl* had been discarded leaving on 14 mls apparently unaccounted for.

Dealing with the apparent discrepancy of 14 mls of *fentanyl,* the register and the progress notes demonstrate that, on occasions, syringes were changed before they had been entirely exhausted. Thus, at 0615 hrs on 26 May, the syringe was changed when 12 mls remained unused and, again, at 0600 hrs on 27 May, the syringe was once again replaced while still containing a quantity of fentanyl. This was recorded on the medication chart (2/79) and in the Register (1/26) although, for reasons I do not understand, not on the *PCA* form. At that stage, having in mind the earlier use of 108 rather than 120 mls on 26 May, the cumulative amount of *fentanyl* consumed by Mr. AA would seem to have been no more than 168 mls.

The note for 8am on 27 May has the cumulative *fentanyl* usage as 177mls suggesting that something like 9 mls had been consumed between 0600 and 0800 that morning. Then, between 0800 and 2200 hrs on 27 May 34mls of *fentanyl* were administered bringing the cumulative total to 211mls. l5mls were then discarded as recorded and, assuming the accuracy of the estimate that 9mls had been used in the 2 hours to 0800 on 27 May, there would appear to have been only 2 mls of *fentanyl,* at most, unaccounted for in the almost 4 hour period from 10pm on 27 May 2008 until Mr. AA's death - insufficient, Dr. MacPherson believes, to have had any appreciable effect.

But the evidence of *RN* Suzanne Pagett relieves the inquest of much of the necessity of striving for mathematical certainty with regard to AA's use of *PCA fentanyl.* Ms. Pagett is a *Clinical Nurse Consultant*, attached to the *Acute Pain Service* at Westmead Hospital. She was not associated with Mr. AA's care during his final admission there and in that connection, Ms. Pagett told us two things.

Firstly, she said that, on many occasions, minor quantities of *fentanyl* are discarded without being recorded in the Register so that, even after an examination of the records, the precise amount discarded might remain unknown.

And secondly, she told the inquest that, as a matter of course, there was a quantity of f*entanyl* - about 5mls, which corresponds to the amount used to *prime* the line on each occasion of cannulation and goes unrecorded by the computerised *PCA* machine and is ultimately lost. For those reasons, despite the elaborate and helpful mathematical exercise undertaken by learned Senior Counsel, it may not be possible to be very exact about the quantum of *fentanyl* introduced into Mr. AA's body. Suffice to say that the evidence does not establish that he took sufficient *fentanyl* to have caused death.

But, at the same time he was using *PCA fentanyl*, AA was being treated with other powerful analgesia. The original, modest prescription was for *Oxychodone* syrup and was written by Dr. Pudspeddi. Twelve hours later, at 2000 hrs on 26 May, somebody from the *Acute Pain Service* decided to continue him on the *PCA fentanyl,* to be supplemented by *oxycontin* 20ml. but which was then changed, by hand, to 30mg. By 2000 hrs on 27 May, he was allowed *oxycontin* 40mg. bd. At first sight, this appears to be an alarming increase in analgesia but *RN* Pagett's evidence is that it is good practice in the cause of weening the patient off *IV* medication to introduce oral analgesia while reducing *PCA* analgesia and, she maintains, that this is what happened in Mr. AA's case.

Observations

EEN Tricia Hunt gave evidence by *AVL* from Townsville. She had the nursing care of AA at Westmead on the evening of 27 May 2008. Mr. AA's *PCA Observations Chart* bears the initials *TH* for 1600, 1800, 2000 and 2200hrs. On 27 May and she says the observations marked at those times are hers. *RN* Lesley Jane Wiley took over from Ms. Hunt at the end of her shift and the entry at 2200hrs is countersigned *LW*. Ms. Wiley says that it was she who made the observations at 2200hrs. While Ms. Hunt told the inquest that one has only to look at the handwriting relating to those four observations to know that the columns were made out in the same hand. To my untrained eye, that may be not the case. Further, *EEN* Hunt's shift that evening was due to finish at 2130 hrs and, although she might not have been able to get away right on time, one would have expected her to have left the ward before 2200 hrs. I think there is a strong possibility that the observations 2200 hrs were undertaken not by Ms. Hunt but by Ms. Wiley as the latter says.

According to *EEN* Hunt, she saw Mr. AA sleeping when she came into his room to make her 2200 hrs observations and *"you have to wake the patient on a PCA just to check the machine and enquire about pain levels and to check how they are."* Ms. Hunt says she did this.

RN Hunt told the inquest that she has little recollection of the actual events but the *sedation score* allocated to Mr. AA at 2200 hrs. On 27 May, 2008 is halfway between *alert* and *asleep (rousable)* and Ms. Hunt told the inquest that she had allocated that score because, when she came to make her observations, she had wakened him *"only half way."*

RN Hunt's entry into the progress notes at 2100 hrs on 27 May describes Mr. AA as *"alert and orientated."* That is certainly not the way the two Corrections Officers,

Cobden and Whitaker, described him. They gave their statements to Police only a few hours after Mr. AA's death. They speak of his incoherent and slurred speech as early as about 2130 hrs and his apparent difficulty in understanding what they were saying to him as well as his unsteadiness on his feet at about midnight and his apparent struggle to stay awake. According to *RN* Hunt, she was aware that the patient was receiving both *fentanyl* and *oxycontin* and she says that, accordingly, she would have focused on his respiratory changes, slurred speech and difficulties in walking. There is nothing in the notes and little in the evidence to assist me in determining the accuracy of her observations in those areas but I cannot dismiss the possibility that Mr. AA's decline was quite rapid.

RN Lesley Anne Wiley, whose statement was signed in May 2011, three years after the event, and based, she said, only partly on her memory and partly on her notes, was in charge for the following shift commencing at 2130 hrs. On 27 May, 2008 and she, too, was aware that AA was using both *PCA fentanyl* and *oxycontin* analgesia so that special care should be taken to observe any difficulties in his speech, any inappropriate behaviour, possible respiratory depression and any problems in rousing him. She told the inquest that the best means of doing so was to engage him in conversation. Evidently, Ms. Wiley formed a view that evening that Mr. AA was *"alright"* and she says he told her so every time they spoke. Her evidence is that, on some of the occasions when she visited his room, Mr. AA was asleep but on other occasions she says he appeared to understand what she was saying and answered her appropriately. She described him as *"polite and softly spoken"* and the picture she paints of AA on the last evening of his life is very hard to reconcile with the evidence of the Corrections Officers.

The *sedation score* allocated by *EEN* Hunt or, more probably, *RN* Wiley at the 2200 hrs observations, is between *Alert* and *Asleep (Rousable)* and Ms. Wiley's evidence is that, when she went to his bedside at that time, AA was lying back in his bed with his eyes closed but, she says, when she spoke to him, he opened his eyes and replied. Evidently, she did not worry about checking his *respiration rate* at 2200 hrs. Because she was very busy and she merely reproduced the note, which EEN Hunt had, taken some two hours earlier but she told the inquest that, in doing so, she noticed that Mr. AA was awake and not laboured in his breathing.

Given that *RN* Wiley was aware of Mr. AA's regime of analgesia and the heightened need to keep an eye on his respiration, it is disappointing to learn that his respiration may have been unobserved from 2000 hrs until his death. *RN* Wiley admitted that she made no entries on the *PCA Observations Chart* for midnight on 27 May 2008. She explained that, by that stage, the patient was *"several days post-op."* She added that she *"would have intended"* to do observations twice during the course of her shift and it did not seem important just when they were undertaken.

Attached to *RN* Wiley's statement is a document entitled *"Shift Report"* which, she told the inquest, she composed four or five days after Mr. AA's death. She did so because she understood that Mr. AA's death would be a matter for the Coroner and that her insights into the matter were likely to be important. When she composed the document, she did not have access to the medical records.

In the event, the *"Shift Report"* may not be as complete or accurate document as she would have intended. In the first place, referring to 2200 hrs, the document recites, *"I charted his PCA Obs (Trish had accidentally signed the 2200 hrs column, so I signed alongside). The reading was the one same as the one for 2000 hrs – I understood this to mean that despite encouragement, he had not used the PCA."* In this regard, Ms. Wiley said nothing about having reproduced some of the entries, which Ms. Hunt had charted at 2000 hrs.

Further, Ms. Wiley's *Shift Report* says nothing about AA's cannula having become disconnected when he went to the bath room at about midnight, as a result of which it was necessary to call Dr. Reyes to recannulate him at about 0100 hrs on 28 May.

Thirdly, *RN* Wiley's *Shift Report* says nothing about the midnight *PCA Observations* not having been undertaken. It seems clear that, as a matter of good nursing practice - particularly with regard to respiration given his regime of analgesia, these observations should have been undertaken and noted even if, technically, they were not mandated, Mr. AA's cannular having become disconnected. But *RN* Wiley explained to the inquest that, on that night, she had had seven patients to look after and AA had seemed well on the occasions during her shift that she had noticed him. Here are two things, which should be said about this particular aspect of the *Shift Report* - firstly that *RN* Wiley's estimate that there had been 4 or 5 occasions before 2345 hrs. When she had visited Mr. AA in his room might not be accurate.

I think, in fact, there may have been as few as only one, namely at about 2230 hrs when she visited and installed a fresh *IV* bag for him. Secondly, her opinion that Mr. AA had appeared well on the occasions she had visited him was in stark contrast to the opinions of the two corrections officers guarding him.

Ms. Wiley told the inquest that she had not been aware that, when he emerged from the lavatory, Mr. AA was drowsy and unsteady on his feet as the corrections officers say he was. Her evidence is that, when she entered his room at 0040 to let him know about the recannulation, AA was sitting forward in his bed, calm and trying to decide whether he should wait for the doctor or go to sleep. She noticed nothing untoward. She heard no slurring of speech and she saw nothing of him swaying back and forth as Officer Whitaker says he was. At some time, the Corrections Officers recall, he fell asleep and was snoring loudly but, if *RN* Wiley visited his room while this was happening, she failed to make any note of it.

It is not clear what time Dr. Reyes came to AA's room to resite the cannular. She says it was at about 0100 hrs. She had been in theatre when first paged and, no doubt, came to him as soon as she could. *RN* Wiley was not present at the time. Mr. AA was apparently asleep, lying in bed and snoring loudly, when Dr. Reyes visited him and she tried unsuccessfully to awaken him by shaking him and calling his name.

So did Corrections Officer Cobden who took hold of his ankle cuffs and shook them, trying to rouse him. Dr. Reyes failed in her first attempt to insert the cannular but was successful when she tried on his other arm.

Through all this performance, AA did not awaken. Dr. Reyes remarked on this. Perhaps she asked the Corrections Officers *"Is it normal for him to be like this – snoring loudly?*" or perhaps, as they recall, she said *"Maybe he's a heavy sleeper"* but, in either event, after she had inserted the cannular, she left his room, mentioning as she passed a nurse, probably *RN* Wiley, that *"I've reinserted the cannular. Can you hook up the PCA again?"* Sadly, the expert evidence is that, even at this point, AA might still have been saved had his condition been recognised.

It is difficult to understand how Dr. Reyes could have failed to check AA's condition after finding it impossible to rouse him. Perhaps she might not have been alarmed when *"calling his name and lightly shaking him"* failed to waken him but one would have thought his failure to respond to having a cannular inserted in his arm and to Mr. Cobden pulling on his ankle cuff would have alerted her to the possibility that he was in danger – the more so given that he was post-operative and using opioid analgesia. Dr. Reyes told the inquest that, *"knowing what I know now, if I were unable to rouse a patient, I would think he had a problem"* but she had assumed that Mr. AA was asleep rather than unconscious and she told the inquest that she had not been aware that strenuous snoring might indicate opiate excess. Nor did she appreciate that the use of the *PCA* machine might indicate the use of opioid, which, in turn, might mean the risk of respiratory depression. Dr. Reyes now thinks that, finding it impossible to rouse Mr. AA, she should have called for help but, back in May 2008 when she had only about four months experience, she did not understand that and, as she explained, it was very late at night.

Sometime after Dr. Reyes left, *RN* Wiley entered AA's room to *hook up the PCA* and found him no longer breathing. Attempts at resuscitation by Drs. Martel and Rush, anaesthetics registrars, and others were in vain and he was pronounced dead at 0152 hrs on 28 May 2008. The passing of this young man, with all his problems and all his promise, is a tragedy which has left a lasting void in the lives of his family and I am certain everybody connected with this inquest would join me in extending our sympathy to Mr. and Mrs. AA and AA's brothers and sister.

Recommendation:

Dr. R.M.T. Halliwell is the Deputy Director of the *Department of Anaesthesia* at *Westmead Hospital.* He was kind enough to attend court throughout almost the whole of the hearing and his presence was an indication of the hospital's care for its patient and desire to assist his parents at that difficult time. Although obviously an expert in his particular field, he was called not as such but as a high ranking hospital official able to tell the inquest about new policies and practices which have been introduced within the District and at *Westmead Hospital* which postdate Mr. AA's death. In particular, Dr. Halliwell referred the inquest to the new policy directive of *NSW Health*, introduced in December 2011, entitled *"Recognition and Management of Patients who are Clinically Deteriorating."*

One of the five key elements of this new regime is called *"DETECT"* which is an acronym for *"**D**etecting deterioration, **E**valuation, **T**reatment, **E**scalation and **C**ommunicating in **T**eams.* A copy of the policy directive was annexed to Dr. Halliwell's statement to the inquest. The thrust of the *DETECT* system is to ensure that deterioration of a patient such as Mr. AA triggers an effective response at the earliest possible time. The discovery of Mr. AA unsteady on his feet, drowsy and slurring words would most probably and Dr. Reyes' inability to awaken him when she recannulated him would certainly, under the new regime, have been immediately recognised for what we now know that it was –evidence of significant deterioration in his condition, and would have mandated the immediate attention of a specially trained resuscitation team, available at Westmead on a 24 hr. per day / 7 days per week basis. Medical and nursing staff, nowadays, are trained in the early detection of and appropriate response to deterioration and special funding has been secured for that purpose. Further, some new forms have been devised to ensure more accurate and informative recording of observations. Dr. Halliwell was kind enough to explain these reforms in some detail and it is clear that they represent a significant improvement on systems in place at the time of AA's death.

As a result, many of the recommendations which this inquest might otherwise have made are no longer necessary but there is one recommendation which I do intend to make it arises out of *RN* Wiley's decision not to make and record *PCA observations* at midnight on 27 May, 2008 which, technically, she was not required to make since Mr. AA's line was disconnected and he was no longer using *PCA* medication but which I think, and she seemed to think, she should have made as a matter good nursing practice might have. It seems to me to be important that PCA observations not be abandoned simply because a connection has been lost but continue until a clinical judgment has been taken as to the path forward.

Formal Finding:

AA who was born on 29 July 1984, died on 28 May 2008 of cardiac arrest occasioned by respiratory depression as a consequence of *PCA fentanyl* and oxycontin toxicity while a patient at Westmead Hospital, Westmead, NSW.

Recommendations

I recommend that the current policy of the *Western Sydney Local Health District* be amended so as to provide that, once a patient is on *Patient Controlled Analgesia (PCA), PCA* observations are required to continue until a decision is taken to discontinue the *PCA*.

2. 174 of 2009

Inquest in to the death of Graham Johnson at Deepwater on the 18th January 2009. Finding handed down by Deputy State Coroner Dillon.

Introduction

At about 12.40am on 18 January, 2009 Benjamen John Pappin lost control of the unregistered green 1992 Suzuki Swift, Queensland registration no. 866BOZ, that he was driving in a northerly direction on the New England Highway approximately 16 km north of Deepwater and about 1.25 km south of Pyes Creek Road in the State of New South Wales. Seated in the left back seat was Graham Johnson, a young man of 21. He was killed in the crash due to blunt force head injuries. Miraculously, however, the three other occupants of the car, including Mr Pappin, survived.

The crash occurred during a high-speed pursuit by two police vehicles, the primary car being a fully marked Highway Patrol Commodore. As Mr Johnson's death occurred during a police operation, s 27(1)(b) of the *Coroners Act 2009* requires that an inquest be held.

Graham Johnson

Before I consider the issues that the case raises, it is important to focus on the victim of this accident, Graham Johnson. At the heart of almost any inquest, no matter how technical the evidence may be, there is a human tragedy. Graham's parents, Ronald and Barbara Johnson, and his sisters Renee and Leanne, all spoke about him at the inquest. Ronald also read a statement from Graham's twin brother, David.

It was evident from the fact that his parents and siblings and other members of his extended family travelled from Queensland to attend the inquest that Graham was much-loved by those who knew him during his short life. Their statements revealed him to have been a "gentle giant", a generous, lively young man with a playful and kind nature who enjoyed his family and especially the younger members of it and who, because of his generosity, was sometimes taken advantage of. One of the tragic elements of his death is that Graham was not the sort of young man who got into trouble with police. On the evening of 18 January 2009, however, he had the misfortune to be in a car with Benjamen Pappin who had a very troubled history and a tendency to dangerous driving. He is much missed by his family whose grief was very obvious during the inquest.

The pursuit

Most of the facts in the case are not contentious. On 15 January, 2009 a member of the Queensland Police conducted a "street check" of the occupants of the Suzuki Swift in which Graham Johnson died. An intelligence report was made but no further action was taken. Senior Constable Jensen noted that a group of "four people appeared to be camping by the river in a tent and a vehicle" and that "no offence was detected". The fact that the car was unregistered was not apparently noticed at that time but that is probably because the car was not being driven. In retrospect, it appears that an opportunity to put the car off the road may have been lost at that stage but I make no criticism of the police officer.

It appears that on the evening of Saturday 17 January or very early on Sunday 18 January 2009 the group of four young people commenced what may be described as a "road trip" south into New South Wales with Benjamen Pappin driving.

At about 12.30am on 18 January, 2009 Senior Constables Van Akker and Peasley were performing general duties at the Deepwater Races, patrolling the town and conducting mobile random breath testing. S/Con Van Akker was the driver and S/Con Peasley was the observer in a marked Police Mitsubishi Pajero 4WD station wagon known by the call sign "Emmaville 33".

While stationary outside the Deepwater Inn facing north, the officers saw a semi-trailer travelling south on the New England Highway with a green 1992 Suzuki Swift tailgating it. This was the initial sighting by NSW Police of Mr Pappin's vehicle. S/Con Van Akker pulled out, activated the red and blue police lights and proceeded to follow the Suzuki.

The Suzuki then made a sharp left hand turn into Alice Street without indicating. Emmaville 33 followed in pursuit of the small vehicle. At this point S/Con Peasley is recorded as transmitting the following message to VKG:

"Yeah, we're just, ah, trying to do a vehicle stop on Alice Street at Emmaville. Is New England 208 around? We're heading east."

The Suzuki then took another sharp turn into Station Street, and the police vehicle maintained its pursuit.

In her Record of Interview, at question 86, S/Con Peasley observed:
"… I didn't call a pursuit straight away mainly my error, because I've, it was my fourth GD shift and after out for 9 years and I wasn't sure what I was supposed to say, so yeah, that's why I hadn't called pursuit straight away…."

At the same time, unbeknownst to S/Con Peasley, New England 208, a fully marked Category 1 Highway Patrol vehicle, driven by S/Con Michael Opryszko with S/ Con ImantsRamma as observer, was completing a traffic stop in Deepwater. They heard the radio call from Emmaville 33 and, a short time later, took up the role of primary pursuit vehicle on Station Street in

Deepwater. Emmaville 33 continued in the pursuit as the "secondary pursuit vehicle". The Suzuki turned north onto the New England Highway and accelerated away from the police vehicles.

The Highway Patrol car was fitted with an in-car video system, which automatically starts to record once the warning lights in the car are illuminated.

The video shows that:

- the weather was clear;
- the road surface on the New England Highway was bitumen;
- the road was unlit;
- traffic was light;
- the speed of the offending vehicle varied between about 80 to 90 km per hour and a maximum speed of about 140km per hour;
- the Suzuki generally remained on the correct side of the roadway; but that
- the whole vehicle swerved onto the incorrect side of the road on one occasion and encroached partially onto the wrong side a number of times and that, where the roadway consisted of two northbound lanes,
- it swerved back and forth across the two lanes in an apparent attempt to stop the pursuing Police vehicle from passing.[4]

The video footage shows that the pursuit lasted for about seven minutes and that the distance covered from Deepwater to the crash site was about 16.4 kilometres. For most of the distance, the road was not inherently dangerous or demanding. The pursuit, however, culminated on Bolivia Hill, a much more challenging stretch of road. In his second record of interview S/Con Ramma, a Highway Patrol officer with 25 years of local experience, stated:

"The section of road that you must treat with respect. I've been to numerous accidents on that stretch of roadway including two fatals that I can recall. Probably in the last, the last most recent one would have been two semi-trailers at the bottom probably about 3 years ago".[5]

S/Con Ramma agreed with the investigator, Det S/Con Curry, that he regarded the area as a "black spot", that is, a stretch of road recognised for its prevalence of serious motor vehicle accidents.

The accident investigator, Sgt Priest, who conducted the detailed assessment of the crash site and the cause of the crash, reported that approaching the collision site from the south there is a 199.31 metre, 150 degree, right hand bend in the highway. The bend is cut into the side of a steep hill and the roadway has an average gradient of 4.2 degrees, with high ground to the east and a steep embankment to the west. The right-hand bend is the subject of an 85km per hour speed advisory sign, with the sign located a short distance to the south of the collision site.

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[4] For safety reasons, police practice is not to overtake in such situations but Mr Pappin obviously did not know this.

[5] Q 111 on page 223 of the brief.

The need to treat the descent on Bolivia Hill with respect is not only demonstrated by the consequences of Mr Pappin failing to do so but by the fact that Highway Patrol vehicle slowed down rather than attempt to keep up with the Suzuki once the vehicles crested the hill. The Highway Patrol officers exercised caution and common sense. Mr Pappin, regrettably for his passengers, did not.

Having examined the scene of the crash, Sgt Priest deduced that the Suzuki had "yawed", that is, rotated around its centre of mass. The vehicle, travelling too fast for its intended turn of radius, started to side-slip, then spun in a clockwise direction. It is apparent that, after it commenced to spin out of control, the Suzuki left the roadway to the east, where it collided with a rocky embankment, before ricocheting then rolling as it travelled back across the roadway until it collided with the Armco railing located on the western side of the roadway. The vehicle then came to rest on its roof. It sustained extensive collision damage to the front, rear and left side with the side pillars of the car crushed so that the roof was collapsed almost to the body of the car. In fact, due to the catastrophic front-end damage sustained to the vehicle, the engine was torn away from its mounts and was subsequently located some 35 metres away down an embankment on the western side of the roadway in bushland.

All four tyres on the Suzuki Swift had minimal tread insufficient to meet legal requirements [that is, 1.5mm] but otherwise there was no significant mechanical defect found in the car. The primary cause of the crash was excessive speed for the conditions.

Unfortunately, neither the VKG (police radio) supervisor, who was based in Tamworth, nor Sergeant Pringle [call sign "Armidale 14"], who was the senior officer at Armidale that night and who was monitoring the pursuit by radio, had intimate local knowledge of Bolivia Hill.

This meant that the officers charged with supervision of the pursuit were hampered in their ability to make assessments regarding the termination of the pursuit in light of the fact that the pursuit was approaching an area considered locally to be a traffic "black spot".

The issues

Under the Coroners Act a coroner must try to identify the person whose death is the subject of the inquest; the date and place of the death; and the direct physical cause of the death and the circumstances or manner of the death. In this case, the only significant issues concern the circumstances of Graham Johnson's death. Because his death occurred during a police operation, it is necessary to consider how that operation was conducted.

The issues that arise are as follows:

- What police vehicles and crews were engaged in the incident?

- What parts did they play?

- Did they comply with relevant elements of the Safe Driving Policy?
- Was the pursuit properly reported and controlled as it progressed?
- What consideration, if any, was given to termination of the pursuit before the fatal crash?
- In particular, were there any features of the driving on the part of the pursued vehicle that ought to have given rise to a concern that the pursuit was unsafe?
- Were there any characteristics of the road or topography that ought to have given rise to a concern that the pursuit was unsafe?
- What, if any, lessons have been learned from this incident?
- Have any changes in NSW Police practice or policy been instituted as a result of this incident?
- Ought any recommendations be made to the Commissioner of Police as a result of this incident?

Each of these issues raises subsidiary questions that I will deal with under each topic. In particular they raise questions concerning the NSW Police Force's Safe Driving Policy and its application in this case.

What police vehicles and crews were engaged in the incident? What parts did they play?

I have noted above that there were two police vehicles, New England 208, and Emmaville 33, involved in the pursuit. After Emmaville 33 started the pursuit in Deepwater, it quickly handed over the primary pursuit role to New England 208 and followed as a secondary pursuit vehicle. A third vehicle, Tenterfield 34, which was coming south on the New England Highway, at one point illuminated its warning lights as the Suzuki approached it. The Suzuki and the two police vehicles from Deepwater passed in the other direction. Tenterfield 34 followed. It is unclear whether it was involved in the pursuit. If so, its part was minor at best.

Did the police crews comply with the Safe Driving Policy?

S/Con Peasley admitted in her record of interview that, as the escort (non-driver) in her vehicle, she ought to have explicitly called in the pursuit as soon as it started. Nevertheless, she had only returned to General Duties four shifts before and had had little or no recent experience in dealing with the Safe Driving Policy.

Although she did not strictly comply with the Safe Driving Policy by explicitly calling the pursuit, she did notify VKG that Emmaville 33 was following a car that had failed to stop. This implied that her crew was pursuing and was probably sufficient to put VKG on notice of the pursuit.

More problematic is the question whether Emmaville 33 should have remained part of the pursuit. The reason given by S/Con Van Akker was that the Suzuki contained four people and he had thought it advisable to provide back-up to New England 208

It was also problematic that Emmaville 33 remained a pursuit vehicle but did not notify VKG or Sgt Pringle (Armidale 14) who were monitoring the chase that they were acting as secondary pursuit vehicle. S/Con Peasley gave evidence that she had not wanted to cut across radio communications between New England 208 and VKG. This, however, left VKG and Sgt Pringle in the dark as to what Emmaville 33 was doing. At one point, Sgt Pringle explicitly had to enquire over the air to identify the pursuit vehicles. Even after Sgt Pringle sought clarification of the vehicles involved in the pursuit, however, S/Con Peasley did not advise VKG of Emmaville 33's continued role in the pursuit.

It was important for the safety of the officers involved, as well as members of the public, that the supervisors know how many vehicle were involved in the pursuit, their types and the identities of their drivers. While it is plausible that S/Con Peasley had not wanted to interfere with radio traffic between the primary vehicle and VKG, it is equally possible that, given her unfamiliarity with the Safe Driving Policy, she simply did not know what was required of her during the pursuit. (During her evidence she displayed far greater familiarity with the Safe Driving Policy than on the evening in question.)

Was the pursuit properly reported and controlled as it progressed?

This question raises two issues: (a) reporting from the cars in the field and (b) controlling of the chase from Armidale or VKG.

One of the reasons police pursuits are monitored and controlled by senior officers at remote locations is that officers engaged in a pursuit must concentrate very hard on driving at high speed for the circumstances – a complex activity with small margins for error – and may develop, as Sgt Pringle termed it, "tunnel vision". In the heat of the chase, desiring to bring their quarries to heel, officers engaged in a pursuit may lose objectivity and misjudge the degree of potential danger they, or members of the public, may be running into as the pursuit continues. Senior officers controlling the pursuit from remote locations are not personally involved in the same way and can bring a wider and more objective perspective to the various factors that must be taken into account as the chase develops.

A problem will almost inevitably arise when the remote controllers do not have sufficient local knowledge of the course of the pursuit to make fine judgments about whether or not the dangers of the pursuit have exceeded acceptable levels taking all the relevant factors into account. In such a case, the remote controllers then become reliant on the judgment and local knowledge of the officers directly involved in the pursuit.

If human error was a function of character, it would be relatively easy to eliminate: the "bad" operators could be identified and excluded from practising in areas, which might lead to harm to others. The flaw in such an approach is obvious. The truth is that all competent professionals, let alone amateurs, make mistakes. Counter-measures under this approach include discipline, training and litigation. An approach which gives primacy to blaming someone for an error rather than on identifying systems failures is one that leads to a reluctance to take responsibility and, in particular, to report mishaps and mistakes. By over-emphasising personal responsibility and culpability, we may be distracted from rectifying systemic faults.

Professor James Reason famously invented the "Swiss cheese" model of dissecting systems failures. He analysed the problem this way:

Defences, barriers, and safeguards occupy a key position in the system approach… Their function is to protect potential victims and assets from local hazards. Mostly they do this very effectively but there are always weaknesses.

In an ideal world each defensive layer would be intact. In reality, however, they are more like slices of Swiss cheese, having many holes – though unlike in the cheese, these holes are continually opening, shutting, and shifting their location. The presence of holes in any one "slice" does not normally cause a bad outcome.

Usually, this can happen only when the holes in many layers momentarily line up to permit a trajectory of accident opportunity – bringing hazards into damaging contact with victims.

The holes in the defences are for two reasons: active failures and latent conditions.

Active failures are the unsafe acts committed by people who are in direct contact with the [victim] or system. They take a variety of forms: slips, lapses, fumbles, mistakes and procedural violations. Active failures have a direct and usually short-lived impact on the integrity of the defences… Followers of the person approach often look no further for the causes of an adverse event once they have identified these proximal unsafe acts. But… virtually all such acts have a causal history that extends back in time and up through the levels of the system.

Latent conditions are the inevitable "resident pathogens" within the system. They arise from decisions by designers, builders, procedure writers and top level management… Latent conditions have two kinds of adverse effect: they can translate into error-provoking conditions within the local workplace (for example, time pressure, understaffing, inadequate equipment, fatigue and inexperience) and they can create long-lasting holes or weaknesses in the defences… Latent conditions – as the term suggest – may lie dormant within the system for many years before they combine with active failures and local triggers to create an accident opportunity. Unlike active failures, whose specific forms are often hard to foresee, latent conditions can be identified and remedied before an adverse event occurs. Understanding this leads to proactive rather than reactive risk management.

We cannot change the human condition, but we can change the conditions under which humans work. To use another analogy: active failures are like mosquitoes. They can be swatted one by one, but they still keep coming. The best remedies are to create more effective defences and to drain the swamps in which they breed. The swamps, in this case, are the ever-present latent conditions.[6]

The Swiss Cheese Model of Systems Failure

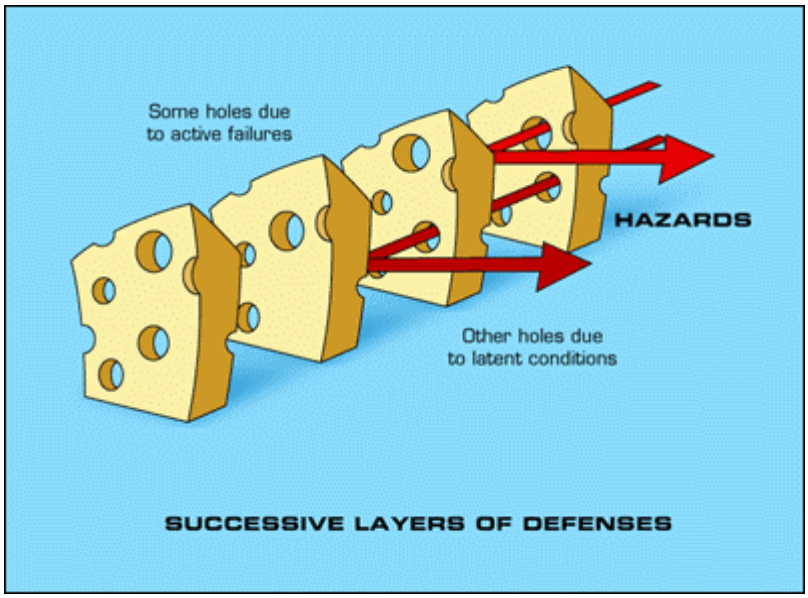

Fig 1. The defence layers work: holes do not line up

[6] "Human error: models and management" (2000) 320 *British Medical Journal* 768-770.

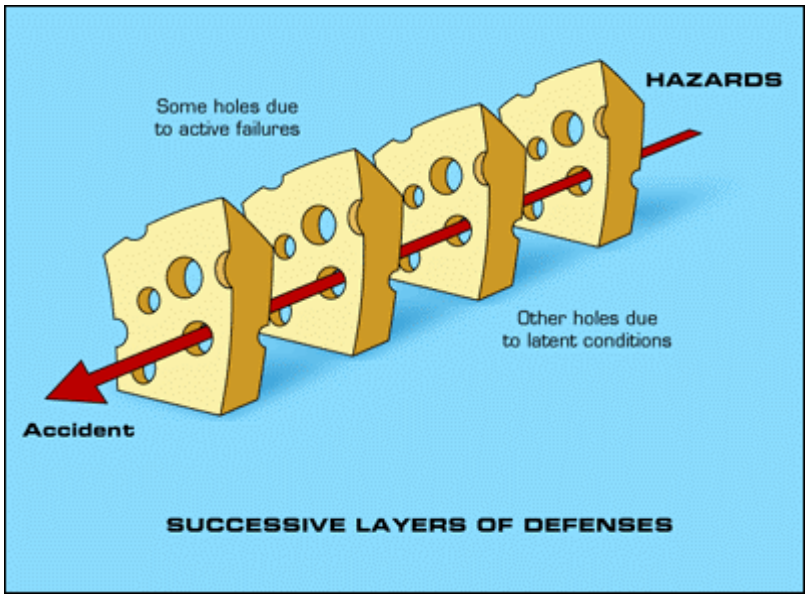

Fig 2. The holes line up: trajectory of accident opportunity[7]

The holes in the cheese slices represent individual weaknesses in individual parts of the system, and are continually varying in size and position in all slices. The system as a whole produces failures when all of the holes in each of the slices momentarily align, permitting (in Reason's words) "a trajectory of accident opportunity", so that a hazard passes through all of the holes in all of the defences, leading to a failure.

The Safe Driving Policy is, overall, an excellent policy designed to promote both good policing and public safety. Yet, as Graham Johnson's death illustrates, the policy is not foolproof. One of the "latent conditions" in this case was that neither Sgt Pringle in Armidale nor VKG had local knowledge of the true characteristics of Bolivia Hill. By default, therefore, real control of the pursuit remained in the hands of the officers in the primary pursuit vehicle, both of whom were very familiar with the road. This is not a criticism of the officers in the primary car – they did not know who was monitoring the chase. Nevertheless, two of the principal defence mechanisms (or slices of "Swiss cheese") -- Armidale 14 and VKG -- were therefore penetrated because of this unidentified flaw in the system.

Sgt Pringle gave evidence that, had he been aware of the characteristics of the road over Bolivia Hill at the time of the pursuit, he would have terminated it either as it reached the crest of the hill or earlier.

In retrospect, it can be seen that, given an absence of detailed local knowledge at the supervisory level, the reporting from the primary car was insufficiently detailed to enable either Sgt Pringle or VKG to monitor and control the pursuit appropriately.

[7] http://patientsafetyed.duhs.duke.edu/module_e/swiss_cheese.html

The “Pursuit Review” prepared by Sergeant McFarlane, now Acting Commander of the Traffic Services Branch, included the following in the summary section:

Police were entitled to initiate the pursuit and it appears to have been conducted professionally and within the Safe Driving Policy parameters. However, as the situation became prolonged serious consideration should have been given to terminating the pursuit.

Any number of police not directly involved in a pursuit can direct that it be terminate. The attached report indicates pursuing police were aware the final descent area of “Bolivia Hill” is a black spot and slowed accordingly. It may have been appropriate to terminate the pursuit prior to this point and turn off the warning devices.

The video footage from the in-car video system was played in court and commented upon by a number of police witnesses, including Inspector Ridley, Sgt Pringle and the two primary car officers. Both Inspector Ridley, the investigating officer, and Sgt Pringle noted some instances of driving that they considered ought to have been notified to VKG but were.

At the hearing, when watching the in-car video recorded by New England 208 during the pursuit, Inspector Ridley gave evidence to that effect about both those incidents.

Sgt Pringle’s evidence was that he did not recall any driving incidents being reported to him and that he had not reviewed the footage after the event. Both officers also thought that VKG ought to have been notified that the pursuit was approaching Bolivia Hill and that the descent on the northern side was windy and dangerous.

What consideration was given to termination of the pursuit before the fatal crash?

Neither S/Con Ramma nor S/Con Opryszko considered terminating the pursuit. They gave evidence that they had conducted pursuits over this stretch of road on previous occasions without incident. Nonetheless, both acknowledged that it had been necessary to slow down once they had crested the brow of the hill. S/Con Ramma told the investigating police that he had assumed that the driver of the Suzuki would exercise “common sense” and also slow down on the descent. Mr Pappin’s performance to that point, however, provided a very weak foundation for that assumption.

With hindsight, it can be seen that termination ought to have been considered. If the officers were uncertain about this, they ought ideally to have consulted Sgt Pringle or VKG. I do not criticise the police officers because this may be an example of the “tunnel vision” against which supervision is meant to be a safe-guard. But there was a systems failure.

Sgt Pringle paid close attention to the radio description of the pursuit as it approached Bolivia Hill because he had a general idea that it was a locality with a history of road accidents. Although he had authority to terminate the pursuit, his lack of local knowledge (he had never driven over Bolivia Hill at that time) and the relative paucity of information he was given about the handling of the Suzuki left him significantly disadvantaged as a controller. VKG was in similar position. I make no criticism of either. Again, the system had failed.

Were there any features of the driving on the part of the pursued vehicle or characteristics of the road or topography that that ought to have given rise to a concern that the pursuit was unsafe?

I have discussed the topography and characteristics of the New England Highway above. The topography of Bolivia Hill and the need to "respect" the road over it gave rise to a concern on the part of the officers in New England 208 that a high-speed pursuit over the hill was unsafe. They slowed down and backed off.

Aspects of Mr Pappin's driving have been described above. A few further comments ought be made. Not only did the length of the chase suggest a determination on his part to get away from police but the swerving back and forth on the uphill section of two northbound lanes and his acceleration downhill at a speed of about 140 kph emphasised this fact.

Mr Pappin's manner of driving demonstrated an absence of common sense and respect for the characteristics of the road and a dangerously high, but misplaced, sense of self-confidence in his driving ability.

Second, the police officers involved in the pursuit observed four people in the car. It is a matter of common knowledge that some young drivers behave more immaturely and irresponsibly when driving their friends than when alone. Police are well of this. For this reason, among others, drivers on "Red Ps" are not permitted to drive more than one person after 11pm.

The Roads and Maritime Services website states that "NSW crash statistics show that young people are over-represented as drivers and motorcycle riders in fatal crashes. *Young drivers are more likely to be involved in fatal crashes at night and when they are carrying passengers*."[8]It also states, "[Young drivers] driving at night (after 10pm) and carrying passengers also increases the crash risk significantly."[9] It would have been reasonable for the police to infer from the fact that there were four people in the car that the driver was more likely to engage in high-risk driving than if he was driving alone and that he would, therefore, imperil his passengers' safety more than if he was driving alone.

[8] http://www.rta.nsw.gov.au/roadsafety/statistics/crashesinvolvingyoungdrivers.html
[9] http://www.rta.nsw.gov.au/roadsafety/youngdrivers/index.html

I propose to make a recommendation that the number of passengers in a vehicle be made an explicit factor (among others) to be taken into account when pursuing police or the radio supervisors are assessing whether or not a pursuit ought be continued.

What, if any, lessons have been learned from this incident?

This incident has taught a number of lessons. First, there are ambiguities in the Safe Driving Policy that ought be addressed.

Second, the assumption made in the policy that senior officers monitoring or controlling pursuits from remote locations have the requisite local knowledge of conditions in which pursuits are taking place is misconceived.

Third, high-speed pursuits into and through traffic "black spots"[10] are more dangerous than elsewhere especially for the occupants of the target vehicles because the drivers are usually less skilful than trained police drivers authorised to conduct pursuits.

Those offending drivers are less likely to drive to the conditions and exercise common sense than the pursuing police because they are seeking to escape from the police; and the inherent dangers of the location that make it a traffic "black spot" considerably reduce margins for error.

Fourth, there appear to be differences of opinion within the Police Force about what constitutes "erratic" driving. The officers in New England 208 were less concerned about Mr Pappin's manner of driving than Sgt Pringle and Inspector Ridley were retrospectively and were less inclined to regard it as "erratic" than they were. This may reflect the fact that their long experience in the Highway Patrol has exposed them too much worse driving than Mr Pappin displayed before the crash. It may also indicate that their real intuitive benchmark was actual danger to members of the public. Because the traffic was light, there was relatively little danger before the pursuit reached Bolivia Hill despite some aspects of Mr Pappin's driving.

Have any changes in NSW Police practice or policy been instituted as a result of this incident?

At this stage no changes to NSW Police policy or practice have been made as a result of this incident. Counsel for the Commissioner, however, indicated that close consideration would be given to any recommendations made during this inquest. A number of draft recommendations were suggested during the inquest in Tenterfield. The Commissioner's response to them is contained in a report dated 9 April 2012 prepared by the Commander of the Traffic Policy Section.

[10] I use the term "traffic black spots" because it is in common usage both in the community and the Police Force as a shorthand descriptor of locations where there is a higher than normal prevalence of dangerous traffic incidents than on other parts of the road system.

Ought any recommendations be made?

For reasons outlined above, this incident, in my view, requires some amendments to the Safe Driving Policy. During the hearing in Tenterfield, I proposed a number of potential recommendations. The Commissioner of Police has responded to them by way of written submissions from the Traffic Branch. I have given them careful consideration.

The first six proposed recommendations suggested amendments to the Safe Driving Policy to take into account explicitly the dangers of known traffic "black spots" (that is, locations where the higher than normal prevalence of dangerous traffic incidents is recognised).

The Assistant Commissioner in charge of the Traffic Services Branch and Highway Patrol, Mr Hartley, the commander of the Traffic Policy Section and the State Pursuit Management Committee considered the suggestions. They raised a number of issues concerning the proposed recommendations and made a number of counter-proposals.

The first difficulty raised is a matter of definition. At present, the Safe Driving Policy uses the term "radio black spots" to describe locations where radio communication with VKG is impossible. The Police Force argues that the simultaneous usage of "black spots" in reference to "*traffic* black spots" could lead to confusion and increase the difficulty of controlling and managing pursuits by radio.

There is substance in that objection. The problem is solved, however, by the use of a different term. For example, what I have referred to above as "traffic black spots" might be called "traffic red zones" or "traffic danger zones" or some other distinctive term.

That is a good idea but is not a foolproof answer to the issues that Graham Johnson's death raises.

The problems with this approach are twofold: first, it is reliant on the judgment of pursuing police to provide the advice; and, second, it impliedly relies on the supervisors having sufficient local knowledge to be aware of the potential danger if they have not been given the relevant advice. But, as we have seen, both those problems arose in this particular case. The subjective judgment of the pursuing police was that there were no particularly adverse conditions that they needed to report. VKG and Sgt Pringle did not have the local knowledge to challenge that judgment.

A second objection to the proposed recommendations concerning "traffic black spots" is that there are 185,000 kilometres of road network in NSW and that it would be logistically impracticable to conduct the exercise of identifying all potential "black spots" (or "traffic red zones") and marking up maps used by

the Highway Patrol, VKG and supervisors accordingly. Again, this is a reasonable objection. A more limited approach, however, seems feasible.

Based primarily on crash statistics but also other criteria, such as suitability for roadside camera operations, the NSW Centre for Road Safety, in consultation with the Police Force and the NRMA, has identified approximately 140 "traffic black spots" (my term, not theirs) throughout NSW as locations where mobile speed cameras are deployed.[11] Most, if not all of them, are located on main roads both in the country and the metropolitan area. (I note that at present the crash statistics relied on go up to 2008 only and therefore, do not include the location of Graham Johnson's fatal incident.) This may be a start towards identification of "red zones".

A distinction should probably be made between pursuits confined within major built-up areas, such as Sydney, Newcastle, Wollongong, Wagga Wagga and Albury, and pursuits on major country arterial roads.

Pursuits within major built-up areas are likely to be comparatively more hazardous than on country highways because of the heavier concentrations of traffic, pedestrians, pushbikes, intersections, traffic signals, school zones, and multi-lane roads. Paradoxically, the obviousness of these hazards may lead to a relatively heightened sense of caution on the parts of pursuing police and their supervisors. On the other hand, the type of pursuit with which occurred in this case may subconsciously engender a degree of relative complacency on the parts of pursuing police. I therefore propose to confine my recommendations to pursuits conducted on country highways only.

Given the experience and professionalism of the NSW Police Traffic Services Branch and the Highway Patrol, it seems to me that it would not be beyond the capacity of the NSW Police Force, perhaps in conjunction with the NSW Centre for Road Safety, to identify stretches of country highways where it would be hazardous to conduct pursuits even in good weather with good road conditions and moderate traffic. Steep, winding descents are one obvious source of significantly increased danger for the pursued and the pursuers as this case demonstrates. Narrow winding stretches of road, such as are common on the Pacific Highway and Princes Highway, also present major challenges for high-speed driving.

There are three Police Force country regions: Northern, Southern and Western. In each there are 11 or 12 Local Area Commands. Highway Patrol units are distributed among the Local Area Commands. The number of major highways in country NSW is relatively limited. There are about 30 highways, which are designated as National Highways, National Routes and State Routes.[12] If members of the Highway Patrol who regularly patrol sections of highway accumulate local knowledge of traffic "black spots",

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[11] See http://www.rta.nsw.gov.au/roadsafety/speedandspeedcameras/mobilespeedcameras/index.html viewed 13/04/12.

[12] http://www.ozroads.com.au/NSW/Highways/highways.htm viewed 13/04/12.

as they demonstrably do, it is unclear why this knowledge could not be collated in documentary form for the use of local supervisors and VKG operators, new members of a local Highway Patrol unit and Highway Patrol units crossing boundaries during a pursuit. In other words, local knowledge could be disseminated to the region. The knowledge already resides in the Highway Patrol units. The real question is one of collation and dissemination.

It is not my purpose, or suggestion, that the Police Force identify every potential hazard on a highway. My suggestion is limited to identifying those areas that Highway Patrol officers themselves already regard as locations which they must treat "with respect" due to the inherent dangers of conducting high-speed pursuits through them. I doubt that in any patrol area on major highways there would be a large numbers of such locations. In this case, the chase lasted about 16 minutes before one was reached. On the western slopes and plains they are likely to be few and far between although far more common on the coast and through mountain regions.

The recommendation is further limited to the identification of locations that are inherently hazardous due to their *permanent* features, such as the topography, rather than because of temporary conditions such as roadworks or weather conditions. (I presume that the Highway Patrol and other police would keep up to date with such developments.)

Against this background, and taking into account the submissions of the NSW Police Force, I have decided to make seven recommendations concerning the issue of "traffic zones" and the Safe Driving Policy. In addition to the matters outlined above, the recommendations touch on communication between cars and supervisors, training and a suggestion that the Safe Driving Policy be amended to establish a default position that pursuits will not be conducted through "traffic red zones" unless there is at least a strong countervailing reason to continue.

A further proposed recommendation was that the Safe Driving Policy be amended to include a specific reference to the number of occupants in the pursued vehicle as one factor to be taken into account in the decision whether or not to terminate the pursuit. I appreciate that it is not always possible to determine how many people are in a car. I also appreciate that it is already a requirement that police pursuing vehicles alert VKG to the number of occupants, if that is possible, so that appropriate support can be provided to the pursuit vehicle. It is not my intention that pursuits necessarily be terminated in situations when the targeted car contains an arbitrary number of people. Rather, the intention is explicitly to emphasise the added risk of loss of life, or serious harm, as the number of occupants increases. The NSW Police Force has accepted this recommendation.

One reading of the policy is that a Category 4 vehicle ought to terminate its part in the pursuit once a Category 1, 2 or 3 vehicle takes over the pursuit.

Another interpretation is that if the Category 4 vehicle has commenced a pursuit in a remote location and the pursuit is then taken up (as in this case) by a higher category vehicle, the Category 4 vehicle may continue its pursuit but as a secondary vehicle.

In this case, the police officers involved both in the pursuit and in supervising appear either to have adopted the second interpretation or not to have considered the question at all.

The proposed recommendation perhaps did not make sufficiently clear the issue that was of concern. As a consequence, the response from the Police Force related to the definition of Category 4 vehicle. The recommendation has been redrafted.

Conclusions

There are about 1600 police pursuits in NSW per annum although this varies from year to year.[13] According to figures published recently in the *Sydney Morning Herald*, since 2004 police pursuits in NSW have resulted in 15 deaths and 388 injuries.[14] Of the fifteen killed, seven were offending drivers, six were passengers and two were bystanders. Of the injured, 71 were bystanders. (The article did not identify the numbers of police officers injured during pursuits but none have been killed in that period.) The number of pursuits has fallen from 2145 in 2004-05 to 1652 in 2010-11.

Although most pursuits end without anyone being injured, all high-speed pursuits are inherently risky and it is entirely unpredictable which ones will end fatally or in serious injury. The risks of police pursuits are greater for the pursued than for the police pursuing them. This is probably because the police are generally more skilful and experienced but also because the police control the pursuit more than the driver of the vehicle being pursued. All pursuits involve a fine judgment for the officers involved and those controlling or monitoring the pursuit. They must balance the potential risks with the need to enforce the law. That balance may alter during the course of the pursuit as conditions change. Accident research has shown that for every fatal or serious accident, there are many more near misses and minor incidents.[15] The fact that most pursuits do not result in serious harm is not a cause for complacency because in many instances luck rather than good management has probably avoided serious accidents.

With the benefit of hindsight it can be seen that it would have been appropriate and preferable for this pursuit to be terminated before it reached Bolivia Hill.

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[13] "Fall in police chases attributed to tighter pursuits policy" *Sydney Morning Herald* 5 January 2010.
[14] "Police car chases have led to 'terrible toll' of 15 deaths" *Sydney Morning Herald* 6 April 2012.
[15] See, for example, the "Heinrich accident triangle" which posited that for every serious workplace accident there were 30 accidents of similar nature that caused minor injury and 300 near misses. The safety expert Herbert Heinrich argued that addressing the root causes of commonplace accidents that caused little or no harm would reduce the prevalence of the serious accidents.

It is possible that if the pursuit had been terminated earlier Mr Pappin may not have driven so dangerously down Bolivia Hill. Nevertheless, given his previous history of dangerous driving and the manner he drove under police observation on the night of 18 January, this accident may well have happened anyway once the pursuit began. In my view, the police officers in New England 208 did not cause this fatal accident.

The real cause of the accident was that Mr Pappin not only refused to stop but also accelerated to a very high speed, probably exceeding 140 kph, on the northern descent of Bolivia Hill.

The car's tyres lacked tread and he lacked sufficient skill and experience to handle the car safely on that challenging stretch of road. He also lacked the judgment and "common sense" to slow down and drive to the conditions rather than attempting to seize the opportunity to widen the gap between his vehicle and the following police car.

Graham Johnson was an innocent victim caught in this web of circumstances. Mr Pappin is serving a prison sentence as a result of Graham's death but that can be no comfort to his grieving family. I hope that the recommendations that I make below will improve the safety of police pursuits in future and reduce the chances of other families suffering the devastating loss that the Johnson family has borne.

I offer the grieving family, especially Graham Johnson's parents and his twin brother David, my sincere condolences and respects.

FORMAL FINDING:

I find that Graham Johnson died on 18 January 2009 on the New England Highway, Bolivia Hill approximately 16 kilometres north of Deepwater, New South Wales as a result of blunt force head injuries inflicted while a passenger in a motor vehicle driven by Benjamin Pappin which crashed while being pursued by the NSW Police Highway Patrol.

Recommendations:

I make the following recommendations to the Commissioner of Police:

- That the NSW Police Traffic Services Branch develop a set of criteria in relation to the identification of locations outside major built-up areas on National Highways, National Routes and State Routes in NSW Police Northern, Southern and Western Regions which, due to known permanent road conditions that may be adverse to the continuation of a high-speed pursuit or known prevalence of serious traffic incidents,

require monitoring and supervision pursuant to the "Pursuit Response – Roles and Responsibilities of Part 6(5)(a) and (b) of the Safe Driving Policy. Such locations to be distinguished in the Safe Driving Policy from radio "black spots" by an appropriate identifier such as "traffic red zones" or "traffic danger zones". (***Note***: In this recommendation "permanent 'traffic red zone'" is intended to connote to a section of highway on which there is significantly increased risk in conducting a high-speed pursuit due to permanent topographical features or road characteristics even in good weather with good road surface and light to moderate traffic compared with relatively safe or unchallenging sections.)

(i) That the Commander of the Traffic Services Branch require each Highway Patrol in the Northern, Western and Southern Regions to collate and provide to him, or his delegate, information identifying permanent "traffic red zones" in its patrol area and that the Traffic Services Branch then collate and disseminate that material in suitable form to VKG and regional Duty Officers and supervisors.

(ii) That the NSW Police Safe Driving Policy be amended to require all persons conducting monitoring or supervision of pursuits to take into account traffic "red zones" being approached in the course of the pursuit in determining whether to permit a pursuit to continue or be terminated.

(iii) That the Safe Driving Policy be amended to establish a default position that *high-speed* pursuits will not be conducted through "traffic red zones" unless there are strong countervailing reasons for continuing the pursuit.

(iv) That supervisors and monitors of police pursuits be given suitable training or induction in the location and characteristics of "traffic red zones" before being required to take responsibility for supervising pursuits in relevant areas.

(vi) That VKG and/or officers monitoring and/or supervising pursuits notify police vehicles involved in a pursuit that the target vehicle is approaching an identified "traffic red zone" when the target vehicle reaches a nominated distance from an identified "traffic danger zone". The appropriate distance should be determined by the regional Highway Patrol commander, the State Pursuit Management Committee or by some other suitable means. [***Note***: the appropriate distance may vary from location to location.]

3. 1949 of 2009

Inquest into the death of AA at Parklea on the 10th July 2009. Finding handed down by Deputy State Coroner Mitchell.

This is a mandatory inquest into the death of AA who died while he was in custody, awaiting sentence, having been convicted of murder.

He was born in the Republic of Korea on 29 November 1951 and arrived in this country some time in 1984. There was a time when he had family in Australia, or at least I think a son, but that appears no longer to be the case so that he is not here today. No family member is here today.

AA died at Parklea Correctional Centre on 10 July 2009.

AA was convicted of murder I think on 3 July 2009. In relation to the death of his wife on 27 May 2005 he had been tried three times until finally a conviction was recorded. No doubt those who made a decision in that regard acted from a very, very wise vantage point, but it does seem to me extraordinary that someone can be in gaol for four years before they get a conviction, and I am not surprised in those circumstances that it apparently weighed very heavily on Mr AA's mind. It would be hard to think that it could not have had some significant impact on his wish to live.

He was using a preparation called Mirtazapine, which is a prescription drug, it is an anti-depressant, and there is some evidence of the sort of effect it might have had on Mr AA. You can say it was a malign or a benign effect, depending on your point of view, but there was some evidence from Mr Whale and also from Dr Allender, and essentially what it might have done was diminish Mr AA's fear of the consequences of things he might be minded to do, and perhaps in this instance diminish his fear of hanging, which ultimately caused his death.

I have a report, an autopsy report from Dr Van Vuuren. It is part of exhibit 1, along with the other formal documents, and it cites hanging as the cause of death. Clearly it was an act of suicide and as such there are automatic restrictions imposed by the statute on the publication of material arising out of this inquest.

Mr AA had been in prison for a long time. He had initially been on a higher degree of security by reason of the offence, but over the period since he had come into custody, as I said, some four years earlier, he had shown that he was not a high risk of self harm. There was no suicidal ideation of which anyone could have been aware, and he was living in a cell with a new cellmate.

I must say I think it is reasonable to say that to reflect on one very nice thing that Mr AA did, which might say something about really nice aspects to his character at a time when not a great deal is being said in that regard, and that

is that his cellmate, who was new to prison, this was the first time he had ever been in gaol, and was newly in the prison, was somewhat comforted by Mr AA and feeling - Mr AA offering him his blanket in case Mr Jagmore was cold. I thought that was a very nice thing for him to have done and it is something that we should reflect on given that, as I said, not many nice things are being said about Mr AA today.

Mr Jagmore was appropriately investigated and checked and tested for DNA and interviewed to make sure that he had nothing to do with what befell Mr AA, and there is no doubt in my mind that those investigations were thorough as they were appropriate and there is no doubt in my mind that Mr Jagmore had absolutely nothing to do with the Mr AA's death, except that it was he who first saw Mr AA hanging.

There was a knock up call late at night, but it was not anything to do with Mr AA. Mr Jagmore, who was new to gaol was having difficulty sleeping. He has an asthma condition and what with one thing and another he needed some medical or at least some nursing help and he pressed the knock up button to summon help.

When the Justice Health nurse accompanied by Corrections officers came to the cell, they had in mind assisting Mr Jagmore, and it was while they were there that they noticed Mr AA hanging. I have already said to Mr Walters that the cell in which Mr AA and Mr Jagmore were living was generous with respect to the provision of hanging points. Almost since - well, for so long, long before I became a coroner, coroners have been complaining about hanging points and I think Royal Commissions have had a go and just about anybody who has had to look into the prison system has had a go. We still have hanging points in profusion.

There is not much point in me recommending that they be eliminated, and I accept that it is expensive to eliminate them, but you really do have to wonder about it, this cell, if you had gone out of your way to provide hanging points, you could not have done better.

Anyway, when Mr AA was discovered the prisons officers needed to cut him down very quickly. They should have been carrying what is called a 911 knife, it is a special knife that is tailor made to deal with situations like this. The rules of the prison said that they should be carrying them or that somebody should be carrying one and that there should be one available, they were not and there was not, and there was a bit of a delay, in fact a delay of about three minutes while they went off to find a knife. In the event, they did not find a 911 knife, and they cut Mr AA down with scissors.

A couple of things happened during that period. The first one is that Mr Jagmore was left in the cell with Mr AA unaccompanied and that was a breach of common sense among other things, but it is a breach that was looked at internally by the Department of Corrective Services. I have had the benefit of reading the investigator's report and a deal of correspondence arising out of that report and I note that in my opinion the investigation was

thorough and the officers involved in this matter were disciplined within the department's processes.

At the same time I should say that exhibit 3 is a bundle of correspondence and memoranda within the Department of Corrective Services and that deals with the efforts of the department, its senior officers, in fact extremely senior officers of the department, to reinforce the need of officers to make sure that a 911 rescue tool is available and indeed it shows a change in policy dated 2 February 2012 directed to just that.

It seems to me that the new policy, which is not revolutionary, it is just an improvement on the old policy, a beefing up of the old policy, is extremely effective as long as it's complied with.

There is always a degree of human error but everything that the department is able to do to ensure the availability of a 911 rescue tool seems to have been, and to be being done by the department, and I think that in those circumstances there is no point in me making any recommendations in regard to the matter.

I have no criticisms at all to make of any of the Justice Health staff in the matter. It seems to me abundantly plain that Mr AA took his own life. It was not one of those suicides where somebody shows a lot of angst and can clearly be seen as a risk to themselves. It seems to have been a long, thought out plan, heaven knows he had a long time to think it out. Perhaps assisted in its execution by the Mirtazapine, and it may well have proceeded from a feeling that in Mr AA's life all was lost and he did not have a great deal more to live for. It is a very sad matter.

He was hanging from a cord fashioned from linen of the type used in the prison and indeed of the type used in his cell, but one cannot tell if - or how long it had been since it had been fashioned. I assume that at some time Mr AA tore a part of the sheeting or a part of the pillow casing(as said) from that supplied to him to make this cord, but whether that happened the night before or some weeks before, it is impossible to tell.

Mr Whale made some inquiries in regard to this, to be told that soiled sheeting is left outside cells and taken off to the laundry. Nobody checks its integrity while it is still in the vicinity of the cell and so if it is ever seen to be damaged and to have strips torn off it, it would be impossible to say where that had happened and to sheet home responsibility to any particular person.

FORMAL FINDNG:

AA WHO WAS BORN ON 29 NOVEMBER 1951 DIED AT PARKLEA CORRECTIONAL CENTRE ON 10 JULY 2009 AND THE CAUSE OF DEATH WAS HANGING.

4. 2539 of 2009

Inquest into the death of Tevita (David) Taufahema at Canley Vale on the 1st September 2009. Finding handed down by Deputy State Coroner Mitchell.

This is an inquest into the death of Tevita Taufahema, sometimes known as David Taufahema who was born on 20 July, 1991 and died, still only eighteen years of age, in the early hours of 1 September, 2009 at the front door of the *Canley Heights Hotel*, Canley Vale Rd., Canley Heights, NSW.

Having been involved with an even younger juvenile accomplice known as *M,* in a *hold up* and robbery of the hotel and its patrons, Mr. Taufahema was shot in the head as he was attempting to leave the hotel while holding a hostage at gunpoint. *M* was subsequently dealt with in the *Children's Court of NSW* and placed on a number of control orders and, by virtue of section 15A of the *Children (Criminal Proceedings) Act 1987*, publication of his name is forbidden.

The evidence is that *David* as his parents prefer him to be known was killed in the course of a police operation which had been mounted in response to a *000* phone call from a patron of the hotel who had managed to secret herself in a disabled lavatory during the robbery. As such, the inquest is *mandatory*.

The Inquest:

The inquest took place on 13 to 17 February 2012. I was very ably assisted by Mr. Peter Aitken, solicitor/advocate of the Crown Solicitor's Officer and his instructing solicitor, Ms. R. Fraser. Mr. R. Button of Senior Counsel, instructed by Mr. J. Harris, solicitor of *Legal Aid NSW* appeared for the family, Mr. S. Wilkinson of Counsel appeared for Senior Constable Simon Ross and Mr. R. Hood of Senior Counsel appeared for *NSW Police*. Detective Inspector Christopher Raymond Olen of the Homicide Squad was the Officer in Charge of the Police investigation and prepared an extremely thorough Coronial Brief.

David Taufahema:

Mr. Button read to the inquest a prepared statement written by David Taufahema's father regarding his son. David was greatly loved within his family and was a loving and affectionate son and brother. He completed Year 10 at school and then undertook *TAFE* studies. He loved football and played every week, sometimes representing Parramatta. His father had thought that David could go a long way in sport.

According to his father, David Taufahema was a peacemaker among his seven brothers and three sisters, settling disputes and misunderstandings between them not by violent means but verbally and with reason. He was extremely proud, as well he might have been, of his Tongan heritage and he was a keen and faithful member of his church.

Through Mr. Button, Mr. Taufahema told the inquest that his son *"had his life ahead of him"* and the tragedy is that such was the case and that it was cut short as a result of his own criminal actions. As his father conceded, those actions, particularly the taking and threatening of a hostage, were appalling but they do not represent the sum total of David Taufahema's life. Far from it. They represent the dark side of a young man who had much to recommend him and who will always be remembered as such by those who loved him. I feel certain that those who were involved in the Coronial process would wish to join me in extending our sympathy to Mr. and Mrs. Taufahema and their family.

The *Canley Heights Hotel*:

The *Canley Heights Hotel*, since renamed the *Canley Hotel,* is a small tavern on Canley Vale Road near its intersection with the Cumberland Highway, which, at that point, is known as Cambridge Street, Canley Heights. It does not resemble what might be thought of as a traditional pub. It is not a *stand-alone* building, it does not have large windows onto the street or a beer garden and it has no rear entrance. Indeed, it has only one entrance being double glass, swinging doors inside a recessed entrance alcove. On the ceiling of the awning over the front entrance are three *CCTV* cameras, two of them, *dome* style, look up and down the street and the other, shaped like a rectangular box, looks straight down the alcove to the glass doors but, due to *flare* from a nearby illuminated sign, provides a very poor picture of the interior of the alcove, the front doors and the interior of the hotel.

Inside, the swinging doors, one enters a corridor running to lavatories at the rear of the premises. To the right of the corridor is a bar and, beyond it, disabled lavatories. To the left of the corridor are two gaming rooms, the one nearest the street for smokers, separated by a glass wall and sliding glass doors. Further along the left side of the corridor is a *TAB* room and a bistro. There were a number of *CCTV* cameras inside the premises providing images of the bar area and the corridor leading to the front doors.

It appears that the *CCTV* cameras and equipment may not have been well maintained and, in particular, the times shown by the digital clocks supered over images corresponded neither with each other nor with actual time.

On Monday 31 August 2009 the manager of the hotel was Ninos Shlaimon who continues in the employ of the owner of the hotel. He was styled *bar manager* but told the inquest that, in effect, he was in solely in charge of the hotel that night. By midnight, a security operative, Sione Tu'ipolotu, who had been hired for the night, was still on duty and there were about 18 patrons in the hotel.

The *hold up*:

Shortly after half past midnight, the deceased accompanied by *"M"* arrived at the hotel. Each was disguised, the Deceased by a red *hoodie* and a dark balaclava and *M* by a dark top and a black bandana over his lower part of his face including his mouth. The deceased was wearing a backpack and each was wearing gloves. The Deceased was carrying a silver pistol sometimes known as a 9mm *Luger*

pistol. Lucas van der Walt, an expert witness regarding firearms was able to say that this is a high powered pistol capable of firing high powered ammunition. He told the inquest that the weapon had contained one unspent round in its breach and that another similar unfired round had been found, along with a large amount of cash, in Taufahema's clothing. As to *M.,* he confirmed that his weapon, which to all intents and purposes looked like a rifle, had turned out to be an air rifle albeit one in working order and capable of inflicting serious and perhaps even fatal injury.

The *Pioneer* Chinese Restaurant:

Mr. van der Walt was able to confirm that it was from Taufahema's pistol that two rounds had been fired on the previous night, the night of 30 August, 2009, one into the ceiling of the *Pioneer Chinese Restaurant* at Yagoona in the course of a *hold up* and the other in the street outside the *Pioneer* premises at the driver of a passing silver coloured *BMW* motor car who evidently had failed to stop to assist in the offenders' *get away*. When interviewed on 1 September 2009, *M.* admitted that he and David Taufahema had been involved in that *hold up* and that it had been Taufahema who had fired those shots.

Robbing the hotel:

On arrival, patrons along with the security man were herded by *M* into the smokers' gaming room where they were forced onto the ground and made hand over their wallets and valuables while *M* swore at them and abused them and brandished his rifle over them, threatening to *"pop"* them if they failed to comply with his demands. Meanwhile David Taufahema approached Mr. Shlaimon, told him *"this is a robbery"* and demanded to be shown the safe. After emptying the contents of the safe into his bag and putting some notes down the front of his pants, David Taufahema told Mr. Shlaimon *"shut up or I'll put a bullet in your head"* when the latter hesitated in handing over his *I phone*.

David Taufahema walked with Mr. Shlaimon, pointing his pistol menacingly as the latter was forced to empty the bar tills and the poker machines, emptying them of cash and handing it over to him.

The *000* call:

While this was going on, one very resourceful and brave patron, Thanh Thai Thi Pham, slipped away and hid in the disabled toilet where she made the *000* telephone call, a recording of which is Exhibit 11. In that call, she reported that an armed robbery was under way. She told the operator that she had glimpsed patrons being forced to lie down on the floor and that she could hear the sound of poker machines being opened and emptied of money. She sought Police assistance.

VKG:

It was that telephone call which alerted Police to what was going on and prompted them to direct resources there. The broadcast over the Police radio network *VKG*, a recording of which is Exhibit 10, shows a call at about 12.37am call directing

Police resources to the *Canley Heights Hotel* where a robbery, possibly an armed robbery, was in progress. *Dog Squad 36*, driven by Senior Constable Robert Parkin with Senior Constable Simon Ross as his passenger was the nearest unit and responded to the call at 12.38 am.

Meanwhile, at Fairfield police station, Detective Sergeant Ashley Stokes and Detective Constable Nathan Deery had been investigating a number of armed robberies in the south west Sydney area which seemed to present a number of common features including use of disguises, menacing and aggressive behaviour, robberies of patrons as well of the premises generally and, most significantly, the use of a rifle and a pistol.

Mr. Stokes noticed what he thought might be similarities between his robberies and the robbery underway at the *Canley Heights Hotel* and he decided to go and have a look. Before doing so, he made a broadcast on *VKG* warning other police that, if his intuition proved correct, the offenders might well be armed. Senior Constables Parkin and Ross are unsure whether they heard or noticed that broadcast.

The Arrival of Police:

Dog Squad 36 had been only two or three minutes away from the hotel when they heard the call. Initially, they proceeded under lights and sirens until, approaching the *Canley Heights Hotel,* they lowered their profile so as not to alarm the offenders and alert them to their presence. I accept that this is what they did and I understand from the material before me that this is what their training had taught them to do and what their superiors expected of them. There was no significant delay in their arrival even though Messrs. Parkin and Ross were unfamiliar with the Canley Heights area and had some difficulty finding the hotel.

When they did arrive, at about12.40am, Mr. Parkin had to pull up at short notice and he parked hurriedly and in a position outside the front doors where the tail of the fully marked police van could be seen from inside the hotel. Perhaps it was that which first announced their presence and alerted David Taufahema and *M.* to the presence of police but there is no evidence that the two offenders were any more alarmed than they would have been had police adopted a more formal and considered way of announcing their presence and announcing their presence one way or another is something they had to do.

Senior Constables Parkin and Ross alighted, neither wearing a bullet proof vest even though there was one available in the van, and made their way towards the front door of the hotel to observe what was going on, taking cover on either side of the entrance alcove and leaving the dog in the van. According to Mr. Parkin, this was not the type of operation for which a police dog is suited and he believed that to have employed the dog would have been to render it a *"sacrificial victim."* As to the bulletproof vest, Sergeant Brown endorsed the decision not to use it. My understanding of the bullet proof vest is that it is heavy and very cumbersome and a very imperfect protection at any event. There is no reason to think that the absence of bullet proof vests played any part, one way or another, in the unhappy events, which now unfolded.

Regarding the decision of Senior Constables Parkin and Ross to take up their positions in the street at the left and right corners of the entrance alcove, Mr. Button of Senior Counsel questioned whether they might have been better to have positioned themselves at a further distance from the hotel doors. At the time when Mr. Parkin fired his gun, he was only about four or four and a half meters from *M.* and Senior Constable Ross was even closer to David Taufahema when he shot him – perhaps as close as 2 to 3 metres. Mr. Button suggested that, at a greater distance, there might have been better opportunities for cover, for negotiations and for additional consideration and reflection as to what might be the best action to take. I doubt this is so.

There is no evidence that further down or across the street there was any useful and reliable cover, particularly cover that might allow police to observe what was going on inside the hotel and, at the same time, enhance their own safety. According to Mr. van der Walk, the police van itself should not, be seen as reliable cover. Only a very small part of it could be relied on to withstand gunfire. Furthermore, it seems to me that the further from the hotel doors Robert Parkin and Simon Ross took up position, the greater the scope for violence to escape from the confines of the hotel into the street.

There is little reason to think David Taufahema would have released his hostage and, if allowed bring Mr. Shlaimon into the street, his distance from police would reduce their ability to move against him in order to protect his hostage. The events of the night before at the *Pioneer Chinese Restaurant* and the shot fired at a passing motorist illustrate the wisdom of the police practice of containing violence rather than allowing it to spread.

As to consideration and reflection, David Taufahema and *M.* were within the hotel when they first became aware of a police presence outside. There is no evidence from their decision to take a hostage, march up to the front door and continue towards police, ignoring the police officers' directions to drop weapons, of any willingness to consider or negotiate. Concerning reflection on the part of police, Mr. Ross' evidence is clear that he acted neither in panic nor as a reflex but deliberately when he saw an opportunity to eliminate the threat to Mr. Shlaimon's life.

Neither Sergeant Brown nor Inspector Olen, the Officer-in-Charge was able to identify any significant departure by Parkin or Ross from proper police practice and in my respectful opinion, sad as the outcome was, they acted properly and with great bravery in an extremely dangerous and fast-moving situation created by the criminal behaviour of David Taufahema and his young companion.

It is about six minutes into her *000* call that Ms. Pham can be heard to tell the operator that she could hear voices outside the lavatory saying *"shit, coppers, coppers."* While Ms. Pham remained in the lavatory and other patrons were on the floor of the smoker's gaming room being terrorised by *M*, David Taufahema continued robbing the poker machines. Then, perhaps because he heard something outside or perhaps because of something *M* told him, Mr. Taufahema can be seen on *CCTV* to step from the gaming room into the corridor, glance

towards the front door and return hurriedly to the gaming room, saying *"police, police. The police are here"* and asking Mr. Shlaimon *"Did you press the buzzer?"*

Taking the Hostage:

David Taufahema then put Mr. Shlaimon in a *headlock* with his left arm around Mr. Shlaimon's neck, pointed his pistol up against his head or neck and said *"go"* and, as can be seen in the *CCTV* material Exhibit 14, marched him out into the corridor and towards the front doors. Mr. Parkin was able to broadcast that the offenders were armed. It is clear that by his actions David Taufahema presented to police a threat to seriously injure and, if necessary, kill the hostage should he be prevented from leaving the premises.

From their vantage point at the opposite sides of the opening of the alcove to the street, Senior Constables Parkin and Ross, with guns drawn, watched as David Taufahema, holding the pistol to the head of the hostage, followed by *M*, with what they reasonably believed to be a drawn rifle, approached the front door of the *Canley Heights Hotel.* They could see David Taufahema and, no doubt, he could see them. Taufehema and his hostage continued on through the front doors, walking to within two or three metres of Mr. Ross, followed by *M* with his rifle raised.

The Confrontation:

Both officers, still the only police on the scene, shouted over and over again *"Police. Put the gun down"* and *"Police. Let him go"* (referring to the hostage) or similar words. Mr. Shlaimon was calling *"don't shoot, don't shoot"* although whether to his captor or police I am unable to say. According to *M, "they were all screaming."* Taufahema continued to point his pistol at the hostage's head. Senior Constable Parkin told the inquest that Taufahema appeared totally to ignore police directions *"He seemed extremely calm,"* Mr. Parkin told the inquest, *"the police presence seemed not to affect his attitude."*

And Mr. Ross told the inquest that *"I couldn't believe they were continuing to approach rather than give up."* Mr. Ross cannot remember David Taufahema saying anything but the hostage, Ninos Shlaimon recalls his captor shouting out *"I'll shoot him"* and, certainly, his actions in advancing so far and continuing to hold a gun to Mr. Shlaiman's face suggest that he was capable of doing so. In forming the view that the hostage and police themselves remained at risk at David Taufahema's hands, Senior Constable Ross finds himself in good company because the co-offender, *M.*, told the inquest that he too had believed that the pistol was loaded and that David Taufahema would use it should anybody try to stop him.

Mr. Parkin was able to send a radio message describing the unfolding drama but, when he saw *M* apparently aiming his rifle at him, as *M.* concedes was the case, so that he feared he was about to be shot and possibly killed, he called to Mr. Ross *"he's pointing the rifle at me"* and discharged a single shot missing the youth but sending him falling backwards against the wall inside the door. Within a very short time, perhaps a second, as can be heard from the recording of the *000* telephone

call, there was a second shot when, as ballistic evidence confirms, Senior Constable Ross fired at David Taufahema.

Mr. van der Walt's evidence confirms that Constables Parkin and Ross each fired one round only, Mr. Parkin's missing its mark and damaging a blackboard attached to the wall of the hotel and Mr. Ross' hitting Mr. Taufahema.

The Death of David Taufahema:

David Taufahema was hit in the head and fell backwards towards the hotel doors where he lay on the alcove floor. As his weight came off the hostage, Ninos Shlaimon sprang forward, ran out into the street, slipped and fell, recovered himself and took off down the street until he was stopped by other police officers, newly arrived on the scene, who could not have known whether he was an innocent witness or a fellow offender.

So soon after Mr. Parkins shot did Mr. Ross fire his gun that it was suggested by Mr. Button of Senior Counsel that the second shot was a reflex to the first but Mr. Ross vehemently denies that. The sound of two gunshots in very close succession were heard by Ms. Pham and, this, can be heard in the recording of the *000* phone call. Evidently, those shots were one fired by Senior Constable Robert Parkin from near the left hand corner of the alcove which missed *M* and a subsequent shot fired by Senior Constable Simon Ross from behind the right hand corner which killed David Taufahema, probably instantly. On all the evidence before the inquest, those were the only two shots fired within or near the *Canley Heights Hotel* that night. The recording, Exhibit 11, amply demonstrates the short period of time between the first shot and the second.

Mr. Ross says that, irrespective of Mr. Parkin's actions, he fired and shot at Taufehema when he did because, for a moment, Mr. Shlaimon's head moved forward, perhaps as a reflex to Mr. Parkin's shot, leaving Taufahema's head momentarily exposed rather than shielded by the hostage and, believing that the hostage's life and his own were in immediate danger, he took the opportunity to fire. He told his superiors when he made his *ERISP* on 1 September 2009 that he acted, as he did *"to make sure he was no further threat."*

Dealing with the Deceased:

By that stage, Senior Constables Parkin and Ross had been joined by Detective Sergeant Stokes and Detective Constable Deery. Mr. Stokes was the senior officer present. It was under his authority that the firearms carried by Taufahema and *M*. were removed and placed on a table where they could be secured.

Together with Parkin, Ross and Deery, Sergeant Stokes entered the hotel for the purpose of *clearing* it. At that stage, police knew little of the state of the patrons who had been held inside at gunpoint and, in particular, no knowledge of whether other offenders, armed or unarmed, were still present in the premises. Mr. Parkin's evidence is that, at the time, he had *"no idea"* who might be there.

Police witnesses at the inquest agreed that it was proper practice was that police officers secure the scene, ensure the safety of the patrons, apprehend any other offenders who might still be present and ensure their own safety before placing themselves in a vulnerable position – near the front doors, in order to render assistance to David Taufahema and *M.* But, at any event, the weight of evidence suggests that it is more likely than not that Mr. Taufahema was already dead. When Senior Constable Parkin made a statement to Police relatively shortly after the incident, he told them that David Taufahema *"was still moving, I believe"* and his evidence before the inquest is that there were no *"gross movements"* even if he was breathing.

But Mr. Stokes told the inquest that *"looking back at it, I believe I really knew that the Deceased was already dead"* and, according to Mr. Deery, *"I could tell this person was dead."* Mr. Ross' evidence is that, despite hearing somebody calling for an ambulance, he, too, believed David Taufahema to be dead and he said to Mr. Parkin *"I can't see his chest moving."*

An ambulance arrived at 12.52am and another a minute or so later. It was Senior Constable Parkin who decided that an ambulance was needed urgently. I am not sure whether it was he or Probationary Constable Adam Rigny, or, perhaps, both, who actually made the radio call. Unlike, Mr. Ross, Parkin was wearing a radio with the microphone/speaker pinned to his shoulder and, throughout the incident, he broadcast a number of messages.

When he could see the offenders approaching down the corridor, he messaged *"They have firearms"* and a little later, seeking to contain the incident and assuming, erroneously, that there was a rear entrance to the hotel, he messaged *"We need police out the back."* Then, he reported *"shots have been fired"* and, six seconds later, he signalled, *"I need an ambulance urgently."* On the other hand, Constable Adam Rigny's evidence is that, almost immediately after David Taufahema was shot, Mr. Parkin told him to *"get an ambulance quick"* which he says he did. Perhaps they each made similar calls.

The Ambos:

CCTV played at the inquest shows the arrival of the first paramedic, Wendy Woodward. She received the call at 12.44 am and was at the entrance to the *Canley Heights Hotel* at 12.50, about eight to eight and a half minutes after the fatal shot was fired. *OH and S* issues to do with the security of the scene prevented her making a *hands on* assessment but she observed David Taufahema *"for a couple of minutes"* and saw that *"he was not breathing … … that there was no movement of the chest… and … that he was unconscious or dead."* His pupils appeared fixed.

It was not until shortly after 12.54am, when the scene had been sufficiently secured, that Paramedic Aaron Casey was able to approach Mr. Taufahema more closely for the purpose of establishing that he was indeed dead. He checked the carotid and femoral pulses and it was while he was doing this that he *"pulled down the top of the track pants and found a large amount of money."* Mr. Casey performed an ECG and found the patient monitored in asystole

Handcuffing the Deceased:

The hotel was cleared and Ms. Pham was liberated from the disabled lavatory some 5 minutes and 40 seconds after the shots had been filed. Detective Stokes arranged that the firearms of Senior Constables Parkin and Ross be secured and they were separated. By that time, newly-arrived Chief Inspector O'Connor had assumed command and he began putting in place and implement various protocols applicable whenever there has been a police shooting. In the course of so doing, he appears to have directed that both offenders, David Taufahema and *M*, be handcuffed.

It is not clear to me why this direction was given. It was Constable Mirza Mustafic, a young general duties officer, who frisk searched Taufahema, finding *"large amounts of money"* in the process, and handcuffed him in accordance with his directions. Mr. Mustafic recorded that David Taufahema *"was non-responsive and had small traces of blood emitting from his eyes"* and *"a small hole on the right side of his head which appeared to be inflicted by the bullet."* Mr. Mustafic *"shook his body and attempted to raise him to no avail as the male remained unresponsive"* and he says that he formed the view that he was dead. As far as I can tell, the direction to handcuff David Taufahema was an urgent direction given in fast moving circumstances, designed to enhance safety, given by an in-coming commanding officer who had just arrived on the scene and was still unaware of all the details with which he had to cope. In particular, I do not think that handcuffing David Taufahema was intended as any slight or sign of disrespect to that young man or to his family. The evidence, which I accept, is that Police were not aware of the identity of the Deceased until later in the morning when *M*. made his statement and, before that, even Mr. Stokes and Mr. Deery, who had been investigating not dissimilar events, had been unaware of the persons with whom they were dealing.

Police Conduct:

I have already commented on what, despite the sad outcome, I see as proper and brave conduct on the part of Mr. Parkin and Mr. Ross. I think that Mr. Stokes' conduct in taking control of a difficult and fast moving situation until the arrival of a superior officer reflects very well on him.

The police investigation of this *critical incident*, conducted and overseen by Inspector Christopher Olen of the *Homicide Squad* has been thorough, painstaking and professional and I thank him for and congratulate him on it.

I think that the only criticism, which might be made of Police, in this case related to the manner in which the family was advised of David Taufahema's death. Strictly speaking, I wonder if that is a matter falling within the area of my jurisdiction and it was touched on during the inquest only peripherally. But it was a sad aspect of this sad matter and one, which occasioned great unhappiness among David Taufahema's family.

I think it is pertinent to recall that there were a great many matters, most of them urgent, facing Mr. Olen when he took up his duties on 1 September, 209 but his evidence is that he would have liked the contact to the family to have unfolded differently and, where they felt aggrieved by the way contact did unfold, he apologised to Mr. and Mrs. Taufahema and David's family.

Since the death of David Taufahema, although not necessarily as a consequence of it, there has been some significant change to Police protocols and practices regarding critical incidents. I heard about these *in camera* when Sergeant Warren Brown and Inspector Olen gave their evidence. Obviously, I do not propose disclosing this evidence. I note though that, in my opinion, there is no scope for recommendations arising from this matter.

Formal Finding:

I find that Tevita (David) Taufahema who was born on 26 July 1991 died of a gunshot wound to the head on 1 September 2009 at the *Canley Heights Hotel*, Canley Vale Road, Canley Heights, NSW.

5. 3605 of 2009

Inquest into the death of Warren Holman at Lisarow on the 25th December 2009. Finding handed down by Deputy State Coroner Mitchell.

This is an inquest into the death of Warren Robert Holman who was born on 2 October 1953. Mr Holman was convicted of a murder, which took place on the 17 August 2005, and on 15 June 2007 he was sentenced to a term of twenty-one years imprisonment from 20 August 2005. It follows that he was a serving inmate at the time of his death and that this is therefore a mandatory inquest.

He died on 14 or 15 December 2009 at the Lithgow Correctional Facility. I have the P79A report, the report of the hospital at Lithgow an identification statement, the autopsy report of Dr Samarasinga and Professor Carla and the certificate, toxicology certificate of the Division of Analytical Laboratories and they are jointly exhibit 1 and I have also the coronial brief which is exhibit 2 and the Department of Corrective Services has provided a file of its investigation report and that document is without objection tendered, and it is exhibit 3. I have had the opportunity of read that. I also had the benefit of hearing the evidence of Detective Senior Constable Jeff Sinton who was not the original officer in charge, but assisted her, in the initial stages of this matter, and is now effectively the officer in charge.

He was able to tell me among other things of the very thorough and painstaking investigation, which took place at the Lithgow Gaol and elsewhere.

The purpose of mandatory inquests, I suppose, is to ensure that the power of the state hasn't been exceeded in cases where the deceased was particularly vulnerable to an excessive power and in this case I am pleased to say that there is no indication at all that anybody in corrective services or for that matter in Justice health did anything untoward and exceeded their authority and failed to live up to their responsibilities there is nothing like that at all. The evidence is that Mr Holman was suffering, indeed chronically suffering a number of heart related conditions, which obviously ultimately led to his death.

FORMAL FINDING:

THAT WARREN ROBERT HOLMAN WHO WAS BORN ON 2 OCTOBER 1953 DIED ON 14 OR 15 DECEMBER 2009 AT THE LITHGOW CORRECTIONAL FACILITY OF CORONARY ARTERY DISEASE AND ATHEROSCLEROSIS ON A BACKGROUND OF SYSTEMIC HYPERTENSION AND CARDIOMEGALY

6. 3716 of 2009

Inquest into the death of Ian Cowie at Lisarow on the 25th December 2009. Finding handed down by Deputy State Coroner Freund.

Ian Saunders Cowie was 48 years old when he was shot and killed by police at this Central Coast home on Christmas Day in 2009. He is survived by his family namely his wife of 27 years, Wendy, his daughters Rebecca and Jane, son in law Scott and grandchildren Eliza and Isaac.

As Mr. Cowie's death arises "out of a police operation" this is a mandatory inquest pursuant to s23 of the Coroners Act 2009.

The undisputed facts can be summarised as follows. Mr. Cowie who was a "mental health consumer" had, according to those who knew him best namely his wife Wendy Cowie, and daughters Rebecca Collis and Jane Cowie, a "bad morning". He had refused to attend the Christmas Day celebrations at his son in law's family's home and had remained at his home 12 The Rise, Lisarow ("**the Residence**") on his own. At about 4.41pm pm Senior Constable Owen and Probationary Constable Berghoffer in BW16 arrive at 6 The Rise, Lisarow having responded to a job broadcast from VKG of malicious damage to a car at that address. They attend on Mr.Nelson, the neighbour of Mr. Cowie and are advised that there is a history of neighbourhood disputes, they are shown the damage to his car and two rocks that are said to have caused the damage and hear loud music coming from the Residence. Thereafter VKG informs Senior Constable Owen that:

"An Ian Cowie has got a couple of warnings, aggressive towards police, may have a psych illness (no-one else at the address known; nothing outstanding against Mr. Cowie)"[16].

The evidence indicates that at this stage, Senior Constable Owen and Probationary Constable Berghoffer intended to issue a noise abatement order and investigate the malicious damage to the neighbour's vehicle and attend on the Residence to speak to the occupant. However, they are unable to raise anyone at the Residence. Senior Constable Owen disconnects the power, which has the effect of stopping the loud noise. Still unable to raise the occupant of the Residence, they advise the neighbour to contact police again if the noise resumes, return to their vehicle and drive away.

As Senior Constable Owen and Probationary Constable Berghoffer drive away from the Residence they notice a motor vehicle pull into the driveway of the Residence. They do a U-turn and park BW16 across or along side the driveway of the Residence.

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16 Exhibit 2, Volume 2, tab 100, page 4;

They approach Mrs. Cowie and her daughter Jane Cowie in the driveway of the Residence and, in essence, advise Mrs. Cowie why they are there, namely that they had received a complaint of malicious damage to the neighbour's car and make inquiries of Mrs.Cowie as to Mr. Cowie's medical condition. They are told by Mrs. Cowie that he is on a medication regime and that he had taken his medication that morning. Senior Constable Owen enlists the assistance of Mrs. Cowie to talk to Mr. Cowie into coming outside to speak to them about the malicious damage complaint.

During this period, Mr. Cowie comes to the door and says words to the effect *"what the fuck do you want? Fuck off*." Senior Constable Owen says that he wishes to speak to him about an incident involving an allegation from a neighbour. Mr. Cowie swears aggressively and tells the police to get off his property. Senior Constable Owen warns Mr. Cowie about using offensive language. Mr. Cowie continues to swear, using what Senior Constable Owen describes as a random selection of words. Mr. Cowie slams the door. Senior Constable Owen knocks again. Mr. Cowie returns to the front door, again swearing and telling police to get off his property. Mr. Cowie pushes at the door, but is prevented from opening it as Senior Constable Owen has his foot against the door. Senior Constable Owen asks Probationary Constable Berghoffer to call for back up.[17]

At about 5.08 pm (approximately 27 minutes after BW16 had arrived first at the location of The Rise), BW16 makes a request for assistance from VKG saying:

> *"The offender is getting pretty violent with us"*[18]

At about 5.09 pm BW205 driven by Senior Constable Prest offers assistance and proceeds to the Residence. Thereafter, Senior Constable Owen tells VKG not to use Code Red.

At 5.10 pm BW208 broadcasts over VKG:

> *"Yeah radio, the person that there (sic) dealing with at that address, is that an Ian Cowie? Radio, he's a dead set nutter. I'm leaving Gosford now. I'm only about 5 minutes. I've dealt with this person before."*

Shortly, after this time Senior Constable Owen informs Mrs. Cowie that the priority is Mr. Cowie's mental health and they intend to take him to hospital for an assessment.

At about 5.14 pm Mr. Cowie calls from inside the Residence, with Senior Constable Owen and Probationary Constable Berghoffer, and Mrs. Cowie still at the front door words to the effect of:

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[17] Exhibit 2, Volume 1, Tab 11, ERISP Senior Constable Owen at pages 16 to 20;

[18] Exhibit 2, Volume 2, Tab 100 at page 7;

"I'll get a knife and I'll stab them".

Upon hearing the threat, Senior Constable Owen requests a taser from VKG. At approximately 5:15 pm Senior Constable Prest arrives at the Residence (approximately 34 minutes after BW16 initially arrived at The Rise).

He walks up the driveway and joins Senior Constable Owen and Probationary Constable Berghoffer at the vicinity of the front door of the Residence. There is no briefing of Senior Constable Prest by the other officers.

Mr. Cowie returns to the front door is observed by Senior Constable Prest to be verbally aggressive. Senior Constable Prest says to Senior Constable Owen "OC him".

Senior Constable Owen reaches for his OC canister. At about this time Mr. Cowie either kicks or pushes the flyscreen door open and assumes a boxing stance and says words to the following effect:

"fucking take me" or "fucking take you".

He has nothing in his hands. Senior Constable Owen sprays Mr. Cowie with the OC spray who then runs back into the house with both Senior Constables Owen and Prest in pursuit.

Mr. Cowie manages to get to the kitchen drawer and obtain a knife. Senior Constable Prest attempts to disarm Mr. Cowie by the use of his baton but is unsuccessful. Senior Constable Prest finds himself effectively cornered by Mr. Cowie who lunges towards him with the knife. Senior Constable Prest fires two rounds from his revolver and Senior Constable Owen fires one. At 5.17 pm VKG receives urgent broadcast from BW 16 "shots fired, suspect down".

A Coroner's function is to seek to answer five questions namely, who died, when they died, where they died and the manner and cause of their death. The cause of death refers to the direct physical cause, where the manner of death relates to the surrounding circumstances. As this is a death arising out of a police operation, it becomes a central issue for this inquest to determine whether the force used by the police was appropriate in the circumstances. A coroner, pursuant to s82 of the Coroners Act 2009 has the power to make recommendations not in attempt to lay blame but to look forward in attempt to prevent future similar deaths and the pain and suffering that has been experienced by Mr. Cowie's family being experienced by others in the future.

As stated at the start of this inquest, there is no controversy in relation to the identity of Mr. Cowie or where, when and how he died. The primary issue to be considered by this inquest is what were the surrounding circumstances that led to that fateful outcome for Mr. Cowie, namely what were the precursors leading up to the confrontation between Mr. Cowie, Senior Constable Owen, Senior Constable Prest and Probationary Constable Berghoffer, was the use of force justified and avoidable, in particular :

Upon attending the Residence and being unable to raise Mr. Cowie what further steps could Senior Constable Owen take in relation to the malicious damage complaint?

- Was it appropriate for Senior Constable Owen to seek the assistance of Mr. Cowie's family in order to communicate with him and further investigate the malicious damage complaint?
- Were the police trespassing once they were told to go away by Mr. Cowie?
- Was there a proper basis for either Senior Constable Prest or Senior Constable Owen to conclude that they needed to apprehend Mr. Cowie pursuant to s.22 of the Mental Health Act 2007?
- What happened at the front door to change the situation from one of containment to a fatal shooting in two minutes from 5.15pm to 5.17pm?
- Were the actions by police in following Mr. Cowie into his home in order to detain him reasonable in the circumstances?
- Was there a command by the police to Mr. Cowie to "drop the knife"?
- Was there compliance with the Central Coast Mental Health Protocol?
- Was the treatment of the family members by police investigating Mr. Cowie's treatment appropriate in the circumstances?

I will deal with each of these issues in turn.

Upon attending the Residence and being unable to raise Mr. Cowie what further steps could Senior Constable Owen take in relation to the malicious damage complaint?

The evidence indicates that prior to the arrival of Wendy and Jane Cowie at the Residence, and after unsuccessfully attempting to raise the attention of Mr. Cowie at the Residence, Senior Constable Owen and Probationary Constable Berghoffer advised Mr. Michael Nelson, the neighbour who had complained about the malicious damage to his vehicle, that there was no answer at the Residence, and that if the behaviour was to start up again to ring the police and let them know[19].

At that point, with the occupant of the Residence not attending the door, Senior Constable Owen concluded that their "investigation was finished"[20].

This view was confirmed by both Professor Alpert and Inspector Peter Davis.

Was it appropriate for Senior Constable Owen to seek the assistance of Mr. Cowie's family in order to communicate with him and further investigate the malicious damage complaint?

Upon the arrival of Jane and Wendy at the Residence, BW16 completed a U-turn and parked across or along side the driveway of the Residence. Senior Constable Owen approached Mrs. Cowie and said words to the effect of:

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19 Exhibit 2, Volume 2, Tab 61, paragraph 16;

20 Exhibit 2, Volume 1, Tab 11, ERISP Senior Constable Owen at p.11;

"a neighbour has complained that a rock had come over the fence we know someone is in the house we would like to speak with them... we heard the radio on earlier, but it is now turned off"[21].

Both Professor Alpert and Inspector Davis agree that returning to the Residence, enlisting the assistance of family members in order to speak to the occupant who was a person of interest with respect to the report of malicious damage by the neighbour was a proper attempt to further investigate the offence[22].

Were the police trespassing once told to "go away" by Mr. Cowie?

It was submitted by Mr. Pearce, solicitor on behalf of the family inter-alia that:

Mr. Cowie through his wife indicated to Senior Constable Owen that "he won't come out and he said he did nothing wrong"[23];

Thereafter, Mr. Cowie came to the front door on three separate occasions, on each of those occasions Mr. Cowie said words to the effect of "Fuck off", "Get off my property", "get your hands off my door" and that "he had done nothing wrong";

That as soon as Mr. Cowie made the comments referred to in the preceding paragraph, he was exercising his right to silence and demanding that the Police leave his premises, it therefore follows that the police from that point were trespassing on his property;

By continuing to remain at the front door of the Residence and after being told in no uncertain terms to leave by Mr. Cowie, the Police were in contravention of the Inclosed Lands Protection Act 1901, and the Police remained there without lawful excuse (as the investigation of the malicious damage offence was over as Mr. Cowie was also clearly exercising his right to silence and nothing further could be achieved by continuing to remain at or on the Residence).

In attempting to ground his submissions in law, Mr. Pearce referred me to the High Court decision of *Kuru-v-State of NSW*[24] stating that it supported his submission that the Police were acting without lawful excuse and were trespassing at the Residence as their licence to be there had been revoked.

I do not agree.

The pertinent facts in *Kuru-v-State of NSW*[25] involve the police responding to a reported domestic violence incident, the person of interest namely Mr. Kuru, the occupier of the dwelling house had invited the police to "look around" the flat. He thereafter asked them to leave.

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21 Exhibit 2, Volume 2, Tab 54, Statement of Wendy Cowie at paragraph 12;

22 Exhibit 6 (Alpert Report) p.6, paragraph 5 and Oral Evidence of Inspector Davis on 13 December 2012;

23 Exhibit 2, Volume 2, Tab 54, statement of Wendy Cowie at paragraph 14;

24 [2008]HCA26;

25 Ibid;

The police did not leave and remained on the premises for longer than it would have reasonably taken them to leave. Much of the majority decision involved the analysis of sections 357F and 357H of the Crimes Act 1900 which have since been repealed.

The majority held:

"by the time police went to the appellant's flat, there was no continuing breach of the peace and nothing in the evidence of what happened thereafter suggested that but for the police officers not leaving the flat when asked to do so, any further breach of the peace was threatened or expected, let alone imminent. However, broadly understood may be the notion of a duty or right to take reasonable steps to make a person who is breaching or threatening to breach the peace refrain from doing so, that duty or right was no engaged in this case. It was not engaged because, by the time police arrived at the appellants flat there was no continuing or threatened breach of the peace. And no breach of the peace was later committed or threatened before the eruption of the violent struggle that culminated in the appellants flat, after he had asked them to go and a reasonable time for them had elapsed....."[26]

The circumstances before this inquest can be distinguished from that in *Kuru-v-State of NSW* for three distinct reasons. Firstly, in *Kuru* the breach of the peace had ceased and was no longer continuing nor was it imminent whereas the breach of the peace by Mr. Cowie's was continuing. Mr. Cowie's behaviour, which although only directed at the police presence was loud, offensive and aggressive was evolving and continuing. Despite slamming the front door in the faces of police he continued to reappear and engage with them.

Secondly, in *Kuru* the police had actually entered and remained inside the dwelling house after being asked to leave that is, they were actually inside the flat (or house) which the appellant occupied whereas the police never entered the dwelling house of the Residence until after a decision was made to detain Mr. Cowie pursuant to s.22 of the Mental Health Act 2007, and threats were made to stab them and "to come and get me".

Finally, in *Kuru* the appellant was the sole occupant of the dwelling house at the time the police were asked to leave the premises, however, in the facts before me despite Mr. Cowie's demands that the police in effect get off his property there is no evidence to suggest that Mrs. Cowie or for that matter Jane Cowie, both also occupiers of the Residence, made similar such requests of the police. In fact, Mrs. Cowie in my view continued to engage, talk and communicate with police about her husband and his condition while they remained in the vicinity of the front door and after he had asked them to leave.

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[26] Ibid 53-54;

Section 4 of the Inclosed Lands Protection Act 1901 defines Inclosed lands as

"(a) Prescribed premises; or

any land, either public or private inclosed or surrounded by any fence, wall or other erection, or partly by a fence, wall or other erection partly by a canal or by some natural feature such as a river or cliff by which its boundaries may be known or recognised, including the whole or part of any building or structure and any land occupied or used in connection with the whole or part of any building or structure."

The photos of the Residence[27] do not indicate or demonstrate that it was inclosed or surrounded by any fence, wall or other erection or natural feature as set out in section 4(b) of the Inclosed Lands Protection Act. Moreover, the High Court in *Halliday-v- Neville*[28] held:

"The evidence indicates that the premises …were residential premises with an open driveway to the roadway. There is no suggestion that the driveway was closed off by a locked gate or any other obstruction or that there was any notice or other indication advising either visitors generally or a particular class or type of visitor that intrusion upon the open driveway was forbidden. That being so, a variety of persons with a variety of legitimate purposes had, as a matter of law, an implied licence from the occupier to go upon the driveway. The question which arises is whether, in those circumstances, the proper inference as a matter of law is that a member of the police force had an implied or tacit licence from the occupier to set foot on the open driveway for the purpose of questioning or arresting a person whom he had observed committing an offence on a public street in the immediate vicinity of that driveway.

The conclusion, which we have reached, is that common sense, reinforced by considerations of public policy, requires that that question be answered in the affirmative. That conclusion does not involve any derogation of the right of an occupier of a suburban dwelling to prevent a member of the police force who has no overriding statutory or common law right of entry from coming upon his land. Any such occupier who desires to convert his path or driveway adjoining the public road into a haven for minor miscreants can, by taking appropriate steps, preclude the implication of a licence to a member of the police force to enter upon the path or driveway to effect an arrest with the result that a police officer's rights of entry are restricted to whatever overriding rights he might possess under some express provision …..or the common law. All that that conclusion involves is that, in the absence of any indication to the contrary, the implied or tacit licence to persons to go upon the open driveway of a suburban dwelling for legitimate purposes is not so confined as to exclude from its scope a member of the police force who goes upon the driveway in the ordinary

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27 Exhibit 2, Volume 4, photographs 1, 2 and 41 of 273;

28 (1984) 155 CLR 1;

course of his duty for the purpose of questioning or arresting a trespasser or a lawful visitor upon it…. "[29]

Accordingly, I am satisfied that Senior Constable Owen, Probationary Constable Berghoffer and also Senior Constable Prest were **not** trespassing after they were told to leave by Mr. Cowie.

Was there a proper basis for either Senior Constable Prest or Senior Constable Owen to conclude that they needed to apprehend Mr. Cowie pursuant to s.22 of the Mental Health Act 2007?

Section 22 of the Mental Health Act 2007 states:

" (1) A police officer who, in any place, finds a person who appears to be mentally ill or mentally disturbed may apprehend the person and take the person to a declared mental health facility if the officer believes on reasonable grounds that:

the person is committing or has recently committed an offence or that the person has recently attempted to kill himself or herself or that it is probable that the person will attempt to kill himself or herself or any other person or attempt to cause serious physical harm to himself or herself or any other person, and

it would be beneficial to the person's welfare to be dealt with in accordance with this Act, rather than otherwise in accordance with law.

(2) A police officer may apprehend a person under this section 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."

It was submitted by Mr. Higgins, Counsel Assisting inter-alia that:

the conclusion by Senior Constable Owen that the behaviour being exhibited by Mr. Cowie entitled an involuntary detention of him pursuant to s. 22 of the Mental Health Act 2007 was a misunderstanding of the legislation and of the events evolving at the front door;

That Senior Constable Owen had no information to indicate that Mr. Cowie was a "person suffering from a mental illness" as defined by s.14 of the Mental Health Act, which states:

" (1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

for the person's own protection from serious harm, or

for the protection of others from serious harm.

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[29] Ibid at 8;

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account."

As Senior Constable Owen had no information to indicate that Mr. Cowie would cause either himself or another person serious harm his detaining him for his care, treatment or control was not necessary;

Accordingly, the police had no right to seek to detain and it was not enough for Mrs Cowie to have wanted him detained and taken for assessment at a psychiatric facility.

The information/ intelligence that Senior Constable Owen had gathered in relation to Mr. Cowie by the time he had requested backup from VKG at 5.08.20 pm was as follows:

That Mr. Cowie had a possible psych illness and was aggressive towards police (from inquiries with police radio);

That the neighbours had complained of malicious damage to their motor vehicle and it was suspected that Mr. Cowie had caused that damage;

That Mrs. Cowie had confirmed that Mr. Cowie was in the house, suffered from a mental illness, was prescribed medication and had taken it that morning;

That he had not been right that day;

That he had appeared at the door on two occasions was abusive, incoherent, loud and aggressive to police (I note that the yelling by Mr. Cowie could be heard by the neighbours in the house opposite);

That Mr. Cowie had attempted to push the screen door open and there was a small physical engagement at the screen door between Senior Constable Owen and Mr. Cowie in order to contain the situation;

It is clear from the ERISP of Senior Constable Owen[30] that his focus had shifted from investigating the malicious damage complaint to possibly detaining Mr. Cowie under s.22 of the Mental Health Act 2007:

"I think around, very soon after the door got slammed again, he slammed the door, the timber door...I had a conversation straight away, almost immediately I think the, the wife came to the door, I spoke to her, she was inside...I made, made reference to her, and I made it perfectly clear to her that he didn't seem himself at this point, and that his behaviour was concerning towards, his, was concerning me his behaviour. And I made it perfectly clear to her now that I am putting, and I use, I remember using the exact words, I'm putting the other stuff aside, I said. But now I'm concentrating on his behaviour. I said, We're now going to look at taking him to hospital"[31].

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30 Exhibit 2, Volume 1, Tab 11;

31 Ibid at page 21, A80;

Between 5.08 pm and 5.15pm (when the request for a Taser was made) the following further events were known to have occurred:

Mrs. Cowie had advised Senior Constable Owen of Mr. Cowie's prior suicide attempt by hanging almost a year earlier[32];

Rebecca and Scott Collis had returned to the Residence with their daughter Eliza;

He had asked Rebecca and Scott Collis to speak to Mr. Cowie and:

"*I made a general comment to all of them, if they thought that he, the gentleman inside...would respond better to them trying to get him to come down to the hospital either with us or ambulance or by any other means.*

I think I would have used words to, you know, Can you guys have a chat to him and see if you can, if he's willing to come down either with you or get him some help"[33];

He continued to ask questions of Mrs. Cowie;

Thereafter, some 6.5 minutes later at 5.15 pm Senior Constable Owen requested a taser at the location as a threat had been made by Mr. Cowie to the effect of *"if youse don't leave I'll put a ten inch knife into every cunt."*[34]. It is around this time that Senior Constable Owen made a request of the family members to all come outside[35].

At that time, namely around 5.15 pm the objective matters of which Senior Constable Owen was aware was firstly, that Mr. Cowie was becoming increasingly agitated and aggressive. Secondly, his attempts to communicate with Mr. Cowie by enlisting the help of family members had failed. Thirdly, there were a number of family members (including a young child) in the house and the threat to get a knife and "stab them" was made loudly from inside the house prior to Mr. Cowie attending the front door for the third and final time Fin

Although the agitation and aggression at this stage was only directed at police, Senior Constable Owen had asked all the family to come outside. Accordingly, I am satisfied on balance that Senior Constable Owen was entitled to apprehend Mr. Cowie to take him to a mental health facility as to Senior Constable Owen, Mr. Owen **appeared** to be mentally ill or mentally disturbed and that it was probable that Mr. Cowie would attempt to cause serious physical harm to another person.

This is a convenient point in the findings to consider the submission made by Counsel Assisting that the fact that this incident evolved and occurred over such a short period of time is irrelevant, in particular:

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32 Ibid at pages 25-26, A93;

33 Ibid at page 23, A85;

34 Exhibit 2, Volume 2, Tab 56, statement of Jane Cowieat paragraph 8;

35 Exhibit 2, Volume 2, Tab 54, statement of Wendy Cowie at paragraph 16 and - Exhibit 2, Volume 2, Tab 54A, second statement of Wendy Cowie at paragraph 7;

"The conclusion by police that the use of communication as a fundamental use of force within the Tactical Options Model framework justified the remaining at the front door until Mr Cowie attended failed to adapt with the evolving confrontation. Whilst communication is a positive and fundamental use of force, its use must be balanced against the dynamics of a situation such that judgment may necessitate the disengagement from communication. This incident was such a situation; the continued presence of police at the front door up to and including the third contact with Mr Cowie at the front door served no investigative purpose in relation to the original malicious damage complaint. Its only purpose at the cessation of the third contact was to escalate the behaviours of Mr Cowie to a point when a physical force option would be necessary to achieve a resolution of the incident.

The public expectation that police will attend a complaint, investigate it, and resolve it must be balanced against a consideration of the purpose in being there and how the situation is evolving as a dynamic. It is an oversimplification of policing to say:

" we can't just leave when someone tells us they don't want to speak to us. If that was the case, we'd be walking away from 99% of all accused" [36]. The public has an equally compelling expectation that police will resolve a dispute with as little force as is necessary in the situation. The assessment on this occasion failed to consider the fact that police were investigating a malicious damage complaint for which the accused was refusing to engage in the investigation, and failed to consider the limited utility of remaining for the advancing of the investigation. This failure was compounded by the failure to balance these above mentioned considerations as against the apparent escalation in the behaviour of Mr Cowie, and the reasonably anticipated outcome[37]".[38]

Throughout this inquest, in order to assist me to gain an understanding of the sequence of events that occurred Counsel Assisting adopted the frames used by Professor Alpert in his report dated 7 December 2012[39]. However, in my view to use those frames to analyse the minutia of the decision making process of Senior Constable Owen without reference to the short time in which this whole situation unfurled is both artificial and unrealistic.

This situation evolved over a space of minutes and the decisions were made in a highly stressed emotive and dynamic environment. It is clear that the focus of Senior Constable Owen shifted whilst at the door of the Residence from investigating the malicious damage complaint to responding to a man who was becoming more and more aggressive, antagonistic, agitated and threatening towards police and appeared to have a mental illness or was mentally disturbed. Mr. Higgins submitted that the focus changed at a specific point in frame 4 however the ERISP in my view does not support that.

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36 13 December 2012 – evidence of Sen Sgt Davis to counsel assisting

37 as evidenced by the necessity to call for back-up

38 Outline of submission dated 14 December 2012;

39 Exhibit 6;

At various points Senior Constable Owen enunciates as Mr. Cowie continues to come to the door and abuse the police that his focus was shifting and he was considering his powers under the Mental Health Act. Accordingly, I am of the view that the shift in his focus was reasonable in the circumstances.

What happened at the front door to change the situation from one of containment to a fatal shooting in two minutes from 5.15pm to 5.17pm?

Senior Constable Prest arrived at the Residence at about 5:15 pm. The evidence indicates that he parked the police vehicle on the opposite side of the road, alighted, obtained his baton from its holder on the door of the vehicle and walked up the driveway of the Residence.

Much was made during the cross examination of various members of the family about what Senior Constable Prest did with his baton while walking up the driveway.

It was the evidence of Jane Cowie in her written statements that " *one of the police officers turned up with a baton in his hand"* [40] and in her oral evidence stated words to the effect *" she saw him hold the baton in his right hand and hit his left hand with it"* . Whilst Scott Collis was outside on the driveway having a cigarette when Senior Constable Prest arrived, his evidence was he saw Senior Constable Prest putting on his gloves when he was walking up the driveway and that he did not see the police baton at that time and would have seen it if he was carrying it. Finally it was the evidence of Mrs. Cowie who conceded in cross-examination that although she included in her second statement " *I saw Prest who is the third Police Office …approach. He was putting his gloves on. He was getting his baton out"* [41] she really could not recall him with the baton at that stage.

Accordingly, I am satisfied that when Senior Constable Prest walked up the driveway of the Residence he simply fitted his baton to his appointments belt and put on his gloves and was not holding the baton in an aggressive confrontational manner as indicated by Jane Cowie in her oral evidence.

Although there was a temporal nexus between the arrival of Senior Constable Prest and the further escalation of what occurred with Mr. Cowie it was not the determinative factor. The evidence of Scott Collis made it quite clear that the behaviour of Mr. Cowie was escalating prior to the arrival of Senior Constable Prest and becoming more aggressive and irrational and it had already become physical when Mr. Cowie attended the front door on the second occasion to confront police.

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40 Exhibit 2, Volume 2, Tab 54, statement of Wendy Cowie at paragraph 10;

41 Exhibit 2, Volume 2, Tab 54A, second statement of Wendy Cowieat paragraph 8;

Upon the arrival of Senior Constable Prest at the vicinity the front door, I am satisfied on balance the following occurred:
Mr. Cowie came back to the front door and either pushed or kicked the fly screen open; Senior Constable Owen tried again to talk to him about taking him to hospital;

> Upon seeing Senior Constable Prest, Mr. Cowie screamed words to the effect of " *I'll fucking take you*" [42] or "*I'll belt the crap out of youse"* [43];

Mr. Cowie then took a step forward and assumed a boxing stance;

At about that same time Senior Constable Owen reached for his OC canister and administered the OC Spray to Mr. Cowie's face whilst Senior Constable Prest took his baton in his right arm raised it above his shoulder in a defensive pose and put his left hand in front of him;

Mr. Cowie upon the spray being administered stepped back and ran into the back of the house followed by Senior Constable Prest and then Senior Constable Owen;
Mr. Cowie got to the kitchen drawer and armed himself with a large knife;

Senior Constable Prest attempted to disarm Mr. Cowie of the knife by administering two blows to Mr. Cowie's right arm by using his baton. He was unsuccessful[44];

As this occurred Senior Constable Prest found himself backed into a corner of the lounge room by Mr. Cowie who was brandishing the knife and lunging forward. Senior Constable Prest at this point had dropped his baton and armed himself with his service revolver and fired once; Mr. Cowie fell backwards onto the lounge and sprung straight back up again. Thereafter Senior Constable Prest fired another shot and at the same or similar time so did Senior Constable Owen.

At 5:17pm, VKG broadcast was made by BW16

> " *Urgent, shot fired, suspect down*." .

Were the actions by police in following Mr. Cowie into his home in order to detain him reasonable in the circumstances?

I have already indicated during the course of these findings that Senior Constable Owen's decision to apprehend Mr. Cowie to take him to a Mental Health Facility pursuant to section 22 of the Mental Health Act was reasonable in the circumstances.

42Exhibt 2, Volume 1, Tab 15, ERISP Senior Constable Prest at page 7, A42;
43Exhibit 2, Volume 1, Tab 17, walk-through of Scott Collis at page 12, A122;
44 This fact is corroborated by the bruising evidenced on Mr. Cowie' s rightarm noted in the post mortem report dated 11 February 2010 - Exhibit 2, Volume 1, Tab 7 page 4;

One thing is abundantly clear at not time did either Senior Constable Prest or Senior Constable Owen seek the outcome that eventuated that Christmas afternoon. It is not my role as Coroner to critique the decisions of those faced with the evolving circumstances as they then existed and unfolded with hindsight, it is however my role to determine whether the actions or decisions taken were reasonable. There is no doubt that with the benefit of hindsight that Senior Constable Owen and Senior Constable Prest could have chosen not to follow Mr. Cowie into the premises and could have remained at the front door or simply walked away at an earlier point in the afternoon. They did not. It may or may not have led to a different outcome. But that is pure speculation and I am satisfied that the decisions made were reasonable and that the officers were entitled to make the decisions they did at the time.

Was there a command by the police to Mr. Cowie to "drop the knife"?

All the evidence indicates that there was no verbal command by either Senior Constable Owen or Senior Constable Prest for Mr. Cowie to " drop the knife" however I accept the submission from Mr. Docking, counsel for Senior Constable Prest, that by his use of the baton to try and disarm Mr. Cowie, Senior Constable Prest had sought to get him to drop the knife.

Was there compliance with the Central Coast Mental Health protocol?

The CCLMH Protocol is an agreement between the Brisbane Water and Tuggerah Lakes Local Area Commands of NSW Police, the Central Coast Mental Health Services and the Ambulance Services of New South Wales. The version of I have been provided is dated 2004 and I understand it was applicable as at December 2009 however it does not have the force of law.

Mr. Haverfield, Counsel for Senior Constable Owen, submitted that Chart 8 of the Central Coast Local Mental Health Protocol (the " **CCLMH Protocol**") was not applicable as this was not a High Risk Situation, having regard to the examples set out in Chart 8.

" Chart 8 - High Risk Situations" states that it applies:

" …where police suspect that a person is mentally ill or mentally disordered and where it is judged that the real or impending violence or threat to be countered is such that the degree of force that could be applied by Police is fully justified. Examples relevant to this MOU include: sieges, any situation where a person is threatening to, or it is suspected they may, attempt to take their own life, threatening violence with possession of a weapon or any situation where it is believed that a trained negotiation would be of assistance to police."

Senior Sergeant Peter Davis gave evidence that, in his view, the situation confronting Senior Constable Owen was not a High Risk Situation. Senior Sergeant Davis also gave evidence that he was not intimately familiar with the CCLMH Protocol. Therefore his view that this was not a High Risk Situation

does not assist me to resolve the issue of whether Chart 8 was applicable and this was a High Risk Situation as set out in the CCLMH Protocol.

In my view, the situation that confronted Senior Constable Owen fell within the first sentence, that is: Senior Constable Owen suspected that Mr. Cowie was mentally ill or mentally disturbed (I deliberately use the words " mentally disturbed" here as those are the terms under the Mental Health Act in s. 22, which does not refer to " mentally disordered"); Senior Constable Owen considered that the threat represented by Mr. Cowie that he was to counter was " such that the degree of force that could be applied by Police is fully justified." I base this conclusion on:
the request for back up; and the request for a taster; and on Senior Constable Owens's statement:

" I said …probably …three or four times, that we didn't care about the other stuff at the moment, our focus was on him and getting him help to hospital. And I, I would have said the words, I think I used the words like, to, to the wife, not when the guy was there, but that he comes with us on his with, on his own or by force to the hospital to get him assessed and helped" [45].

In my view, the specific examples of High Risk Situations given in the second sentence quoted above are examples only. I accept that, to the knowledge of Senior Constable Owen, Mr. Cowie was not " threatening violence with possession of a weapon" . Nevertheless, he was threatening violence such that Senior Constable Owen considered him to constitute a threat such that he may need to forcibly take him to a mental hospital for assessment.

Accordingly, in the circumstances I am satisfied that the CCLMH Protocol was not complied with. However, I note that the speed with which the events unfolded may have had an impact on the failure to comply with the protocol. Nevertheless, at the time that calls were made for additional back up and for a police officer with a taser to attend the scene were made, calls should have also been made for the Duty Operations Inspector (or the Mental Health Intervention Team) to attend the scene, or at very least, give some guidance remotely.

Again, noting the speed with which events unfolded, I am unable to say that adherence to the protocol would have played a role in preventing the death of Mr. Cowie.

Nevertheless consideration should be given by Brisbane Waters LAC (and if considered necessary, the NSW Police Force in general) to additional training being provided and awareness otherwise being raised amongst serving police officers of the contents of the CCLMH Protocol (or other appropriate protocol if done more generally by the NSW Police Force).

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[45] Exhibit 2, Volume 1, Tab 11, ERISP of Senior Constable Owen at page 46, A146;

Was the treatment of the family members by police investigating Mr. Cowie's treatment appropriate in the circumstances?

After Mr. Cowie had been shot the various family members scattered outside the residence but remained in the vicinity. Mrs. Cowie and her daughter Jane remained in the care of their neighbours at 3 the Rise, Rebecca Collis and her husband Scott and daughter remained in their motor vehicle, which was parked outside the family home. They remained there for some time until they were told that they needed to attend Gosford police station. Rebecca and Scott were allowed to travel in their own car while Mrs. Cowie and Jane were escorted in a police vehicle.

They were not provided with updates as to the condition of Mr. Cowie.

When they arrived at Gosford Police Station Rebecca and Scott Collis were allowed to remain together with their daughter Eliza. Jane and Mrs. Cowie were separated from each other and other members of the family. No one was given an update as to Mr. Cowie's condition nor did anyone take the time to explain to them why they were being kept apart. Despite the presence of a very young child, who may or may not have been affected by the OC spray no inquiry was made of her condition, nor whether anything was required to ensure her well being. They were not offered food or drink. In essence they were effectively ignored until Jane Cowie had a " tantrum" after finding out by text message and google that her dad had in fact passed away.

I note that the officer in charge of the investigation of the death of Mr. Cowie, Detective Inspector Laidlaw, did not know at the time that the family were treated in this way and that if he had known would have rectified the situation. He apologised to the family as to how they were treated during the course of his evidence.

I do note that the offer of counselling was eventually made to Mrs. Cowie and that the hierarchy of the NSW Police Force has considered and taken on board the evidence of the Cowie family in this inquest and will be consider taking steps to ensure this situation will not happen again.

Accordingly, I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2009.

Formal Finding:

I find that Ian Saunders Cowie died on 25 December 2009 at 12 The Rise, Lisarow as a result of blood loss occasioned by multiple gunshot wounds.

Recommendations:

To the Commander of Brisbane Waters Local Area Command

Please give consideration to additional training being provided to serving police officers in order to raise awareness of the contents of the Central Coast Local Mental Health Protocol.

7. 485 of 2010

Inquest into the death of Geoffrey Stewart at Malabar on the 25th February 2010. Finding handed down by Deputy State Coroner Mitchell.

This is a mandatory inquest into the death of Geoffrey Stewart who was born on 20 September 1951 and died on 25 February 2010. It is mandatory because at the time of his death, Mr Stewart was serving a term of imprisonment and was in Long Bay Gaol, indeed in the Long Bay Gaol Hospital.

The officer in charge of the police investigation is Constable Ryan Morgan from Maroubra Police and he gave evidence today and I am grateful to him for a careful investigation and a comprehensive coronial brief and I should mention that Mr Stewart in his final stages was cared for particularly by Dr Veronica Stewart and under the care of Professor Tom Shakespeare from Prince of Wales. The formal documents in this case are the P79A report, the ID certificate and the autopsy report.

The autopsy report was received on 27 August 2010, it was authored by Dr Brower of the Department of Forensic Medicine here at Glebe. Those documents, the formal documents are exhibit A in the proceedings and Dr Brower's findings with regard to cause of death are that Mr Stewart died of airway obstruction, consequent on bronchus infiltration of non-small cell carcinoma of the lung. He died of lung cancer, and against a background of chronic ischaemic heart disease.

Mr Stewart was diagnosed and I think told that his prognosis was extremely poor as early as August 2007. He was convicted and sentenced by Judge Coorey in the District Court on 10 October 2008. He understood a course of radio and chemotherapy, which ended in about August 2009, and he was removed from the general prison population and admitted to the Long Bay Gaol hospital on 14 January 2010. His passing was very difficult for him. It is a wretched disease but there are varying degrees I think from what I can make out, Mr Stewarts was one of the more pernicious, it was a very painful death for him, and of course undertaken in what are necessarily adverse circumstances and it was very painful for his family as well as they watched and waited while he approached his death.

My function is primarily to determine the identity of Mr Stewart and there is no question about that, and the cause of his death and the time and place of his death, and date. And there's really not much controversy there, either. He died at about 17.15 to 17.33 hours on 25 February 2010 at the Long Bay Gaol Hospital medical surgery unit at Long Bay. He died of airway obstruction consequent upon bronchus infiltration of non-small cell carcinoma.

I am also required to look at the manner of his death and in that connection a number of matters have been raised by the family and some by police which have been looked at here but which more particularly, and in greater detail and with more input from the family than is possible in Coronial proceedings by the Health Care Complaints Commission and I have a copy of the Commission's report. They took the view that care and treatment was in their words, "satisfactory". Now, that is not a finding, which has found favour with the family, and they are hurt by that I think it is fair to say. They raised with the Health Care Commission in some significant detail some matters, which they raised, if I can say it, peripherally here. And they are matters of real concern and those matters have been reported on by the Commission, I do not think that I can go further than accept what the Commission has to say and so accept with some regret that there was likely to be a feeling in the family of unhappiness as a result of the matters which they perceive.

Ms Pilgrim raised some other matters, which were not strictly the province of the Health Care Complaints Commission, and she raised them here this morning. She spoke of what she perceived to be disrespect shown by Corrective Services and by some of its officers to visiting families. I am not in a position to investigate those matters in specific detail and in fact the specifics have really not been given me in close detail and I should say that it's likely that families are likely to be particularly sensitive at a time like this where a loved one is ill and facing death and where he is incarcerated. On the other hand, it is extremely important that families and loved ones of prisoners, particularly ill prisoners, be treated with sympathy and respect and care and it is a matter of real disappointment that Mr Stewart and Ms Pilgrim perceive that that did not happen in their instance.

Perhaps they are mistaken but even if they are mistaken it is something of a failure of the system that allows people in their vulnerable position to be disgruntled and disappointed. It would have been better clearly for everybody and it would have indicated a better, smoother operation of Corrective Services New South Wales had the treatment that had been handed to Ms Pilgrim and Mr Stewart been of a type which they could only praise and be grateful for.

I should say though that it is often that Departments of State are let down, if they are going to be let down at all in their dealings with citizens, by individual officers rather than by a system and sometimes those individual officers are harassed and overworked and preoccupied. It is not always the deliberate fault of the system and it is not always the deliberate fault of individual officers. It is though I repeat a matter of real regret.

I am told by Ms Pilgrim that the Department or the Prison, I am not sure which had responsibility, gave very late notice to the family that Mr Stewart was approaching the end stage of his life and the result of that was that the family got to the prison too late too make their goodbyes to Mr Stewart, he had lost consciousness by the time he got there. Now, sometimes these things are unavoidable, but one would hope that that would not happen in the future and that if somebody is approaching the end stage, plenty of notice is given to

families, particularly families who live a long way from the prison. I think that Mr Stewart would almost certainly have gained great comfort from his consciousness of the presence of his father and his sister and at a time when one is approaching death, one is entitled to that sort of comfort. That is to say nothing about the comfort that early notice might have given to his family. It is a matter of regret.

The other complaint or concern I should call it, that Ms Pilgrim makes relates to some failings, some perceived failings of medical treatment, in particular with regard to follow-ups. I should say that I am told that she has no complaints to raise in relation to the period after which Mr Stewart was admitted into the Prison Hospital. Prior to that though, there are a number of complaints. They have as I said, been looked at by the Health Care Complaints Commission and sad as it may be there is nothing further that I can do about it, given that they have dealt with it to their satisfaction. In all the circumstances then, I should extend my sympathy and that of everyone connected with this process and with the Coronial Service to Mr Stewart's family. It is a particularly sad business. Ms Pilgrim reminded me that at no time had Mr Stewart ever admitted guilt in relation to the matters which brought him to notice and which resulted in his incarceration and for one reason or another, that is a particularly sad matter and a source of real pain I think for the family. Nevertheless the best I can do is offer our sympathy and I certainly do that.

FORMAL FINDING:

THAT GEOFFREY STEWART WHO WAS BORN ON 20 SEPTEMBER 1951, DIED ON 25 FEBRUARY 2010 AT ABOUT 17.15 TO 17.33 HOURS AT LONG BAY GAOL HOSPITAL MEDICAL SURGERY UNIT, BED 30, AND THE CAUSE OF HIS DEATH WAS AIRWAY OBSTRUCTION CONSEQUENT ON BRONCHUS INFILTRATION OF NON-SMALL CELL CARCINOMA.

8. 520 OF 2010

Inquest into the death of Dragan Urgic at Mount Ousley on the 28th February 2010. Finding handed down by Deputy State Coroner Mitchell.

This is an inquest into the death of Dragan Urgic of 92/4 Todd Street, Warrawong who was born in Germany on 14 April 1970 and died on 27 February 2010. At the time of his death, police officers were searching for him and, accordingly, it is arguable that his death occurred in the course of a police operation so that the inquest is mandatory pursuant to the provisions of section 23

Mr. Urgic's mother and sister, Daniele Todorovski, were present throughout the inquest. They were not represented but played an active part in shaping the course of the investigation and frequently consulted Mr. McGorey before and during the hearing. Ms. Todorovski accepted an invitation to make a statement to the inquest outlining her brother's personality and character and describing the sense of loss experienced by her family. Ms. Todorovski spoke of a fit, funny, easygoing brother, reliable and good to his parents and his family. She recalled how good he had been with his two daughters, Anita now 11 years of age and Natasha, now 9, as well as her own son, Josh. She recalled how Dragan Urgic had seemed always ready to help out and how reliable he had been and good to his parents Anica and Milan Urgic. She underlined the tragedy of what happened by her observation that "no parent should have to bury a child" and she spoke of the blow, which his death had been to Mr. and Mrs. Urgic and to the whole family. I am certain that everybody connected with the inquest will wish to join me in offering to Dragan Urgic's family our sympathy on his sad passing.

The formal documents being the P79A Report, the Declaration of Life Extinct, the Autopsy Report of Dr. R. Van Vuuren of the Department of Forensic Medicine and the Toxicology Report of the Division of Analytical Laboratories are EXHIBIT 1. According to Dr. Van Vuuren, the cause of death was "multiple injuries" and these were occasioned when Dragan Urgic was struck by a motor vehicle or, perhaps, by motor vehicles a little after half past midnight on 28 February, 2010 on Mount Ousley Road, Mount Ousley, NSW. The injuries included skull fractures with cerebral injuries leading to haemorrhages, fracture of the 2nd and 3rd cervical vertebrae with total transection of the spinal cord, rib fractures, contusions and lacerations of the lung and contusions of the diaphragm and concentric ventricular hypertrophy. As Dr. Van Vuuren reported, "toxicology showed a moderate to high level of alcohol; and the metabolite of cannabis."

On 27 February 2010 Dragan Urgic and two friends went to Sydney to watch the Gay and Lesbian Mardi Gras parade in Oxford Street, Sydney. He and a friend, Nicholas Klaus, motored from Warrawong in Mr. Klaus' father's car. When they arrived at Sutherland they were met by Mr. Urgic's girlfriend, Catherine Watkins, and all three took the train into the city, alighting at Town Hall. In the car and later at Sutherland, Mr. Urgic drank both beer and bourbon whiskey but it is not clear how much and they carried a quantity of beer with them on the train.

Once in the city, Mr. Urgic and Ms. Watkins both drank more alcohol and it seems likely that Mr. Urgic became significantly affected as the evening wore on.

While in the Oxford Street area and even before the parade took place, there was a disagreement between Mr. Urgic and Ms. Watkins and, to a lesser extent, Mr. Klaus and there was some minor violence and harsh words and Ms. Watkins left the group and made her own way back to Sutherland. Then Urgic and Klaus decided that they, too, would head for home and they left Town Hall station for Sutherland, joining the train at about 7,30pm.

Although it had not been planned, Urgic and Klaus met up again at Sutherland and, setting aside their differences, they decided they would travel back home together in Mr. Klaus' car, departing at about 8.30 or 9pm.

There was more drinking in the car and the disagreements between Mr. Urgic and the others, especially Ms. Watkins, resurfaced and it appears that Mr. Urgic grew more and more angry and, I think, more and more affected by alcohol. Once again there were harsh words and, at one point, a physical altercation between the two men while Mr. Klaus was driving. Finally, somewhere past Bulli Tops, Mr. Klaus decided he could go no further and he stopped the car, demanding that Mr. Urgic, who, by that stage, was punching and hitting things within the car, get out. Ms. Watkins got out and started walking down Mount Ousley Road and then Mr. Urgic followed her, carrying an empty ESKY with the lid missing.

For a time, Mr. Klaus followed Urgic and Watkins, occasionally driving ahead of them and stopping while they caught up to him, hoping that Ms. Watkins would get back into the car and that, perhaps. Mr. Urgic would have calmed down so that he too could get back into the car. But both Klaus and Watkins say that Mr. Urgic remained angry, sometimes hitting the car with his ESKY and, on one occasion, throwing a beer bottle at the car. Finally Mr. Watkins, perhaps realising that his continued presence was only exacerbation the situation, decided to drive off, leaving both Mr. Urgic and Ms. Watkins walking southwards along the side of the road. Between 9.52pm and 10.24pm, Mr. Klaus made three 000 telephone calls reporting to Police that Ms. Watkins and Mr. Urgic were walking along Mount Ousley Road and seeking Police assistance, particularly for Ms. Watkins whom he thought may have been at risk from Mr. Urgic.

At about 9.43pm a broadcast went out on VKG regarding an unknown woman and child said to have been walking along Mount Ousley Road, about 2 kilometres from Bulli Tops. At 9.48pm Senior Constable McPhie and Constable Lockyer of Wollongong Highway Patrol acknowledged that call and commenced looking for those persons. The origin of the report is unknown and it now seems likely that the two persons mistakenly described were Mr. Urgic and Ms. Watkins. At any event, Officers McPhie and Lockyer went searching and came across Ms. Watkins and then Mr. Urgic at about 10pm.

Because they had stopped briefly on the way to issue an infringement notice to a motorist, their in car camera was activated and, inadvertently, continued to record so that, in EXHIBIT 6,

I have seen a videorecording of their journey from “South Gate” just south of Panarama House, to the foot of Mount Ousley including the stretch of Mount Ousley Road along which Mr.Urgic and Ms. Watkins walked.

Mr. McPhie did not appear to give evidence. His psychiatrist Dr. Durrell provided a written statement, EXHIBIT 8, suggesting that his mental health had been damaged, apparently irrevocably, by an appearance before a Coroner in about 1999!

In the circumstances of the present inquest, it was not necessary to test the validity of Dr. Durrell’s claim. Mr. McPhie was able, however, to provide a written statement to the inquest and his partner on 27 February 2010, Constable Martin Lockyer did appear to give evidence. It appears that they offered Ms. Watkins a lift home in their marked police car but were unable to accommodate Mr. Urgic because the equipment they were carrying left them with insufficient space. Instead they offered to send for another Police vehicle to pick up Mr. Urgic and ferry him down to Warrawong but he refused.

According to Mr. Lockyer, Mr. Urgic “brushed past (made contact with) Senior Constable McPhie and said something similar to ‘you guys don’t care’” and walked off. Although Mr. Lockyer says he “formed the opinion he (Mr. Urgic) was moderately affected by alcohol” and somewhat agitated, “he was steady on his feet and appeared to be in control of his actions.” Constable Lockyer told the inquest that, if he had been unaware of the finer points of LEPRA, the Law Enforcement (Powers and Responsibilities) Act, he was aware that he owed a duty of care to Mr. Urgic and he knew that, in appropriate case, he was entitled to detain him even though he had committed no offence.

But it did not appear to Mr. Lockyer that Urgic was in any danger. As Police drove off with Ms. Watkins in the car, Mr. Urgic was seen “about one hundred metres away from where we had first spoken to him. He was still walking at a fast pace along side the Amco railing and was well off the roadway. He was approximately three metres away from the edge of lane 1. As he was walking in that vicinity of the roadway I did not have any concerns about his welfare or safety. He appeared to be steady on his feet and was walking in a straight line.” The in car camera captured Mr. Urgic walking away and his gait is consistent with Mr. Lockyer’s description of it. Police delivered Ms. Watkins safely home to her residence at Warrawong at 10.12pm. In the circumstances, I make no criticism of Constables McPhie and Lockyer.

It appears that Nicholas Klaus had not driven far when he decided to stop and wait for his friends to catch up with him. He wanted to provide one more opportunity for them to accept a lift home. Sometime after Police drove off with Ms. Watkins and Mr. Urgic went on his way, he caught up to where Mr. Klaus was parked and Mr. Klaus offered him a lift. At first it looked as if the problems were over and Dragan Urgic got into the car but, soon after, his anger apparently returned and there was a physical altercation in the course of which, according to Mr. Klaus, Mr. Urgic struck the car with his ESKY, grabbed the GPS and threw it on to the ground and started throwing sticks and stones at the car.

Mr. Klaus told the inquest that, eventually, he gave up trying to calm Mr. Urgic in order to give him a lift and, instead, drove off, arriving at Wollongong Police Station to make a report.

Thereafter Mr. Urgic was on his own. Mount Ousley Road along the stretch that Mr. Urgic travelled is unlit and busy and traffic moves along it very quickly. The speed limit is 100kph but, as the witness Ian King observed, the topography lends itself to somewhat higher speeds. As EXHIBITS 4 and 6 demonstrate, the southbound breakdown lane sometimes narrows to a width of only a foot or two and there are very few exits. The chances of hailing a lift are remote and the area is dark with dense undergrowth and scrub along the sides of the road. It is a most inhospitable place.

A number of witnesses reported seeing a pedestrian who I believe to have been Mr. Urgic. Ian and Kathryn King each reported a branch lying across both southbound lanes and a man standing on the shoulder of the road, by which I think they means the breakdown lane, waving an ESKY around although not, she thought, trying to flag down a passing car. So alarmed were Mr. and Mrs. King that she phoned 000 and reported the matter to Police who allocated it to Officers Sheppard and Brun but I think she may have made a mistake as to the location of the pedestrian so that those officers were directed south of the Picton Road overpass whereas I think they should have been directed further north.

Two other motorists, Sally Sopniewski at10.59 pm and “Robin” at 10.57 pm made phone calls to Police reporting a pedestrian on the side of the road acting dangerously. They correctly nominated an area north of the Picton Rd., overpass but, evidently, Officers Sheppard and Brun were not updated with that information until it was too late.

Kyama Cruse and her friend Rebecca Unicomb saw a motor car parked in the parking bay on the left hand side of the road and a man, who may have been Mr. Kraus, sitting on the bonnet and, about fifty metres further on, they saw a man who may have been Mr. Urgic, bending down whilst standing in the outside southbound lane, carrying what they thought may have been a blue bucket. Ms Cruse cried out in alarm and Rebecca Unicomb who was driving, swerved to avoid him.

About 2 kilometres north of the Picton Road turn off on Mount Ousley Road, Neville Hill, a professional bus driver travelling to Wollongong saw a male person who may have been Mr. Urgic, walking in a southerly direction along the breakdown lane. Apparently, that man was wholly within the breakdown lane but, even so, Mr. Hill regarded it as very dangerous and he phoned the RTA to report the matter and was told by the operator that she would refer the matter to Police. According to Mr. Hill, the male person did not appear to be drunk and was not stumbling. He seemed to be strolling and he did not appear to be stressed but he was carrying a branch of a tree.

Another witness, Mandy Hynard saw a male person who I think was Mr. Urgic “swinging an ESKY around in his right hand and he was staggering along the edge of the roadway.” Ms. Hynard thought the person she saw was “drugged or under the influence of alcohol”

Then, at 11.10 pm, a 000 call was received from a motorist, Mary Madschi reporting that a car had just struck a male person, now known to be Dragan Urgic, as he ran across Mount Ousley Road, north of the Picton Road overpass and, very shortly afterwards, another motorist, Tunnies Kemper of 23/7 Edward Street, North Wollongong, reported to Police that he had struck a male person who had "…run straight out in front of him."

Tunnies Kemper gave a statement to Police concerning the collision. He was driving south from Stanwell Park in his maroon 2001 model Ford Falcon station wagon TK009. He was driving in lane 1 at about 70 or 75 kph and listening to the 11pm news on his car radio when, suddenly, he heard a bump and saw an object hit his windscreen. He pulled over, stopped the car, alighted and "saw a man lying on the road and in the second lane…" Mr. Kemper went on to saw that "as I was stopping, I saw a number of vehicles drive past. I heard what can be described as a 'bump bump…" Mr Kemper dialled 000 and reported the matter and then went over to the person on the road but "there was not much I could do" and, very shortly after, Police and ambulance arrived.

The Patient Health Care Record dated 27 February submitted by the Ambulance Service notes that, when examined at 2320 Hrs, Dragan Urgic was asystole, apnoeic with weak thready pulse rate and goes on to record "Pt. Deceased. Injuries incompatible with life."

Police investigating this matter have come to the conclusion that Tunnies Kemper is not culpable with regard to this matter and he has not been nor will he be prosecuted.

Frank Riva who appeared at the inquest by telephone and also provided a detailed statement witnessed this event. He was returning to Wollongong from a St. George/Rabbitohs football match and was driving along Mount Ousley Road in the lane 1 of 2 southbound lanes and driving down an incline known as the big dipper. He could see two southbound motor vehicles ahead of him, one about 50 metres and the other about 100 metres ahead of him, both in the left hand lane.

Then "his headlights picked up a person darting from right to left from the centre concrete barrier over to the shoulder of the road. He ran out right in front of the first car that was about 100 metres in front of me. It looked as if this man was carrying something in one of his hands… … He had his head down and was running. He turned and looked at the car coming towards him. I didn't hear any screeching of breaks or a horn sounding. I saw the tail lights; the brake lights go red… I knew he had been hit. I didn't hear any noise as if he had been hit but I knew he had. "

Mr. Riva pulled over to the breakdown lane and alighted from his car. He could see Mr. Urgic lying on his stomach on the carriageway of lane 2, his feet almost up against the concrete barrier and his head pointing to the left shoulder of the road "…basically at right angles to the concrete barrier." Mr. Riva made a quick call to 000 to report what he had seen and, at some risk to himself, walked northwards along the breakdown lane, hoping to warn oncoming motorists to slow down

and take evasive action but finding that some seemed more likely to respond to his warnings by swerving into lane 2.

Before long, Mr. Riva noticed that another motorist, probably Darren Thompson, wearing a high visibility reflective vest and carrying a torch had taken his place up the road and he returned to Dragan Urgic. He says Mr. Urgic was still alive. There was a good deal of blood on his face and his breathing was laboured and then became shallow. Mr. Riva was reluctant to move him and, shortly after that, Police arrived and took charge. Dragan Urgic was transported by ambulance to Wollongong Hospital where he was pronounced life extinct at 0035 Hrs. on 28 February 2010.

Darren Thompson, driving southwards, saw what he described as a large object lying across lane 2 and took avoidant action by moving into the left hand lane. As he passed the object to his right, he recognised it as the body of a man. Mr. Thompson gave a description of the body and there is no doubt it was Dragan Urgic. Mr. Thompson pulled over, parked his car and stood on the shoulder of the road to see a motorcar approaching at about 30 or 40 kph. He cannot recall the make of the car nor how many people were in the car nor what the driver looked like. He told the inquest that " the car came down the hill and drove straight over the body lying on the road. It appeared as if this car did not even see the body lying on the road. There was no attempt to veer to the left or merge to avoid hitting the body. I didn't hear any breaks or skidding. The tyres went over the shoulders and middle of the back of the body.

I remember the thud as the car drove over the body. It was like a thud as if you were going over a speed hump. Almost like a slapping noise. I still don't remember seeing any injuries on the body. I don't know if he was breathing or not.

This car kept on going and left my field of vision but it certainly did not stop."

Credence was lent to the suggestion that Dragan Urgic may have been hit by more than one motor vehicle by Senior Constable Sasha Debnam of the Forensic Services Group, Wollongong Crime Scene Section. She examined the surface of Mount Ousley Road and found an area of faint red coloured staining consistent in appearance with blood and light coloured scrape marks with fabric piling on the surface of the roadway, near the centre of lane 2. Ms. Debnam told the inquest that the fabric scraps may have come from Mr. Urgic's trousers.

Sergeant Ben Hartley of the Southern Region Crash Investigation Unit provided a statement regarding the damage to Mr. Kemper's Ford Falcon station wagon, which he inspected at Albion Park Police Station on 11 March 2010. Relevantly, he reported that the damage to Mr. Kemper's motor vehicle was confined to the front driver's side panel and the windscreen at the front driver's side bottom corner. This damage is plainly visible in photographs part of EXHIBIT 4. Senior Constable Phillip Hamilton of the Southern Region Crash Investigation Unit told the inquest that, in his opinion, the damage to the Ford falcon indicated that Mr. Urgic was struck by the front right mudguard.

That he was struck on the left leg is demonstrated by the fractures to his tibia and fibula. In Mr. Hamilton's opinion, Mr. Urgic was probably moving at the time, heading back to the centre strip, facing towards the breakdown lane. According to Mr. Hamilton, the force of the initial blow has tossed him into the air, rotating his body so that his left elbow has collided with the lower part of the windscreen on the driver's side and thrown him rightwards into lane 2 where he has been struck by another vehicle or vehicles.

In forming those views, Senior Constable Hamilton has considered that the damage to the windscreen is too small to have been caused by the impact of Dragan Urgic's head and that many of the injuries noted in the ambulance report appear to lack any corresponding damage to the Ford Falcon.

The identity of any motor vehicle or motor vehicles, other than Mr. Kemper's Ford Falcon, coming into collision with Dragan Urgic has never been established.

Formal Finding

That Dragan Urgic born on 14 April, 1970 died shortly after 2320 hours on 27 February, 2010 at Mount Ousley Road, Mount Ousley, NSW of Multiple Injuries sustained when, as a pedestrian, he was accidentally struck by a motor vehicle or motor vehicles travelling south on that road.

9. 778 of 2010

Inquest into the death of Paul Ahsin at Campbelltown on the 2nd April 2010. Finding handed down by Deputy State Coroner Freund.

Paul Ahsin was 40 years of age when he passed away on 2 April 2010 after getting into an altercation with John Payne and subsequently being restrained by security personnel following his eviction from the Campbelltown Club Hotel with his brother Daniel Ahsin. He is survived by his wife, Lisa Ahsin, and their four children, Jessie, Daniel, Vanessa and Trinity.

A coroner's function is to attempt to answer five questions namely: Who died? When did he or she die? Where did he or she die? What was the cause of death? And finally, what was the manner of death? The cause of death is the immediate physical cause. The manner of death refers to a way a person dies, including the surrounding circumstances. A coroner may also make recommendations concerning public health or safety issues arising out of the death in question.

In relation to Mr. Ahsin's death, there is no issue in relation to Mr. Ahsin's identity, date or place of his death. The issues to be determined by this inquest are in relation to firstly how Mr. Ahsin died and the surrounding circumstances in relation to his death. Mr. McGorey, Counsel Assisting, outlined these issues in his opening statement in greater particularly and they included following:

- **Should Mr. Ahsin and his brother Daniel have been permitted entry into the Campbelltown Club Hotel on 2 April 2010;**
- **How intoxicated was Mr. Ahsin at the time he was asked to leave the Campbelltown Club Hotel?**
- **What happened to cause Mr. Ahsin and his brother to be restrained by security personnel at the Campbelltown Club Hotel?**
- **How was Paul Ahsin retrained and what was his condition during the course of his restraint?**
- **Was the restraint used justifiable?**
- **What was the awareness of the security guards who restrained Paul Ahsin about the risks associated with positional asphyxiation? and**
- **Whether the police response was appropriate?**

I will deal with each of these issues in turn.

SHOULD MR. AHSIN AND HIS BROTHER DANIEL HAVE BEEN PERMITTED ENTRY INTO THE CAMPBELLTOWN CLUB HOTEL ON 2 APRIL 2010;

Prior to his arrival at the Campbelltown Club Hotel at about midnight or the early hours of 2 April 2010 with his brother Daniel, it is uncontroversial that Mr. Ahsin had been drinking. The evidence before the inquest in this regard can be summarised as follows:

On Thursday 1 April 2010, Paul Ahsin commenced a shift at his work, being the Coles distribution centre, Smeaton Grange, at about 2 pm[46]. At about 4:30 pm, his brother Daniel picked him up and they both attended a rugby game at the Cabramatta League Grounds that started at about 6 pm. Paul Ahsin's son, Daniel, was playing in this game[47].

After leaving the game, Paul and Daniel Ahsin briefly stopped by and saw Lisa Ahsin at her work. At some point after leaving the game, they also purchased alcohol from Dan Murphy's outlet. Records show that this occurred at around 8:11 pm[48], and this purchase may have comprised of a 24 case of Jim Beam and cola mixes, and a 24 case of beer (Dry Docks)[49].

After purchasing that alcohol, they attended the Club Hotel Leumeah Pub (Pembroke Road, Leumeah):

This is a licensed premises owned by the NLG Group Operations Pty Ltd[50]. No.1 Group Services Pty Ltd had a contract with those premises to provide security guards.

A security guard employed with No.1 Group Services Pty Ltd, Feroti Vetemotu, was working that that venue that evening and knew Paul Ahsin.

Paul and Daniel Ahsin likely had one round of beers at these premises before Feroti Vetemotu suggested to Paul Ahsin that he get some take away beer and go home. According to a statement given by Vetemotu, he did not consider either to be drunk, but his prior experience with Paul Ahsin and his observations of him on this night suggested to him that it was appropriate to ask/suggest to him that he leave at that time[51].

CCTV footage shows the pair entering at 8:33 and departing at about 8:58 pm[52].

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46 Exhibit 2 Vol 2 Tab 48a at paragraph 5;
47 Exhibit 2 Vol 2 Tab 28 page 2 and Exhibit 2 Vol 2 Tab 48a at paragraph 8;
48 Exhibit 5;
49 Exhibit 2 Vol 2 Tab 28 at p.4.
50 See http://www.nlghotelgroup.com.au/articles/Leumeah_Club_Hotel/30
51 Exhibit 2 Vol 1 Tab 21a paragraphs 5 and 15;
52 Exhibit 5;

After departing those premises, they went to Paul Ahsin's home (11 Selby Place, Minto), where they consumed an unknown amount of the takeaway alcohol purchased earlier[53].

At around midnight, Paul Ahsin asked Lisa to drop him and Daniel off at the Club Hotel Campbelltown. They travelled there in her car and she dropped the pair off in the car park near the front entrance. At this time:

Paul Ahsin was wearing a green basket ball singlet (possibly with no.9 on back) with a black T-shirt underneath; dark shorts and white shoes[54]; and

Daniel Ahsin was wearing a white polo shirt, dark long sleeve shirt underneath, black cap and white shoes[55].

The evidence thereafter indicates that Neetia Patiole, a security guard employed by Number 1 Group Services P/L and contracted to work at the Campbelltown Club Hotel on the night of 1 April 2010 initially stopped Paul and Daniel Ahsin from entering, as he thought Paul Ahsin had been barred. However, they were ultimately permitted entry by Amy O'Keefe, the assistant manager of the Campbelltown Club Hotel.

I heard evidence from both John Payne the former licencee of the Campbelltown Club Hotel and who is currently the Area Manager for the NLG Group (that owns the Campbelltown Club Hotel) and Kevin Skerton, the current licencee of the Campbelltown Club Hotel, in relation to what policies and procedures were and are in place at the Campbelltown Club Hotel and the other hotels owned by the NLG group in relation to the barring of patrons. The evidence that became abundantly clear was that at the time of Paul Ahsin's death:

the Campbelltown Club Hotel kept no written list of who was barred and the reasons why (despite previous lists existing);

decisions in relation to the removal of patrons for disorderly behaviour and/or intoxication could be made by the licensee, the manager on duty, or security personnel (decisions about the imposition of a barring were ultimately made by the licensee only);

the information (regarding who had been barred from the hotel) was passed onto managers orally during the course of meetings; the licensee could lift the barring of an individual;

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53 Exhibit 2 Vol 2 Tab 28 page 4-5;

54 Exhibit 3 - photo#3.

55 Exhibit 3 - photo#4.

It is clear from the evidence that Paul Ahsin had been barred, likely on more than one occasion, from the Campbelltown Club Hotel and had been the subject of a barring that was lifted approximately 3 - 4 months prior to his death.

As both the previous licensee of the Campbelltown Club Hotel and now the area manager of the NLG group (who owns the Campbelltown Club Hotel along with 34 other clubs), Mr. Payne was the best person to give evidence as to the former and current practices in relation to keeping patrons and staff safe from violent patrons. However, Mr. Payne's evidence in this regard was vague, often contradictory and difficult to extract.

For example, he gave evidence that Paul Ahsin had approached him about 3-4 months prior to his death and had asked for his barring to be lifted. Despite not being the licensee at the time of this conversation with Paul Ahsin, Mr. Payne ultimately lifted the barring. Before doing so, Mr Payne testified that he had checked with staff at the Campbelltown Club Hotel that Paul Ahsin had not been causing problems over the period of the barring to ensure that it was appropriate to lift it. However, Aimy O'Keefe, who was the manager on duty at the time of Paul Ahsin's death and also at about the time the barring was lifted, testified that she had not been consulted about whether or not the barring should be lifted; she was simply advised that it had been lifted.

Furthermore, there was evidence from Ron Meigan[56], the actual Licensee of the Campbelltown Club Hotel from March 2009 to early 2010, that Paul Ahsin had in fact continually presented himself at the premises, over the course of the period in which he had been barred, seeking re-entry. Mr. Meigan was also not consulted by Mr. Payne about his decision to lift the barring and moreover would not have been in favour of it.

In my view the systems, if they could be said to exist at all were of an ad hoc nature dependent on what knowledge was disseminated about incidents that occurred at various hotels from time to time. The decision to ban or lift a ban was dependent on the various licencees but the reasons for such decisions were not clear or required to be articulated in any way. I note however upon these issues being ventilated during the course of this inquest and my concerns being raised as to the lack of a proper procedure the NLG has implemented and circulated guidelines for the proper management of banning and lifting bans upon patrons. A copy of those guidelines is annexed to these findings.

HOW INTOXICATED WAS MR. AHSIN AT THE TIME HE WAS ASKED TO LEAVE THE CAMPBELLTOWN CLUB HOTEL?

It is uncontroversial that at about 3.25am, Danny Faatagi a security guard employed by the Number 1 Group Services P/L to work at the Campbelltown Club Hotel approached Daniel Ahsin and asked him to leave as he was showing signs of intoxication.

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[56] Oral evidence on 14/10/11 and Exhibit 2 Vol 1 Tab 27c paragraphs 3 and 4;

Paul Ahsin was not asked to leave but was approached by Ms O'Keefe who advised him that his brother was to be ejected and requested that he assist in ensuring that he leave quietly.

This is corroborated by the CCTV footage, which shows Mr. Faatagi exiting the front door, with Daniel Ahsin following; and the evidence of Paul Siulepa, another security guard employed by number 1 Group Services P/L to work at the Campbelltown Club Hotel, who stated in evidence he was standing outside when Mr. Faatagi brought Daniel Ahsin outside due to his intoxication.

It was the evidence of Daniel Ahsin that he was well intoxicated in the early hours of 2 April 2010. His evidence was that he was drinking approximately 15 drinks per hour for a period of 3 hours. His brother though was not drinking at the same rate and was not as intoxicated. I note the evidence outlined earlier in these findings that both brothers had spent most of the late afternoon and evening of 1 April 2010 consuming unknown amounts of alcohol.

Despite his brother being ejected from Campbelltown Club Hotel for intoxication Paul Ahsin was not similarly ejected. There is no indication on the CCTV footage or any other evidence that he displayed any of the usual signs of intoxication whilst at the Campbelltown Club Hotel in the early hours of 2 April 2010. However, I note the evidence of his wife Lisa Ahsin that he held is alcohol well and didn't usually display signs of intoxication[57].

The toxicology report conducted post mortem on Mr. Ahsin revealed a blood alcohol of 0.179g/100mL: over three times the legal driving limit.

Accordingly, at the time Mr. Ahsin left the Campbelltown Club Hotel at about 3.30am on 2 April 2010, despite the fact he showed no outward signs of intoxication, I am satisfied on balance that he was well affected by alcohol.

WHAT HAPPENED TO CAUSE MR. AHSIN AND HIS BROTHER TO BE RESTRAINED BY SECURITY PERSONEL AT THE CAMPBELLTOWN CLUB HOTEL?

There is no dispute as to what occurred upon Daniel Ahsin being asked to leave the Campbelltown Club Hotel. The evidence in this regard can be summarised as follows:

According to the evidence of Mr Siulepa[58] and Mr Patiole[59], Paul Ahsin then tried to calm Daniel Ahsin down and persuade him to leave. Eventually, Paul Ahsin and Daniel Ahsin walked away into the car park area. That is captured on CCTV footage and occurred at about 3:28 am[60];

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57 Exhibit 2 Vol 2 Tab48a at paragraph 10;

58 Exhibit 2 Vol 1 Tab15 at Q378, p.33 – "…Ah, Paul was tyring to explain to him as well, you know, don't worry about it, we'll, we'll, we'll, we'll go, we'll just go, let's go, let's go…"

59 Exhibit 2 Vol 1 Tab19 at [26] – "The guy in the green t-shirt was trying to calm him down saying to him, "Calm down". He was patting him on the shoulder."

60 Exhibit 3 -Photo#8.

At the time they commenced walking into the car park, Mr Payne (who by chance was at the premises that morning) and Bruno Grutzner, the security dog handler were standing towards the entrance into the car park talking. After walking a short distance towards the bottle shop drive-in, Paul Ahsin and Daniel Ahsin changed direction and headed towards Mr Payne[61];

Thereafter, Mr. Ahsin approached Mr. Payne and said words to the effect of "*this was your doing, wasn't it?*"[62]. He then struck Mr Payne once to his face without warning, causing his glasses to fall off his head. That strike is corroborated by a number of witnesses including Mr Grutzner, Mr Foweraker, Mr Patiole and Mr Siulepa.

After Paul Ahsin struck Mr. Payne, Mr. Suilepa and Mr. Patiole came to his assistance. According to the evidence given by Mr Faatagi, as well as his interview with police, he ran outside through the front entrance after seeing the altercation outside and ultimately went to assistance of Mr Suilepa and Mr Patiole. This is corroborated by CCTV footage that shows Mr Faatagi and Malefuia Tui, another security guard working at the premises through No.1 Group Services Pty Ltd, running out through the front entrance towards the carpark.

I heard evidence from a number of witnesses, including Mr Foweraker, Mr. Patiole, Mr. Siulepa and Mr. Faatagi as to what then occurred between the punch and the Ahsin brothers being restrained.

Mr. Siulepa's testified that Daniel Ahsin punched him as he attempted to grab Paul Ahsin. Paul Ahsin then turned around and concentrated his efforts on him.

Mr Foweraker testified that he saw Mr. Faatagi (identified as the guard wearing a black jacket and possibly black cap) holding Paul Ahsin from behind and Mr. Siulepa (identified as the guard wearing a red shirt who subsequently involved in the restraint of Paul Ahsin) delivering a number of uppercuts with a closed fist to Paul Ahsin's head or face area.

Mr.Siulepa conceded during the course of his evidence that "he may have hit him (Paul Ahsin) with a closed fist" and that after the tussle he and Mr. Faatagi both ended up on the ground at which time Paul Ahsin was restrained.

The Post Mortem report indicates that Mr. Paul Ahsin had a laceration to the nose and bruise under the eye that was consistent with being caused by a blunt force trauma, which could include a punch. However, if Mr. Foweraker's version of events were correct I would have expected the injuries to Paul Ahsin's face being greater than what was described in the Post Mortem report.

Accordingly, I am satisfied that punches were exchanged between Mr. Ahsin and Mr. Suilipa wherein they all ultimately ended on the ground with Mr. Suilepa and Mr. Faatagi restraining Paul Ahsin face down. However I am <u>not</u> satisfied on balance that this aspect of the altercation occurred exactly as Mr Foweraker described

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61 Exhibit 2 Vol 1 Tab 21 at paragraph 17;

62 Exhibit 2 Vol 1 Tab22 at Q19, p.3.

HOW WAS PAUL AHSIN RESTRAINED AND WHAT WAS HIS CONDITION DURING THE COURSE OF THE RESTRAINT?

One of the main issues focused on during the course of this inquest was in relation to the manner in which Mr. Paul Ahsin was restrained, the duration of the restraint and his condition over the course of that restraint. This was not an easy factual issue to resolve, as there was considerable variance amongst witnesses about what unfolded. For example different witnesses place Mr. Faatagi and Mr. Siulepa on different sides of Paul Ahsin[63] whilst others appeared to have both guards on the same side at some points[64].

I will start considering the evidence of the guards who actually restrained Paul Ahsin:

The evidence of Mr. Suilepa[65] can be summarised as follows:

He was restraining Paul Ahsin face down together with Mr. Faatagi;

Mr. Faatagi was on "the right hand side" of Paul Ahsin[66] lying on the right-hand side and upper back of Paul Ahsin;

Mr. Siulepa had himself on opposite side to Mr. Faatagi[67] holding Paul Ahsin down by putting pressure down on his arm[68].

Mr. Siulepa ended up having his knee around Paul Ahsin's left elbow[69];

He denies ever having put any pressure on Paul Ahsin's torso[70]:and maintains his knees only ever made contact with Paul Ahsin's arm[71].

Mr. Faatagi provided slightly greater detail. He also placed himself on the right hand side of Paul Ahsin[72], with his left arm on Paul Ahsin's right upper arm area and stated that he had his right knee on Paul Ahsin's upper right arm[73]. He described Mr. Siulepa as having Paul Ahsin's left arm 'kind of like in a chicken wing...just holding it towards his back...."[74], but he couldn't really see if Mr. Siulepa was on Paul Ahsin's back[75].

Both security guards denied placing their knees on Paul Ahsin's back.

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63 Ms. O'Keefe has Mr. Siulepa on Left Hand Side and Mr. Faatagi on right hand side; Mr Payne has Mr. Siulepa on right hand side;
64 Mr Grutzner and Mr Foweraker;
65 Exhibit 2 Vol 1 Tab 16 at pp.34; 58 & 78;
66 Ibid at p78
67 Ibid at p58
68 Ibid at p.34;
69 Ibid at p.58;
70 Ibid at p.81;
71 Ibid at p.83;
72 Exhibit 2 Vol 1 Tab15 at p.19;
73 Ibid;
74 Ibid at p.20;
75 Ibid at p.24;

I note the evidence of Dr Irvine, the forensic pathologist, was that she observed a bruise on the right flank that had a pattern possibly consistent with jean line or seam, though not a definitive identification of pattern. However, she could not advise whether that resulted from sustained pressure (namely pushing down with a knee over a period of time); or from a short instance of pressure (that is, when Paul Ahsin fell to the ground).

The restraint of Paul Ahsin was witnessed by a number of other people. I summarise their evidence:

Mr Payne's evidence contrasts markedly in that he was unsure if there were two guards involved in the restraint and he places Mr. Siulepa on the right hand side of Mr. Ahsin with at least one of Paul Ahsin's arms pulled behind his back with some downward pressure on arm being applied;

Ms O'Keefe's evidence had Mr. Siulepa kneeling on the ground on Paul Ahsin's left hand side holding Paul Ahsin's left arm behind his back. In the diagrams annexed to her statements dated 2 April 2010 and 16 May 2011[76], she indicated that Mr. Faatagi was on the right hand side of Paul Ahsin[77], however she was not clear in this regard when giving her evidence in the course of the inquest;

Mr Grutzner's evidence had Mr. Siulepa sitting on the ground on Paul Ahsin's right hand side holding his arm in a wrist lock behind his back in a chicken wing hold, while Mr. Faatagi was on Paul Ahsin's left hand side holding his arm straight out in an "arm bar" hold.

He also described Mr Faatagi changing position during the restraint to restrain Mr Ahsin's leg area. Mr Grutzner maintained in evidence that he did not see either guard with their knees on top of Paul Ahsin. At best, Mr Faatagi's knees may have been touching Paul Ahsin's side whilst Mr Faatagi knelt on the ground;

Mr Foweraker's evidence had Mr. Faatagi (identified as being the guard wearing the black jacket) on the left hand side of Paul Ahsin pushing him down around the back of the neck and shoulder area, whilst Mr. Siulepa (identified as being the guard wearing the red shirt) had hold of Paul Ahsin's right arm. However, he had Mr Siulepa being positioned very close to Mr. Faatagi, possibly on the same side. Mr. Foweraker also testified that it was possible that Mr Faatagi's right knee might have been in contact with Paul Ahsin's shoulder whilst he was lying face down. However, I observe that Mr Foweraker made no mention of that possibility in either the statement he declared to police[78], or in the re-enactment he gave to police that was visually recorded, on 2 April 2010;

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[76] Exhibit 2 Vol 1 Tab 27 and Tab 27a;
[77] Ibid;
[78] Exhibit 2 Vol 2 Tab 33

Finally, the evidence from the various police officers. Police were called to the premises soon after Paul Ahsin struck Mr Payne. Senior Constable Burraston was the first on scene, followed thereafter by a police van manned by Constable Day, Constable Cumulato and Probationary Constable Woodward. In her recorded interview with police, Senior Constable Burraston described one guard as having Paul Ahsin's right arm pinned behind his back area with palm facing outwards on the small of his back.

That guard also had his left knee on Paul Ahsin's right shoulder. The other guard had Paul Ahsin's left arm outstretched and had his right knee on Paul Ahsin's shoulder blade. The other police were not very precise in what they observed except to say that the guards were low and positioned over Paul Ahsin when they approached.

There is no clear evidence to determine with precision exactly how Mr. Faatagi and Mr. Siulepa were holding Paul Ahsin down on the ground. However I am satisfied on balance that both were involved in his restraint and that Paul Ahsin was restrained in a face down position, which involved pressure being applied to his upper arm/shoulder area and back. The pressure was applied with enough force to ensure that Paul Ahsin was "pinned" to ground such that he could not get up. Notwithstanding the evidence of Senior Constable Burraston, given the totality of evidence, I am not satisfied on balance that the guards were applying pressure to the back of Paul Ahsin by way of their knees.

The second limb to this issue was Paul Ahsin's condition during the course of the restraint. The evidence in this regard can be summarised as follows:

The evidence of both Mr. Fataagi and Mr. Siulepa was very similar in this regard, and essentially described Paul Ahsin as difficult to hold due to him struggling, cursing and rolling back and forth in an apparent attempt to get free. About the time police arrived, Paul Ahsin could be heard "groaning" after which he was quiet;

The evidence of Mr. Payne that he approached Paul Ahsin after he calls police but prior to the arrival of Senior Constable Burraston. His evidence was that he heard "puffing" and moaning or groaning. It was at about this time he saw an islander lady yelling at guards to get off him and he told her to go;

The evidence of Gumma Ammerman, who was the islander lady described by Mr. Payne. She was clearly very intoxicated at the time of the incident, having been ejected from the Campbelltown Club Hotel just prior to this incident unfolding. Despite this her account dovetails very closely with that of Mr. Payne.

She can only recollect one guard being involved in the restraint of Paul Ahsin however she also described Paul Ahsin as "puffing" and, in her assessment he "appeared to be suffocating"[79]. She also remembers being told to leave by a "tall white fella", who was likely Mr. Payne.

The evidence of Ms O'Keefe gives evidence that Paul Ahsin was yelling whilst being restrained, but that he had quietened down a lot and that at one point she heard moaning or groaning just prior to the arrival of the police; and finally, the evidence of Mr Foweraker that he thought he was unconscious as he did not see any movement, although he conceded he could not see Paul Ahsin's face.

Paul Ahsin was still being restrained by one or more guards at the time Constable Cumerlato and Probationary Constable Woodward took hold of Paul Ahsin's arms, whilst he was face down, and applied handcuffs to him. However when they initially arrived at the Campbelltown Club Hotel, Constable Cumerlato and Probationary Constable Woodward first focused on handcuffing and placing Daniel Ahsin into the police van, as he happened to be closest to where the police van had pulled over and also presented as the most vocal of the two at the time. After Daniel Ahsin was handcuffed and placed into the back of the police van, those officers proceeded over to Paul Ahsin to do the same.

By this time all the Police describe Paul Ahsin as making no noise, not moving and being totally unresponsive to stimuli, verbal or otherwise. I also note that they observed Paul Ahsin was also observed lying in a patch of fluid.

After considering all the evidence in relation to this issue I accept on balance that Paul Ahsin was thrashing about when he went to ground and resisting the restraint. However, his condition began to deteriorate prior to arrival of Burraston at 3:36 am, and as his restraint by guards probably lasted another 8 or more minutes beyond her arrival he became unconscious sometime thereafter.

WAS THE RESTRAINT USED JUSTIFIABLE?

As previously indicated I am satisfied on balance that Paul Ahsin was unconscious at the time the police took him into custody and attended to place him in handcuffs.

However, there is no evidence that either Mr. Faatagi or Mr. Siulepa were aware that he was unconscious nor that they in fact realised that his condition was deteriorating.

Both Mr. Siuilepa and Mr. Fataagi in their respective ERISPs spoke of their fears of what would happen if they released their hold on Paul Ahsin. Those fears in my view were corroborated by the actions of the police who clearly did not want to risk removing the handcuffs when they had a doubt with respect to his level of consciousness; notwithstanding his lack of response to their stimuli

[79] Exhibit 2 Vol 2 Tab 48d;

and that he did not hold his own weight when attempts were made to stand him up.

Mr. Ahsin by all accounts was a man of very large build. He weighed 133kg and was 1.76m tall. He was well fuelled with alcohol and had already been violent leading up to his restraint.

This coupled with his history of violent behaviour, which was well known to the security personnel and his initial attempts to resist the restraint in my view made the restraint and his continued restraint justifiable. My view would be different if I was satisfied on balance that both guards realised that Paul Ahsin was in fact unconscious but persisted with their restraint nonetheless however I am not satisfied that either of the guards were aware that his condition had deteriorated.

WHAT WERE THE SECURITY GUARDS LEVEL OF AWARENESS OF THE RISKS OF RESTRAINING PAUL AHSIN IN THE PRONE POSITION?

The evidence showed that Mr Siulepa, Mr Faatagi, Mr Patiole and Mr Tui had received, at one time or another, NSW provisional 1A (unarmed guard) and provisional 1C (crowd control) licences following the completion of training with various registered training organisations in NSW[80].

At the time of Paul Ahsin's death, all four guards also held ACT equivalent 1A/1C licences that had been issued to them following their completion of training with an organisation in the ACT in the early part of 2010. It was uncontroversial that there was an intention on the part of all four guards, when they commenced their training in the ACT, to eventually seek the mutual recognition of their ACT equivalent 1A/1C licenses in NSW. In fact, at the time of Paul Ahsin's death, Mr Siulepa and Mr Patiole had applications pending with the Security Licensing & Enforcement Directorate, NSW Police Force, to receive NSW 1A/1C licence on the basis of their ACT licenses[81].

According to evidence of all the security guards who gave evidence during the course of the inquest, none had ever received any proper training about positional asphyxiation or its' dangers. At the very least, none were able to properly explain what positional asphyxiation was or the risks associated with the restraint of persons on the ground in a prone position; and all effectively maintained that they lacked a proper understanding about the same when the events unfolded on 2 April 2010. The evidence about the training they did receive suggests it was possibly minimal, though it is possible they did get some basic training in positional asphyxiation in the ACT. In my view, neither Mr. Siulepa nor Mr. Fataagi considered Paul Ahsin to be at risk of asphyxiation whilst he was being restrained.

Positional asphyxiation is a complicated issue particularly in light of the circumstances of this case.

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80 Statement of Cameron Smith, Exhibit 2 Vol 3 Tab 88;

81 Ibid.

I heard evidence from a number of police officers in relation to their training with respect to positional asphyxia and accept that when police seek to restrain a person who is violent and is resisting arrest they will take control initially by placing them into the prone position, which is face down on the ground. However, they then rely on their ability to handcuff the person being restrained and placing them into a recovery position to avoid asphyxiation. They are also specifically trained to be vigilant in assessing persons being restrained on the ground.

Like police, security guards often find themselves confronted by violent patrons. In such circumstances, like those in this inquest, they are required to restrain those persons until police arrive. In all likelihood this involves restraint of the person in the prone position on the ground.

However, security guards to do no have handcuffs at their disposal, thereby minimizing the risk of the restraint by then being able to place the offender in the recovery position.

It is important that all persons who receive security guard licenses are always hyper-vigilant about the risks and signs of positional asphyxiation, particularly when they lack the ability to handcuff a person and place them in a recovery position. Mandatory training of security guards, to an appropriate standard, about positional asphyxiation is therefore very important in order to minimise the risks of death or injury from positional asphyxiation occurring. That said it would be unrealistic to expect that theoretical training of itself, about the risks and signs of positional asphyxiation, would entirely eradicate that risk having regard to the reality often involved with restraining an intoxicated and violent person.

What became clear from the evidence was that standard and quality of the training given to security guard applicants, including that about positional asphyxiation, varies considerably from jurisdiction to jurisdiction. However, despite this, security guards can be trained interstate and then seek to be registered in NSW under the *Mutual Recognition Act 1992*. This in my view leaves a system that is open to abuse and can result in people with insufficient training being employed in this state (and others as the case may be) and ultimately putting lives at risk.

Cameron Smith, the Director of the Security Licensing & Enforcement Directorate, NSW Police Force, gave evidence in these proceedings.

His evidence was that this jurisdiction had advocated to other jurisdictions (e.g. in forums such as the Council of Australian Governments) about the importance of standard training and quality requirements being adopted across all jurisdictions as regarded the training and licensing of applicants for security guard licenses. Through the Counsel for the NSW Police Force, it was submitted that the efforts of this jurisdiction to address this issue would be assisted were the Council of Australian Governments to consider implementing a review of the *Mutual Recognition Act 1992* as it applies to the manpower sector of the private security industry.

WAS THE POLICE RESPONSE APPROPRIATE?

The evidence before this inquest in relation to the police response, which I note was not in dispute can be summarised by the following chronology:

Time	Event
3:30am	VKG recordings to 000
3:36am	Senior Constable Burraston arrives at the Campbelltown Club Hotel;
3:40am	Constables Cumerlato, Day and Woodward arrive at the Campbelltown Club Hotel
3:45am approximately	Guards cease restraint of Paul Ahsin and handcuffs applied
3:48am approximately	Burraston calls VKG to request ambulance
3:49am	Constables Cini and Thorn arrive at Campbelltown Club Hotel
3:54am approximately	Senior Constable Burraston makes a VKG request to expedite ambulance. Constables Cini & Thorn also make a similar request;
3:56am approximately	First ambulance arrives. Found to be asystolic with no vital signs.

Mr. Gross QC, counsel for the family made no submissions with respect to the adequacy of the response by police. In my view the police responded in a timely manner to the incident, upon the triple 0 call being made, and dealt with the matter as it unfolded at the Campbelltown Club Hotel in a proper manner given that they had two men being restrained one of which was more vocal at the time of the police arrival.

CONCLUSION

Accordingly I now turn to the findings I am required to make pursuant to section 81 of the *Coroners Act 2009*.

Formal Finding:

That Paul Ahsin died on 2 April 2010 at Campbelltown Hospital, Campbelltown directly from asphyxia caused by his restraint, which had occurred at the Campbelltown Club Hotel earlier that morning. Other significant factors that contributed his death were his acute ethanol intoxication and his morbid obesity.

Formal Recommendations:

To the Council of Australian Governments ("the COAG")

So as to ensure the competence of persons licensed to work in the manpower sector of the private security industry, the COAG give consideration to implementing a review of the *Mutual Recognition Act 1992* as it applies to the manpower sector of the private security industry.

10. 1564 of 2010

Inquest into the death of AA at Parklea on the 30th June 2010. Finding handed down by Deputy State Coroner MacMahon

This has been an inquest touching the death of AA in file number 1564/2010 at the State Coroner's Court at Glebe. The inquest has been conducted at Parramatta Local Court between 26 and 27 March 2012. Mr AA was born on 17 June 1963.

AA resided in 2010 in Frederick Street, Lalor Park. He had been married until 2003. He and his former wife had two children who at this stage, that is in 2012 I am told are eighteen and sixteen and both at school.

Following the break-up of his marriage, AA entered into a relationship with a Ms AM in about 2006. That relationship ended in about August 2009 after which Ms M commenced a relationship with JS. On 30 March 2010 and 12 April 2010 certain events occurred which I don't believe is necessary to detail, those events involved Mr S and an attempt could be categorised or characterised as an attempt to intimidate him. AA was a suspect in respect of those events.

On 13 May 2010, AA came to the notice of police. His vehicle was searched and in his vehicle was located certain items. As a result thereof AA was charged with an offence of possess explosive in a public place. Following his arrest, his house was searched and as a result of that search certain other items were located therein and AA was then charged with two counts of possession of unregistered firearm and one count of possession of a prohibited article.

AA was taken into custody and taken to the MRRC at Silverwater. During the course of his intake assessment undertaken by a registered nurse AA was identified as having "experiencing a moderate level of distress consistent with a diagnosis of moderate depression and/or anxiety disorder". As a result of this assessment, he was referred for assessment by a mental nurse. That assessment occurred on 17 May 2010 and was undertaken by Nurse Skye Freeman, an employee of Justice Health. I don't propose to go into detail in terms of the assessment and the manner under which it was undertaken other than to note that the interview for the assessment took approximately an hour.

During the course of that interview AA denied he'd had any previous contact with Mental Health Services, however, he did acknowledge that he was somewhat depressed and that that circumstance or that condition arose

from the breakdown of that relationship. Nurse Freeman was a somewhat experienced mental health nurse. She had undertaken her bachelor of nursing at the University of Technology at Sydney. She had undertaken mental health as part of that bachelor of nursing. She had on her employment by Justice Health undertaken a new graduates program and during that program had undertaken studies with regard to mental health matters. As important perhaps, Nurse Freeman had been an enrolled nurse at Cumberland Hospital specialist psychiatric hospital near Parramatta for an extensive number of years during which it was part of her function to undertake regular assessments of patients at risk of self harm.

Nurse Freeman, having undertaken the assessment of AA, recommended that he be, firstly, located in a cell with another prisoner and, secondly be reassessed for his cell placement in approximately one month's time. Nurse Freeman did not recommend at the time that AA be assessed by a psychologist or a psychiatrist as she did not consider that it was appropriate having regard to the assessment that she'd undertaken. She did, however, recommend to AA that he see a psychologist on his own referral for the purpose of assisting him to deal with the relationship issues which he had identified as causing him some distress.

AA indicated to Nurse Freeman that he would do so once he had been sentenced. He also indicated to Nurse Freeman that he did not want to see a psychiatrist and did not want to be prescribed medication for his depression. Nurse Freeman having regard to the assessment that she'd undertaken did not identify AA as being a person where there was an active risk of self harm. On 24 May 2010, AA was further assessed by a psychologist, Amanda Cutajar at the MRRC. Ms Cutajar's assessment was that AA was stable and did not appear to be at risk of self harm or suicide.

By 9 June 2010, AA was at Parklea Correctional Centre. On that day, he was spoken to by Psychologist Kathleena Pullan who was undertaking function of AA's case officer. Ms Pullan, following her interaction with AA, did not observe any "acute risk issues".

On 26 June 2010, AA was visited by his former wife, J. The visit went for approximately one hour. His former wife observed AA to be stooped; unable to make eye contact; very quiet and he reported that he had not been sleeping and had been ruminating over past events. He also appeared to have recommenced smoking. J found her visit to AA to be very distressing.

The evidence shows that over the next several days AA was observed by his cellmate to be writing letters. Subsequent to his death, it was identified that those letters were to his former wife, Ms M, his father, brother and sister and to his children. He also wrote a will.

On 30 June 2010 at morning muster AA was found to be hanging in the shower of a section of his cell. He had used material that he had put together to create a noose which was attached to the shower nozzle within the cell. It is important at this stage to identify the relevant legislation that is associated

with this matter, that is the **Coroner's Act 2009**. The general sections relating to inquests that deal with matters where a finding of intentional self harm is made are s 81(1). 82 and 75.

Section 81(1) requires that at the end of an inquest a coroner, if there is sufficient evidence available, is to make findings as to the identity of the deceased person, the date and place of their death and the cause and manner thereof. Section 82 entitles a coroner or gives a coroner discretion to make recommendations as to any matter that arises out of the death the inquest has been the subject of. Such recommendations are discretionary and usually but not necessarily always relate to matters of public interest and deal with the manner in which services are provided by public instrumentalities.

The purpose of the making recommendation is to be forward looking and where there are systemic or structural issues identified that may have contributed to the death of a person those could be amended with a view to ensuring that such deaths do not occur in the future.

It is clear that the purpose of a coronial inquest is not to attribute blame but to identify the factual circumstances surrounding the death and, where possible, to identify issues that might improve situations for others in the future. Section 75 provide that where a finding is made that the death is the result of an action by the deceased with the intention of ending their life, the report of the findings is not to be published unless the coroner makes a specific order that that occur. Such a specific order can only occur if the coroner forms the view that it is in the public interest that a report in fact be made.

In this case, AA was in custody at the time of his death. His liberty had been removed from him. There are other sections of the Act which relate to such circumstances. Firstly, s 27(1)(b) of the Act requires that where a person dies in custody an inquest is mandatory. Section 23 provides that a senior coroner has the exclusive jurisdiction to undertake such an inquest and s 22(1) defines a senior coroner as being either the state coroner or a deputy state coroner. The reason why such inquests are mandatory is it is important that where a person's liberty has been removed from them and they subsequently die there be a full and public examination of the circumstances.

The former State Coroner Magistrate Kevin Waller asked that question and answered it in the following terms:

> "The answer must be that society having effected the arrest and incarceration of a person who has seriously breached the laws has a duty to those persons of ensuring that their punishment is restricted to the loss of liberty and not exacerbated by ill treatment or probation whilst awaiting trial or serving a sentence. The rationale is that by making a full and public inquiry into the deaths of such persons in prisons and police cells, the government provides a positive incentive to custodians to treat their prisoners in a humane fashion and satisfy the community that the deaths in such places are properly investigated".

In this case, it is not in contention that - and the evidence satisfied me to the standard required that the deceased was in fact AA. That identification was undertaken by his former wife, J. The place of his death is not in contention. I am satisfied that AA died at the Parklea Correctional Centre, Parklea in the State of New South Wales and the cause of his death was recommended by the forensic pathologist, Dr Isabella Brouwer, as being asphyxia due to hanging and the manner of AA's death is not in contention that the hanging occurred as a result of action taken by him with the intention of ending his life.

There is no evidence to suggest that there was any third party involvement in his death. The letters which I have already outlined that were found following his death and which were observed being written by his cell mate in the days prior to his death are clearly indicative of an intention on his part to end his life. As to the date of AA's death, it is clear that the events that resulted in his death occurred late in the night of 29 June 2010 or early in the morning of 30 June 2010. For the purpose of the formal finding, I propose to record the date of his death as being "On or about 30 June 2010".

The real issue examined in this inquest was the question of whether or not AA was given proper care whilst his liberty was deprived from him. I am satisfied that on the evidence available to me there is nothing to suggest that that care was not appropriate. I am satisfied that the assessment by Ms Freeman, Ms Cataja and Ms Pullan did not identify him as being at risk of self harm at the time that they undertook their assessments and observations. There is nothing in the evidence before me to suggest that those assessments and observations were not undertaken in a professional and competent fashion. Added to that, Barry Day and Craig Carpenter are cell mates did not identify him as being at risk. Barry Day gave specific evidence that had he had any concerns he would have, firstly, tried to convince AA against such action and if he was unable to convince him he would have reported it. I have no doubt that Mr Day would indeed have made such a report.

Mrs H although she was distressed by her visit on 26 June did not identify such a risk either. She could not, of course, have been expected to have done so. The interview or her visit would have no doubt been of considerable embarrassment to AA being found in the circumstances he was in prison facing a sentence of a custodial sentence and there are many good reasons why he would have been quiet and not wanting to make eye contact with his former wife at the time.

Indeed, there is no evidence available to me to suggest that at that time AA had indeed come to a decision that he obviously eventually did that he would take action to end his life. He may well not at that time have in fact been suicidal.

I am satisfied that on the evidence available to me, AA did not exhibit or display any signs or symptoms that ought to have raised concerns to those in authority that he was acutely at risk of self harm in such a fashion which would have required those in authority to take action for his protection.

I am satisfied that in fact his death by suicide was indeed unexpected. Section 82, as I have already indicated, I have a discretion to make recommendations. The evidence available to me is that it is not common practice when a person is brought into custody for the police statement of facts associated with the charges which result in them being in custody to accompany them when they enter corrective services' control. Both Nurse Freeman and Dr Martin indicated in their evidence that the information that is in the police statement of acts might have been of assistance to them in undertaking a mental health assessment.

As has been pointed out, individuals may not be deliberately lying when responding to questions of a mental health assessor but their perception may not necessarily be accurate. The information as to the circumstances of a charge, that is what the police assert to be the case may also not be accurate, however, the information may when undertaking a mental health assessment highlight or identify issues which a self reporting process may not identify. That is why Nurse Freeman and Dr Martin each thought having such material available to them during the course of the assessment might be of assistance. It may well not have been in any particular case but if it is not there the case in which it would be of assistance it won't be available.

It does not appear on the evidence available to me that there is any practical reason why a copy of such facts should not accompany the prisoner on their admission into corrective services' custody.

In this case the issues arises out of the death of AA although, of course, I cannot say one way or the other as to whether or not it might have made a difference as to his wellbeing. Who is to know whether or not Nurse Freeman had she had the factual circumstances which were, of course, very unusual she may have referred AA to a psychiatrist or a psychologist and who is to know what might have occurred as a result of that.

Dr Martin did not think having examined the file did not think it would have made a difference but that is an ex post facto assessment of circumstances. Who is to know, as I have said, whether or not it might have made a difference, however, for the occasions when it could be of benefit, it seems to me appropriate to make a recommendation in accordance with s 82 of the Act that such information in fact be made available for consideration as part of the assessment process on admission to corrective services' custody. It is trite to say that having some information is better than having no information. In some cases it may make a significant difference.

Other matters which were identified as a result of AA's death is the existence of hanging points within corrective services and within the prison environment. The existence of hanging points in prison environment has been the subject of numerous recommendations by coroners over many years. I have evidence available to me in this matter as to the efforts being undertaken to as part of a continuing program to remove hanging points. I do not consider that it is necessary in those circumstances to make a recommendation relating to the existence of hanging points.

I note that there has been changes at Parklea relating to the process of undertaking musters. I note those changes . I do not consider that the muster process that occurred at the time was a contributing factor to AA's death.

Section 75(5) of the Act provides that where a finding is made that a person died as a result of self inflicted injuries a report of the finding is not to be published unless an order is made by the coroner that that be allowed to occur.

Section 75(6) of the Act provides that a coroner can only make such an order if he or she considers it in the public interest for a report to occur. In this situation there are two competing public interests. The first is the privacy of the family suffering the grief that they experience on the death of a loved one. The second aspect of that public interest is in this case that as I have already mentioned AA had two children who are I am told both of school age at the present time. He had a rather unique surname and publication of this matter might easily identify him and his children.

The second public interest is, of course, that which former State Coroner Waller identified which I quoted previously. It is important where a person dies in custody that there be full and public examination of their death to determine whether or not there has been any failure on the part of the public instrumentalities which have contributed to the death. In this case, I consider that it is important that a report of the proceedings should be made. It is in the public interest that the public know where deaths occur there is no finding of contribution on the part of the organisation, however, it is important to protect the privacy of AA's family.

Formal Finding:

AA (born 17 June 1961) died on or about 30 June 2010 at the Parklea Correctional Centre, Parklea in the State of New South Wales. The cause of his death was asphyxia due to hanging that occurred as a consequence of actions taken by him with the intention of ending his life.

Formal Recommendation:

To: The Commissioner of Police and the Commissioner of Corrective Services:

That a protocol be developed to ensure that when a prisoner is taken into custody by Corrective Services a copy of the Police Statement of Facts associated with the relevant police charges is provided to Corrective Services so that the information provided therein might be considered when the prisoners risk of self harm or suicide is assessed.

11. 1576 of 2010

Inquest into the death of Ian Klum at Brisbane Inquest suspended by Deputy State Coroner MacPherson.

After considering the evidence presented at inquest, the Deputy State Coroner suspended the inquest and referred the papers to the Director of Public Prosecutions.

In accordance with a Directive from the State Coroner all suspended matters are placed in a call over at Glebe until a decision has been made by the DPP or the courts have completed the proceedings of any charges.

12. 1809 of 2010

Inquest into the death of AA at Parklea on the 23rd July 2009. Finding handed down by Deputy State Coroner Mitchell.

This is an inquest into the death of AA. It is a sad business because there is no one here for Mr AA. He had as far as I know, no family in Australia. I understand that his mother who lived in Hungary came to Australia after his death to see his burial place and I think I should ask the advocate to perhaps get a copy of these proceedings when they are available and send it to his mother.

Mr AA was born on 19 September 1967 in Hungary and died here in Australia some time between 11.15am and 12.45pm on 23 July 2010. He died at Parklea Correctional Centre at Stanhope Gardens in New South Wales and he was a prisoner therefore this is a mandatory inquest.

There has not been seen to be anything suspicious with regard to Mr AA's death and I say this for the benefit of his mother in case she does see have notice of these findings. The policy of the law in New South Wales is that where somebody dies in custody in circumstances where they don't have the ordinary opportunities that citizens who aren't imprisoned have to look after their own interests the law requires that a judge, a judicial officer, investigate the matter to ensure that nothing untoward happened and that everybody, in particular prison authorities performed their tasks properly and I can say that in my opinion that certainly happened in this case.

The autopsy report, which is before me, part of exhibit one that is prepared by Professor Duflou of the Department of Forensic Medicine here at Glebe is that the cause of Mr AA's death was hanging.

In this inquest, I am assisted by police advocate Sergeant Arnold; Mr Walters appears for the Department of Corrective Services; Ms Rudland appears for GEO Group Australia which has the management of Parklea Correctional Centre and Mr Singh appears for Justice Health.

There were two officers in charge, firstly, Senior Constable Petersen and since her injury, Senior Constable Whale and Mr Whale gave evidence before me today and it is he who prepared the coronial brief. Although Mr AA had no family in Australia I understand that he had - perhaps still has, a de facto partner by the name of XX and I note that she is not here today but I know very little about her and it may be that there are very good reasons why she is not here.

Mr AA was arrested on 31 May 2010. He was charged with a number of serious drug importation matters. He was bail refused and he arrived at Parklea having spent some time at the Metropolitan Remand Centre. He arrived at Parklea on 18 June 2010.

The P79A police report to the coroner together with an identification certificate, a life extinct certificate and the autopsy report are jointly exhibit 1.

The coronial brief is exhibit 2. I have as exhibit 3 a folder of documents relating to the internal departmental investigation into Mr AA's death, which was conducted by and on behalf of the Department of Corrective Services. I read those documents in chambers earlier this morning and it seems to me that the investigation, which was carried out in this matter, was a thorough and complete one and I compliment the Corrective Services officers in that regard. That folder of documents relating to the internal departmental investigation is exhibit 3.

Exhibit 4 is a bundle of documents, protocols and the like of Parklea Correctional Centre and exhibit 5 is a very helpful document which has been prepared in the Department of Corrective Services relating to an audit of obvious hanging points in correctional centres and in police and court cells in New South Wales. The existence of hanging points in places of detention has long been a source of anxiety to my brothers here in the coronial jurisdiction and I think to officers in the Corrective Services Department.

A lot of the facilities which are being used by the department are old and there are a great many of them and the elimination of hanging points is a long and I think perhaps never ending task. It is important as I think a number of coroners have pointed out and as I think the departmental officers understand that efforts continue to be made to eliminate those hanging points. I don't expect that we will, any of us, live to see their total elimination but every little helps.

I should say in relation to Mr AA's death that his method of hanging himself was very sophisticated and elaborate and I think would have defied a great deal of thought and expense in terms of trying to eliminate the hanging point that he used but I am grateful to the department for having given me this information as to the audit that it is presently conducting in perhaps a never ending attempt to eliminate any point.

Mr AA was a pretty satisfactory prisoner as far as I can make out. He was given a job as a sweeper and I gather that is a job that is given to prisoners who show a sense of responsibility and who are properly manageable and responsive to the efforts of the prison's authority to assist them and in general he was a man who seems to have been in good spirits.

Towards the end of his life, he was, I think, worried by a number of matters. Mr Whale's view is that he was worried by, firstly, the arrest of his girlfriend. Secondly, the terms of her bail conditions which inhibited her visits to him in gaol and, thirdly, perhaps by some dealings he had had with the Crime Commission and his understanding that the Crime Commission was threatening the confiscation of his assets. Now, I don't know the rights and wrongs of that.

The Crime Commission is, I think it is fair to say, generally uncommunicative with most other institutions in the State perhaps other than the Daily Telegraph and what it did or said to Mr AA and what it might have intended to do to his assets or with his assets; what authority it might have acted under and what cause it might have had to take any particular steps are unknown to me and in the real world there is no real prospect of me finding out what was in their minds. I am not able therefore to comment other than to say that for some reason and perhaps that is one of them, Mr AA appeared troubled and his normal good spirits seem to have been disturbed.

At 11.15 on the morning of 23 July 2010, he attended the muster. Apparently, there was nothing wrong. There was no reason to think that he was a risk to himself or that he was at all a suicide risk. By 12.45 he hanged himself. I don't know the reasons for it. He left a suicide note and I have seen a copy of that but it doesn't go into any detail. It certainly doesn't enable me to look into his mind and work out what it was that drove him to this sad ending but it is quite clear from the medical evidence and from the surrounding circumstances that Mr AA managed to find the time and the wherewithal to hang himself and that is what he did.

As far as I can see from the material that's been provided to me, the response of those who had responsibility for caring for Mr AA was prompt and efficient. They did everything that should have been done and that could have been done but, of course, there was nothing that could be done to save his life.

FORMAL FINDING:

I WOULD MAKE THEREFORE ARE THAT OF AA WHO WAS BORN ON 19 SEPTEMBER 1967 DIED AT PARKLEA CORRECTIONAL CENTRE AT STANHOPE GARDENS IN NEW SOUTH WALES SOMETIME BETWEEN 11.15AM AND 12.45PM ON 23 JULY 2010, HAVING HANGED HIMSELF.

13. 1889 of 2010

Inquest into the death of Kathleen Worrall at Berkshire Park on the 31st July 2010. Finding handed down by Deputy State Coroner Mitchell.

This is a mandatory inquest and because Kathleen Worrall, the subject of the inquest, died in custody. Now there are a number of reasons for an inquest and there are a number of reasons why an inquest like this is mandatory.

One of the reasons for an inquest is that a member of our community, a fellow Australian, a young woman, has died. She died at the age of 22, that is too young to die, and the community as whole needs to mark her passing, needs to look at what happened and make sure as far as we can make sure, that nothing untoward happened and that nothing, no huge unfairness or injustice was done. And it is mandatory in this case because Kathleen died in custody where many of her rights and her abilities to protect herself were stripped away from her by society. And so society takes on the responsibility of caring for people in that situation and making sure that they are safe and properly looked after. And the mandatory inquest is part of the machinery of the State to make sure that people in custody have been looked after properly. That is the reason it is a mandatory inquest.

In this particular inquest Ms Williamson, police advocate, appears to assist the inquest. Mr Walters appears for the Department of Corrective Services and Mr Singh appears for Justice Health. And Mr and Mrs Worrall, Kathleen's' parents, are present. I know that this must be one of the terrible days of their lives because to attend your daughter's inquest is just a dreadful thing to happen to you, and it is a mark of their love for and respect for their daughter that they are here today and I am extremely grateful to them. It goes without saying but I am really grateful that Mr Walters said it, that they have the respect and sympathy of everyone involved in the coronial process and I am sure everybody in the court. Mr and Mrs Worrall have been through the most horrendous things and it is a tribute to their love of their daughter that they are here today, faithful to her memory.

Kathleen was born on 27 November 1987 and she died on 31 July or 1 August 2010. It is not clear. She was seen and spoken to at about a little bit before 9.30 I think on 31 July, in the evening 31 July and then found on the morning of 1 August so it is some time in that period. She died at Dillwynia Correctional Centre at Berkshire Park in New South Wales.

In relation to the Dillwynia Correctional facility I must say that some of the evidence in this inquest has indicated that she was well cared for and looked after at Dillwynia She had been in Silverwater until she was sentenced and Silverwater is a big tough place and I imagine for a 22 year old it is a frightening place. It is not a disservice to Correctional Services to say that, it is just a reality. It is a big prison.

And after her sentencing, sadly only twelve or so days before her death, she was moved to Dillwynia, which I think she found as a totally different situation.

I think it was her father who said she had an opportunity there to walk amongst the gum trees. She had an opportunity to live a relatively normal life there in a house with 11 other young women. Even when they were locked down they had access to each other and they had access to a kitchen and a common room and they could live a life and make friendships in a way that I think probably was not open to her at Silverwater. Her father describes her on the last day he saw her and, as he understand it, on previous times since she had been at Dillwynia, as euphoric, happy and a going concern. A young lady who was in a position where she could make some plans for her future and recover some the ground she had lost.

Further to that, I have read the reports from, I think it is called the case notes, but anyway it is the notes taken by people who have a pastoral care of Kathleen in Dillwynia and they seem to me to be perceptive and caring and to illustrate that they, the officers in the Correctional Centre, had a deal of respect and liking for Kathleen and felt that they would be able to work with her constructively and usefully towards firstly enabling her to have a decent life at Dillwynia and no doubt planning for her ultimate release because she was due for release in 2013. It follows from that that I found a great deal that was praiseworthy in the way in which Dillwynia operated as far as Kathleen was concerned.

As against that, there is the allegation that there may have been a sexual advance made and that there may have been an assault as a result of Kathleen resisting that. The first thing I should say about it is that it may or may not have been true. I do not know whether it was or it was not.

I think what has happened in the inquiries that have been made of Corrective Services officers and in the information that has been obtained from some of the inmates and in particular from the special friend that Kathleen made in Dillwynia, are an indication that it did not happen. But none of those investigations is absolutely infallible. It is something we will never know. If it did not happen, if Kathleen made it up, then that is an indication of the trouble and the distress which she was experiencing. And I would not be surprised if there was a degree of distress in Kathleen at that time. It had been a traumatic time for her.

If it did happen then all I can say is that police have tried and failed to clarify the matter. But something of comfort which the parents can hold is this, even if it did happen, Kathleen seemed to be happy, outgoing, loved and keen to get on with her life and as her father said, euphoric. And that is something that the parents I think can cling to and can bear in mind, whatever may have been the truth of the other issue.

Kathleen had a serious medical condition; a chronic medical condition and I think it probably presented really cruel choices because she was required to have medication and pretty severe and difficult medication at that. And the choices were to have the medication and be faced with very significant weight gain, which she obviously trying to control but it is not easy to control it. On the other hand, the other choice was not having the medication and descends to occasional mania and obviously she could not have that. So she had to do the best she could and it might be an indication of her spirit that she was having the medication and fighting the weight gain.

I do not know if it is a very good idea for a young lady to survive on a tin of tuna but what it does indicate is that Kathleen was doing her best and I think that is very important.

We will never really understand all of the sometimes-conflicting feelings that Kathleen experienced but I think it is very important for us all, and for her parents in particular, to cling to the demonstrably good things that she sought to do in her life.

The medical evidence is clear in relation to cause of death and I think probably - well I think almost certainly her medical condition, her lifelong medical condition and the medication she was required to use, contributed significantly to her death because as Dr Ord has said, the direct cause of death was firstly pulmonary thromboembolism but the antecedent cause giving rise to the cause of death was the obesity to which the medication obviously contributed. She died really too young but we know that she died in circumstances where she could see some cause for optimism at the end of, life at the end of the tunnel so to speak.

FORMAL FINIDNGS:

THAT KATHLEEN WORRALL BORN ON 27 NOVEMBER 1987 DIED ON 31 JULY OR 1 AUGUST 2010 AT DILLWYNIA CORRECTIONAL CENTRE, BERKSHIRE PARK, OF PULMONARY THROMBOEMBOLISM, OBESITY BEING AN ANTECEDENT CAUSE.

14. 2076 of 2010

Inquest into the death Alan Rennex at Malabar on the 21st August 2010. Finding handed down by Deputy State Coroner Mitchell.

Based on the available evidence I am of the opinion that the deceased died as a result of complications derived from advanced stages of cancer. I am of the opinion that the deceased received adequate treatment whilst in custody and believe that whether or not the deceased was in custody or free he would have succumbed to the same fate. This is supported by the copious amounts of reports outlining the deceased's condition, treatment and prognosis. Unfortunately due to the unco-operative stance adopted by Dr Veronica Stewart and Nurse Katherine Dooner these opinions are unable to be further substantiated and I believe efforts should be made that compel staff of the medical profession to provide any person investigating a matter on behalf of the Coroner with statements in circumstances such as this that require police to investigate and prepare a mandatory full brief of evidence in relation to the death of an inmate HER HONOUR: I will just turn to my formal duties pursuant to s 81 of the act.

FORMAL FINDING:

I FIND THAT ALAN GEORGE RENNEX DIED ON 21 AUGUST 2010 AT LONG BAY GAOL HOSPITAL AGE AND REHABILITATION UNIT, WARD 8, CELL 8 AND THAT HIS CAUSE OF DEATH IS A DIRECT RESULT OF A METASTATIC COLORECTAL ENDOCARCINOMA.

15. 2209 of 2010

Inquest into the death of Peter Jones at Randwick on the 6th September 2010. Finding handed down by Magistrate Forbes.

86 year old man who died of lung cancer, the cause of death is natural causes there are no issues following the investigation that require attention and there are no suspicious circumstances. It is a mandatory inquest due to the fact that this man died in custody albeit of natural causes. I am satisfied of all the statutory requirements required of me under the act

FORMAL FINDING

THAT THE DIRECT CAUSE OF HIS DEATH WAS A DISSEMINATED PULMONARY ADENOCARCINOMA WITH INDIRECT CONTRIBUTING FACTORS OF ISCHAEMIC AND VALVULAR HEART DISEASE.

16. 2222 of 2010

Inquest into the death of William Crews at Bankstown on the 9th September 2010. Inquest suspended by State Coroner Jerram.

The inquest into the death of William Crews was suspended following advice that a person has been charged with an indictable offence in connection with this death. In accordance with State Coroner instructions all suspended matters are placed in a call over to be reviewed upon completion of criminal proceedings.

17. 2325 of 2010 AA
18. 2804 of 2010 BB
21. 2980 of 2010 CC

Inquest into the deaths of AA, BB, CC at Villawood on the 20th September 2010, the 16th November 2010 and the 8th December 2010

This Inquest took place over more than three weeks. It concerns three male Immigration detainees who died at Villawood Immigration Detention Centre in a three-month period on late 2010. Parties represented were the Department of Immigration and Citizenship (hereafter called DIAC), Serco Australia Pty Ltd, International Health and Medical Services Pty Ltd (hereafter called IHMS), nurses, an individual officer from Serco and the families of each three men who died at Villawood.

A large number of witnesses gave evidence both in person and by audiovisual link, including personnel involved with the three men, senior staff of both DIAC and Serco, health staff from IHMS and expert psychiatrists. Ms Sharp of counsel and instructing solicitors from the Crown Solicitor's Office assisted me. Volumes of material were tendered in a large and painstaking brief assembled by the hard work and skill of the police officers in charge. These deaths occurred within three months of each other in 2010 and each was, on the evidence, clearly self-inflicted. AA jumped to his death from a balcony rail and BB and CC each hanged himself in a shower area of one of the Centre's bathrooms.

THE ISSUES

Given the close proximity and time of each suicide were there systemic issues, which may have contributed to the deaths? Was the treatment of the three deceased by DIAC, IHMS and Serco staff appropriate and humane? Could their deaths have been prevented or any risk of suicide has been detected? Have any necessary changes been made to protocols and procedure at Villawood following these tragedies.

THE FACTS

The **Migration Act** 1958 (Cth) empowers the Minister for Immigration and Citizenship to detain unlawful non-citizens and the create detention centres. DIAC outsourced its management of all Australian detention centres to the company Serco in December 2009. In January 2009 it outsourced the provision of health services in detention centres to IHMS. DIAC retains a non-delegable duty of care to all immigration detainees, which is essentially a duty to ensure that reasonable care is taken for persons over whom DIAC exercises control and authority. The numbers of detainees held at Villawood increased strongly in 2010 with an influx coming from Christmas Island. In September 2010 there were approximately 370 detainees at Villawood.

Mr AA was a Fijian citizen who had been in Australia since November 2008 initially on a tourist visa and subsequently on short term bridging visas while he applied for a protection visa on the grounds that he feared persecution if he was returned to Fiji for his political beliefs. That protection visa was refused in July 2010 and he was apprehended by DIAC on 17 August as an unlawful non-citizen and detained at Villawood. Staff from all three authorities interviewed him shortly after his detention and assessed him as cooperative and at low risk of self-harm.

He stated that he wanted to return to Fiji but only when its forthcoming elections were over. He made an application for a further bridging visa to that end but was refused it on 27 August 2010. Mr AA again requested a ministerial intervention to grant him a protection visa only until after the election was over. And on 30 August he applied to the Migration Review Tribunal for a review of the refusal. Throughout early September DIAC commenced arrangements for Mr AA's removal under escort while various applications by AA were refused.

ES, his DIAC case officer, advised the other authorities on September 16 that he was to be told the following day of his imminent removal to Fiji. SM, the IHMS mental health team leader, advised that no immediate risk issues are identified. On Friday, September 17, JI a DIAC removals officer, informed him that he was to be removed the following Monday, September 20, and that his latest request for a ministerial intervention had failed.

She advised his supervisors and IHMS that he was shocked and fearful and would be lodging another application for protection. He did so that afternoon setting out his fears and their confirmation by another Fijian. He stated to his nephew XX, also a Villawood inmate, that if unsuccessful he "would try to get media attention and find somewhere to jump from". He sent two further faxes to the Minister on Sunday, September 19 in which he stated that if he was returned it would be his "dead body".

From 8am on Monday, September 20 several Serco staff and DT, a DIAC removals officer, spoke with AA who was on the balcony of the first floor outside his doorway in the Gwydir building expressing his fears of returning to Fiji and threatening to jump. Serco escort and removal officers MG and CC arrived then advised their supervisor SA of the situation. She joined them on the ground below the balcony. Various emails and phone calls took place between Serco and DIAC staff.

EM, Serco duty manager, was advised that AA was refusing to move until he received a reply from the Minister to his last request. She went to the scene and asked him to come down and he refused, threatening to jump if approached. She phoned her senior manager, JP, and sought permission to use force. P said he was happy for her to continue with the removal but says he was not told that AA was standing up on a railing and did not realise there was any serious risk that AA could harm himself. Prior then phoned KR, the DIAC regional manager, seeking permission to use force to effect the removal. After VR phoned EL, a DIAC officer in the case management team, she spoke with P and authorised the use of force if necessary.

Prior confirmed to M that authorisation to use force had been given. She in turn passed that on to the Serco removal officers and directed the use of video and the

placing of mattresses on the ground below where AA was stepping up and down on the balcony railing. Serco officers and M all returned to the chaotic scene with people shouting at AA, who was becoming increasingly upset, stepping up onto the balcony railing and then off again and constantly threatening to jump.

Ms AL told him several times that he would be, "Coming down one way or another and going to the airport." DT arrived at the scene at 9.25am and went up to the landing to discuss with AA the fact that the Minister had received the letter and was looking at it at that moment. After speaking with AA for five minutes DT was told to leave by a Serco officer. Soon after his departure AL directed the escort team to approach AA. As they commenced up the stairs AA climbed onto the railing and dived head first onto the concrete further out from the mattresses. He was pronounced deceased at 9.47am.

I have watched a DVD of the incident from the time that Ms M and her team returned to AA. I also head the expert opinion of psychiatrist, Dr Michael Diamond, a specialist in negotiations, who reviewed the entire incident, watched the DVD and read transcripts and statements made in this Inquest. He was highly critical of the management of the entire situation. In his view, AA was clearly a high risk and the response to his situation lacked coordination and orderliness. It was not clear who was in charge.

Serco should have obtained background information on AA. Negotiation in any real sense was non-existent. The sense of urgency should have been de-escalated and the deferment of the removal considered. It was entirely open to DIAC and to Serco to abort the removal and the direction for the use of force was made precipitously and without negotiation. The placing of mattresses would have increased the feelings of threat for AA. Although DT himself had conducted himself kindly so as to calm AA, he had not been briefed by DIAC, did not know who was in charge and was told to leave by Serco staff just as his presence was beginning to de-escalate the crisis.

Overall Dr Diamond criticised the lack of coordination between Serco and DIAC officials as a standout and that was his word and deplored the absence of basic awareness training and capability to handle a situation of this nature. He was of the view that:

> "The people dealing with him that morning ignored certain opportunities to begin to engage in a negotiation process because they were ignorant of them."

The evidence of Chief Inspector Peter Able, the most senior negotiator in the New South Wales Police Force, echoed his opinion. He too considered that the situation should have been seen as high risk, that there was no evidence of any clear command structure and nor was there any single negotiator.

I move to the death of BB, an Iraqi who was forty-one years old at the time of his death and who had been in detention for nearly a year. He arrived by boat at Christmas Island on December 10, 2009 and spent the next four months in detention there. He reported a number of health complaints but was assessed by Serco staff as not being at any risk of suicide or mental illness.

He made an application for a protection visa on the grounds of religious persecution and claimed to have been imprisoned, beaten and tortured in Iraq. He made a request for refugee status but in late March this refused on the grounds of his not being a genuine refugee. In early April he was transferred to Villawood, having been assessed again prior to his transfer, as being at low risk of suicide or self-harm.

Upon his arrival at Villawood, Serco completed a suicide and self harm risk assessment (known as SASH) and he ticked yes to questions as to whether he had felt that life was not worth living and whether anything had recently happened to him or his family to cause distress or worry but he also ticked no to a question whether he had ever considered or tried to hurt himself. The result was not considered high enough to warrant a SASH placement.

However, on the same day he requested to see the mental health nurse. IHMS records show that on 7 April he was prescribed Avanza at fifteen milligrams, an anti-depressant which assists also in insomnia. The records do not reveal the reason for the prescription or how many tablets were prescribed. Mr BB saw a mental health nurse again on 8 April and spoke of stress and anxiety about his visa.

Three days later he apparently received news that a bomb in Iraq had killed his sister and two of her children. It appears that neither DIAC, Serco nor IHMS staff were ever aware of this. He went on a hunger strike and was briefly hospitalised. A week later, Serco, in a full client placement assessment, found that there was no evidence of a risk of self harm or suicide.

For the next seven months BB continued to attend IHMS regularly for both physical and emotional conditions. A considerable number of IHMS CIRON records note his increasing worry, depression and insomnia until, in early August, he was referred to a psychiatrist, whom he eventually saw on August 30th.

The psychiatrist, Dr V may not have fully read the referral notes from the IHMS nurse. She seems not to have been aware that BB had been previously prescribed Avanza but felt it was not helping. She diagnosed his problems as adjustment disorder with anxiety/depression and prescribed him at Avanza at 30 milligrams.

She arranged to see him again a fortnight later, on 13 September, at which time she made very brief notes - and there is a typographical there. It says 13 September 2011, which should read 2010 - at which time she made very brief notes that he felt good that day and was complying with medication. BB told a Serco officer the following day that he was not taking medication.

In early October he was notified that he would be removed from Australia. He told his lawyer, who notified the DIAC case manager, that fellow detainees had made threats against his family in Iraq. The DIAC case manager did not do anything in respect to this information and in evidence said he could not remember having been provided with that information.

The case manager notified Serco and IHMS of the pending removal but did not request IHMS to provide any support to BB. BB himself had some counselling with the mental health nurse at his own request. Both an IHMS general practitioner and a psychologist, as well as his new case manager made notes around this time about BB's distressed, despondent state, his non-compliance with medication and his request to be relocated from Villawood before his return to Iraq.

BB was hospitalised again in late October with chest pains. He continued to request a transfer to Melbourne. He was requested by a Serco officer to put his request in writing, which he did on October 29th, stating, "My health is not very good. I want to be transferred to Melbourne, where I have friends and relatives to look after me. Because of my mental health and heart problems, I need their support. I don't have anyone here. No one visits me here." No action was ever taken on that request.

On 1 November he was assessed again by Dr V, who found he was a low risk. BB informed her that he felt good and told her he no longer needed the anti-depressants. BB's report that day was inconsistent with the more negative reports he had made to other IHMS staff over the preceding fortnight. The same day he was hospitalised again with chest pains and continued to ask for removal.

IHMS notes made on this date do not refer to his numerous mental health visits and record that he is on Avanza, though Dr V had noted that he had stopped taking the medication. Although at this period DIAC staff seem to have made real efforts to expedite his current wish to return to Iraq quickly because he felt his health was declining and he wanted to see his family, difficulties arose about his travel papers. BB then withdrew the request to return, advising that he feared he would be arrested by Iraqi intelligence.

This man had asked for mental health assistance from his first day at Villawood. It is clear that both his mental and physical health deteriorated gradually over the period of his detention and that though DIAC and IHMS staff recorded that, very little was done to assist him. The SASH protocol, which set out a procedure for ensuring that a detainee's risk of self harm or suicide was carefully evaluated and monitored, was not followed.

On November 15 he failed to keep an appointment with Dr V. That evening he was seen to take a phone call, which left him upset and distressed. Shortly after midnight he was found hanging from a pipe in a bathroom.

Associate Professor Suresh Sundram, a consultant psychiatrist with wide experience of asylum seekers and refugees, was critical of the treatment of BB in evidence he gave from Melbourne by audio visual link and in his written expert report. He asserted that there was a demonstrated absence of recommended and mandated screening for mental health issues in immigration detainees as required by DIAC. He deplored the ineffective record keeping of IHMS and the failure to disseminate important information between all three authorities.

Importance was placed by him on the inaction or lack of outreach of IHMA to follow up on BB, particularly after he missed two appointments in the week before his death.

He disagreed with Dr V's diagnosis of BB and with the medication prescribed. He called the treatment of BB limited and without any consideration of altering or augmenting it when it appeared ineffective. It was his strong view that BB should have been diagnosed as having a major depressive, rather than an adjustment disorder and that Avanza should have been discontinued when its ineffectiveness was evident.

Finally I deal with the death of CC, who was a citizen of the United Kingdom. At the time of his death he was aged twenty-nine. He had been detained at Villawood for twenty-five days. He had flown to Australian in May 2010 on a tourist visa. He was, at the time, under investigation but not charged by United Kingdom police after allegations that he possessed and distributed child and adult pornography and that he had committed a sexual assault on a child.

I am told that he was on bail, which he breached by leaving the United Kingdom, despite the fact he had not been charged. His extended tourist visa was to expire on November 10, 2010. The Australian Federal Police were advised by English police of the allegations and his apparently breach of bail and on November 11, the day after his tourist visa expired, CC was apprehended on the basis that he was an unlawful non-citizen. He was detained in immigration detention and placed into the Blaxland compound, the most high security compound at Villawood.

DIAC was advised on the investigation and of the fact that CC'S partner and infant child had been stopped at Heathrow airport on their way to join him in Australia and the child taken into care as being at risk in his presence, however, DIAC did not pass that information on to Serco. Federal police were made aware that CC had threatened suicide in the past, information provided by his mother in England, Mrs X.

Federal Agent Ryan considered that he was at serious risk and advised DIAC accordingly. Serco, knowing nothing of either the allegations or his mother's expressed fears and accepting what CC told them assessed him as at nil risk of self harm. By November 16, his DIAC case manager was made aware of the allegations and of his partner and child's aborted attempt to join him.

Mrs B, on the same date, emailed the UK police for forwarding to who she called the Australian High Commissioner of Immigration details of CC past attempt at Suicide and recent threats to self harm. This information was passed on to DIAC staff and thence, on 18 November, to Serco. The evidence is conflicting as to when it was in turn provided to IHMS. CC was certainly not referred to IHMS for assessment or counselling. He was examined on a standard mental state examination by an IHMS psychologist, whose evidence was that he knew none of the pertinent information about CC and was misled completely by CC himself, including the assertion that he had never thought of or attempted self harm.

The first date on which there is cogent evidence that IHMS were notified of CC's past suicide attempt is November 24, when a DIAC manager emailed SM, as well as Serco staff, an extract of Mrs B's email. Ms M did not realise that he'd also made recent suicidal threats. She did refer CC to a counsellor the following day, after being advised that he would receive a negative notification.

On November 25 Serco placed him on officer's watch, sometimes called security watch, which required observations every sixty minutes. The reasons for this placement remain unclear. At no time was he placed on SASH watch. Serco officers were not aware of CCs' suicidal risk but thought that he was on watch because of an escape attempt by him on November 29 2009.

On December 7 CC was requesting to be returned to the United Kingdom. He spoke by phone with his partner, Ms X, in the United Kingdom, and told her so. Sadly, he was in the terrible position that if he returned to her the child would likely be taken back into care. Although he and his partner wanted to be together, they could not do so and keep their child. Ms X was afraid that he was suicidal during the phone call. It seems he may well have determined to kill himself in order to ensure that Ms X could remain with their son.

CCTV footage from the early hours of December 8 shows that the Serco officer required to maintain the sixty-minute observations of CC failed to do so. CC is seen to enter the bathroom at 1.27am. He is not seen again on the footage. At 3.31am he was discovered by another detainee, hanging in a running shower. A suicide note was found in his pocket.

Partly as a parenthesis, I should say at this stage that I was concerned at reports that his hands were tied by a shoelace and thence to his ankle, although he was hanging by a belt and a cord around his neck. There was also one witness who claimed that there was a ligature looped around his genitals. Unfortunately the scene was contaminated partly because of the panic, and attempts to rescue CC, but also from apparent ignorance by staff of crime scene protocol. In any case, I am persuaded by all counsel that this puzzling evidence is not an indication of foul play, and as well, that the ties around his hands were sufficiently loose that he easily could have tied them himself.

CONCLUSIONS

Although speaking particularly about AA, Professor Sundram in his Rishton report, makes a reference, which in my view must apply, to almost all persons in immigration detention centres, and certainly to all three deceased whose deaths these inquests have investigated. He refers to:

> "the frustration, resentment and feelings of powerlessness and helplessness at being in immigration detention. These feelings have a potent capacity to exacerbate depressive disorders, which in turn will exacerbate these feelings."

It is surely stating the obvious to observe that persons detained in immigration detention centres must, by the nature of their various situations, be at much greater risk of suicide than those in the general community. Loss of families, freedom, status, work and the length of time must all play their part. The corollary of that is that those responsible for detainees owe a greater than normal duty of care to those persons regarding their health and wellbeing. That DIAC owes a non-delegable duty of care to immigration detainees is indisputable, and it follows that that is an elevated duty. Serco and IHMS bear their own share of that duty.

It has to be said that none of the three authorities escape criticism for the manner in which those duties were fulfilled in caring for the inmates at Villawood, at least in the last months of 2010.

Despite the above, I note and accept, the quotation from senior counsel appearing on behalf of DIAC, from "Autopsy of a Suicidal Mind" by Edwin S. Shneidman, and that is "hindsight is not only clearer than perception in the moment, but also unfair to those who actually lived through the moment". Of course those considering suicide are not necessarily prepared to discuss, warn, or threaten those thoughts to health or other professionals in authority.

However, in view of the higher risk, it cannot be said that appropriate screenings or protocols were in place, or at least carried out, to minimise the risk or treat appropriately any of these three men. The lack of consistency arising from constant changing of case managers and health professionals was exacerbated by a failure to record or share important information. Policies and protocols were often ignored.

Mr AA was served with his final removal notice for the following Monday on a Friday, quite contrary to DIAC's required standards, which recognised that detainees would be in more than usual distress at that point, but that no mental health staff would be available. Serco staff were completely unprepared and untrained in dealing with him once he'd refused to leave and was threatening to jump from the balcony.

Mr BB was probably misdiagnosed and medicated. His records were both lacking in detail and apparently not consulted. He, in fact, did make clear to officials that he was depressed and in a poor state both physically and mentally, and that he was extremely fearful and concerned about his family in Iraq and himself if he were to be returned. Very little action or assistance was offered to him. IHMS did not take adequate steps to make DIAC or Serco aware of his true level of risk.

Similarly, Mr CC particularly difficult circumstances, known as they were to DIAC and ultimately to Serco, and partially to IHMS, should have alerted staff to the probability of risk to himself, particularly as it was known that he had made a previous suicide attempt. The failure by IHMS, DIAC or Serco to place him on SASH watch, and by the Serco officer to fulfil his obligations to observe him sufficiently, are deplorable.

I accept that the particular officer concerned had not been told that CC was a suicide risk. Nevertheless, his observations were scant and not in accordance with even the lesser requirements of a security watch.

In all three deaths, some of the actions of some staff were careless, ignorant or both, and communications were sadly lacking. SASH procedures were not followed by DIAC or Serco personnel. DIAC failed to ensure that Serco and that IHMS were fulfilling the terms of the contract between them, and there were startling examples of mismanagement on the part of DIAC, Serco and IHMS.

However, no one acted in bad faith deliberately, and I consequently see no utility in naming or criticising individuals. It is the failure of systems, which in my view require remedy.

I am advised that Serco has conducted investigations following the deaths, the result of which has been to implement some appropriate changes to its policies and procedures, which have subsequently been introduced, according to pt 2 of the submissions of Mr Gibson, counsel for Serco.

IHMS must be said to have failed in its duty of care to BB. Its system, however, was under-resourced and under stress. The seriousness of his mental state was not detected. Documentation practices were extremely poor and there was a sad lack of continuity in his clinical care. Information available to staff on CIRON went unread or ignored.

The principle of patient confidentiality was allowed to take precedence over patient safety, with poor, if any, communication to DIAC or Serco about BB's vulnerability and deteriorating mental state. Of the three suicides, BB's was probably the most foreseeable, and therefore at least theoretically preventable. There has been no explanation of why SASH protocols were not implemented for BB.

Similarly, the SASH protocol was not followed by IHMS, DIAC or Serco in relation to CC. There is a real question about whether IHMS did assess CC risk of suicide. There are also doubts about what, if anything, IHMS advised DIAC and Serco about CC risk of suicide. It should be said further, however, that IHMS played no role in the death of AA. Although counsel for IHMS submitted that a range of reforms had been introduced at Villawood since these tragedies, no evidence has been led which establishes that finally. Neither DIAC nor Serco fully fulfilled their duty of care to AA or CC.

When government chooses to maintain a detention system it carries a heavy responsibility. Similarly, a company which contracts to shoulder a large part of that responsibility is under a major obligation to fulfil its contract, both to government and to those in its care. For the reasons I have given, it cannot be said that either DIAC or Serco met those responsibilities in full.

During closing submissions, DIAC raised a jurisdictional objection to the making of recommendations directed to the Minister for Immigration and Citizenship, and presumably to DIAC itself.

Section 82(1) of the **Coroners Act** of 2009 (NSW) confers the power to make recommendations. It is in broad and general terms. Section 82(4) imposes an obligation upon a coroner, to make a copy of a record including recommendations to persons or bodies to which a recommendation is directed, as well as to the Minister.

DIAC has suggested that the power to make recommendations conferred by s 82 of the Act is limited to a power to make recommendations directed to State, as opposed to Commonwealth, Ministers. DIAC says that this conclusion followers as the word "Minister" in s 82(4) must be read as meaning minister in and of New South Wales. I reject this submission. In the first place, there is no reason to think that the Act does not bind the Crown in right of Commonwealth. While the Act does not contain express provision for this, it seems to me that it must follow as a matter of statutory construction, given the purposes of the coronial jurisdiction: see the case of **Bropho v West Australia** (1990) 171 CLR 1.

Of course, a recommendation under s 82 of the Act does not bind. Secondly, there is no warrant for applying the presumption against extra territorial operation found in s 12 of the **Interpretation Act** of 1987 (NSW) to s 82 of the **Coroners Act**. To hold that the words in s 82 of the Act must be read as including the limitation in and of New South Wales, would, in my view, defeat the clear purpose of the Act. I, therefore, consider that I have the power to make recommendations directly to Commonwealth ministers, persons or bodies wherever it is necessary or desirable to do so in relation to any matter connected with the death subject of the inquest.

It is to be hoped that the Minister will wish to improve departmental operations in detention centres after the concerning number of suicides at Villawood, in particular in the last twelve months, and I make recommendations in that spirit accordingly.

FORMAL FINDINGS:

I FIND THAT AA DIED AT VILLAWOOD IMMIGRATION DETENTION CENTRE IN THE STATE OF NEW SOUTH WALES, BUT REGARDED IN THE LAW AS A COMMONWEALTH PLACE, ON SEPTEMBER 20, 2010 OF MULTIPLE INJURIES SUSTAINED AFTER HE TOOK HIS OWN LIFE BY DIVING FROM A FIRST FLOOR BALCONY RAILING ONTO CONCRETE.

I FIND THAT BB DIED AT VILLAWOOD IMMIGRATION DETENTION CENTRE IN THE STATE OF NEW SOUTH WALES, BUT REGARDED IN THE LAW AS A COMMONWEALTH PLACE, EITHER LATE ON NOVEMBER 15 OR EARLY IN NOVEMBER 16, 2010 OF HANGING HAVING TAKEN HIS OWN LIFE.

I FIND THAT CC DIED AT VILLAWOOD IMMIGRATION DETENTION CENTRE IN THE STATE OF NEW SOUTH WALES, BUT REGARDED IN THE LAW AS A COMMONWEALTH PLACE, ON DECEMBER 8, 2010 OF HANGING HAVING TAKEN HIS OWN LIFE.

FORMAL RECOMMENDATIONS:

I shall read out the following recommendations made under s 82 of the **Coroners Act**.

> "To the Honourable Christopher Bowen MP, Minister for Immigration and Citizenship:
>
> 1. Regarding the use of force in effecting a removal the Act should revise:

(a) the Serco contract and the procedures advice manual to make clear provision as to the procedure to follow and who has authority to abort a removal in a situation where a detainee is resisting his or her removal and is threatening self-harm or suicide;

(b) should revise its policies on use of force to provide guidance to DIAC officers as to what matters should be taken into account when they are requested to give a use a force authorisation in order to effect the removal; and

(c) the detention services manual should be amended to prohibit notification of negative decisions including removals on a Thursday or Friday.

2. In regard to case management. In relation to case management of detainees DIAC should:

(a) direct case managers that they are responsible for making referrals for risk assessments to IHMS as soon as risk factors become apparent;

(b) implement a policy that all referrals for risk assessment be made to IHMS in writing, that there be periodic follow-up of the results of risk assessment in writing and that the results of the risk assessment be documented in writing and recorded in portal;

(c) direct all staff with responsibilities towards detainees to make contemporaneous notes in portal regarding their dealings with respect to the detainees and to record specifically any observations made in relation to risk factors and any information received from DIAC, IHMS or Serco regarding the mental health or wellbeing of a detainee; and

(d) implement a procedure whereby when information is obtained by DIAC suggesting that a detainee is at risk of self-harm or suicide the DIAC case manger is required to seek all information held by DIAC on the detainee and also obtain corroborative or clarifying information to the extent that that is reasonably practicable to do so in the circumstances.

3. A recommendation to Serco Australia Pty Ltd that Serco should develop procedures for:

(a) encouraging Serco officers to seek proactively information on the outcome of risk assessments where Serco is aware that risk factors have been identified with respect to a detainee and/or a detainee has been referred to IHMS for a risk assessment;

(b) documenting in detainee files the presence of risk factors, the referral of risk assessments to IHMS and the outcomes of risk assessments;

(c) ensuring that where there is a need for additional vigilance with respect to a detainee that need is effectively communicated to all Serco officers in the compound in which the detainee is accommodated; and

(d) that Serco formulate a policy on the basis upon which authority to use force is to be used, including the assessment of risk, appropriate planning to reduce risk and the consideration of de-escalation techniques.

4. A recommendation to International Health and Medical Services Pty Ltd. In relation to assessing a detainee's risk of self-harm or suicide, IHMS should:

(a) develop a standard procedure for such an assessment which inter alia provides clear guidance as to what topics should be canvassed with the detainee, what instruments for risk assessment tools should be used to guide clinical judgment, stresses the importance of seeking corroborative information where available, provides for the documentation of corroborative information obtained and provides clear guidance as to what must be documented by the clinician;

(b) periodically train its mental health staff on the above procedure and on the minimum requirements to be satisfied in documenting their consultations with and assessments of clients; and

(c) to notify DIAC and Serco on the outcome of its risk assessments in writing.

5. A further recommendation to the Honourable, Christopher Bowen MP, Minister for Immigration and Citizenship, to Serco Australia Pty Ltd and to International Health and Medical Services Pty Ltd that DIAC, IHMS and Serco should work together to develop policy guidance on what information about a detainee's mental health can be provided by IHMS to DIAC and Serco officers and in what circumstances on the basis of the need to know without having to first consult via detention health services.

6. To the Honourable Minister for Immigration and Serco this recommendation that DIAC and Serco formulate a policy with the New South Wales Police or the Federal Police or both to permit the police to provide timely assistance, including trained negotiators, for high risk situations.

7. To the Honourable Minister for Immigration and to IHMS, DIAC and IHMS give consideration to changing the clinical governance structure at Villawood in relation to the provision of mental health services so that they are overseen by a consultant psychiatrist.

ACCESS SHALL BE GRANTED TO THE MEDIA TO WRITTEN SUBMISSIONS OF ALL PARTIES MADE IN THESE INQUESTS.

BUT I MAKE A NON-PUBLICATION ORDER UNDER S 74 AS TO THE NAMES OF ANY INDIVIDUALS FROM THE DEPARTMENT OF IMMIGRATION, FROM SERCO OR FROM IHMS STAFF OR ANYTHING, WHICH MIGHT IDENTIFY THOSE INDIVIDUALS.

19. 2877 of 2010

Inquest into the death of AA at Silverwater on the 24 November 2010. Finding handed down by Deputy State Coroner Freund.

AA was just twenty years old when he passed away after taking his own life on 24 November 2010 in his cell, being cell 478 pod 15 at the MRRC at Silverwater Correctional Centre. He identified and was of Aboriginal descent. There is no doubt he was much loved and is much missed by his parents. The inquest into his early passing has been heard before me today. AA's parents being represented by Mr Dogulin from the Aboriginal Legal Service. Corrective Services and also Justice Health being represented. AA was bail refused and went into corrective's custody on about 18 October 2010. He died not much more than a month later. I note the submission by ALS on behalf of the parents but they do recognise that he needed to be in gaol at that time. They did not expect unfortunately to lose their son.

A detailed investigation has been carried out by both the police and by Corrective Services. The result of those investigations form part of the brief and also exhibit 3 in the proceedings. I have had regard to all those documents prior to the commencement of this inquest today. Unfortunately AA had made two attempts to self harm prior to him succeeding on 24 November. Those incidents, and I note the comments and submissions made by Mr Dogulin in relation to, no expert evidence was called in relation to the assessment of his mental health, did note that he was assessed, although not high risk, at low risk but requiring supervision at all times by being placed in a two out cell. The systems in place at the MRRC at that time was that to be recognised by way of a green card placed on the outside of his cell together with the inmate identification card which have also recognised that he was to be in a two out cell placement.

All the evidence indicates, including the CCTV that AA managed to switch the green card and place his white inmate identification card, which is significantly different to the green card, into the container outside the cell. The two corrective service officers who were on duty that day did not pick up this change. As a result of that AA was left alone in his cell for a significant period of time which enabled him to carry out what, which was unfortunately on balance a premeditated act that was something he wanted to do. Unfortunately young people, and in this job I see it all the time and still it leaves me at a loss, make these decisions and leave the people they love most wondering why.

Having said all of that and taking into account the detailed investigation that was carried out by Corrective Services and police I accept there were some flaws in relation to systems in place at AA's death and that was conceded by Mr Walters on behalf of Corrective Services. Having said that Corrective Services, and I commend them for it, have taken steps to audit the policies and procedures in place to ensure similar deaths do not occur again. The detailed responses by Corrective Services are set out in exhibit 4 in the proceedings. They have taken into account, and I go through them in detail, the various issues raised by AA's early passing. This includes they are taking an audit and responding to the cell cards and holders and are looking into implementing once that audit takes place systems that may be more secure to prevent similar interchanging of cards by inmates.

Secondly they are doing an audit of the various hanging points found in cells. Presently there is also new lock in and muster procedures to ensure that there is a checking system in place. Having regard to all of that I am declining to make any recommendations arising out of the death because I note that Corrective Services has done that job for me.

FORMAL FINDING:

I FIND THAT AA DIED ON 24 NOVEMBER 2010 AT POD 15 CELL 478 AT THE MRRC SILVERWATER CORRECTIONAL CENTRE. THE CAUSE OF HIS DEATH WAS HANGING AND THE MANNER OF HIS DEATH WAS SUICIDE.

20. 2924 of 2010

Inquest into the death of AA at Parklea on the 1st December 2010. Finding handed down by Deputy State Coroner Freund.

Mr AA was 35 years old when he was found dead in his cell on the morning of 1 December 2010 at the Parklea Correctional Centre.

He had been convicted of the murder of his wife the day before, in the Supreme Court of New South Wales after a lengthy trial. As Mr AA's death occurred whilst in custody, this is a mandatory inquest pursuant to section 23 of the **Crimes Act 2009**.

I also note that as there is no dispute that Mr AA took his own life that these findings are subject to a non-publication order pursuant to section 75 of the Crimes Act.

The issues outlined by advocate assisting Lolis at the opening of this inquest can be summarised as follows. Firstly, Mr AA's access or inmate's access to cable ties. Secondly, the access of inmates to razors. Thirdly, the manner and appropriateness of any mental health assessment of inmates on return to prison after post conviction, or after conviction. And finally, what indicators were evident in Mr AA prior to his suicide on the evening or morning of 30 November 1 December 2010.

Mr AA was arrested in 2009 and charged with the murder of his wife. He was initially housed at the MRRC from 12 August 2009 before transfer to Goulburn Correctional Centre in October 2009.

On 3 March 2010, Mr AA was transferred to Parklea. Mr AA suffered from irritable bowel syndrome that caused him problems with sharing a cell.

This is evidenced in the Corrective Services documents in volume 2 of the brief as being an issue at MRRC and was not confined to his period in incarceration at Parklea.

In July 2010, Mr AA self referred to the counselling and psychology services of Parklea for the purposes of obtaining support for being housed in a one out cell. At that time, Mr AA informed the psychologist Miss Pullan that he was fearful in a two out cell because his cellmate had threatened him with physical harm to his need to use the toilet after eating. This was causing him considerable stress and he was not eating. Miss Pullan supported his request for a one out cell but also referred him to a counsellor Miss Hanlon-Schaffer and the Justice Health Clinic for medical assistance with the issue.

Mr AA was subsequently moved to a one out cell. He was housed in cell 14, unit 5C or 5 Charlie as it has been referred to in this inquest, and for all intents and purposes, fitted in with the unit and other inmates.

On 30 November 2010, Mr AA was convicted of the murder of his wife. He returned to Parklea from Court that evening.

On his return, he was seen by a number of people, Correctional officers and reception, reception nurse, Correctional officers in unit 5 who escorted Mr AA and other inmates from the reception clinic yard and placed him in his cell. None of these persons noticed any difference in Mr AA's demeanour or anything that would suggest he was suffering mental or emotional anguish.

His neighbouring inmates, Mr Brian and Mr Dillon, informed the investigative police that he was not as talkative as usual on his return to cell but there was no actual evidence that he appeared in any way distressed.

At approximately 6 in the morning on 1 December 2010, the Correctional officers Holman and Pedoe(?) began opening the cell doors to let the inmates out and Mr AA was found deceased.

Turning to each of the issues set out, in relation to the first issue of inmates having access to cable ties, I accept that the new protocol implemented by Parklea Correctional Centre provides accountability and security and prohibits the accumulation of these ties by inmates. And in my view, the issue has now been adequately dealt with by GEO Australia Pty Limited, the operators of Parklea Correctional Centre, since AA's death.

In relation to inmate's possession of razors, I have heard evidence that inmates are provided with one disposable razor but can also purchase extra razors through their various buy ups. This means there is an opportunity for blades to be removed from the actual razor devices. It is against protocols for this to occur and exposed blades are actually considered contraband. However, I note and the evidence is clear that cells are searched daily and in the event that exposed blades are found, they are confiscated and inmates subject to discipline. Accordingly, I am satisfied that the system currently in place is acceptable and no recommendations in relation to the issue of inmates possessing razors needs to be considered.

Turning to Mr AA's assessment and his return from Court. The evidence before me establishes that at the time of Mr AA's death there was no protocol in place whereby inmates returning from Court, having been convicted of a crime, were seen by a Justice Health nurse for the purpose of screening the inmate for mental health perspective.

In Mr AA's case, although the reception nurse for the purpose of receiving his medication, saw him, the possible effect of his conviction that day on his psyche was not considered.

It is now protocol at the Parklea Correctional Centre that Justice Health person will clear every inmate returning from Court before he is returned to his cell.

Accordingly, I am satisfied this protocol provides an opportunity for an inmate adversely affected by the day's proceedings or events generally, to either inform the reception nurse of this issue or for the reception nurse to actually pick up that there is in fact a problem and therefore various RIT processes can be put in place and the inmate placed in a safe cell until a full assessment can be made.

This process will not be foolproof and unfortunately, there still will be cases where people at risk will not be identified. However, it is a form of risk minimisation and is in the benefit of all inmates.

I finally turn to the various interactions Mr AA had with counsellors and psychologists while he resided at the Parklea Correctional Centre. Mr AA saw a counsellor and a psychologist while he was housed at the Parklea Correctional Centre. He saw a counsellor Miss Hanlon-Schaffer who saw Mr AA on 15 July 2010 and 31 August 2010. He was also seen by psychologist, Kathleen Pullan on 26 July 2010. I note I had the benefit of Miss Pullan's oral evidence yesterday. At the time of his interview with Miss Pullan, Mr AA wanted support for obtaining a one out cell due to his problems associated with his irritable bowel syndrome. It was that issue that was the focus of the interview.

However, there was discussion between them as to his concerns regarding his court case, the grief associated with the loss of his wife and his reputation. It is clear that Miss Pullan did not explore with Mr AA his imminent trial and the effect that would have on his psyche. However, she did carry out some assessment as to whether or not he had suicidal ideation or intent. She had formed the opinion that he was at risk of neither.

There is no evidence before me that is critical of the care or treatment provided by Mr AA by either Miss Hanlon-Schaffer or Miss Pullan. Those closest to Mr AA, namely his legal counsel, were unaware of his intention and in fact surprised by his suicide. So no criticism is made of either practitioner.

I now turn to the formal findings I must make pursuant to section 81 of the Crimes Act 2009.

FORMAL FINDING:

I FIND THAT AA DIED BETWEEN 30 NOVEMBER 2010 AND 1 DECEMBER 2010 AT THE PARKLEA CORRECTIONAL CENTRE FROM THE COMBINED EFFECTS OF LIGATURE STRANGULATION AND BLOOD LOSS FROM INCISED WOUNDS OF THE RIGHT INTERNAL JUGULAR VEINS. I FOUND THAT HIS DEATH WAS SELF-INFLICTED.

22. 3036 of 2010

Inquest into the death of Reg Clarke at Terrigal on the 12th December 2010. Finding handed down by State Coroner Jerram.

This has been a sad inquest investigation into the death of Reginald Clarke who died in the early hours of 12 December 2010 after falling from a ledge at the skillion, the cliffs at Terrigal. He was aged only fifty at the time.

Prior to his death he was apparently suffering financial difficulties; his marriage appeared to have ended, his wife having asked him to leave the house for a variety of reasons and him being without home or, as I understand it, work and in severe financial difficulties as well. He apparently had been on some antidepressant medication for some considerable time. At about 9.30pm police from the Brisbane Water Local Area Command attended Gosford Sailing Club on the waterfront in Gosford in response to concerns for Mr Clarke's welfare having been raised.

Mr Clarke apparently had contacted Lifeline threatening to commit suicide by jumping off Brian McGowan Bridge. He was at a public wharf off the highway, in fact outside the infamous Iguana Joe's nightclub, was handcuffed and detained by police and taken by them on their assessment of his being in a very troubled state to the Mandala Mental Health facility at Gosford Hospital where he was not scheduled under s 22 of the **Mental Health Act**.

He was assessed by a young registrar, very inexperienced, Dr Ariyasinghe, accompanied by an also young enrolled nurse who assisted essentially and whose role seems to have been to try to make some rapport with Reg Clarke during the time that he stayed at the hospital. Dr Ariyasinghe was a junior registrar and her consultant psychiatrist was Dr McKeough who was on duty but not at the hospital - it was the middle of the night.

After quite considerable time, and it is not quite clear how long it was because nobody actually wrote it at the time, she having gone through the then still required procedures for assessing whether somebody ought to be detained or not, went from the room where Reg Clarke remained with the enrolled nurse and rang the consultant Dr McKeough.

After considerable conversation between them Dr McKeough gave her his view based on the information she had given to Dr McKeough, that Mr Clarke was not legally detainable under the **Mental Health Act** but that she should do her best to persuade him voluntarily to stay in the hospital at least overnight.

Dr Ariyasinghe went back to Mr Clarke and did make those attempts assisted by Mr Thomson, the nurse, but Mr Clarke rejected the offer and said he would rather go and sleep in his car. He could not have been stopped without being detained under the **Mental Health Act**.

No actual follow up appointments were made to him partly because he was itinerant at the time but mainly because he said he had a good rapport with his general practitioner and said he would see the general practitioner on Monday morning and asked that the hospital fax through details of his attendance at the hospital. He was also given a number that he could call at the mental health unit if he felt the need in the immediate future and told he could return at any time.

A lot of this inquest focused on that initial assessment and the decision of Drs McKeough and Ariyasinghe not to detain Reg Clarke at the time against his will and it very much would have been against his will. In fact perhaps we could have even looked more carefully at the fact that the following day he returned to the hospital in the early evening. He was seen by a mental health nurse who said he needed to consult with a doctor and in the time that it took for him to wait for that doctor, Reg Clarke changed his mind and left. Of course he had not been detained and of course he was free to leave.

It was on that night that he then apparently drove out to the cliffs at the skillion. He was seen sitting on a ledge by some passers-by or some people who were picnicking I think then who rang the police. One of the issues we had to look at, and it was an important one, was the police response. I have no comments to make whatsoever about their having taken Reg Clarke to the hospital on the night of the 10th. They had somebody who they saw sitting on the end of a wharf threatening to jump in and saying he wanted to kill himself.

As for the attendance of police after the call from those who saw Reg Clarke at the cliff, I can only give those officers the highest praise. Their response was swift. By this time it was late at night and very dark. When they got to the cliff and finally located Reg Clarke he had got himself onto a very dangerous and narrow ledge further down the face of the cliff. After a considerable amount of negotiating he seems to have changed his mind and have welcomed the fact that police were going to try and get him up from there, and in fact he said words to them such as “Make it quick, be quick, I don’t know how long I can hold on. I didn’t want it to end this way”.

Senior Constable Coles abseiled down to the ledge below Mr Clarke - remembering this is all in pitch darkness - and virtually had his hands on him to try and bring him up where he could be winched to the top, when it seems that Mr Clarke somehow lost his very slight hold on the ledge, slipped and fell to his death. That of course makes this whole terrible story even more tragic because it seems, and we heard some interesting evidence about it today from psychiatrists, that he was pretty ambivalent about what he wanted for himself and at the last moment that probably was not what he had wanted.

As I say I think that the two police involved in the rescue, closely involved, there were others, deserve great commendation for their bravery and it is a great secondary tragedy that I am told that Senior Constable Coles having got so close but not been able to help him through no fault of his, has been so traumatised that he has left the Police Service which is a terrible shame by the sound of it.

The issues that we looked at then were first the adequacy of the police response on the evening of 11 to 12 December and I have made my comments on those. The adequacy of the police response on the first night, 10 December, and I have made my comments on those, and the adequacy of the mental health assessment and care given to Mr Clarke on 10 and 11 December, that is when he first appeared and was assessed by Dr Ariyasinghe and Dr McKeough and then on the early evening of the 11th.

We first had an expert's report provided by Dr Guiffrida who is a long term highly experienced psychiatrist who bears a great deal of respect in the psychiatric world I understand, and that report was really quite critical of the assessment made by Dr Ariyasinghe and confirmed really by Dr McKeough. He made a comment such as that the notes were sparse as any he had ever seen. Essentially what he said was that he absolutely would have on the information that was given would have detained Mr Clarke under the **Mental Health Act.**

Then we had a further report from an equally eminent psychiatrist from whom you heard today, Dr Matthew Large who held a different view. His view was that he would not have detained Reg Clarke on that same information and that in fact he believed it would have been illegal to do so. We had already heard from Dr McKeough who had indeed taken that view as you know. What to me became clear from hearing the two experts who gave concurrent evidence - I am not going to use that terrible word that is sometimes used for it, the hot tubbing for the sake of the audience. It is a dreadful word. Concurrent evidence is a bit more dignified I think.

They did not agree on every point, you all heard that, but the very fact that they disagreed on that main matter of whether Reg should have been detained on the night of the 10th and 11th, made it clear as they both agreed that psychiatry is not an exact science, that there is always scope for the individual good psychiatrist to make a decision either way without even though we had two views, that one would do one thing and one another, that there is always scope to balance the fact that somebody may well be at risk to themselves in this case against the fact that it is a very serious matter indeed to incarcerate, because that is what really what it amounts to, to incarcerate somebody against their will. Dr Large I think made the comment that only two groups of people in the community have the power to do that, psychiatrists on the one hand under the **Mental Health Act,** and the judiciary and I am sure you all accept that the judiciary certainly realises what a huge responsibility and weight that is.

Both Dr Large and indeed Dr McKeough had made it clear that they felt that the damage done to any further possibility of a good professional relationship between Mr Clarke and the mental health staff.

That damage done would have been so great that it might have been irreparable and that that too had to be taken strongly into account had they said "No Mr Clarke we're keeping you here whether you like it or not". But to me the most significant thing is that was not the note where having left of his own volition he killed himself or tried to kill himself. In fact he seems to spend the night in his car. I was told that the next morning he visited his estranged wife to see her and to see their dog.

It wasn't until later that evening that he presented again and I think that says something for those staff who were at Gosford Hospital the night before, that he was not repelled, he was not scared to go back, he did in fact go back again to the Mandala unit.

Unfortunately although he was seen by a mental health nurse, her view probably quite correctly was that he needed to be assessed again by a doctor, meaning presumably a psychiatrist, and there was a wait, as there so often is in hospitals because of resources and understaffing, and during that wait he said "I am not staying" - well he said it to himself at least - and left the hospital again. Then it seems he went out to the cliff and we have just heard the events that happened then.

I am not in a position to criticise what happened on that second night because I was not told just how long he had waited before not seeing anybody and therefore leaving. It does no seem to be any criticism of the nurse who saw him, but the doctor just was not available and certainly not on the spot.

It is a really sad story and we heard very movingly from Mrs Clarke who has faithfully been here throughout all the day as of this inquest. She was obviously fond of him. The marriage had clearly come to an end for her. I hope her poor heart is settled a little now on that. She said some telling things though in her short address to the Court including that Reg knew how to, I think her term was "play the game". He had in fact, as we now know, had previous contact with mental units.

He had never been admitted to hospital for mental health reasons but he certainly had - well he was treated for depression and he had also had contact with community mental health. So as she said herself he knew how to present when it suited him and as we also heard from both the expert psychiatrists Reg like many persons with a mental disorder or perhaps in his case as the doctors felt it might be, a personality disorder, he wavered, he was ambivalent himself about what he wanted.

One moment he was in despair and then he obviously sometimes did rally and think, "I can cope, I'll be all right". He was as I said offered a bed that first night in the hospital. Perhaps if he had taken it, and that as Mr McGoary said a couple of times, is not to criticise him, he was in a bad state. Perhaps if he had taken it he might still be with us. He might have just settled down, realised there were people who care and who wanted to help but it was a matter for him and he did choose not to take up that offer.

I told Ms Sandford who as you know has been representing the hospital and the doctors involved, that I was not making any serious criticism of them and I still do not and in fact she put to me, perhaps you should not make any criticism at all.

The only thing I would say and it is not really anything other than a comment, Dr Ariyasinghe was young and fairly inexperienced.

She was not fully fledged as a psychiatrist if I can put it like that. Her note taking was not great but I do not think anything hinged on that really.

Reg himself did not give them all the information that he could have such as the fact that under a different name he had in fact - he would have medical records that might have helped in assessing whatever risk he presented to himself at the time. All they knew was that he had been for personal reasons very upset and threatening to hurt himself or kill himself when the police found him and that by the time the nurse and Dr Ariyasinghe saw him he had settled. I think quite a lot of that settling might be to the credit of Mr Thompson because he seems to have been - he said himself he felt a rapport with Reg, he had just been going through a relationship break up and he understood and he seemed to me to be an extremely pleasant and caring young man in any case.

I do say, and again it is a very difficult thing to say because it I can be taken the wrong way, but I heard from Mr Thompson that he felt Mr Clarke became agitated when he could not make himself understood by Dr Ariyasinghe or totally understand her. We heard from her yesterday by phone. Her English is fluent as you heard but she was a bit difficult always to understand because she has an accent. I do not for a moment suggest that any of us working in another country in another language would be as good as she was. But I can see that that just makes things just another step more difficult; not to blame her in the least, just a fact that I comment upon.

So overall I think the issues we set out to address, I am certainly satisfied that they have been met, that the police response both nights was nothing but exactly what we hoped for from our police, and that while there is always a shortage of resources and staff in all hospitals and in particular in mental health, because there were differences even between the three experienced psychiatrists we have heard from, who are we to say that - or who am I to say that I choose one or the other view, rather it just became so clear, as I have said, that in psychiatry two opposite views can be equally valid. Difficult but it is not like diagnosing an earache or an ulcer or even something like a cancer I suppose.

You heard just before we broke for lunch some discussion between me and two of the three counsel at the bar table as to recommendations. You are aware that my primary duty under the **Coroner's Act** 2009 falls under s 81 which is that I must find the identity of a deceased person, no question about that. The date and place of his death, we know that, and most importantly ultimately because that is usually why inquests are held, the cause and manner of his death.

Under s 82 of the same act I have the power to make recommendations particularly in the interests of public health or safety. You probably heard Ms Sandford's very cogent arguments, and in fact I encouraged her at one stage to argue it, that because we do not now, or I am not going to find that had they done something different at the hospital on the night of the 10th that Reg would not have died on the night of the 11th and 12th.

That I therefore should not make any comment on that part of the, I suppose, of the incident which does not arise directly.

But during the lunch break and probably Ms Sandford and maybe Mr McGoary did the same, I looked at some cases and at **Waller** which is the leading text for Coronial Law in New South Wales, and it is my view from a number of findings of the past, that the power to make a recommendation is not limited to the making of recommendations which would prevent the recurrence of a similar death or fire, that is, it is not necessary for the Coroner to be of the view that the recommendation in question would have, or even could have, averted the death in question.

Rather all that is necessary is that the recommendation be connected with the death or suspected death, in this case the death. And then I have read a number of cases including **D'Magy v Clements** which suggests that the recommendation goes to a public health and safety issue, it is quite valid to make it even though it might not have, had it already been made, averted Reg Clarke's death.

What I intend to do is make this one recommendation to the Minister of Health, that is that the Minister of Health consider reviewing in consultation with experienced psychiatric and nursing clinicians the current polices and documents for assessing patients presenting to mental health units with a view to de-emphasising the bureaucratic nature of forms and promoting more personal clinical consultation.

I do not think that treads on anybody's toes. It is not making criticism of anyone but I could not help but hear all three psychiatrists including Dr McKeough all criticised, the current documentation and its bureaucratic nature and said that because of that the personal experience of the interviewing staff person, nurse or doctor, often gets lost because of document ticking. So that puts no utter onus.

The onus, according to a Premier's direction to Ministers, is that the department to which a recommendation from this court is addressed must respond, must acknowledge the recommendation within three months and advise Parliament and the Coroner's Court what actions have been taken - I think it is within six months - and surprisingly enough they usually do. It doesn't mean they will take up the recommendation but they will certainly acknowledge it and have a look at it.

I know that Mrs Clarke asked me to consider recommending that there be something like a safe room with a staff member to stay with a person who is in the situation that Reg was. I would love to make that recommendation but I think it might be to futility in these times of resource winding back. I agree it would be an ideal situation. I think it's just not the time for it to be made and nor do I think actually that it would have helped Mr Clarke because of course if he wasn't to be detained, then he could have been made to stay even in a safe room with another member of staff. He was free at any time to walk out and in fact he did stay till the end of coming to their view. It says something for him and for them I think.

Formal Finding:

That Reginald Clarke died in the early hours of 12 December 2012 after falling from a ledge at the skillion at Terrigal, the manner of his death being by misadventure.

23. 3037 of 2010

Inquest into the death of AA at Lismore on the 11th December 2010. Finding handed down by Deputy State Coroner MacPherson.

A DEATH IN CUSTODY

Notwithstanding the fact that at the time of his death AA was at the Lismore Base Hospital, he was otherwise lawfully detained and in the custody of the Corrective Services NSW. Accordingly his death occurred at a point of time that he was in lawful custody.[82] As such an Inquest into his death was and is mandatory by virtue of ss.23 and 27 of the Coroners Act 2009.

ROLE OF CORONER

My role as Coroner is to establish, if possible, the identity, the date of death, the place of death and the manner and cause of death. The formal finding will be recorded at the Registry of Births, Deaths and Marriages

A Coronial Inquest is essentially an enquiry. It is not a criminal or civil trial in which two opposing parties engage in legal combat. It is not the role of the Coroner to attribute fault or make findings in relation to negligence or breach of duty of care

Another important function of an inquest is the making of recommendations, which are necessary or desirable in relation to any matter connected with a death. In this way the coronial proceedings can be forward looking, aiming to prevent future deaths, rather than allocating blame.

I say this not so much for the benefit of leaned counsel, but more for the benefit of the family of AA who may not always appreciate and understand the role of a Coroner or the Coronial Inquest.

DID AA TAKE HIS OWN LIFE?

In coming to that decision it is generally accepted that a coroner should apply the *Briginshaw*[83] standard of being "comfortably satisfied" before making a finding of suicide. In fact suicide cannot be presumed but must be proved by evidence.[84]

The evidence is overwhelming that no other person was involved in AA's hanging. There is no suggestion that the inmate, who found AA, Anish Nigam, was involved. AA was a much bigger man and there were no injuries that would suggest he had been overpowered.

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[82] (see generally s23 (a) of the Coroners Act 2009)
[83] Briginshaw v Briginshaw (1938) 60 CLR 336
[84] R v Coroner for City of London, Ex parte Barber (1975) 1 WLR 1310

There were no other inmates in the unit, apart from Anish, and Corrective Services Staff were on the scene very quickly and had the unit locked down with Officers indicating there were no other inmates present.

AA had spoken to Corrections Officer Glenn Meade at about 10am on the 9 December, about obtaining a ticket so he could travel to Lismore on his release and AA had made a telephone call logged at 10.24am to Leonard Johnson an ex inmate and friend which was shortly before he was discovered by inmate Anish Nigam.

Finally Inmate Gary Blairs told Detective Senior Constable Scott that at about 10.30am on the 9 December he heard AA complaining about his parole and that later he was on the pushbike down the end about ten feet from the door to Unit C4 and he heard a noise like someone clearing his throat and a few minutes after that he saw officers running over to that Unit.

I am comfortably satisfied that AA placed the coaxial cable around his neck with the intention of taking his own life.

The next question is why?

WHY DID AA ATTEMPT TO AND EVENTUALLY SUCCEED IN TAKING HIS OWN LIFE?

MENTAL HEALTH

Apart from taking medication for depression there is no evidence to suggest that AA was suffering from a mental illness at the time of his death or that he was suicidal.

His sister and the fellow inmates who knew him and gave evidence were all shocked when told he had self-harmed. They had no inkling that issues for him had become overwhelming.

He had lived with his depression for many years and there is no evidence that he ever attempted or spoke about harming himself given that this was not the first time he had been incarcerated for criminal offences so what was different about this incarceration.

RELATIONSHIPS

I think one of the main differences was he was estranged from his family and that estrangement seemed to be connected with AA's relationship with girlfriend RH.

The relationship with RH had broken down and he had difficulty in accepting that fact although he was still in contact with R's parents who he had nominated as Accommodation Sponsors on his release to parole.[85]

His relationship with his family was strained to the point that he did not, as he had in the past, put his sister JM down as an Accommodation Sponsor.

[85] Additional Documents Tab 3 'Probation and Parole' page 51 and 58

In an interview with Probation Officer Christine Barnes on 18 June 2010 as part of post release procedures he said that his mother and siblings had disowned him due to his long-term criminal behaviour.[86]

JM said that she had not talked to AA during his final incarceration and that AA had stopped ringing her because she had not been able to assist AA's then girlfriend RH.[87]

J told this Inquest that even though AA had not spoken to her she expected that he would, as he had done in the past, stay with her on his release.

ISSUES WITH OTHER PRISONERS

There has been some evidence that he was having issues with one particular inmate but as inmate Gary Lacey, who was a friend of AA's, said that the only issue was that he did not want to do anything that would jeopardise his release on parole because AA much bigger than the inmate giving him problems.[88] However, it was clear that some inmates knew his past conviction in relation to the rape.

ISSUES WITH IMPENDING PAROLE

AA was serving a 15 months non-parole period and was due for release from gaol on 16 December 2010.

His release on parole on this date was clearly the biggest issue affecting AA. Since the process had commenced prior to his release to parole the Sponsors that he had nominated that would accommodate him on his release were being rejected, he thought, by the Probation and Parole Officer Christine Barnes.

AA said as much to inmates Gary Lacey, Brian Henderson and Paul McMahon. Paul McMahon said that he had a conversation with AA on the morning of his attempt at self-harm and he got the impression that AA thought that his whole parole was contingent on having a place to stay.[89]

However, for those who do have difficulty in finding suitable accommodation there are Community Offender Support Program Centres that fill the gap in these circumstances, although in AA's case he was not interested in going there and tragically his last Accommodation Sponsor was approved the day he was taken to hospital.

This view that AA had apparently taken is further evidenced by the transcript of the phone conversation he had with Lenny at 10.24am shortly before he placed the television co axial cable around his neck a conversation that went for 6 minutes and 13 seconds.

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[86] Ibid page 51
[87] Statement Tab 29 page 5 paragraph 31
[88] Exhibit '2' ERISP Tab 14 page 88
[89] Exhibit '2' ERISP Tab 13 pages 72-73

AA was asking if Lenny's partner had contacted Grafton about his accommodation post release. He said;

> 'Yeah, yeah just been a bit of a hassle trying to get, yeah cause they won't release me unless I've got an address to go to, otherwise I, I stay in gaol and.'[90]

AA was clearly of the view, wrongly, that he could be held past his release date of 16 December 2010. The tenor of the rest of his conversation was he was convinced he was not going to get out;

> 'Yeah, it looks like I'll be in for a lot longer, yeah.'[91]

I believe he was seeking some assurance from Lenny (Leonard Johnson) that he would be released and be able to stay with him because that was, he believed, his last chance at being released. When he did not get that assurance he then attempted to end his life.

PROBATION AND PAROLE

The evidence suggests that the Probation Officer Christine Barnes, who was handling AA's release on parole, was prejudiced and was deliberately frustrating his attempts to find suitable accommodation on his release on parole.

Clearly there will inevitably be some tension during this pre release period and I can find no evidence to support the suggestion of prejudice. Christine Barnes was simply doing her job and in fact it turns out that to save Veronica Cooling from having to disappoint AA she took the decision herself to reject that accommodation as suitable when it was clear that Veronica had second thoughts.

The 1993 conviction and sentence for the serious rape with violence of a 65-year-old woman kept cropping up in terms of him getting suitable accommodation on release. One can understand the policy behind the need for disclosure but it does present a barrier for an inmate being released on parole in finding suitable accommodation and beginning his or her rehabilitation.

[90] Exhibit '2' Tab 25 page 2 paragraph 18
[91] Exhibit '2' Tab 25 page 9 paragraph 105

When does a conviction like that stop being relevant. We heard evidence that the authorities do a risk assessment and that his risk of re offending was medium to high and probably related to alcohol abuse. However, the conviction and sentence was 1993 some 17 years previously one has to ask when does it stop being a factor.

One may judge AA by looking at his criminal record and in particular the 1993 conviction but today we heard from the family of AA who described AA as a gentle giant who had been scarred by his experiences as a child and who despite his size had the mind of a 16 year old and even though he continued to disappoint them still loved by his family who are left to wonder why he did what he did when they were only a phone call away.

RECOMMENDATIONS

There are no issues that need to be addressed the death seems to be the result of a snap decision after a phone call that led AA to believe that he would not be released to parole on 16 December 2010.

ACKNOWLEDGMENTS

I acknowledge the work done by Detective Senior Constable Matthew Sipple in preparing such a comprehensive and thorough brief of evidence and I will convey my views about his professionalism to his superior.

I also thank my Advocate Assisting Sergeant Deborah Williamson.

FORMAL FINDING

I FIND THAT AA DIED ON THE 11 DECEMBER 2010 AT LISMORE BASE HOSPITAL OF HYPOXIC ENCEPHALOPATHY WHEN HE DID ON THE 9 DECMEBER 2010 AT GRAFTON CORRECTIONAL CENTRE HANG HIMSELF WITH THE INTENTION OF TAKING HIS OWN LIFE.

24. 3159 of 2010

Inquest into the death of Roy Fulton at Bathurst on the 25th December 2010. Finding handed down by Deputy State Coroner Freund.

Roy John Fulton was 80 years old when he died on Christmas Day 2010 from injuries he sustained after the motor vehicle he was driving collided with a Police Car driven by Leading Senior Constable Mounce-Stephens at the intersection of Rankin and Durham Streets at Bathurst. He is much missed and survived by his brothers Glen, John, Ken and Colin, sisters Thelma and Jeanette, his sister-in-law Margaret and extended family.

On the final day of the inquest Mr. Fulton's brother Glen, gave an emotional address detailing the "man" his brother was. Mr. Fulton was clearly the family patriarch, the glue that bound his siblings and their respective families together, a person who was community minded, cared for others, who was intelligent and passionate with many talents (some of which were hidden from his family), who is and will continue to be much missed and loved.

A coroner' s function is to attempt to answer five questions pursuant to s.81 of the Coroners Act 2009 ("**the Act**") namely, who died? When did he or she die? Where did he or she die? What was the cause of death? And finally, what was the manner of death? The cause of death is the immediate physical cause. The manner of death refers to a way a person dies, including the surrounding circumstances.

This is a mandatory inquest pursuant to s23 of the Act as Mr. Fulton's death arises out of or incidental to a police operation. In this way the family and friends of Mr. Fulton can be assured that the circumstances of his death have been thoroughly investigated and there has been total transparency in relation to those inquiries.

In relation to Mr. Fulton's death there is no issue in relation to the identity, date, place or direct cause of his death. The issues to be determined by this inquest are in relation to the circumstances surrounding Mr. Fulton's death which were outlined by Mr. Ranken, Counsel Assisting in his opening address, namely:

- What were the precise circumstances of the collision and the manner of driving of both vehicles prior to the collision?
- Was it appropriate for Leading Senior Constable Mounce-Stephens to proceed "code red" in response to the Police VKG broadcast from Bathurst 15?
- What was the status of leading Senior Constable Mounce-Stephens' driver accreditation with the NSW Police?
- Were the Critical Incident Guidelines complied with following the accident?

I will deal with each of these issues in turn.

WHAT WERE THE PRECISE CIRCUMSTANCES OF THE COLLISION AND THE MANNER OF DRIVING OF BOTH VEHICLES PRIOR TO THE COLLISION?

The first matter that needs to be considered was whether the lights and sirens were engaged on the police vehicle as it travelled down Durham Street towards the Rankin Street intersection. The accident and/or its aftermath were witnessed by a number of people all of whom gave evidence on the first day of the inquest. These witnesses include:

1.Mr. Greg Glencourse and his son Michael;

2.Ms. Leilani Driscoll;

3.Ms. Rheannah Bogle;

4.Mr. Phillip Holder;

5.Mrs. Kay Holder; and

6.Mr. Timothy White.

The actual collision was witnessed by Mr. Greg Glencourse, his son Michael and Ms. Driscoll. The Glencourses at the time of the accident were travelling in a south-east direction along Durham Street just prior to the collision. Their evidence can be summarised as follows:

1. Mr. Glencourse was driving the motor vehicle. His son was in the front passenger seat and his wife and daughter were in the back passenger seats;
2. They had stopped at the lights on Durham Street at the intersection of Stewart Street;
3. Just as the lights turned green they were passed on the "inside" (on the passenger side or left hand lane) by a police car whose lights and sirens were activated;
4. The police car passed their motor vehicle just as they entered the intersection;
5. Shortly thereafter Mr. Glencourse moved to the left lane;
6. Both witnesses saw the police car pull away from their motor vehicle as it travelled towards the intersection with Rankin Street;
7. They noticed the white Gemini as it travelled into the intersection of Durham Street and Rankin Streets;
8. The white Gemini did not stop as it passed the centre median street of Durham Street;
9. Neither witness noticed whether or not the Gemini had stopped at the intersection prior to entering the intersection.

It was the evidence of Ms. Driscoll who was following in her motor vehicle at least 100m behind Mr. Fulton's white Gemini on Rankin Street prior to its entering the intersection with Durham Street inter-alia that:

- she was clearly uncertain as to whether or not the white Gemini actually stopped at the intersection;
- she did not notice the brake lights of the white Gemini;

- she heard the sirens of the emergency services vehicle as she was travelling down Rankin Street but was uncertain of the direction from which the sound was coming;
- at the time of the collision her motor vehicle had not quite reached the intersection of Durham Street and Rankin Street; and
- she did not see the police car before it collided with the white Gemini.

The other witnesses did not actually witness the collision. However, Ms. Bogle's evidence was that although she did not hear the police sirens she did notice the flashing lights of the police car in her rear view mirror. Mr. White gave evidence that he heard and saw the lights and sirens on the police vehicle as it travelled down Durham Street towards the Rankin Street intersection.

Mr. and Mrs Holder, who were driving in their car on Durham Street, gave evidence that they did not see or hear the lights or sirens on the police car but did hear the "bang" of the collision. When they passed the scene of the accident at the intersection of Durham and Rankin Streets they did not realise that the police car was involved in the accident but thought it had arrived on the scene of the accident very quickly.

I note that Leading Senior Constable Mounce-Stephens insisted that his lights and sirens were activated prior to the collision.

Despite the evidence of Mr. and Mrs. Holder, I am satisfied after hearing the evidence of all the eye-witnesses, that on the balance of probabilities Leading Senior Constable Mounce-Stephens was travelling along Durham Street with the lights and sirens of the police vehicle engaged.

The second aspect that must be considered in relation to the manner of driving of both the vehicles is what speed the vehicles were travelling at prior to and at the time of the collision.

Following the accident, the crash scene was preserved and ultimately examined, photographed and measured by Senior Constable Ian Stibbard, a specialist in crash investigation attached to the Bathurst Crash Investigation Unit.[92] The evidence of Senior Constable Stibbard can be summarised as follows:

- He was notified of the collision on 25 December 2010 and arrived at the scene at about 4.15pm that same day;
- The motor vehicles involved in the collision were still in situ;
- He took photos and various measurements in relation to the accident.

Further evidence was obtained from Mr. Simon Parker, a mechanical engineer specialising in collision analysis with NSW Police[93] and from Mr. John Jamieson, a consultant engineer specialising in traffic safety. [94]

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[92] Statement Exhibit 2, Volume 1, Tab 24;
[93] report dated 2 August 2011, Exhibit 2,Volume 1, Tab 25;
[94] report dated 22 March 2011, Exhibit 2, Volume 3, Tab 80; I note that Mr. Jamieson was initially retained by the family of Mr. Fulton.

Prior to giving their evidence these experts were given the opportunity to confer with each other, to discuss each other' s respective findings. As a result of the conclave all the experts agreed on the following:

> At the time of impact the Ford Falcon driven by Leading Senior Constable Mounce-Stephens was travelling at approximately 70km per hour and the white Gemini driven by Mr. Fulton was travelling at approximately 40km per hour;
>
> There was no evidence at all that the Gemini driven by Mr. Fulton had braked before impact. Mr. Jamieson explained that as the Gemini did not feature anti-lock brakes you would expect that if the brakes had been applied before impact they would have locked and caused skid marks on the road surface. No skid marks were observed.

There was also no physical evidence at the crash scene that the Ford Falcon driven by Leading Senior Constable Mounce-Stephens had braked before impact. However data retrieved from the Anti-lock Braking System known as the RCM indicated that there was in fact braking. I should note at this point that all the experts warned the Court about the reliability of the data retrieved from the RCM as it was "not a flight recorder, nor is it a purpose built crash recorder" and the collision itself may have damaged the system and therefore the data contained within it.

The appropriate "perception-reaction" time for Leading Senior Constable Mounce-Stephens, that is the reaction time from perceiving the white Gemini in the intersection to braking was 1 second. This time was derived by applying the usual perception reaction time for an ordinary driver being between 0.9 and 1.5 seconds. Mr. Parker explained that as Leading Senior Constable Mounce-Stephens was a professional driver they all deemed it appropriate that his "perception-reaction" time was at the shorter end of that range.

Leading Senior Constable Mounce-Stephens would have first perceived and reacted to the white Gemini between approximately 72 - 63 metres before impact. At that time Mr. Fulton would have been between 16 - 17 metres from the point of impact and would have been expected to be able to perceive the police vehicle;

The speed the police vehicle was travelling prior to braking, based on the RCM data and taking into account a 10% variation was approximately 107km per hour;

If Mr. Fulton had applied his brakes (and there is absolutely no evidence to indicate that he did) when at the point the experts agreed he could have first perceived the police vehicle, there would have been ample opportunity for him to avoid the collision.

WAS IT APPROPRIATE FOR LEADING SENIOR CONSTABLE MOUNCE-STEPHENS TO PROCEED "CODE RED" IN RESPONSE TO THE POLICE VKG BROADCAST FROM BATHURST 15?

On the second day of the inquest I heard evidence from the following police witnesses:

Former Constable Milczarek; and

Senior Constable Simmons.

Both officers were in police vehicle Bathurst 15 on the afternoon of 25 December 2010 and were involved in the pursuit of an Aboriginal young person who was known to police and wanted in relation to a number of offences including breaches of bail and also escape lawful custody. I note that I have made a non-publication order in relation to the name of the young person and accordingly will not be referring to him by name during the course of these findings.

It was conceded by both officers during the course of their examination by Mr. Ranken, that:

- at the time Constable Milczarek called in his foot pursuit to VKG he simply wanted to let his partner, Senior Constable Simmons know his location;
- he was not requesting assistance from other officers; and
- it was not a life threatening or urgent situation.

In determining whether or not it was appropriate for Leading Senior Constable Mounce-Stephens to proceed "code red" it is not, as submitted by Mr. Saidi, counsel for the Commissioner of NSW Police, for me to "judge with hindsight but rather to judge an event as it occurs".

It was the evidence of Leading Senior Constable Mounce-Stephens that at the time he heard and responded to the VKG broadcast from Bathurst 15 his decision to proceed to assist "code red" was essentially based on the following:

- The officer that made the broadcast about the "foot pursuit" sounded "panicked and rushed";
- He knew he was the only patrol car in Bathurst that would be able to assist;
- When he acknowledged the broadcast and sought confirmation that it was from Bathurst 15, the police radio officer asked him if he could assist;
- His awareness and understanding of the location of the foot pursuit.

It was the evidence of Acting Sergeant Kris Cooper, a Senior Policy Advisor of the Traffic Policy Section, Traffic & Highway Patrol Command that the response of Leading Senior Constable Mounce-Stephens to proceed "code red":

"*was an appropriate response based upon the information available to LSC Mounce-Stephens at the time. Police requested assistance to apprehend a known offender actively avoiding apprehension. Police radio reinforced this by asking if Bathurst 12 could assist.*

From the material supplied it would appear that Bathurst 12 driven by Mounce-Stephens was the only available vehicle in the Bathurst area in a position to assist. This is supported by the radio log for the channel and the statement of Detective Sergeant Howard. The log reflects only one other vehicle, Bathurst 16, in the area but on site at Bathurst Gaol. He advised VKG of his "code red" response. The VKG operator must have approved of the response or otherwise would have directed he downgrade his response to "blue"."[95]

Accordingly, having heard all the evidence in relation to this issue I am satisfied on the balance of probabilities that it was appropriate for Leading Senior Constable Mounce-Stephens to proceed "code red" in the circumstances.

Having determined that it was appropriate for Leading Senior Constable Mounce-Stephens to proceed as an urgent response "code red" it becomes incumbent on me to determine whether or not his manner of driving when proceeding "code red" prior to the collision was appropriate.

Christmas day 2010 in Bathurst was a fine sunny day. The traffic was very light and Bathurst 12 was a fully marked category 1 police Ford Falcon sedan driving above the posted speed limit of 60 km per hour with lights and sirens activated.

It was the evidence of Mr. Glencourse[96] and his son Michael[97] that as the police car passed their vehicle at the intersection of Durham Street and Stewart Street it accelerated away from their vehicle however it did not swerve and in their view it was not being driven erratically. Accordingly, the sole issue in relation to the manner of Leading Senior Constable Mounce-Stephens' driving whilst proceeding "code red" was whether the speed he was travelling at was excessive.

The evidence with respect to this point comes from a number of sources.

Firstly there is the evidence of the lay witnesses, namely the Glencourse family who witnessed the driving of the police vehicle just prior to the collision. Mr. Glencourse a licensed driver for 35 years and who was also a professional truck driver for a number of years was of the view that the police vehicle was not being driven at an excessive speed. His son Michael, who had very limited driving experience as of 2010 was of a similar view however, Mrs. Glencourse who did not give evidence did comment at the time they were passed by the police vehicle that it was going very fast.[98]

Secondly, the experts[99] all agreed that the speed the police vehicle was travelling prior to braking was between 100 - 110 km per hour but it may have been possibly as low as 90km per hour.

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95 Exhibit 6, paragraph 6.

96 Exhibit 2, Volume 2, Tab 52

97 Exhibit 2, Volume 2, Tab 51

98 This evidence was given by Michael Glencourse during the course of his oral evidence on 18 June 2012;

99 Senior Constable Ian Stibbard, Mr. Simon Parker and Mr. Jamieson;

Finally, the evidence of Leading Senior Constable Mounce-Stephens whose evidence was that he thought he was travelling at approximately 80 - 90 km per hour, however he was focused on the road and not on his speedometer and that the speed at which he thought he was travelling was based on his experience alone.

This is a convenient point to consider the evidence of Leading Senior Constable Mounce-Stephens as a whole. Leading Senior Constable Mounce-Stephens gave evidence on the third day of the inquest. He also provided an ERISP on 26 December 2010 the day after the collision and took what can only be described as contemporaneous notes in his police notebook shortly after the incident. All these various forms of evidence have been consistent.

Leading Senior Constable Mounce-Stephens has always been cooperative with investigators, forthright and frank in his responses and clearly a witness of truth. In fact, it was Leading Senior Constable Mounce-Stephens himself that drew the attention of investigators to the elf / Christmas hat he was wearing at the time of the collision despite no evidence of the hat being found in the police vehicle he was driving or from any of the eyewitnesses spoken to by police up to that point.

Much was made of this "elf hat" during the course of this inquest, not because there was anything inherently wrong with it being worn by Leading Senior Constable Mounce-Stephens or that it contributed to the collision in anyway but because quite simply the perception of transparency of the investigation was paramount. The issue was resolved once Leading Senior Constable Mounce-Stephens gave his evidence, namely that he had simply put the elf hat in his cargo pants.

Is a speed of between 90- 110 km per hour on a main thorough fare which has a posted speed limit of 60km per hour excessive for a police vehicle responding "code-red"?

Mr. Abigail solicitor for the family submitted in essence it was. The effect of his closing submissions was that clearly Leading Senior Constable Mounce-Stephens was unable to stop in time to avoid the fatal collision with Mr. Fulton's motor vehicle. I do not agree.

As at December 2010, Leading Senior Constable Mounce-Stephens was an experienced police officer with appropriate driving experience and accreditation to engage in urgent duty driving. All the evidence indicated that at the time he proceeded "code red" on the afternoon of 25 December 2010 he endeavoured to keep a proper look out, proceeded with caution having slowed down at the roundabout at the intersection of Mitre Street and slowing for the traffic lights at the intersection of Stewart Street and Durham Street prior to the lights turning green. He cannot be criticised for concentrating on the road and its surroundings whilst proceeding "code red" and not on his speedometer.

Moreover the evidence of the various experienced senior police who gave evidence during the course of this inquest indicate that it was their view that the speed travelled by the police car prior to impact was not excessive. This includes the evidence of:

1. Acting Sergeant Kris Cooper who stated in evidence on the second day of the inquest that the speed was not excessive and was within the Safe Driving Policy; and

2. Inspector Nicholas Weyland who stated in evidence that "the speed of the vehicle was not excessive under the circumstances"[100].

Accordingly, I am satisfied on the balance of probabilities that whilst proceeding "code red" the manner of driving of Leading Senior Constable Mounce-Stephens, including the speed that he was travelling at, was appropriate in the circumstances.

WHAT WAS THE STATUS OF LEADING SENIOR CONSTABLE MOUNCE-STEPHENS' DRIVE ACCREDITATION WITH NSW POLICE?

The NSW Police Safe Driving Policy is quite specific in relation to who can engage in a code or urgent duty response. It states:

"Urgent Duty is: "Duty which has become pressing or demanding prompt action".

Urgent Duty Guidelines:

> *Could require you to travel in excess of the prevailing speed limit.*
>
> *Requires all emergency warning devices to be activated giving the best practicable warning of your approach.*
>
> *The vehicle must be a category 1 or 2 (unless it is LIFE THREATENING or an EMERGENCY where such a response is appropriate, in which case the vehicle can be a Category 3 or 4).*
>
> *You must be a SILVER or GOLD classified driver.*
>
> *Bronze Classified Drivers will NOT engage in urgent duty driving under ANY circumstances"*[101]

The evidence before this inquest indicates that Leading Senior Constable Mounce-Stephens has held a silver accreditation continually since 2001. However, in August 2010 Leading Senior Constable Mounce-Stephens' driver accreditation was called into question. At this time he was subject to a Safe Driver Panel Review as a result of two driving incidents in July and August of that year. One of those incidents related to the use of a category 4 vehicle in a pursuit that ended without incident.

I note that the Safe Driver Panel Review as a result of reviewing that incident recommended the following:

- Leading Senior Constable Mounce-Stephens' driving status should be reduced from a silver to bronze for six months;
- Leading Senior Constable Mounce-Stephens should be made to undergo full silver CAS test prior to his status being reinstated; and
- Leading Senior Constable Mounce-Stephens review the Safe Driving Policy and acknowledge in writing when this was complete.

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100 Exhibit 2, Volume 1, Tab 8 paragraph 111;

101 Exhibit 2, Volume 4, Tab 98 at page 24;

Leading Senior Constable Mounce-Stephens was advised of the recommendation by Inspector Alderidge however was also told that it was ultimately up to Superintendent Robinson as to whether or not the recommendations of the Review Panel would be implemented.

What became abundantly clear from the evidence of Superintendent Robinson on the second day of the hearing was that he had chosen to override the recommendation of the Safe Driver Review Panel and not downgrade Leading Senior Constable Mounce-Stephens' status from silver to bronze.

Accordingly I am satisfied that at the time of the collision, Leading Senior Constable Mounce-Stephens held the appropriate accreditation to engage in urgent duty or "code red" driving.

WERE THE CRITICAL INCIDENT GUIDELINES COMPLIED WITH FOLLOWING THE ACCIDENT?

Following the collision, the evidence indicates uncontroversially that the following steps were taken:

- Leading Senior Constable Mounce-Stephens got out of his vehicle and went to check on Mr. Fulton;
- Thereafter, recognising that Mr. Fulton had been injured, at about 3.09pm he went back to his vehicle and called for assistance;
- First police to arrive at the scene were Senior Constable Simmons and Constable Milczarek;
- At about 3.19pm (approximately 10 minutes after the collision), Sergeant McCann declared the incident as a critical incident;[102]
- VKG was contacted by Senior Constable Beattie at approximately 3.24pm to advise that the matter is to be treated as a critical incident and the appropriate protocols were to be put in place;[103]
- Leading Senior Constable Mounce-Stephens was placed in Bathurst 12 and eventually removed from the scene and taken back to Bathurst Police Station where he sat in a supervisors office. He eventually telephoned and was later joined by his wife;
- At about 4.40pm Senior Constable Cole performed a breath test on Leading Senior Constable Mounce-Stephens using alcolizer serial number 104831 in the direct mode using a tube and it produced a negative (that is no alcohol detected) result;[104]
- Between 5.15 and 6.15pm Senior Constable Cole accompanied Leading Senior Constable Mounce-Stephens to Bathurst Base Hospital where he provided a blood and urine sample for testing.[105] I note that these produced a negative result, that is, neither drugs nor alcohol were detected in his system;[106]

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102 Statement of Inspector Hoolahan - Exhibit 2, Volume 1 Tab 18 at paragraph 3 and Statement of Sergeant McCann - Exhibit 2, Volume 1, Tab 22 at paragraph 5;

103 Statement of Senior Constable Beattie - Exhibit 2, Volume 1, Tab 11 at paragraph 11 and CAD incident log 117934-25122010 - Exhibit 2, Volume 2 at Tab 66 at 15:24:02;

104 Exhibit 2, Volume 1, Tab 17 at paragraph 9;

105 Ibid at paragraphs 12 and 14;

106 Exhibit 2, Volume 1, Tabs 40 and 41;

- Leading Senior Constable Mounce-Stephens did not provide an ERISP until the following day. Although the Critical Incident Guidelines indicate that interviews with involved officers "should be conducted at the first reasonable opportunity" and that if, for any reason the critical incident investigators "decide not to interview an involved officer until a later stage" they must "consider what could be lost or potentially compromised by following this course of action".[107] I note the evidence of the OIC, Detective Sergeant Howard, that as no other officer was involved in the incident there was no opportunity for collusion. Accordingly, he thought it preferable to gather as much information from the scene in order to interview Leading Senior Constable Mounce-Stephens properly and only once.

Having regard to all the evidence in this inquest I am satisfied that the Critical Incident Guidelines have been complied with. However, it has become abundantly clear during the course of this inquest that there currently seems to be no formal education of at least the officers who appeared at this inquest as to what is a critical incident and what the guidelines involve.

Moreover, many of the junior officers were uncertain of the practical ramifications of an incident being declared a critical incident. This came to light as result of the confusion as to whether or not officers from the Bathurst LAC should attend to the breath testing of Leading Senior Constable Mounce-Stephens or await the arrival of the Critical Incident Investigation Team from the neighbouring LAC who would be taking over the investigation.

Leading Senior Constable Mounce-Stephens was ultimately tested and produced a negative result, however, the possibility for this confusion and lack of understanding and insight as to their respective duties and responsibilities could potentially cause an issue in the future, particularly in remote areas where it can take considerable time to mobilise a critical incident team of senior officers from a neighbouring local area command. Often time is of the essence.

I note the submissions of Mr. Saidi for the NSW Commissioner of Police that this issue was only raised for the first time on the third day of the inquest. That is not correct. At the outset of this inquest Mr. Ranken stated:

"A final aspect of this inquest is the question of compliance with the Critical Incident Guidelines themselves. An important aspect of the Critical Incident Guidelines concerns the management of the scene and, in particular, the involved officer in the immediate aftermath of a critical incident. These include requirements for the officer to be separated and arrangements for the testing of involved officers for alcohol and other drugs.

Whether these requirements have been properly followed will be explored and, if they have not been properly followed, whether that is due to any deficiency in the guidelines themselves or, perhaps, in the officers' understanding, experience and/or training in the content and application of the guidelines."

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[107] Exhibit 2, Volume 4, Tab 97 page 21 - 22;

Mr. Saidi also submitted that ultimately, it was not for junior officers first on scene to make the decisions as to whether an incident is a critical incident or to determine what steps are to be taken as that it is for more experienced senior officers. However, the evidence of the more senior officers in this inquest indicates that the education with respect to critical incident guidelines was scant at best, and most of their knowledge came from experience and word of mouth. There was in fact confusion as to whether a breath test should be conducted and that is of concern.

I accept I had no direct evidence as to what education is currently being offered and that the Critical Incident Guidelines are in the process of being updated and improved. However, the effectiveness of any form of guideline is in its implementation and that can only be done by way of communication and education. If the guidelines and the reasons for those guidelines are not adequately communicated to those who are to comply with them then there is the potential for inconsistency in their implementation.

I am stopping short of making a formal recommendation in this matter but urge the NSW Commissioner of Police to consider these findings and implement education for all his officers on the current or the new Critical Incident Guidelines and their ramifications. Accordingly, I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2009.

Formal Finding:

I find that Roy John Fulton died on 25 December 2010 at Bathurst Base Hospital as a result of multiple injuries sustained in a motor vehicle accident involving a police vehicle engaged in an urgent duty response.

For the reasons set out in these findings I will not be making any recommendations pursuant to section 82 of the Coroners Act 2009.

At the end of the day the death Roy John Fulton was a terrible and tragic accident that has impacted the lives of his loved ones, the Bathurst Community and also Leading Senior Constable Mounce-Stephens. Once again I extend my condolences to the family.

25. 339 of 2011

Inquest into the death of Gillian Harman at Armidale on the 9th February 2011. Finding handed down by State Coroner Jerram.

This was a mandatory inquest because this involved under s 23 of the **Coroners Act**, a death, the death of Gillian Marie Harman during the course of a police operation. I am told by the highly qualified and competent Inspector Beattie, who was the investigator appointed in this matter, that the police officer involved in the collision was on his way as one of several cars to a domestic violence life-threatening incident, but that he implemented procedures which he was not qualified to use, having not passed any of the advanced driving courses, and in fact, only one month before having been told he was not yet suitable to undertake extra training.

In other words, that officer, Constable Simpson, was not authorised to drive other than like any member of the public. For whatever reason, he was travelling at a speed in the eighties in a fifty k zone as he entered an intersection on his way to the incident and collided with the car driven by Ms Harman who presumably was on her way home from work looking at the time of the accident. Both cars rolled. The two police were not seriously injured, but Ms Harman died on the spot of multiple injuries.

We have heard today from the Inspector that it has been a tragedy for her family and that she was the primary carer it sounds of her elderly and not very well parents and it has had a huge impact for them. The officer was charged very promptly with dangerous driving causing death. He pleaded guilty at the first opportunity and I see that when he appeared in the District Court in Armidale on 9 November 2011 some nine months after the accident he was given as required a twenty-five per cent discount on his sentence because of his immediate plea.

It appears from what I have seen of the judgment that the District Court judge was also impressed by the extreme remorse and contrition felt and expressed by Constable Simpson and I accept that. It had occurred to me to recommend that he really should be an appropriate person to stay on the police force, however, I am told by Inspector Beattie that the Commissioner has made no decision until this matter is completed as it will be from our point of view today. I think it more appropriate that that is a decision for the Police Commissioner and I will not make such a recommendation. He has certainly already received considerable punishment.

I quite accept that anybody with any conscience at all and he clearly has, will carry this burden for his life and it may be that the Commissioner takes a certain view. As I say I will leave that to him.

I have also heard and I think it is important to say that in the Inspector's view it was a dangerous intersection. It currently only has Give Way signs and it is his view that those signs should be Stop signs rather than Give Way.

That matter had already been raised by my instructing solicitor, and counsel assisting, with the council and as exhibit 4 before me is a letter from the council saying that the Local Traffic Committee recommended that current Give Way signs on the intersection be replaced by Stop signs as determined from Site Distance Investigations. The council adopted those recommendations and I understand that they then go on to once it gets to the seriousness of the Stop sign the Road and Maritime Services.

I am not quite sure why but apparently that is the way that particular bureaucracy works, the grinding small like mills, I think. I will add to that by making a recommendation under s 82 to the Minister for Transport that I recommend strongly that the Roads and Maritime Services accept the recommendation of the Local Traffic Committee. No, I think it would now be actually of Armidale Council that that Stop signs replace Give Way signs at the intersection of Faulkner and Newton Street and that that be implemented as quickly as possible.

FORMAL FINDING:

THAT GILLIAN MARIE HARMAN DIED ON 9 FEBRUARY 2011 AT THE INTERSECTION OF FAULKNER AND NEWTON STREET, NEW SOUTH WALES FROM MULTIPLE INJURIES FOLLOWING A MOTOR VEHICLE ACCIDENT.

26. 473 of 2011

Inquest into the death of Fredderick McGregor at Liverpool on the 25th February 2011. Inquest suspended by State Coroner Jerram.

After being informed that a person has been charged with an indictable offence arising out of this death, State Coroner suspended the inquest on the 31st May 2012.

In accordance with State Coroners instructions the matter will be placed into the suspended matters call over until the criminal proceedings have been finalised.

27. 746 of 2011

Inquest into the death of Isidro Iglesias at Malabar on the 4th April 2011. Finding handed down by State Coroner Jerram.

Following examination of the all the material available to me, I am satisfied that this man has died of natural causes whilst at an inmate at the Goulburn Correctional Centre. There are no suspicious circumstances and no issues that require any further examination. The statutory requirements that I am required to find are all disclosed sufficiently. As he has died in custody it is mandatory under the act that an inquest is held.

FORMAL FINDING:

THAT ISIDRO IGLESIAS DIED AT LONG BAY GAOL HOSPITAL ON 4 APRIL 2011 OF PULMONARY THROMBOEMBOLUS AND DEEP VENOUS THROMBOSIS COMBINED WITH METASTATIC CARCINOMA OF THE LUNG.

28. 965 of 2011

Inquest into the death of Floyd Dowley at Junee on the 1st May 2011. Finding handed down by Deputy State Coroner Dillon.

Mr Floyd Dowley was a prisoner in the Junee Correctional Centre when he died on 1 May 2011. He was serving a sentence from July 2009 for convictions of manslaughter and take and drive conveyance. He was sentenced to a non-parole period of seven years backdated to 24 November 2007, with an additional term of four years.

On the morning of 1 May 2011 he was discovered lying in a pool of blood in his cell. Of interest in the period leading up to 1 May, he had been spoken to by a correctional officer concerning his mental health, in fact on the day before, 30 April 2011 he had had a conversation with one of the officers who approached him and had a discussion about his feelings. Mr Dowley told the officer, "Yeah I'm fine chief, just a bit down". The officer then asked whether he needed to see a medical officer and have a chat, and he said, "No I'm fine".

Other inmates or at least one other inmate had brought to the attention of staff that Mr Dowley wasn't eating and seemed depressed. The staff took an interest in that and obviously raised the issue with Mr Dowley.

When Mr Dowley was found in his cell it was initially thought that he had committed suicide by taking apart a disposable razor and using the razor to cut himself, self inflicted injuries. He certainly had inflicted injuries on himself and he had lost what appears to be a considerable amount of blood.

The post mortem examination however, which is done in all such cases, found that the direct cause of his death was atherosclerotic cardio vascular disease. It was also noted in the post mortem report that the disease was severe, especially in the left anterior descending coronary artery, he had a couple of superficial wounds on his left forearm. He had also a history of hepatitis C, which obviously reduces ones health status and in the period before his death decreased nutritional intake over several weeks. He also had moderate chronic lung disease.

It therefore appears that on the weight of evidence, far more probable than not that he died of natural causes, namely atherosclerotic cardio vascular disease. Obviously in a case such as this, there is a real concern, especially when suicide at least at first blush appears to have been the cause of death.

The state of those who carry out duties on behalf of the state such as the Geo Group owe a duty of care to those inmates who are in their custody. It is part of our society's approach to dealing with people serving sentences of imprisonment that an independent judicial inquiry will take place if someone dies in custody. It is a requirement under the Coroner's Act that an inquest be conducted and that is obviously to ensure that those who have custody of others remain ultimately accountable to society.

In this case Detective Harris has praised the work of and the approach of the Geo Organisation to the investigation of Mr Dowley's death. The material that I have read in the brief, both the corrective services brief and the police brief suggest to me that the Geo staff at Junee in fact were solicitous of Mr Dowley's health, were interested in his well being and would have taken steps if he had indicated that he needed help.

It is an interesting coincidence that he was both very depressed or apparently very depressed but he also died at that time. There may be some connection I suppose between bleeding and the atherosclerotic disease, but it appears on the medical evidence to be coincidental.

In any event, I have now read the submissions put on behalf of Geo by Ms Rudland, I do not have any adverse findings to make, in fact quite the opposite as I have just said.

Formal Finding:

I find that Floyd Dowley died on 1 May 2001 at the Junee Correctional Centre of atherosclerotic cardio vascular disease.

I propose to make no recommendations under s 82 of the **Coroner's Act** and I direct that these findings be published, or they be published under the Act.

29. 1197 of 2011

Inquest into the death of Gheorghe Lisita at Campbelltown on the 28th May 2011. Finding handed down by State Coroner Jerram.

For the last two days I have heard evidence into the death of Gheorghe Lisita-Cocheci who died very clearly of a heart attack, and I will be more formal about that when I make the formal finding, on 28 May 2011. It is a sad story. Gheorghe, Mr Lisita, if I may call him that, his own son who obviously loved him exceedingly admits, was not an angel.

He had had sometimes a difficult past but he had been living a normal calm decent life for a long time. He was not allowed to drive. He had been, it turned out, although nobody knew this at the time, disqualified for years and years and years from driving and hence was on a bicycle on the day in question. It was a motorised bicycle, presumably because he knew that he had some sort of heart problem. Anyway, I am told that he lived about ten kilometres away from the shops where he had gone to buy household provisions and other things on this day.

He did, it appears, commit a very minor offence in not wearing his helmet. It also seems that he had been riding on the footpath, which is a minor offence. We say minor, but on the other hand, if somebody hurts themselves because they are not wearing a helmet there is a huge cost to that person and to the community. As for riding on the footpath, if a pedestrian is hit by somebody riding on the footpath, that is a serious matter too. I must say, every now and then I walk down Parramatta Road and almost get skittled by somebody coming along at speed behind me and I know that even pushbikes can be dangerous.

In any case Constable Goldie as he then was and Constable Poke, a very new officer, he had only been in the force for six months and was still a probationary officer, were doing their general rounds, as I understand it, in a police van and saw Mr Lisita. They stopped the van and called out to him that he should be wearing a helmet and Mr Lisita at this stage, not the slightest about the police having done anything wrong because they were observing what they knew to be, albeit minor, breaches of the law.

Mr Lisita may not have liked police very much. I think his family would probably agree with that, but to put it politely, he blew his top; he did not like being told what to do. His own son tells us that he was not one who liked being told what to do. He wanted argue the toss, as the saying goes, about the law itself.

I think he was probably wrong but he began first of all by putting his head through the passenger window of the police van and then by waggling his finger at the driver, who was Constable Goldie, to the point that Constable Goldie got out of the van and the argument continued. It then unfortunately became physical. It is not quite clear how that happened. Mr Lisita, again I have this description form the son, was European and he tended to use his arms and hands a lot and was no doubt throwing them around; and he was, from all witnesses, being pretty loud.

He then, and I accept this, at least used the work "fuck" and was remonstrated by Constable Poke who said, "Look, you can't say that, that's offensive language."

Things just go worse; all the time watched by at least two, if probably three, civilian witnesses whom I will come to in a moment. It became a bit of a struggle. Constable Goldie said to Mr Lisita, "Look, I am going to issue an infringement notice. What's your ID?" and Mr Lisita refused to give it. The struggle continues. At one point they went a few yards probably away, a few metres, and actually banged into the shop window further down from the real estate. Terribly sad that this all happened from relatively minor beginnings.

I have a feeling that Constable Goldie was getting pretty cross and I have no doubt that Mr Lisita, as I have said, had blown his lid - to use that expression. He refused to give any ID. Constable Goldie sent Probationary Constable Poke to the van to get the traffic infringement notice book, which incidentally he could not find although I do not think that really is terribly relevant. But when he would not give ID, even had the book being found, it would have been pointless without details. The sad thing that is if Mr Lisita had just told them who he was right from the beginning, and his address, I think the police - it was never absolutely said, but I think they intended just to either later send an infringement notice in the mail or had they found the book to give him the notice on the spot.

Unknown absolutely to the police, Mr Lisita and we know this now from a large number of medical documents which are part of the brief - had quite serious cardiac problems. Indeed he was due for an angiogram within the next two weeks. I think it was Robert, his son, who raised the question of why if it was that bad why would he have not been given the angiogram quicker or earlier? Unfortunately, I think that is a comment on the public hospital system rather than any measure of how urgent or how serious Mr Lisita's medical condition was. From the medical notes, which are part of the brief, and from the post mortem report, sadly there is no question at all that he had very serious heart issues and that it was he was a walking risk. He did not know that of course quite himself, I imagine, but certainly the police did not.

Constable Goldie says that he felt fearful that he or Constable Poke were going to be assaulted. Although that does not quite sit well with the description that all the time what was happening was that Mr Lisita was trying to get away. I accept from Constable Goldie that he believed that if he did he would immediately ride his bike again without the helmet and probably on the footpath. I am not sure that I accept that there was a serious fear of any form of serious assault. Yes, there may have been a lot of flailing around and there is no question that Mr Lisita was resisting what - I agree with Mr Spartalis - the police were entitled to do by that stage which was to arrest him because they did not have ID.

At the point where the two police officers had put Mr Lisita over the bonnet of the car, and that would have been a frightening experience but I am not suggesting the police were not entitled to do that, Constable Goldie got to a point where he said, "Calm down or I'll taser you". The question is was that a warning or a threat, I am not going to go into. I looked up both words during the lunchbreak and they are slightly different, I agree, but it is a fine line and if you are in the state that Mr Lisita was by then I think it could have easily been he would have probably seen it as a threat.

In any case at the same time Constable Goldie pulled from his left chest area, where tasers are kept, his taser from his holster, took it over to his right shoulder. Mr Spartalis suggests that Mr Lisita might not have even realised that he had done that. I suppose that is a possibility but it is equally possible that he did especially as it happened at the same time as the words, "Calm down or I'm going to taser you". He then, quite rightly, realised that it would not work; that it was not something he should have done because they were all too close and it was not far enough away for the taser to be deployed successfully and it could have done harm to either of them. He, within seconds - and I accept that - put it back in its holster.

From all the evidence, other than Constable Goldie's, immediately Mr Lisita calmed down. He became compliant according to Constable Poke, according to the observers, and in fact he obviously stopped struggling to the point that he was worried about his bike and asked what is going to happen to that; and he asked Mr Machuca, one of the civilian witnesses, to put his hat on for him. No more struggling. Constable Poke was then told to put him in the van. Constable Goldie took the bike into the shop.

I think Constable Goldie's feelings are somewhat revealed by the comment he made as he took the bike into the shop. I am not seriously criticising him for that, I think everybody must have been pretty upset by that stage, but the point was Mr Lisita was so clearly no longer a threat or resisting that Constable Goldie left Constable Poke to take him to the back of the van. There, before he could even help him into the van, suddenly Mr Lisita flopped down. All his weight fell, he went to his knees; and, it appears, virtually died on the spot. Nobody has made the slightest criticism of what the police did then. The minute they realised that it was serious, they did what they could. An ambulance was called and was there in about eight minutes, but although he was taken to hospital it sounds as if he was pretty clearly deceased at the scene.

I heard from a number of witnesses. Very important was Sarah Hibbert and Ivan Machuca from the real estate agency outside which all this happened. They heard the voices, first of all, and went to watch through the window of the agency between the housing ads and saw virtually everything that happened. Ms Hibbert did give evidence and I have to say, as I did to her yesterday, that I thought she was an excellent witness; did not have any axe to grind, was not trying to be on anybody's side, did agree that Mr Lisita was struggling and resisting and also said that she that she thought that the police were possibly exerting excessive force. Mr Machuca, her boss, said much the same.

They both saw what they saw then as a yellow object, which turned out, to be the taser pulled, but that is not denied now. Ms Hibbert and Mr Machuca, particularly Ms Hibbert, described Mr Lisita as hysterical. But they also said, both he and she, that he was distressed and scared.

I have a statement, which is tab 19 of the brief, from a Peter McKenzie who sadly was not able to be called to give evidence because he is very ill. I have not put much weight on it, because of course he could not be cross-examined on it and it also does seem to me to be somewhat biased and one-sided. I do not know, of course. He apparently did know - I do not know how well - at least Constable Goldie because Constable Goldie mentioned that he saw Peter from the Court.

I am not saying that he gave false evidence but the trouble is it was not able to be tested so I cannot put a great deal of weight on it.

I really cannot be sure about the particularly foul swear phrases that Constable Goldie says he heard from Mr Lisita. I accept Mr Lisita said the word "fuck" at least once, if not more. I am not sure about the highly colourful obscene phrases he is said to have used because nobody else heard them. I know Constable Poke was looking in the car, he was not far away and he could hear everything else. Mr Machuca did not hear it and said in evidence that he was sure he would have remembered if it was said.

I then heard from the two officers. I say right from the outset, and I am putting them in the opposite way from which gave evidence, there is not a word to be said against Constable Poke. He gave his evidence to the investigating officer, Detective Sergeant Clements, absolutely straight as far as I can tell right at the start. He mentioned the taser use or drawing without being prodded and in the witness box yesterday I thought he was a very straightforward and open and honest witness. He was very new, as I said, at the time. He had not done any taser training but he has since, and I thought it was significant that when I asked him yesterday if in that circumstance he would have used the taser he said no he would not. So I really need say no more about Constable Poke other that he corroborates a lot of the evidence that I am summing-up.

I come to Constable Goldie. Can I say, I do not think Constable Goldie is a bad police officer. I do not think he set out that day, or even when he was interviewed or gave his evidence, to do wrong. I completely accept that no matter how much you write down rules and protocols and standard operating procedures, about everything really but particularly when it comes to use of force and weapons, in the end everything comes down to an officer's judgment. In this case I think he misjudged. I do not think it goes a lot higher than that. I think he misjudged but he recognised it himself, that having drawn the taser he recognised it was the wrong circumstances and put it away again.

If only he had told that from the beginning he would barely be criticised. But he was very careful with the truth, and that is a polite way of putting it, when he was first interviewed by Sergeant Clements. It was not until Sergeant Clements, given some information partway through the interview, was told that there was a taser use or at least drawing having been alleged, put it directly to him that he said yes he had drawn it. When he was first asked, in a general way, by Detective Clements about the use of weapons at all, he had this opportunity then and he did not answer honestly. Or you could say, within that whole phrase, it was not the whole truth. Sergeant Clements did, as I say, then put it to him and he did say, Yes, I drew it but I put it away quickly. But Sergeant Clements had to interview him a second time to get the full admission about what happened with the taser.

Let me say this: we have spent a lot of time on the taser because it is worrying and because tasers are constantly in the news at the moment and the subject of inquests and journalist articles and so on. We cannot know that the drawing of that taser had any direct effect at all on the death of Mr Lisita. I completely accept that most people would be frightened if any sort of weapon is drawn in your close vicinity.

Dr Chau(?) gives an opinion that with the sort of heart condition Mr Lisita had, stress and physical exertion, might well have exacerbated what was a heart attack waiting to happen. Those are my words not Dr Chau. The physical exertion was partly Mr Lisita's own doing. The whole thing was stressy for everybody and it could well have had some indirect connection but we simply cannot know that for sure. It might have been, for example, that the bike trip home that afternoon was enough to have set off a cardiac arrest. He was, and we must not forget, much sicker than anybody knew including himself.

However, so far as we need to have a look at the drawing of the taser, I repeat again, I think Constable Goldie made a mistake. I do not think it was the biggest mistake ever and he rectified it extremely quickly. Had he been open and honest about it right from the start and even in the witness box said, "Yes, I think I might have misjudged that," because he virtually was indirectly saying so when he said he put it away so quickly, we might not have had to spend so much time on the matter.

I am not going to make a recommendation about tasers themselves for a couple of reasons (1) because I cannot see it is directly connected, in this case, with the death; also because as you have heard from Mr Spartalis there are other matters pending that involve actual use of tasers; that is, deploying, and more attention will no doubt be given to those in the next few weeks.

I do not mean to say this death does not matter because it does. All I say is we cannot make the direct connection and it was not actually used on Mr Lisita. I cannot be sure of this because it was not raised with either Sergeant Clements or with the two police officers involved. It did occur to me afterwards and too late to ask them. Once Mr Lisita had calmed down, as completely as it seems he did, after the taser warning and the cuffs, I wonder if it had not then been an option to consider putting to him again, would you give us your ID and we will give you a traffic infringement notice.

As I say, I cannot be sure because it was not put to the witnesses, but it just occurred to me that from all descriptions, other than that slight difference from Constable Goldie, he was a different kettle of fish at that point. Mr Lisita, I do not mean to be disrespectful about your father in saying that. He seemed to be really calm, worrying about his bike, asking his hat and sunglasses. So I do not know, perhaps it was too late.

I do not think anything that happened after the cuffing needs criticism, but I just wonder if at that point - it probably would not have saved him by that stage. One can only imagine that the heart attack was building up because it was only two minutes later that he collapsed at the back of the truck.

I am sorry that the family seem to feel that they have not been treated well by the police. Unfortunately police get an enormous amount of criticism and some of it is justified and a lot of it is not. In this case as I have said I think it is a pity that if Constable Goldie had said, I wish I had not done that, I would have felt happier myself. But I do not think there is anything that the family need to worry about that has not been cleared here or that has not been investigated. That is not going to bring Mr Lisita back. I wish I had a wand that could do that. If only I did, would I not be a good coroner, but I cannot do that for you.

I can only say that I really try and so does my counsel assisting and Mr Spartalis too, whatever you feel about all of this, to hear what happened and bring out the truth. It just seems to me this was an awful situation that started from such a tiny problem, relatively tiny, got right out of control partly because Mr Lisita himself was pretty volatile. The only real mistake I can see was the drawing of the taser but I cannot say that had any, as I have already said a couple of times, actual effect in leading to the death.

I am going to make the formal finding. I am not going to make any recommendations this time. I just want to say to the whole family how terribly sorry I am and I absolutely accept that it is a dreadful loss for you and particularly for you, ma'am. I am just glad for you that you have got lovely family around you and those dear little girls, because they are good. It must be due to you, and all of you, that they are so good.

FORMAL FINDING:

GHEORGHE LISITA-COCHECI DIED ON OR ABOUT 10.35AM ON 28 MAY 2011 AT BROWNE STREET, CAMPBELLTOWN, HAVING DIED DURING A POLICE OPERATION, BUT AFTER HAVING BEEN ARRESTED, OF ISCHEMIC HEART DISEASE A NATURAL CAUSE.

30. 1308 of 2011

Inquest into the death of AA at Camperdown on the 14th June 2011. Finding handed down by State Coroner Jerram.

This is a mandatory investigation because AA had a gun to his head and died while police were attempting to negotiate with him to put the gun down and come into their custody unharmed. Ms Baker who is a kinder person perhaps than I, certainly more inclined to give benefit of the doubt, has suggested that he was a desperate man and he may very well have been. He had a business which had been suffering as was many people's, since the global financial crisis in particular. He was aging, he lived in a house, which had originally belonged to himself and his first wife and still in fact was in those joint names.

I cannot help but notice that he seems to have been able to stay in that house with a second wife for 14 years, while his first wife doesn't seem to have married again and had made no claim upon him until a couple of months before AA's death, she indicated that she needed her money from that house. Hardly seems to me to have been a selfish act on the part of the first wife. When that was indicated, AA became very distressed because due to his financial situation, it seems that he was not able to buy her out.

In other words, to buy the house from her, enabling her to have her share of its net worth. There were legal negotiations, there were discussions about wills, but he seems to have blamed her for what, as I say, seems to me to have been a perfectly natural and indeed rather decent set of actions on her part in that she had left it for so long without making that claim.

He then went to her house the day before his own death and yes, he no doubt was in a mentally agitated state. To me that barely excuses the fact that he took with him a loaded gun. On the arrival home of his wife in her car where he was, for which he seems to have been waiting, he shot her through the window of the car as she attempted to drive off, having seen him. Now, again, I say he clearly was in a mentally agitated state, but not to such an extent that he didn't realise he needed to flee and when he went to the home of a friend, or the warehouse of a friend at Marrickville, to omit the rather serious fact that he had just actually shot his wife.

I suppose he didn't know at that point the result of the shooting. However it is not a series of actions which really gives any credit to Mr AA at this point. The police, through a serious of pieces of information, fairly quickly discovered where he probably was and went to the warehouse outside of which his car was parked and it seems extremely sensibly, made the decision to do nothing, it being dark, until the morning, when having spoken to the friend of Mr AA, who was also the owner of the warehouse, it was confirmed that indeed AA was inside. In the meantime in fact, AA himself had rung triple-0 I think to say that he was in the warehouse and intending to commit suicide.

Tactical Operation Unit officers and the very senior negotiator, in fact I am told by Inspector Hopper one of only two fulltime negotiators in New South Wales, Sergeant Lahey, arrived at the same time at the warehouse. There was some discussion about cutting a padlock in order to gain easier access. That obviously upset AA but I would not put any criticism on police for that action whatsoever. He appeared more than once in the doorway of the warehouse behind the padlocked gate with his gun held tightly to his right temple.

I come back to Ms Baker's kinder view of life. She says that it is possible and I agree it could have been possible that while he was clearly as everybody seems to agree, suicidal and had been for some weeks at least, probably a couple of months, he may have in fact at the very point when the gun went off, not have intended to pull that trigger.

Apparently the firearm was one in which - I'm not quite sure what the word is - but the trigger was very easy and he was according to Sergeant Lahey, in mid-sentence at the time that the trigger was pulled and the shot went off. I am not sure whether being in mid-sentence establishes anything really, especially when I look at what in fact that sentence was.

As I read it, Sergeant Lahey heard him say something like - yes, he said something like, "It's not worth it, it's 20 years", and then the shot went off. I don't know that is necessarily even mid way through a sentence. On the other hand, Sergeant Nelmes says that he saw AA walk away from the gate, turn adjacent to the strong hold door and fire, and Senior Constable Bessant says what he heard was,

"I just made a big mistake and now it is not worth it. I go to gaol for 20 years. There is no way out, there is no point" that he then took one step back and Senior Constable Bessant heard a gunshot.

I have also heard evidence from Inspector Hopper that two weeks before this he had mentioned suicide to his lawyer. He mentioned it certainly that morning when he rang triple-0 and he said it in many different ways to the police who were on the spot that day. Apart from that, in his jacket found after the shot was fired, was a tape recorder, which again is full of suicidal threats and many documents of the sort which often, when we don't have observers to an actual suicide, are found to be pointers to a suicide. I think they included wills, title deeds, et cetera.

Again he had also spoken to his adult son about intending to kill himself. Frankly if it were of vital importance, the more I have heard, the more my view would be that it probably does meet the Briginshaw standard for a suicide, however I don't think, and I agree very much with Ms Baker about this, that it is necessary for me to say more than that it was a self-inflicted gunshot wound.

Formal Finding:

That AA died of a self-inflicted gunshot wound to the head at Royal Prince Alfred Hospital Camperdown, on 14 June 2011.

31. 1659 of 2011

Inquest into the death of John Dunn at Aldavilla on the 19th July 2011. Finding handed down by Deputy State Coroner MacMahon.

This is an inquest touching the death of John David Dunn. Mr Dunn was born on 15 September 1957. Mr Dunn was convicted of various offences at the Parramatta District Court and sentenced to a term of imprisonment on 3 May at 2011. He initially was transferred to the Parklea Correctional Centre classified and then on 7 May 2011 he was transferred to the mid North Coast Correctional Centre which is located at Aldavilla which is in the vicinity of Port Macquarie on the north coast of New South Wales.

Mr Dunn had a history of drug abuse and as a consequence of that was receiving vitra morphine during the course of his incarceration. He was a heavy smoker, had a history of asthma. He used Ventolin to control the asthma. He was diagnosed - suffering from other indications of potential heart disease but - such as high cholesterol level but was not receiving any treatment or suffering any apparent symptoms of any possible heart disease.

On 18 July 2011 Mr Dunn, together with other inmates, undertook various painting duties. He is reported to have been in good spirits and not suffering any ill health. He continued those functions until he returned to his cell at which time he did not complain of any difficulties or illness to any members of staff. He was observed in the pod in which his cell was located until about 3.15 when muster occurred. The evidence available to me is that he received the prescribed medications during the course of the day. He was then placed in his cell around about 3.25 in the afternoon, which is ordinary.

During the course of that evening and the next morning he was not contacted in his cell. He was not visited. The cell was not opened and the cell, which is fitted with a knock up intercom system, was not activated.

The next morning at about 6.15 on 19 July 2011 the cell was opened. Mr Dunn was found to be laying on his bed with his back leaning against the wall. He was not moving. The television was on. He was attempted to be roused by the officer who had opened the door - not roused. He was checked, found to be not responding. A nurse was called. Assistance was rendered. At the time however Mr Dunn's body was cold to touch. He had no pulse. He was not breathing. Efforts to resuscitate him were unsuccessful.

Section 81(1) of the Coroner's Act sets out the primary function of a Coroner following an inquest. That section provides, in summary, that at the conclusion of an inquest the Coroner is required to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

Section 82 of the Act provides the Coroner with the opportunity and discretion to make recommendations, as he or she considers necessary or desirable in respect of any matter connected with the death with which the inquest is concerned. Making recommendations are discretionary usually but not necessarily only to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking aiming to prevent future deaths of a similar nature.

Because Mr Dunn was serving a prison sentence in the custody of Corrective Services at the time of his death Sections 22, 23 and 27 of the act are applicable. The effect of these sections are that an inquest must be conducted into the death of a person who dies whilst in custody and such inquest must be conducted by either the State Coroner or a Deputy State Coroner.

The fact that it is a mandatory inquest that must be conducted it's necessary for the Coroner to inquire as to other matters over and above those, which are set out in Section 81. The former State Coroner, Magistrate Kevin Waller, has described those matters in the following terms.

> "The answer why such an inquest is mandatory is that society having effected the arrest and incarceration of a person who has seriously breached the laws has a duty to those persons of ensuring that their punishment is restricted to the loss of their liberty and not exacerbated by ill treatment or privation whilst awaiting trial or serving their sentence. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides positive incentive to custodians to treat their prisoners in humane fashion and satisfy the community that the deaths in such places are properly investigated."

In this case the death of Mr Dunn has been thoroughly investigated. Firstly, I have available to me the evidence of the Officer in Charge of the investigation, which is exhibit #2. I have also available to me the records of Justice Health which are exhibit #3 and the results of the internal investigation undertaken by Corrective Services together with their records which are exhibit #4. Those various matters have been examined and I do not propose nor is it necessary in this case for me to outline those matters other than what I have already outlined.

I also have available to me an autopsy report prepared by Dr Brian Beer. Dr Beer is a forensic pathologist who undertook an autopsy of Mr Dunn's body on 22 July 2011 at the Department of Forensic Medicine in Newcastle. Dr Beer found that Mr Dunn suffered from a condition of ischemic heart disease, which was the cause of his death.

That disease arose due to the condition of a circumflex coronary artery atherosclerosis and another condition from which Mr Dunn suffered which contributed to his death but did not cause his ultimate death was an ischemic related cardiomyopathy.

These illnesses are always found to be life threatening and Mr Dunn suffered from a number of classic indicators of such disease particularly the fact that he suffered from high cholesterol and he used tobacco and other smoking equipment. He was said to have been a long term heavy smoker, which is a precursor to the condition of ischemic heart disease. The cause of Mr Dunn's death therefore is a natural cause. He had, as I have said, a number of significant indicators. That disease was not, however, diagnosed and there were no indicators available whilst he was in the custody of Corrective Services to suggest that he was suffering symptoms of such underlying disease.

In the circumstances it would seem to me that, and I am satisfied that it is in fact the case, that there is no evidence to suggest that Justice Health or Corrective Services failed in their obligation to provide appropriate medical and other care to Mr Dunn prior to his death and that no failing on their part in any way contributed to his death. It is well known in this jurisdiction that persons who do suffer from ischemic heart disease are subject to sudden and unexpected death.

In the circumstances I do not consider it is necessary or appropriate to make any recommendations in accordance with S 82 and I do not consider it necessary or appropriate to make any orders relating to the non-publication of evidence in this matter In accordance with S 74(1)(b) of the Coroner's Act.

FORMAL FINDNG:

I FIND THAT JOHN DAVID DUNN WAS BORN ON 15 SEPTEMBER 1957 AND DIED ON 19 JULY 2011 AT THE MID NORTH COAST CORRECTIONAL CENTRE, ALDAVILLA, IN THE STATE OF NEW SOUTH WALES. THE CAUSE OF HIS DEATH WAS ISCHAEMIC HEART DISEASE DUE TO CIRCUMFLEX CORONARY ARTERY ATHEROSCLEROSIS WITH A CONTRIBUTING CONDITION OF ISCHEMIC RELATED CARDIOMYOPATHY. THE MANNER OF HIS DEATH WAS NATURAL CAUSE.

32. 1761of 2011

Inquest into the death of Hong Son Le at Randwick on the 28th July 2011. Finding handed down by State Coroner Jerram.

This is a mandatory inquest under s 23 of the **Coroner's Act** because Mr Le died whilst in custody. However, it appears that again he has died of natural causes

FORMAL FINDING:

That Hong Son Le died at Prince of Wales Hospital, Randwick on the 28th of July 2011 as a result of Oesophageal Varicae and Rectal Bleed, end stage of liver disease, Chronic Hepatitis C and Alcohol Abuse

33. 1922 of 2011

Inquest into the death of Dusko Kostovski at Alexandria on the 16th August 2011. Finding handed down by Deputy State Coroner Forbes.

Mr Kostovski was sentenced to a period of home detention, he was fitted with an ankle bracelet in order that his movements could be monitored. Part of the conditions for the home detention however allowed him to leave home to attend his workplace. He was however allowed to attend work. On the day of his death he attended the Combined Taxi's Headquarters at Alexandria. The deceased was to undertake maintenance work at those premises. During the course of this work the deceased had a witnessed fall from a ladder and fell some distance from the ladder after overstretching hitting his head on a step causing the fatal injuries.

Workcover of which I have a copy on file has investigated the incident. There are no suspicious matters arising from this death and it really was an unfortunate work place accident that resulted in the death of this man. It is a mandatory inquest as he was on home detention at the time and in accordance with the Crooner Act it is regarded as a death in custody. It appears from the Workcover investigation and from the police investigation that this was just an accident so I will go on now to make the formal findings that I make and those findings will go off to Births Deaths and Marriages.

FORMAL FINDING:

DUSKO KOSTOVSKI DIED ON 16 AUGUST 2011 AT 72-74 BURROWS ROAD, ALEXANDRIA AS A RESULT OF TRAUMATIC BRAIN AND SPINAL CORD INJURIES THAT HE SUFFERED AS A RESULT OF A FALL.

34. 2133 0f 2011

Inquest into the death of Gary Richards at Malabar on the 5th September 2011. Finding handed down by Deputy State Coroner Freund.

The inquest today is being held as a requirement under s 27 of the Coroner's Act 2009 and the death occurred while Gary Richards was serving a full time prison sentence at Long Bay Gaol. As part of the inquest the coroner is to establish if possible the criteria under s 81 of the Coroner's Act 2009, this includes the date and place of death, the identity of the deceased and the manner and cause of death.

In relation to Gary Richards, Gary had no next of kin and as a consequence there will be none here today nor will there be any friends of Gary's attending the inquest.

There are limited personal antecedents provided to the investigating police in regards to Gary as there is no direct next of kin or persons with knowledge of Gary's past who are willing to provide this information.

Gary was born on 22 August 1961 in Sydney it is believed that he grew up with his father in the suburb of Balmain and spent the majority of his life around the inner western suburbs of Sydney. As stated above there is little knowledge of his adult life other than his different periods of incarceration.

In regards to this inquest Gary was remanded in custody as Central Local Court on 10 February 2011 following his expedition from Queensland on warrants.

Gary was terminally ill and was being treated for this condition at Long Bay Hospital and the Prince of Wales Hospital. His condition deteriorated to the point that he was bedridden and required a wheelchair to mobilise and assist with his activities of daily living.

On 5 April 2011, Dr Chan conducted a mental health assessment, examination on Gary and determined he was competent in making his decision and able to give instructions regarding his advance care directive.'

The rationale was that the doctors wanted to rule out any underlying mental illness suicide thoughts etcetera as he had been previously assessed with depression and suicidal thoughts.

As a result of this interview they formed on the conclusion on 18 April 2011, Dr Ette issued a not for resuscitation order with Gary's signature.

Of note in regards to Gary's illness he was non-compliant with medical treatment, in addition he expressed a desire to die.

On 4 May 2011 Gary was placed under palliative care. His condition continued to deteriorate and then he died about 12.32pm on 5 September 2011.

As a result of reading the brief in the matter and hearing the evidence of Detective Senior Constable Peter McMaugh, the OIC in this matter,

FORMAL FINDING:

THAT GARY RICHARD DIED ON 5 SEPTEMBER 2011 AT CELL 30 LONG BAY HOSPITAL LONG BAY FROM NATURAL CAUSES, NAMELY AS A RESULT OF COMPLICATIONS FROM THE HIV VIRUS.

35. 2161 OF 2011

Inquest into the death of Amedeo Desantis at Lansvale on the 7th September 2011. Finding handed down by Deputy State Coroner Mitchell.

This is an inquest into the sad death of Amedeo Desantis, who was born on 12 February 1963. Mr Desantis was born in Italy but lived in Australia on a permanent basis. I am not sure how long he had been in Australia, but it was at least ten perhaps longer years. He lived at Cumberland Street in Cabramatta and he died at about 2233 hours on 7 September 2011 on the Hume Highway near the intersection of Hume Highway and Cabramatta Road East in Lansvale.

He was driving at the time a silver coloured Commodore station wagon registered number BBK-15G which was owned by his neighbour, Zimming Yi, who was a passenger in the vehicle and with whom Mr Desantis had been drinking whisky since about 11 o'clock that morning. Mr Yi was injured in this motor vehicle collision in which Mr Desantis died.

The intersection was - or the lights on the intersection were being repaired on behalf of the Road and Traffic Authority and police had control of the intersection and were conducting point duty. The intersection, I am told by the officer in charge, was well lit. I have seen a video presentation of the intersection and I have seen in that video material Senior Constable Lynch, who was performing point duty at the time.

There was really nothing untoward in the way in which the intersection was being managed. It was being managed, as far as I could tell, sensibly and in a sober fashion, and I cannot see any basis on which one could be critical of police. When Mr Desantis came to the police attention, as he did after he entered the intersection and drove onto the wrong side of the road and entered the intersection at very high speed, there was a very brief police pursuit and as a result of that and because the intersection was controlled by police at the time, this was considered a critical incident and a death in the course of a police operation.

I think that was a wise thing to do, it is better to err on the side of caution than not, although I suppose it could be argued that this was not one of those instances where in fact an inquest was essential. However, because police, in my view, prudently called it a critical incident, I have proceeded on the basis that this was a mandatory inquest pursuant to the provisions of ss 23 and 27 of the Act. Ms Berry of the Crown Solicitor's office has assisted me in this inquest and Senior Constable Martyn Pepperel is the officer in charge of the investigation.

Mr Desantis had a relationship, a long term relationship, with a Ms Rosa Fotoni, although that relationship had terminated before his death. Ms Fotoni is aware of these proceedings and indeed has given evidence, which is contained in a statement in the coronial brief, but she is not here today.

Mr Desantis and Ms Fotoni have two children, Eric, who at that time was living with his father but now has returned to live with his mother, he was about thirteen years of age, and a younger child, Juliana(?), who as I understand it, lives and at the time of her father's death was living with Ms Fotoni.

Mr Desantis's parents and his sister reside in Italy. They have been informed of these proceedings but not surprisingly they have not been able to be here today.

The formal documents being a P79A report, an identification certificate, a DOA certificate and most significantly the autopsy report, are jointly exhibit 1. The autopsy report reports on a post-mortem examination conducted on 10 November 2011 by Dr Schwarz, supervised by Professor Duflou and the cause of death provided in that document is multiple injuries on a background of alcohol toxicity.

The toxicological certificate, which accompanies the autopsy report indicates a very high blood alcohol level, and there is no doubt whatever Mr Desantis's usual drinking habits were, that on this particular occasion he was very significantly intoxicated.

The Coronial brief together with a tender bundle are exhibit 2 and a videotape, or rather, I suppose, a DVD, which was recorded by Fairfield 205, a police patrol vehicle, which pursued Mr Desantis, showing Mr Desantis's entry into the intersection, his apparently last minute decision to drive on a particular lane in the intersection, his then driving along the median strip and then moving into oncoming traffic, eastbound on Hume Highway as he travelled west, and showing something of the police pursuit is exhibit 3.

Mr Desantis entered the intersection at speed. Senior Constable Lynch signalled to his colleague, Senior Constable Robert Haggerty to pursue Mr Desantis. That was in my respectful opinion an appropriate thing to do. It was important, if at all possible, to stop Mr Desantis before he caused trouble to other drivers or to himself. The length of the pursuit was very, very brief. It was twenty-five seconds, which expired from Mr Desantis's entry into the intersection to the point of impact.

It was only about fifteen seconds, as the exhibit 3 demonstrates, between Mr Haggerty commencing his pursuit at the impact. During that pursuit Mr Desantis drove on the wrong side of the road and into oncoming traffic and indeed moved at one point to lane 1 on his wrong side of the road, and for part of that fifteen seconds he was not in sight of Fairfield 205. I think it is unlikely that he was aware that there was a pursuit underway and if he was aware of it, the pursuit was so brief and the police vehicle so distant that it is extremely unlikely that it had any influence on his mode of driving.

In the event Mr Desantis collided with oncoming traffic. He was killed, I think, on impact, certainly when Mr Haggerty reached him there was no sign of life. Ambulance officers arrived at 10.45, which was a little after the impact and they saw no sign of life nor did they see any indication that Mr Desantis survived the collision for any significant period of time. I think it is likely that he died on impact. Mr Yi was injured and so was the driver of the oncoming vehicle with which Mr Desantis collided.

I should say that the weather was fine and dry. The intersection properly managed and adequately lit, and it seems to me most likely that the cause of this collision had to do with Mr Desantis's sobriety at the time. I extend sympathy of all of us involved in this inquest and all of those involved in the coronial service to Ms Fotoni, to Mr Desantis's two children and to his family in Italy. I thank the officer in charge for a very - may I say with respect - expert brief and for very helpful evidence in the matter.

FORMAL FINDING:

I FIND THAT AMEDEO DESANTIS, WHO WAS BORN ON 12 FEBRUARY 1963 DIED AT ABOUT 10.30PM ON 7 SEPTEMBER 2011 ON THE HUME HIGHWAY NEAR CABRAMATTA ROAD EAST AT LANSVALE OF MULTIPLE INJURIES ACQUIRED IN A MOTOR VEHICLE COLLISION ON A BACKGROUND OF ALCOHOL TOXICITY.

36. 2334 OF 2011

Inquest into the death of Rodney El-Kass at Castle Hill on the 29th September 2011. Finding handed down by Deputy State Coroner Dillon.

The first thing I'd like to say, in summing up the evidence and coming to my conclusions is that what is obvious, although it has become something of cliché I suppose is that this case is a terrible tragedy. In my experience every time something like this happens, not only is a life lost but also many other lives are effected and obviously the most affected people are the family of the person who has died.

Mr Hamill also yesterday described this case as a case with a lot of "what ifs" and "but fors" in it. That is absolutely true. We see if we trace the sequence of events backwards that there were various things that if they had been different or even slightly different might have averted this terrible tragedy. An historian once described the development of history as or real life as a garden of forking paths and this is certainly a garden with many, many forking paths within it.

On 29 September 2011 Rodney Elkass was shot by police in Castle Hill while sitting his utility at traffic lights near the Castle Towers shopping centre and also close to the Castle Hill police station.

The fatal incident unfolded very quickly. Looking at the timeline it appears that from the time that the police exited, left the police until the time the fatal shots were fired was less than a minute, around about 50 seconds. Approximately 40 people were in the near vicinity. Following the shooting a lengthy and painstaking investigation was undertaken by a Critical Incident Team from the Homicide Squad. This inquest has taken nearly two weeks plus many days of preparation out of court to dissect the last few seconds of Rodney Elkass' life.

Before I go on to discuss the evidence and conclusions, I just want to touch on once again but I hope quite briefly, the purposes of an inquest. Then I will speak very briefly about Rodney as a person. Then I want to touch on the issues that have been raised in this inquest.

An inquest is an investigation and the Coroner's role is to run that investigation or to preside over it as an independent judicial officer. There are five statutory questions that need to be answered: Who died, when and where did the death occur, what were the cause and manner of death. In this case of course the question of the manner or circumstances of Rodney's death has been the focus.

Another reason or role for a Coroner is to seek to investigate and perhaps allay the causes of fear and suspicion that can arise from a sudden death. Those close to a person who has died suddenly an unexpectedly, particularly in very shocking circumstances, are themselves shocked and grief-stricken. Those directly involved are also likely to be deeply affected and off course sudden death generates deep emotions.

Corners can cast an independent and objective and rational eye over the evidence with a view to allaying some of these fears and suspicions. An inquest is therefore an open public inquiry where the burning questions can be asked and, if possible, answered.

As I mentioned on Monday, an inquest into deaths in police operations are mandatory in New South Wales and I reiterate some of my comments then. If public confidence is to be maintained in our public institutions, governments, the judiciary, the public service and the police, they must be accountable to the community and subject to scrutiny.

Police officers may not enjoy the experience of explaining their conduct in public but with great power goes great responsibility. It is ultimately for their benefit and that of our society as a whole that they must be called on to do so.
When they cause or are involved in the loss of one their fellow citizens' lives we need explanations.

Finally on this topic briefly, it is well known that Coroners may make recommendations to authorities or agencies if they perceive there are lessons to be learned from the tragedies they investigate and that is one of the most important roles of a Coroner and I will be making some recommendations.

At the heart of this inquest and any inquest is a human being. Rodney Elkass was described, I thought, in very moving terms by his brother Ziad yesterday, as a good man who was warm, generous to his family, careful of children and loving of children. He was a man who was a proud Lebanese Australian. He liked football and he was a very gifted footballer in his youth. He followed the Bulldogs, he followed Hawthorn in Victoria, he played for Coburg. He was also a gifted painted and this is what perhaps marks this case as more than usually tragic, he was also very respectful of police and in fact he had done work for police.

To emphasise this point his character was essentially unblemished. He had no criminal history. There is no police intelligence suggesting that he is involved or was involved in crime. His brother Ziad was a police sergeant of many years experience and his sister-in-law Erica is a serving police officer.

This is a family who have given a great deal to the community and for whom issues of law and order are important and so the portrayal of him, at least in the initial stages, a man out of control, some sort of crazed middle-Eastern gunman, is a real misconception and a mis-portrayal of him.

I will come to the question of whether he intended to shoot anyone on this particular day but in very short terms my conclusion is that he did not.

A number of issues arise for consideration and they were circulated before this inquest started by the Crown Solicitor's office. Of course I have mentioned that there are statutory questions that need to be asked and answered.

More particularly this inquest has explored the circumstances of Mr Elkass' and the questions whether he produced a gun, if he pointed it at the police officers on the day, whether the officers identified or announced themselves as police officers before firing at him, and whether the police complied with relevant training procedures and protocols.

Another series of issues concerns the question of tactics used by police. The overall question being why were firearms used rather than some other method of dealing with the situation. In particular the questions are asked was it reasonably possibly to contain Mr Elkass if he was known to believed to be armed, were there other options reasonably available to police officers in the circumstances as they perceived them to be at the time. Was the response of police officers appropriate in all the circumstances, as they understood them at the time.

We have also explored the police protocols and training documents and so forth that are relevant to this case: current police procedures and training issues, the question of the firearms licence and whether Mr Elkass' firearms licence and the breach of the licence was investigated properly and appropriately and if not, what should have happened. And we have also looked at whether the current guidelines documents and so forth relating to this firearm are appropriate or whether they should be amended.

Questions have also been raised particularly on behalf of Mr Elkass' family concerning whether or not the investigation was conducted impartially and fairly and sufficiently thoroughly. Particular concerns were raised about the cleaning of the car, the search of Mr Elkass' car and communications between investigating police on the day of Rodney's death and in the period afterwards, and those criticism have been aired, they have been put to the investigators, answers have been given and comments have been made about them by counsel for the Elkass family. Finally there is the question of recommendations.

In order to look at the particular incident, that less one minute of time, it is necessary to go back in time to start at this road of forking paths. In 1999 - and I do not intend to go through this in very great length because it is all fresh in people's minds - but in 1999 Rodney Elkass was involved in a violent confrontation with another person who is known as A in these proceedings, another painter.

Mr A sent an offensive text message to his boss, it concerned the Koran, which must have been known to A would be a very offensive kind of so-called joke, if Mr Elkass found out about it, Mr Elkass being Muslim. That led to Mr A being defeated in a fight by Mr Elkass. The assault was reported to police but it did not proceed. Mr A decided not to go through with it.

On 29 September 2011 by coincidence and certainly not by any form of planning on either side, Mr Elkass ran into Mr A and his brother Mr B. There was an exchange, a confrontation, an invitation by A and B to fight or continue the fight from ten or 11 years before. Mr Elkass did not get involved. He got in his car and he drove off.

Mr Elkass had some time before obtained a pistol licence. He enjoyed target shooting. He had a gun safe but unfortunately he did not, at least at this time, was not keeping his pistol in the gun safe as he was required to do under his licence.

He had also been given a warning previously by, Senior Constable as he then was, Tory but Senior Constable Tory despite s 42 of the Firearms Act requiring seizure of the weapon, had exercised his discretion or as he thought it, as he thought he was able to, to allow Mr Elkass to retain the gun. In any event, the gun was in Mr Elkass' car.

Mr Elkass drove away and was followed by and it might be thought stalked by A and B. At some point or other Mr Elkass' car stopped in traffic, he was unable to proceed because there was a car in front of him. A and B stopped behind. A and B jumped out of the car, came round to the driver's side door and according to Jawdat Elkass, Rodney Elkass' 14 year old nephew, Mr Elkass got the gun out, unloaded it and then used it to threaten A and B. A and B do not seem to have been terribly intimidated by it because they challenged him to shoot, in Arabic but presumably they decided that discretion was the better part of valour at that stage, went back to their car and appeared to drive off in the opposite direction.

What we know is, however, that they got in touch with the Triple-0 line. They made a complaint about Mr Elkass, a somewhat misleading complaint, suggesting that he had inflicted some sort of road rage offence upon them, not revealing that they had been the instigators of this particular incident on the road.

Jawdat gave evidence that after this incident was over, Mr Elkass re-loaded his gun and drove off. At some point or other A and B spotted Mr Elkass' vehicle again and gave further information to VKG. A broadcast was made after the first call, six minutes before the police officers in the Castle Hill police station actually exited. The call was heard on the police radio throughout the station. The detectives who would not normally do any kind of vehicle stop, the kind attempted later on, six minutes later, listened to the radio. They thought they may be called to take some sort of action but at that stage they had no inkling that in only a few minutes time they would be confronting a person they thought to be armed and dangerous.

About six minutes after the first VKG call though, while the detectives were sitting in their office I think - and Detective Wilkins was making some enquiries to try and get more details about this armed man who was in a utility driving around in the Castle Hill area, a second call came over VKG in relation to this armed man in the car suggesting that the car was making its way up Castle Street. Of course the police who worked right on the corner of Castle and Pennant Street immediately recognised that the vehicle was probably very close to the police station and more or less ran out in unison, one following the other, three of them, and it appears not very long afterwards followed also by other police in uniform, but who did not participate in what the happened.

Senior Constable Gardiner, Detective Senior Constable Gardiner says that he saw the vehicle a few yards away at the intersection. He ran up towards it to try and make sure that that was the vehicle that VKG was talking about. He identified it, he thought, as the vehicle in question and then he and the other three place ran across the road following Mr Elkass' car up the street.

Detective Gardiner had grabbed a portable radio and his initial idea seems to have been that he would keep in touch with VKG to notify police radio of the direction taken by the car and any other relevant information that may be able to assist in enabling other police to locate the vehicle as it drove off. He also said in his evidence that he also thought about the possibility of a vehicle stop. As the vehicle drove up the hill the possibility of a vehicle was still in mind.

He drove up the hill towards a roundabout which leads into the carpark driveway of the Castle Towers shopping centre. So as the vehicle went up the hill it appeared to the police that it may go into the carpark or it may continue on. What they didn't expect I think, and certainly there is no evidence that they expected it and there was no reason for them to expect it, was that the car did a U-turn at the roundabout.

It was at that stage that the opportunity really arose to stop the vehicle, to approach the driver, to get him out of the car and to investigate whether there was a gun in the car. And that is precisely what happened. There was some yelling at the vehicle to stop. The police, two police officers say that they used the word "police" and then words to the effect of "stop, stop right there, get out of the car" and so forth.

Detective Rosano who ended up being, approaching the driver's door, was frank in his evidence that he told Mr Elkass to get out of the car, shouted at him to get out of the car but did not announce himself as a police officer. Critically none of the police were wearing anything that could easily identify him as a police officer by anyone looking at him from any kind of a distance or in a short time.

They all their warrant cards but they were not display. Their badges were in their pockets. Some of them, a couple of them, maybe all three, had lanyards with a swipe pass on it. The lanyards have some blue and white checking on it which is indicative of police but not terribly noticeable from any kind of a distance when people are moving. They were not wearing uniform obviously, they were not wearing caps, they were not wearing raid vests, they were not wearing ballistic vests. They were not wearing anything that really distinguished them a police officers easily in a short space of time.

Detective Wilkins said that he, during his evidence, that he believed that Mr Elkass knew that he was being called on by police. I do not think Mr Elkass did know that he was being called on by police. There is a lot of evidence that suggests otherwise.

The first bit is simply that when Detective Rosano approached the door, Detective Rosano observed Mr Elkass to appear to be dumbfounded as he put it when he gave his record of interview to the investigators afterwards. He said "What?" questioning what was going on or who this person was or something to that effect, or questioning what was being said to him or being shouted at him.

None of the civilian witnesses and there were something like 36 around the area, heard the word "police" being yelled. Some of them heard specific words being yelled such as "Stop right there" or "get out of the car" or "Get the fuck out of the car", those sorts of things.

There were also some things which the police have related that they said that were not heard and there were also some things that witnesses say they did hear which the police do not remember saying themselves.

This was a very fluid and dynamic situation where things were apparently being said. There was a fair bit of yelling from three police officers, perhaps some of it over the top of other people, perhaps some but not over the top of other people but certainly from different directions, but the big question in regard to whether the police identified themselves was whether or not they used the word “police”.

Both Detectives Wilkins and Gardiner claim that they did so. It would be in accordance with their training to do so. It would be of course the appropriate thing to do. Senior Constable Titmouse said there is no rule or practise or law that requires it to be the first thing said but police must announce their office. Both these two officers claim they did so.

I have to say I have my doubts whether they did. I have my doubts for a number of reasons. The fact that nobody apart from these two officers that he or she heard the word being yelled out gives rise, is one reason for that doubt. It was argued on behalf of the two officers, Gardiner and Wilkins, by Mr Hood that there is good reason to shout these words out which of course there is and no good reason not to. I do not suggest for a moment they deliberately concealed the fact that they were police but it may be, although they have given sworn evidence and they are adamant about it, it may be that their evidence on this question is reconstructed.

Detective Rosano was quite frank in saying that he not use the word “police”, did not identify himself to Mr Elkass in the car and that just demonstrates that under pressure a trained police officer of considerable experience may not use the word “police” in the first instance. It may be that other priorities take place in a person’s mind before that challenged or identification is issued.

I do not say that the police did not. These two police I do not think were deliberately telling lies at all but as I say I think the possibility certainly lies open that in the heat of the moment they did not yell out. Supporting that impression is also the fact that on the VKG transcript at some point or other Detective Gardiner is recorded as saying “Stop right there, stop”. That was an accidental transmission it seems but it may be that the word he says that he used at the start of that sentence, namely “police” was not recorded because he had not pressed the button at that time but it is an amazingly clean break if that is so.

It would also be surprising if the one word, or the one word that would clearly identify these people, these three men running across the road, being shouted at high volume, was not heard by people who were trying to work out who they were and could not do so. Numbers of people say that, numbers of eye witnesses say that they thought that the police officers running across the road were in fact businessmen or security guards or something of that nature, and some people only identified them as police either when they saw the direction from which they had run or they inferred that they were police from the fact that they drew their pistols. So it seems to me that the weight of evidence suggests that the word was not used or if it was used by one or other of Detective Wilkins or Gardiner, that it was muffled or obliterated by simultaneous shouting or other noise.

The next major issue I think is whether Mr Elkass pulled a gun and pointed it or in the direction of Detective Rosano. In my opinion the weight of evidence supports a conclusion that he did in fact do so. Not only do the three police officers say so but also their evidence is supported by that of Claire Bayley. Without Claire Bayley's evidence it might be that there would be some doubt about it but for two further reasons - and it is true Mr De Mars has said Claire Bayley may have made a mistake - it is possible. But when three witnesses give evidence in similar terms and one of them at least is an independent witness, there is a strong likelihood that that evidence is correct. And in addition to all of that, there are other features of not only the incident itself but also other matters that support the inference that Mr Elkass did draw his gun during the incident.

Another very strong piece of evidence, in fact I think it is probably the decisive piece of evidence, is that as soon as he says Mr Elkass started to lift the gun towards him, Detective Rosano said he ducked away and put his arm up to stop himself being shot in the face, and that was seen by others. That was seen at least by Mr Penman. It is very difficult to make out from the CCTV footage but there is other evidence from the police themselves.

As I said before, I accept Detective Rosano as a truthful and reliable witness. I think he has been frank. He has not lied about an issue that is obviously of critical importance, namely whether he identified himself as a police officer. He told the truth about that, that he had not identified himself to Mr Elkass and he could have lied but did not, so it seems to me that his evidence is prima facie highly reliable.

But there are other things that suggest also that the police version is correct on this point. The gun was found in Mr Elkass' lap and was seen to be removed by Detective Wilkins from the car. Jawdat Elkass, Mr A and B, Caroline Rule, had all seen Mr Elkass pull the gun on A and B some time before this incident in Castle Hill. And that is consistent with, of course, Mr Elkass pulling it at Castle Hill if he believed that he was under threat.

Did he point the gun at Detective Rosano? Well certainly the police officers thought so, Claire Bayley thought so. Perhaps most importantly, Detective Rosano certainly thought so and it was no doubt seen both the gun emerge at the window or just outside it, and Detective Rosano seeking to duck away to take cover or to avoid being shot, that must have prompted the two officers, Wilkins and Gardiner form the same view that Detective Rosano was in danger of being shot.

Obviously Sonal Kumar's evidence is of critical importance. She says that all she saw before the shots were fired was Mr Elkass raise his hands upwards, palms outwards, up around head height. That evidence is very consistent with the evidence given by Constable Rosano who says that when he approached the vehicle and shouted at Rodney Elkass, Rodney said "What?" and looked dumbfounded, then raised his hands in an open fashion up behind his head, before reaching down and grabbing his gun. It seems to me that given Ms Elkass'(as said) evidence and her initial evidence was that she, or appears to read, that she had seen or kept her head up until the shooting took place and then ducked, but in her evidence to counsel assisting, she said that she had ducked down when she saw the guns produced by the police and thought shooting might take place.

She changed that version under cross-examination from Ms Yehia and she repeated that she had not ducked before the shooting when Mr Hood asked her further questions about it.

But my strong impression is that she probably did duck before the shooting took place and if she is confused about whether she did or did not, then one cannot say for certain whether she had her head up to see what took place after Mr Elkass put his hands up. One could not say and place any reliance on her evidence that he was shot with his hands up.

I think much more likely as I have said is that Mr Elkass did produce a gun. In my view the police officers had a reasonable belief, therefore, that Detective Rosano was in immediate danger of being shot and they responded accordingly.

We also explored during the evidence, the question whether the police complied with protocols. The main issue here is with the question of communication and identification of police as police and I have already discussed that. What I would like to add at this point however is that whether or not the police did use the word "police" or one of them used the word "police", that was not communicated. Clearly enough if police are going to take control of a situation and one of the best ways of doing that is to identify themselves as police and to in effect dominate a particular situation, unless they communicate that to the person or persons to whom the are tyring to send the mess, unless the message is received, it does not matter whether they shout it. What really matters is whether the message gets across.

I don't know whether they shouted it, as I say, I have my doubts about that. But what I am very certain of is that Mr Elkass never understood that he was being confronted by police officers. And that in itself I think is circumstantial evidence that the word "police" was not shouted, or not shouted in an intelligible fashion towards him.

Whether other options than a resort to firearms, well, there may have been of course, but another option was attempted, at least before the shooting and that was to approach the car to get Mr Elkass to stop, to tell him to get out of the car and tell him to put his hands in sight. It is not in context that all of those things were attempted by the police. In short, they attempted to use their authority and presence to gain control over him without resort to force initially. For reasons which have been explained at some length in the evidence of Senior Constable Titmouse and others, OC Spray, Tasers, unarmed combat, these sorts of tactics were in the circumstances likely to be ineffective and possibly even more dangerous than confronting a man with a suspected firearm, with firearms. Certainly once Rodney Elkass picked up his gun and pointed it towards Detective Rosano, I think that really closed any other options off. On the information available to the three police officers at the time, their reaction was instantaneous but reasonable.

Now it is important and I understand why the Elkass family have some misgivings about what happened, a lot of misgivings about what happened.

But it is important for those of us who are not related to Rodney to recognise at the very least that when the officers left the police station they had very little information other than the fact that an armed man had pulled a gun on somebody in public and threatened at least a couple of members of the public.

They did not know at that stage that A and B had instigated the incident earlier, they did not know that there was a history of enmity between A and B and Rodney Elkass. They did not know that A and B were seeking revenge. They did not know that to some degree the police were being mislead by the information given by A and B. And of course I don't think most reasonable people would consider it appropriate for people to drive round with guns in their cars, waving them at other people on the roads. That gives rise to a reasonable suspicion at least that the person with the handgun in the car threatening other people with it, is a dangerous person.

Now as we know, as we have learned and as the police learned afterwards, Mr Elkass was not a dangerous person. But that would not have been obvious in the instant when he picked his gun up and pointed it towards Detective Rosano. Nor would they have known that he had a clean criminal record, nor would they have known about his family background and his respect of the police force. Evidence was given by a Senior Constable Titmouse that the various procedures, protocols and training of police is under review. This case of course highlights two issues, that the identification of plain-clothes police in the circumstances must be made more obvious if possible and that is being reviewed. There is also a need for review of, and change to, some aspects of the firearms registry and licensing procedures.

I need to turn to some of the issues raised by Mr De Mars on behalf of the Elkass family. In relation to witnesses A and B, the submission was made that it was the behaviour of A and B that effectively set in train the course that led to this terrible and tragic result. As I say, this a garden of forking paths, and reprehensible as that behaviour on the parts of A and B was, it would not have led to Rodney's death I think, I'm sure, had he not had a gun in the car. So that is sadly one of the factors that came into play and started a line of dominos falling. We could go back further. Had Senior Constable Tory, who I thought was visibly upset when he gave his evidence, seized the gun from Mr Elkass, this incident may well not have taken place. It is not possible to ascribe this incident to bad behaviour on the part of one person without looking at all of the circumstances that contributed to the chain of causation.

It is argued on behalf of the Elkass family that it is highly unlikely that Rodney pointed the gun outside the window as claimed by the police and Miss Bailey because had he done so when he was shot the gun would most likely have dropped outside the vehicle rather than inside. For two reasons I do not accept that. One is that he obviously fell leftwards, that is towards the passenger seat, after he was shot in the head. And the second thing is that people do not instantaneously, or necessarily instantaneously drop a gun once they are shot, even in the head. There are even famous pictures of people being shot, there is a very famous one of a Spanish Civil War soldier being shot and as he falls, he is still hanging onto his rifle, he has not dropped his gun at the instant that he is killed. And there are many others of a similar nature.

If he had his finger in the trigger guard, the gun as Mr Haverfield has argued, might well have been pulled back with him as he collapsed back inside the vehicle, so I do not think that proves anything one way or the other.

I certainly would not necessarily expect the gun to have fallen outside, if he had produced a gun and pointed it at Detective Rosano. Of greater concern though, I think, is the question, and I come back to this, is the question of communications. One of the issues raised in terms of police protocol and training and so on was whether or not a lead communicator ought to have been appointed by the group of Detectives who ran out or whether one of them should have taken the lead role of his own initiative. Criticism of the police was made that there was no planning, I think I have addressed that. There was really no time for any significant planning.

But I think there was a real problem that arose in these circumstances that all the police at different times perhaps, or perhaps at different times and simultaneously, some of them, were shouting at Mr Elkass. This is all in a very short space of time. It is also at a time when the car was coming to a stop naturally, because it had to. It would have been, I think, far far better, and this is obviously with the enormous benefit of hindsight, far far better if only one officer had been attempting to communicate with Mr Elkass. It seems to me that there is a real possibility that the fact that all three officers at least at different times, were issuing directions and commands, may have led to confusion on the part of Mr Elkass, and indeed may have led to confusion on the part of all the eye-witnesses and possibly even on their own parts as to what was being done and said and so forth, what the expectations that the police were trying to communicate to Mr Elkass actually were. In my view, in this case at least, police tactical communications failed.

It was also argued that it was open to police to tactically disengage. As I think was made clear yesterday in evidence by I think it was Senior Constable Titmouse, police tactically disengaged not necessarily to disengage completely, but in order to develop another option. His view was that in the circumstances as they arose so suddenly, there was virtually no other option available to the police particularly if Detective Rosano was in immediate danger of being shot, as they perceived it, and so tactical disengagement perhaps to call in better armed police or people who were more obviously police to contain the situation did not arise before the need to shoot arose.

Mr De Mars has argued that it was open to the police to, for example, get in touch with VKG to suggest a vehicle stop, in accordance with the protocol dealing with vehicle stops. Senior Counsel Assisting, Mr Haverfield, Mr Hood, have all argued, and I think correctly, that the expectation of our community is that police do not stand idlely by if they are told that someone is acting dangerously or an allegation is made that someone is carrying a weapon or may be potentially dangerous to members of the public. That was the information they had. In my opinion they were obliged to attempt to take some action, and that is what they did. In the circumstances and I believe they were taken by surprise by Mr Elkass doing a U-turn at the roundabout, they had to react to what was right in front of them. They did not have time to huddle together and work up a game plan.

They had to act I think then and there, but that said, this was not a terribly complex tactical situation to try to deal with. It was only a question of, really of confronting the man in the car and getting him out of the car and perhaps taking him into custody, following which a vehicle search could take place and all the other procedures. This would not be a particularly complex operation in my opinion.

What made it complex really was the production of the gun by Mr Elkass and of course the apprehension by the officers that Mr Elkass, or the driver of the motor vehicle, might be armed. But all that said, in other respects it was not a very complex problem for the police to have to deal with. There were three police officers, they could cover one of the officers who approached the vehicle, that was done. Gardiner and Wilkins took up positions where they had a clear line of fire towards the vehicle covering Detective Rosano and Detective Rosano approached the vehicle and spoke to the driver. But for the fact that there was no intelligible identification of the police either by a sign, uniform or word, there would have been quite a peaceful end to this whole incident.

Criticism has also been made of the critical incident investigation by the family. I understand the concerns that have been raised. One of the good things about an inquest is that these kinds of concerns can be raised in public with those in charge of an investigation and they can be challenged about their decisions and view and so on. And that was done. I hope that has been helpful to the family to some degree. I understand that there is still some dissatisfaction with the way the investigation was conducted. I suppose in most investigations in hindsight, it is revealed, that some things could have been done better. Certainly in my experience of criminal law which preceded my time in the Coronial Jurisdiction, particularly when I was working in practice as a lawyer, it was very frequently the case that investigations by police were still being fixed up at the start of and during a trial.

Well this case has some of the characteristics of a dynamic investigation that has in my opinion been very thorough, but as has been pointed out, perhaps with the benefit of hindsight, perhaps we could have done better and ultimately as Mr Hamill has said and I will repeat something that I have said previously, the Coroner is ultimately the person who is responsible for directing an investigation under the Coroner's Act. A coroner can ask those who assist him to ask the police officers investigating to do more work to get more statements, to undertake further enquiries and so forth. Of course the police can make their own suggestions and we always hope that the police being the expert investigators will cover everything that we need covered. But sometimes it will not be until we are down the track that we realise that perhaps it would have been better to do something else or something else in addition.

Insofar as there have been deficiencies, I certainly accept the ultimate responsibility and think it is only fair that I do so. There are though, concerns raised that do not go to whether things were done or things were not done, one of the things that Mr Ziad Elkass has said or indicated through counsel for the family, is that the family has a concern about the objectivity of the approach taken by the investigators, and that is to do with really a couple of particular matters. One is whether or not emphasis should have been laid on the evidence of Claire Bailey.

Clare Bailey was taken through a walkthrough interview by the critical incident team, whereas Sonal Kumar was not. Detective Sergeant Robinson explained that, as did Detective Inspector Laidlaw, and I must say I ultimately find myself persuaded that it would not have added greatly to her evidence to have her taken through a walkthrough type interview.

It certainly would have been helpful I think and with hindsight it would have been better had we clarified exactly what her evidence was, because as I said earlier, it ended up being somewhat internally inconsistent although I have a view that she probably did not see the shooting at all, I think she had probably ducked by the time the shooting took place, though just a moment before it took place. But I can understand the concern that Claire Bailey's evidence which was obviously highly corroborative of the police evidence appeared on paper to be emphasised at the expense of the evidence given by Sonal Kumar, those being the two main critical independent witnesses, or most critical independent witnesses. No doubt Inspector Laidlaw's investigation report will reflect that in due course.

The other particular concern that was raised and I think this possibly carries greater weight in all the circumstances as they have unfolded and that is Senior Constable Titmouse's evidence. Senior Constable Titmouse was asked, and this is not a criticism of him, Senior Constable Titmouse gave evidence which was based on certain assumptions which he had been asked to make, namely that the police version of events was his working hypothesis and he was asked on the basis of that working hypothesis to comment on the tactics used by police and whether or not they had complied with police guidelines and protocols, and he came to a view that they had indeed done so. Detective Inspector Laidlaw's opinion at the end of his statement also supportive of police more or less on that basis. As the evidence has developed, I think it has become apparent that it would have been helpful had Senior Constable Titmouse also been asked not to comment on the credibility of witnesses or which version was more likely than another, but to comment on the evidence in terms of at least two or more scenarios, the first scenario being that the police did announce their office, yelled out "Police" and so forth, a second scenario being that the police did not do so, that inference being available from the other evidence, that no one else heard them. Or perhaps a third scenario that they had called out but somehow or other their communication that they were police officers announcing their office had been lost in the hubbub.

At the end of the day an explanation was given that, well these were questions that could always be asked at an inquest, is true, it's not an entirely satisfactory answer because it may give rise, and I do not think that the inference is necessarily right, but it may give rise to people to an inference or a view that the police are biased towards their own, and certainly that was the suggestion made towards Senior Constable Titmouse. He denies it, he says he was just following the request, he was answering the request that he had been given, Detective Sergeant Robinson and Detective Sergeant Baker both said that was all they asked of him and that is where thing lay until he was cross-examined or asked questions by counsel assisting.

But as I said, the impression was available there to the Elkass family and perhaps that is something also that might be reflected in Detective Inspector Laidlaw's report that in future it would be likely to obviate any such criticisms is a police tactician who was asked to give advice, was asked to examine the hypotheses that are available on the evidence, that are reasonably available on the evidence, not just one.

Having said all that, my impression particularly of the way the officer in charge, Detective Sergeant Graeme Robinson gave his evidence, was that he had honestly tried to run an objective and fair investigation.

My impression of Detective Sergeant Robinson was that he was an impressive witness trying to be as thorough as he could. One of the reasons, well one of the strong reasons why I gained the impression that he had tried to do his best in the investigation which had its complexities, was that he made ready concessions when cross-examined about this, about things that were of concern to the family, such as the fact that Mr Elkass senior, Rodney's father, had been left waiting a very long time in the police station, without information.

He conceded that there had been an oversight, a failure on the part of police to adequately undertake liaison or get in touch with the family, there have been criticisms of the communication between the police investigators and the family. Detective Sergeant Robinson explained why the family had not been contacted, at least at the very early states about what was going on, whether or not those explanations are accepted by the Elkass family is ultimately a matter for them, but it struck me that the explanation was reasonable in the circumstances. And I was also particularly struck by the fact that he said, that is Detective Sergeant Robinson, said that he had been horrified to learn that Rodney's blood had not been cleaned up properly from the vehicle before it was returned to the family.

I would echo his horror, that is obviously a disgraceful performance by the forensic cleaners and I was glad to hear both Detective Inspector Laidlaw and Detective Sergeant Robinson explain that they have been in touch with the Commander of the Forensic Services Group to ensure that that person was brought up to speed.

I think that's Detective Superintendent Sweeney was brought up to speed about what had happened and no doubt in the expectation that this will never happen again, that the forensic cleaning company, if they still remain on contract will be held to a very high standard indeed. It is utterly disgraceful that someone who - the people who were required to clean up a crime scene or a scene like this should have failed so dismally in their performance.

With the benefit of hindsight perhaps things could have been done differently or additionally, as I have said I certainly think that more could have been done to obtain evidence from Senior Constable Titmouse about alternative scenarios, police performance in the scene as it unfolded and so forth, perhaps a walk through with Ms Kumar could have been conducted, had that concern been known earlier, perhaps it would have been done, but it was not, no doubt as I say, wiser after the event, these things will be reflected on.

I cannot really speak about what protocols and what communication was had or not had between the investigators and the family. That is ultimately a matter for them and I hope that there can be some reconciliation there. My strong impression is as I say that the investigators tried their best and if they failed in some way to communicate then I hope that there can be some talking about that subject between the various parties.

Coming to the recommendations several have been discussed, some have been proposed by the family and some by counsel assisting. I am very sorry, I think there is one thing that I did not touch on which is important and forgive me if I did not. That is the question of whether Rodney Elkass intended to fire his weapon. This has been spoken of by all counsel I think, but particularly by counsel for the family and counsel assisting.

Of course we don't know precisely what was in Rodney's mind, but I think we can say a number of things suggest very strongly that he would not have fired and did not intend to fire at Constable Rosano.

The first is that while he had a gun he was not a criminal. He had a gun for lawful purposes. True it is that he was using it in an unlawful way by carrying it around in his car, possibly for self defence, though that - this particular incident perhaps is a very good example of why people should not do that.

I said this right at the start at the inquest, Rodney Elkass was not a gangster, he was not a criminal, he was not a person who was a threat to other members of the community. He had his good character and he is entitled to be remembered as a man who has died tragically but who remains of good character in my opinion.

So that's the first thing. The second thing is that when he was confronted by A and B even though he was challenged to a "Awas awas" or "shoot, shoot", he didn't do so he basically used his gun to try and frighten them off and that must have been in his mind again.

The third thing is that and Detective Sergeant Robinson gave evidence about his hypothesis that the reason that Rodney did a U-turn at the round about is that he may have been heading back to try to protect Jawdat from A and B. A and B had appeared on the scene and close to where Jawdat had been dropped off near the police station, this would have been probably in eyeshot of Rodney Elkass and it makes sense that Rodney was heading back to Jawdat because he was a very protective and loving uncle.

If he was approached and in a manner that he regarded as threatening it is not surprising really that he pulled out his gun in a manner that he had done some little time before, in order to use the same form of threat to chase off those threatening him.

In my opinion that is the most likely reason that he pulled this gun out and displayed it, pointed it waved it whatever in the direction of Constable Rosano. In his mind I think it is highly likely that he made a connection between the sudden appearance of Detective Rosano at his window and the previous incident.

The fact that he had been threatened, the fact that he had been pursued and chased and that Jawdat had been in tears and felt extremely frightened that these other men might be armed and pursing them both.

This is also a man who is respectful of the rights of others in general terms and who had respect for police and who at least, according to some of Jawdat's evidence, wanted Jawdat to go and talk to the police about having been followed by A and B, now whether that is a reconstruction on Jawdat's part is difficulty to say exactly, but certainly this is not a man who was an enemy of police or who thought that police were a danger to himself, who might commence a shootout with police. So for those reasons and perhaps there are others I am very doubtful that there was any intention on Rodney's part ever to resort to actual gun fire to deal with a threat that he suddenly perceived at his window.

I am not going to run through at any great length the evidence concerning the licensing provisions that has been discussed by Senior Constable assisting and I have discussed it at a little length. There is clearly a need, I think for tightening of gun laws. I note that today's press has conflicting accounts of whether gun laws are going to be tightened or loosened.

The Herald seems to - they are suggesting that gun laws are about to be loosened by the State Government at the behest of the Shooters Party. The Telegraph suggests on its front page that the government is about to tighten them. I really do not know what is going on and apparently neither does the press, but given that there appears to be a review and perhaps in the light of the incident in Connecticut recently it is a very good time for societies all over the world to reconsider their attitudes to firearms and whether civilians should have access to them and if so, what form of access. I propose to make some recommendations concerning it.

The recommendations by counsel assisting go to four things and I will add a fifth. I will also turn to the recommendations suggested by Mr De Mars in a moment. The first is, in essence, that the New South Wales Police Force investigate or consider the introduction of visible identification of plain clothes officers and detectives as police officers when the need arises

Secondly, introducing a system by which such items are readily accessible in police cars and police stations and thirdly introducing appropriate protocols. The second recommendation is to the effect that the fact sheet used by the New South Wales Police Force entitled "firearms registry stat storage inspections and firearms inspections" be amended to reflect the mandatory terms of s 42 of the **Firearms Act** by stating that "if you have reasonable grounds to believe that a firearm is not being stored in accordance with the Act you must seize that firearm".

Thirdly, that the document entitled "Overview of New South Wales Firearm Licensing Scheme" be amended in similar terms.

Fourthly, to maintain or introduce a system whereby staff of the firearms registry are authorised, are encouraged to raise questions with licensing police, but action or inaction in relation to possible breaches of firearms licence legislation and regulations, I have added to those, this recommendation, that in view of the present New South Wales government review of gun laws,

I recommend that consideration be given to amending licensing regulations to issue gun club licenses class H licenses only on condition that such guns are stored in safe facilities at the club to which the owner belongs. That may need to be thought through at some greater length.

In relation to the submissions made by Mr De Mars on behalf of the family. A number of these overlap with those I have already referred to made by counsel assisting.

The third suggestion and in particular the first two. In relation to the third that is that police policies and training in respect of dangerous vehicle stops be revised, I hesitate to make that recommendation only because I think it may complicate police training rather than simplify it, and it seems to me that police tactics if they are going to be effective and if people are going to employ them, need to be simple, easily understood and easily implemented rather than made more complex by more rules, caveats, questions and so forth. The police need to be able to be instantly reactive to all sorts of situations and it may and I suspect it would make their reactions slower and more complex if I were to make this recommendation. I am not sure how practicable it is. So I do not intend to make that recommendation but no doubt that will be further considered by Detective Inspector Laidlaw in his review.

The fourth recommendation is that the Commissioner be invited to consider disciplinary action against the three officers directly involved. I don't think that that would be appropriate, as I have said I think that there was a loss of communication or a lack of communication that was a tactical failing in practical terms, objectively, these officers did not communicate clearly and intelligibly with Mr Elkass, but given the emergency circumstances as they appeared to these officers I don't think that - first of all I don't think that the Commissioner would accept a recommendation and secondly I don't think it would be reasonable in all the circumstances.

As to the fifth suggestion that the Commission investigate the possibility of conducting a trial use of cameras on guns used by New South Wales police I think there is some merit in that but as Mr Haverfield has said that sort of things is generally being pursued at any given time by the police, nevertheless obviously there is no harm in making the recommendation that it is not impracticable it is not stupid, it is a worthwhile suggestion I think and I will make that recommendation.

The final recommendation suggested is that I recommend to the Attorney General and the Minister of Police that consideration be given to the establishment of a body independent of the New South Wales Police to investigate police critical incidents.

The quotation of the State Coroner in the Curty(?) case I think is apposite here for two reasons I do not propose to make this recommendation, although I think the thinking behind it is certainly reasonable and should be considered, but a recommendation of this sort may be considered implicitly anyway a criticism of the particular investigators who undertook this investigation. In my opinion while I accept that the Elkass family certain have reservations about the objectivity of the investigation and they are now persuaded and they probably will not be persuaded by me that it was objective, thorough or fair, I do not see evidence that it was lacking in the objectivity or unfair or biased towards police. As I say I particularly was struck by the evidence of Detective Sergeant Robinson yesterday.

Nevertheless I do think that for the good of the New South Wales police generally that this is a policy issue that government ought consider. I don't know that establishing a body independent of the New South Wales Police if the emphasis is on establishment is in the government's mind, but I do think it is very necessary to ensure that the New South Wales Police and the New South Wales public can have confidence in investigations that they would be independent.

Police Officers who are ultimately cleared by an investigation, I think, will take much greater comfort from an investigation and should take much greater comfort from an investigation by a body that is seen to be and actually is independent of them, of their association of their hierarchy and so on, than a body that is not. I do not say that to criticise the New South Wales Police, the Homicide Squad or any particular people involved in this particular investigation. It is the course and I having done some studies of this, 20 years ago in Northern Ireland when British Police investigated Northern Irish Police, I can only say that it added greatly to the confidence of the community that Northern Irish Police, a well know Ulster constabulary were investigated by mainland UK police.

There are all sorts of good reasons to and fro and I am not going to, I am not in a position to enter the argument beyond expressing the idea, well expressing my general endorsement of the idea.

The last thing I really need to do here is come to a few things. First of all I am sorry I have been talking for so long. This is an important case and the concerns of everyone need to be taken seriously. Finally I do want to say a few things which don't relate directly to the evidence and that is firstly I need to thank my counsel assisting and the Crown Solicitor's Office. I was gratified to hear that Mr Haverfield commended Mr Hamill on his fairness. I can only say that working with Mr Hamill has been a pleasure, I think he has been impeccably fair and balanced and the Crown Solicitor's Office has also taken a very, I hope and believe to be a very fair and balanced view.

Formal Finding:

I find that Rodney Elkass died on 29 September 2011 on Castle St, near the corner of Pennant St, Castle Hill, NSW due to a gunshot wound to the head when shot by NSW Police.

Recommendations:

To the Commissioner of Police I make the following recommendations

1. That the New South Wales Police Force investigate and/or consider:

(i) The introduction of means of visual identification by which plain clothed officers and detectives are readily identifiable as police officers. Such consideration might include the introduction of caps, hats or other headwear, vests or other items clearly marked with police and/or the wearing of large police badges attached to a chain to be worn around the neck.

(ii) Introducing a system by which such items are readily accessible in police cars and police stations.

(iii) The introduction of training and protocols designed to encourage the use of such means of visual identification by detectives and plain clothed officers.

2. That the words of the NSW Police Force FACT Sheet entitled 'Firearms Registry, Safe Storage Inspections/Firearm Inspections' be amended to reflect the mandatory terms of s. 42 of the Firearms Act stating:
'If you have reasonable grounds to believe that a firearm is not being stored in accordance with the Act you MUST seize that firearm.'

3. That the document or publication entitled Overview NSW Firearms Licensing Scheme' be amended to reflect the mandatory terms of s. 42 of the Firearms Act by stating:
'If you have reasonable grounds to believe that a firearm is not being stored in accordance with the Act you MUST seize that firearm.'

4. That the NSW Police Force maintain (or introduce) a system whereby the staff of the Firearms Registry are authorised and encouraged to raise questions with licensing police about action, or inaction, in relation to possible breaches of Firearms licenses, legislation and regulations.

5. That the NSW Police explore the viability of technology incorporating cameras on pistols issued to NSW police officers as is being done in the United States and United Kingdom and consider trialling such weapons.

The Minister for Police I make the following recommendation:

1. That in light of the current review of the Firearms Act and regulations, the NSW Government consider amending gun licensing regulations so that gun-club pistol licences (Class H licences) may be issued on condition that the registered gun be stored only in safe facilities at the club to which the owner belongs when not in use according to the conditions of the licence.

37. 2406 of 2011

Inquest into the death of James Bond at Aldavilla on the 3rd October 2011. Finding handed downy Deputy State Coroner MacMahon.

This inmate died of natural causes there are no issues that require further investigation, there are no suspicious matters or issues surrounding his care, treatment and confinement.

Formal Finding:

That James Anthony Bond (born 5 July 1962) died on or about 3 October 2011 at the Mid North Coast Correctional Centre Aldavilla in the State of New South Wales. The cause of his death was subarachnoid haemorrhage secondary to a ruptured berry aneurysm. The manner of her death was natural cause.

38. 866602 of 2012

Inquest into the death of Robert Curti at Sydney on the 18th March 2012. Finding handed down by State Coroner Jerram.

Evidence was heard before this court for ten days in October regarding the death of Roberto Laudisio-Curti, a 21 year old Brazilian national, who died in Sydney on March 18, 2012. This inquest was mandatory under s 23 of the Coroners Act 2009, as he died in the course of police operations. Furthermore, facts required to be established by the Coroner under s 81 of the Act include his identity, date and place of death, and the manner and cause of that death. The autopsy performed by a senior forensic pathologist at Glebe was unable to establish that direct cause. The prime focus of this inquest therefore was to attempt to establish both that cause, and its manner, or how Roberto came to die as he did.

I have been assisted with great sensitivity and skill by Mr Jeremy Gormly of Senior Counsel, and by Mr Aitken and Mr Fraser, Advocates and Solicitors of the Crown Solicitor's Office. Roberto's family similarly were represented by Mr Peter Hamill of Senior Counsel, the Police Commissioner by Mr Bruce Hodgkinson of Senior Counsel, and the police involved variously by others, including Mr Thangaraj also of Senior Counsel. Twenty-nine witnesses gave oral evidence, including five medical experts, four of whom were concurrently examined in order to find common ground as to Roberto's cause of death.

This was an inquest, which attracted more than the usual degree of interest from the media, both local and international. The story therefore of Roberto's last hours has been widely reported, mostly but not always accurately. Both Mr Gormly and Mr Hamill outlined those facts in their closing submissions, and I refer to those in particular, but consider it necessary to outline once again the facts as they were established by the evidence.

The Facts

Roberto was a fit and healthy young man, who played first grade soccer with skill and enthusiasm. He had in fact played two games the day before he died. He was resident in Australia in order to improve his English, and had been living with his sister and her husband in Inner West Sydney for a year, working part time as well as studying.

On the evening of March 17, St Patrick's Day, after soccer, Roberto went out with several friends, first for a drink at a friend's Bondi flat, and then at the bar known as "Scruffy Murphy's" on George and Goulburn Streets. He did not drink much alcohol, and indeed toxicology results showed none at the time of his death. However, some time between 9.30 and 11.30 he shared a tab of the illegal drug, LSD, with the two friends. His family have told us that he was not a regular drug user, although he had, like so many of his age, been known to try cannabis. The relevance of the LSD was not its illegality,

But the effect it had on Roberto that night. Dr Jonathan Phillips an expert Psychiatrist, and Professor Alison Jones, a specialist Toxicologist, both agree that

the LSD was almost certainly the cause of the bizarre and uncharacteristic behaviour, which Roberto subsequently exhibited.

At this point, as Mr Gormly submitted, it is hard to avoid commenting on the enormous value to this investigation of the various electronic recording systems, particularly CCTV, throughout the city, installed both by the City of Sydney Council and by a very large number of businesses. The cameras, despite at times showing only fleeting images, enabled Roberto's route and the timing of his movements to be determined. The time saved has been remarkable, but the greatest benefit was to be able to establish precisely places, times and actions that might otherwise have remained speculative.

After taking the drug, the three men went to Kings Cross where they ate pizza and unsuccessfully attempted to enter a night club. They went to a MacDonald's in Darlinghurst Road for half an hour, and then walked down William Street to the corner of College Street. By this stage, Roberto was showing signs, according to his friends, of alternate euphoria, agitation, and paranoia. The friends lent him money and encouraged him to go home. At 4.31, he phoned his sister and asked 'Why do you want to kill me?" The phone cut out and she was unable to recontact him, but rang one of the friends who said Roberto was still with them and that they were walking back to Kings Cross.

At 4.45am, Roberto caught a cab and asked to be taken to Glebe. At the Fish Markets, he jumped out without paying or notice, and ran off. The cab driver described him as odd and scared. He then walked up Market Street into George, where at 5.02 CCTV footage shows some unknown men chasing him. Two minutes later some private security guards intervened as four men assaulted Roberto at the corner of George and King Streets. He was calling for help and for the Police, and had incurred bleeding scratches on his elbows and back. He ran off, and two minutes later entered a convenience store on King Street. What happened there was well captured on CCTV and has been shown to the public on television.

Roberto told the manager that people were trying to kill him. He had lost his jacket by this stage, and carried his T shirt over his shoulder. The manager, Mr Alsheyab, appears to have recognised that Roberto was in fear rather than aggressive. He gave him some water and biscuits and allowed him to rest in the shop. Roberto said he was a messenger of God, and that he did not want the police. He ran out when two tourists entered the shop, but ran in again very shortly after, and forced himself into the enclosed cashier's cubicle by jumping a door with extraordinary strength, and then scrambled across the counter. He left taking two packets of biscuits with him, saying to Mr Alsheyab, "Don't tell anyone". He then is seen turning down King into York Street, walking towards Wynyard, and going in to Australia Square. Here he has obviously removed his shoes, socks and belt, and taken off his underpants while replacing his jeans. (The experts agreed that these actions were almost certainly caused by extreme body heat known to be a side effect of LSD).

Meantime, Mr Alsheyab had not called police, but a street cleaner who had by chance seen, from outside the store, Roberto climb over the counter and the other two men in the shop, assumed she was witnessing a robbery and called 000. She did tell the operator when asked that she had seen no weapons.

However, the operator reported an “Armed Robbery” to police, who initially repeated that in the VKG call. In her statement, the operator stated that this was in accordance with the relevant Police Standard Operating Procedures (“SOPs”). Subsequently, that was twice corrected, but at least one responding officer continued to refer over police radio to “the armed robbery” and it was to that that police in the area receiving the message responded. These were the first two links in the terrible chain of errors, misunderstandings and chaos which was shortly to lead to tragedy.

Roberto is then seen to walk up Pitt Street where two police officers, who had not yet heard the call regarding the suspected robbery, noticed his odd behaviour but did not react at that stage. About this time, a third and erroneous confusion arose when a member of the public saw some people ‘breaking into a motor vehicle’ on Pitt Street between Bathurst and King Streets and called police. Probationary Constable Barling and Senior Constable Ralph went to investigate (the so-called break in was discovered to be by the owners of the car who had locked the keys inside, and were desperate to retrieve documents for travel that morning).

Constable Lim and Probationary Constable Collison of the Surry Hills Local Area Command heard the ‘robbery’ call, and sighted Roberto heading towards them on Pitt Street while they were stopped at the Bathurst Street lights. They believed him to be the suspect. Collison alighted and approached Roberto, saying, he says, “G’day, can you stop there for us? We just want to have a chat.” We see Roberto on film side stepping him, pushing past Constable Lim and rushing off on Pitt Street. We see the two officers start to chase him, joined almost immediately by Senior Constable Ralph who had seen events from where he had been talking with the owners of the car with the smashed window.

Probationary Constable Barling also left that scene, and joined in, crash tackling Roberto into Collison, who was momentarily stunned, but not managing to keep hold of him. Roberto, sweating and desperate, ran off, crossing from the western to the eastern side of Pitt Street, but not before Barling had drawn and fired his Taser at close range during the initial attempt to restrain him. A civilian witness in a hotel close by saw the flash of the Taser. Two probes were later found in Roberto’s flank, but he seems not to have been affected by the shot at this point.

At the same time, Sergeant Cooper of the City Central Local Area Command, who had heard the VKG call, saw the chase and drove his police vehicle on to the western footpath of Pitt Street in an attempt to block Roberto. It was clear from the evidence including the Tasercam footage, that Sergeant Cooper also fired his Taser at that point, and twice more. One probe from that Taser was later found in Roberto’s abdomen, although clearly the electrical connection was not made.

Barling reloaded his Taser, caught up with the other pursuing police, and again tried to tackle Roberto outside Kings Comics. Again, Roberto evaded capture.

The two officers who had first noticed his odd behaviour joined in the pursuit, and one of them, Senior Constable Edmondson, was caught in Taser wires from another Taser shot from Barling which had missed Roberto. By this time, six police officers were chasing Roberto, who ran back across Pitt St to the western side, and evaded a third tackle attempt by Barling, but was brought to the ground on the western footpath by a Taser fired by Senior Constable Lim.

Four more officers arrived shortly after Roberto was on the ground, bringing the police total to 11. The senior officer throughout the incident was Sergeant Cooper. There was a protracted struggle to control Roberto, who police described as having super human strength. Evidence from Tasercam and some officers however, shows that after being bought to the ground he was fairly quickly handcuffed after an initial attempt that left only one cuff on one of his wrists, that one officer lay across his back until another knelt on him, and that others were holding his arms and legs. Worse, five drive stuns were then administered by Probationary Constable Barling, at a similar time to two drive stuns being administered by Senior Constable Edmondson, and at least some of the contents of each of three cans of capsicum (or OC) spray were discharged at his face by Senior Constable Ralph. During at least the first 3 minutes of Roberto's being restrained on the ground, as evident from the tasercam footage, terrible groans and screams are heard from Roberto, which clearly show his pain and distress. At about 6:11:40am (based on VKG reports) he is suddenly seen to be unresponsive and not breathing and is found to be life extinct when ambulance officers arrive as summonsed. No direct cause of death was found by autopsy.

The Issues

The issues which as agreed were investigated by this Court were:

1. The manner and cause of Roberto's death

2. The categorisation of the incident at the King St store as an 'armed robbery'

3. The lawfulness of the arrest including
   a) whether there was a proper basis or reasonable suspicion justifying the arrest
   b) the degree of force used
   c) the reasonableness of the degree of force used

4. Whether police management of the incident conformed with
   a) policies then current relating to use of force
   b) any applicable training relating to the use of force regarding
      i positional asphyxia
      ii monitoring of vital signs
      iii use of Taser devices
      iv use of OC spray

5. Compliance with any standard operating procedures relating to police interaction with persons showing signs of mental health issues or drug affection.

Two days after evidence in this matter was finalised, the NSW Ombudsman released a report reviewing the use of Tasers by the NSW Police Force. It does not, I am advised, refer to this inquest, having been completed well beforehand and reviewing Taser usage during a period prior to Roberto's death. I have deliberately not read that Report, believing it to be inappropriate for me to consider its contents and conclusions during the preparation of these findings.

Witnesses and Evidence

Three civilian witnesses were helpful in providing an independent view of the incident. Wendy Price had watched from her hotel window and described the flash of the first tasering, and the sounds of Roberto "like a wild animal yelling" while he was on the ground. Her comment was that "everything I saw was consistent with a man trying to get away".

Tommy Wang, who lives in the Century Tower in Pitt Street had just alighted from a taxi when he saw a topless man running with six police chasing him. He saw a police officer push him into the glass of the coffee shop and he saw the man ultimately go to the ground, screaming during constant 'zapping' sounds and yelling 'Help' several times. He described the police actions as not appropriate and quite violent and the man as "just trying to run away".

Mr Jialong Wu was one of the group who had to break in to their car that morning. He watched as the police left them and ran after the sweating man, seeing the tackle and then his falling to the ground. He saw a lot of police around him and heard a lot of police shouting, as well as constant zapping sounds. He too did not think what he saw done by the police was right, and that the man was "just trying to get away".

The first police witness was Sergeant Partridge who was on duty that shift at City Central Police Station. He received the first call that there was an 'Armed Robbery' just outside his area and called it over the VKG while he monitored Roberto's whereabouts which he then relayed. He claimed he never heard anyone say that there was no weapon as he was not paying full attention to the radio, he was tired at the end of a twelve hour shift, he was doing his change over with the oncoming shift and the incident at the store was outside his area. He did not recall telling Sergeant Cooper that there was a knife involved, as was later claimed by Cooper.

Senior Constable Lim told the court that he heard the radio call regarding a robbery as he and Probationary Constable Collison were pulling up at the intersection of Pitt and Bathurst Streets. He got out and tried to speak to Roberto who ran away. He agreed that he intended to arrest him based on the radio information and that he believed he was the alleged robbery offender. Lim said that they were all "bucked off" as they tried to bring Roberto down. Because he was so much smaller and thought he himself might have been injured, he changed his mind from tackling Roberto to using his taser and eventually tasered him and brought him to the ground, without knowing that there were four or five other officers immediately behind him in support.

He claimed that once Roberto was on the ground, he watched as other officers tried to cuff him, and cycled his taser again as Roberto looked as if he was going to escape. However, he had to agree that that was incorrect once he was asked to watch the video in court.

Lim became less than credible in his evidence at this point. He claimed that no officer was lying across Roberto, that he only heard a Taser once more, that he saw no officers with their tasers out and did not know that OC spray was used. He never heard Roberto say 'What did I do?" He only agreed that Roberto was cuffed and that he did not 'buck' again once on the ground, after he was shown the video. Of concern, he was insistent that his use of the Taser that night was consistent with his training, and that all that he saw was justified because of the 'bucking off', the fear that Roberto would escape again, and the fact that police officers might be overpowered so that their safety was in question.

This view is in complete conflict with what is seen on the tasercam footage and with the evidence of the civilians, which indicate that Roberto was just trying to get away. Lim's professed failure to see any further tasering, spraying or excessive restraint brought him little credit given the physical evidence as well as the admissions of other officers.

Probationary Constable Chan arrived at the scene only once Roberto was on the ground. Although he saw a little more than Lim, including one drive-stun to the back, he too claimed to see very little, being concentrated on trying to hold down Roberto's leg. He did hear "why are you doing this to me?" from Roberto, but did not see any officer putting weight on the body. As with several other police, he explained this failure to see by his vision being obstructed by the others crowding around, and his 'focussing' only on that part of Roberto, i.e. the leg in his case, which he was holding.

Constable Kim of City Central Police Station was partnered with Chan that night. Arriving at the scene of the struggle on the ground, he admitted to seeing Barling entangled by taser wires and shouting 'Fuck'. He did not see Barling drive stun Roberto at all, let alone five times. He, Kim, merely used his baton to hold Roberto down as he was struggling. He did not see Ralph use the spray although he smelled it, and he did not see the handcuffs on Roberto.

According to Kim, Cooper only had his forearms on the lower back. Once again, he claimed to recall very little, and to have seen almost nothing (despite the evidence of other police) and to have been 'focussing' only on the leg. He appeared to make no genuine effort to give truthful evidence. The term 'focussing' was used suspiciously often by those police whose evidence was unhelpful or worse. Between those officers, there was a similarity of wording and an apparent inability to remember that which did not assist some of them in acceptance of their truthfulness or independence.

Another Probationary Constable, Collison, was in the vehicle with Lim and heard the calls regarding an 'armed robbery'. He followed Lim who failed to persuade Roberto to stop, and saw Barling tackle him, causing Roberto's head to hit Collison's so that he stumbled and fell back.

This meant that he was still about three metres away when Lim used his taser to bring Roberto to the ground. He was then asked to go and search for Cooper's car keys and took no part in the following events, but heard a Taser discharged before Lim's, and did see prongs in Roberto's back.

Constable Annalese Ryan had been observed by Tommy Wang apparently to kick Roberto's prone body in the back. She and Edmondson had seen the shirtless man earlier while in a pie shop, considered him odd but harmless, and only joined in after hearing the broadcast of an armed robbery and the description of the alleged perpetrator. She observed the 2nd tackle and could see a Taser probe in Roberto's stomach. She agreed that she had put her foot on his right thigh once he was face down, for about 15-20 seconds during which time she both heard and felt one Taser used but did not kick at him.

It was she who managed to place one handcuff on him, but could not manage the other, as he was too strong. She did not see Barling drive stun, because of the 'huge amount of police' but did smell OC spray, without knowing who used it. She agreed however that Edmondson used his Taser once in drive stun mode while Roberto was on the ground. Many officers were entangled by Taser wires, and Roberto was still thrashing about. She was obliged to leave the fray to speak with the people who had earlier broken in to their own car, and who needed to be moved away. The whole event was described by her as loud, violent and scary without control, her only similar experience being once dealing with a suspect who was on 'Ice'.

Ryan gave the impression of making a real effort to be open and helpful, and said that when they first saw the shirtless man, they did not feel any need to intervene as he was doing nothing wrong. In retrospect, she told the court, their police presence when they first saw Roberto from a pie shop called Pieface, may have been the partial cause of his odd behaviour, ducking into doorways and hiding. Nevertheless, she saw and heard very little of what in fact happened as confirmed by other witnesses, (such as Roberto's crying out, Barling's five drive stuns, and the repeated use of the OC spray.

Ryan was followed into the witness box by Leading Senior Constable Edmondson, her partner. He was rather more clear in his observations than some of his colleagues, but throughout his evidence was adamant that he and his colleagues had done nothing wrong, and that all of their actions were justified in response to Roberto's strength and violent behaviour. He agreed with Ryan that on first seeing the shirtless shoeless man running south down Pitt Street, while at Pieface, he saw nothing to cause him any concern, or a need to pull him up. However, after hearing reports that Roberto was a suspect for a robbery and seeing Roberto running down Pitt Street from Bathurst Street pursued by other officers, he drove to Castlereagh Street, parked, and as Roberto reached Kings Comics, shoulder-charged him. He bounced off, stumbled, staggered and continued to run.

Edmondson heard someone call "Taser, Taser" and then himself became tangled in Taser wires. Possibly as a result, he did not see any of what followed until he saw the man down on the road. Edmondson then joined the 'struggle', placing his knee on the lower back, and drive stunned him twice within twelve seconds to his lower back.

He described this as seeming to have no effect, and was unaware that Roberto had already been subjected to a Taser in probe mode by Senior Constable Lim.

Simultaneously with his second stun, he became aware that Barling was using his Taser also to drive stun, but considered that there was nothing in his training which prohibited multiple tasering (although in cross examination he agreed that he knew that the Standard Operating Procedures warn that multiple cycles or prolonged use of taser may increase the risk of serious injury or death), and was in any case only aware of Barling using the drive stun mode once.

He had been taught that the Taser is a tactical option, like OC spray and batons, and not a weapon of last resort, other than a firearm. He did not concede that he used the drive stun for 'pain compliance'. Edmondson confirmed that he gave Senior Constable Ralph his OC spray after seeing Ralph's run out. He then noticed that Roberto was cuffed, and had a further cuff flapping free from his right wrist. Edmondson said that Sergeant Cooper was lying with his full weight across Roberto's upper back and was not heard to make any direction to stop tasering or spraying.

When Cooper moved off, Edmondson moved down the body and removed five probes from the back. He became worried then about positional asphyxia and checked his pulse and breathing. Roberto was not put in the recovery position because of the struggle, but when no pulse could be felt, Edmondson rolled him on his back and started CPR. He estimated there to have been one to two minutes between the pulse first being checked and the commencement of CPR.

Constable Waugh gave evidence that when he and his partner Constable Ferguson-Gornalle arrived on the scene, he heard tasers several times, and a lot of shouting including "Don't use cartridges, just drive stun him", and possibly "Hit him again with the Taser". He was aware that multiple taser use was not recommended, as it could cause injury or death. He had attended the City Convenience store with Ferguson-Gornalle, after the original call, and knew that Roberto was not armed and had merely taken biscuits. He was concerned that Roberto was on his stomach, and had been subjected to multiple taser applications, but because of his junior rank, did not feel able to speak out. When Roberto was rolled onto his side, Waugh noticed his face was a dark deep purple.

The court next heard from Constable Ferguson-Gornalle, whose time in the NSW Police was relatively short, but who had spent twelve years in both the Military Police and the Australian Federal Police, and hence was in fact more experienced than most. He heard Roberto shouting 'Help me' and saw Sergeant Cooper on top of him, as well as the spray being applied 10 cm from the face. He barely took part in the fray, as he took responsibility at one point for making radio calls, but was the first to suggest that Roberto's breathing and pulse should be checked, being aware that a person was at higher risk of positional asphyxia if on their stomach.

Senior Constable Ralph was one of the officers whose evidence gave most reason for concern. He was one of the more senior police involved, yet he did not know the prevailing SOPs regarding OC spray. Nor, he said, did he consider that he should have done anything to keep himself up to date on changes.

He changed his evidence more than once. He did or did not take part in cuffing Roberto on the ground. He possibly did or did not spray closer than 30 cms to the face.
Partnered with Probationary Constable Barling, he did not agree that he himself was out of control, yet he claimed to have been 'in a panic' and 'highly aroused' in reaction to what was occurring.

Ralph was attending to the alleged motor vehicle break in when he heard the broadcast about a man running down Pitt Street. With no knowledge of the background he joined the chase after Roberto. He saw who he thought was Sergeant Cooper pull up, run across Pitt Street and attempt to shoulder charge the running man, followed by Barling's ineffective tackle on the western side.

He too saw Cooper lying across Roberto's back once he was brought to the ground. Ralph knew that there had been at least two taser discharges before he, deployed his spray. Ralph said that he initially sprayed Roberto to the face for two to three seconds in response to his violent actions, holding the can horizontally because it was easier to reach his face and spraying for two to three seconds as, he claimed, he was taught at the Police Academy, despite the SOPs stating one second.

In contradiction to the observations of others, Ralph claimed to have held the cans 30 cm from Roberto's face, not 10 cm, but neither, even on his own testimony, the required 60 cm "where practicable" stated by the SOPs. With no sign of regret, he agreed that he sprayed three cans directly at the by now handcuffed Roberto, the second time for as long as seven seconds. Ralph said that he was having difficulty spraying his face because of his movements, stating that some hit the ground so he then pointed it up, and Roberto lifted his body up, and turned to face the ground, away from the spray. Ralph used at least some of three different cans of OC spray, and said that he did not consider using a fourth can as he thought it had taken effect.

While he heard Cooper say 'Handcuff his legs' he did not hear Cooper say 'don't taser him, he's handcuffed' as Cooper later claimed he had done.

Ralph vehemently denied that his use of the spray in this incident was excessive and ineffective, and still believed that it was justified despite there being in his own words, "half a ton of Police Officers on him". It should be noted that Constables Ryan, Barling and Ferguson-Gornalle all saw the spray applied 10 cm or less from the face. Only on being shown the footage from Lim's Tasercam did he agree that he had initially had his knee pressed to the middle of Roberto's abdomen. He continually described Roberto as 'violently resisting', uncontrolled, forceful, and 'fighting our efforts against him'. He said in court that he would do the same again, and that he believed that all that he did was reasonable because he was still fighting, and said that it didn't cross his mind that it was in order to breathe.

Sergeant (now Inspector) Cooper's evidence was so self-contradictory, self-serving and obscure that it hardly bears narrating. Frankly, given that he was the most senior officer involved, both his actions during the event and his attempts to exonerate himself and blame more junior officers afterwards, are little short of contemptible.

He was unable to explain the constant difference between his version of events, and that of other officers and what was shown by Tasercam footage other than personal difficulties and ill health.

He claimed that he had initially been told that there was a knife involved in the event at the convenience store despite there being no suggestion from any other source that that was so. He had driven his car up on to the footpath of Pitt Street in an attempt to block Roberto's flight, and contradicted himself (and the physical evidence) as to the position from which he in fact fired his first Taser. Once Roberto had been brought down by Lim's taser, Cooper's description of his own actions fly in the face of all other evidence.

He said that he merely placed some weight against Roberto's back with his knees then lightly lay across his back a little. Significantly, as not one police officer corroborated him, he said that he gave the instruction, "All Tasers turned off—cartridges out and then turn them off!" after one was deployed while on the ground, and one officer was heard saying "Stop resisting or you'll be tasered again".

His asserted reason for this was that he would not have used a Taser in a circumstance such as this, with the subject on the ground, cuffed, and enough officers to control him. In any case, he was only aware of two deployments of Taser; the one which brought Roberto to the ground, and the one he heard whilst on the ground. Cooper had no explanation for why he did not hear what we now know to be the other six drive stuns during the struggle on the ground.

On one hand, he said that he had no power to stop other officers, whilst on the other, he said that he did have the power to tell them to stop tasering. Cooper denied knowledge of the wording of the Taser SOPs, saying that he had never been provided with the relevant document. When Counsel Assisting put to him that he had failed to take command of the situation and control junior officers, and failed to stop or minimise the use of Tasers and OC spray, Cooper disagreed. His evidence bore almost no credibility.

Probationary Constable Barling did not resile from the fact that he tasered Roberto twice during the run and five times while he was on ground, having assisted in handcuffing him first, and that he knew Senior Constable Ralph had used his OC spray, but insisted that these actions were reasonable (and not contrary to training) as Roberto might get up and run away. Barling, who had no idea why the running man was being chased, claimed that from when he first tried to tackle Roberto, he believed that he was justified in his actions as he was trying to protect other officers, and the man himself. Barling did concede, having seen the Tasercam footage, that what he had first stated was often incorrect. It has to be said that Barling appeared to be trying to give honest evidence, but that his judgement remained appalling, and that his use of the Taser, particularly in the drive stun mode, (which may have been partly due to his inexperience and extremely junior rank), was quite unreasonably violent.

I was informed by Mr Hamill that following his evidence, Probationary Constable Barling approached him and offered some "kind and appropriated words" to be passed onto the family. This is to Barling's credit.

The final police evidence was given by Senior Sergeant Davis, who is a Co-ordinator and Chief Instructor for the Police in Weapon and Tactics Policy and Review.

He is a senior trainer of police, both as cadets and in ongoing use of weapons. He had of course no involvement in events leading to the death of Roberto. The technical evidence which he gave was skilled and useful. He described the effects of tasering and spraying, and the operation of each with knowledge and clarity. He confirmed that Tasers, which have been used by NSW General Duties Police Officers only since November 2009, were introduced primarily to deal with persons with mental health issues, particularly those threatening self-harm, where firearm use would be inappropriate.

Although less lethal than a gun, he said, the use of Tasers also required restrictions and should not exceed the procedures set out in the SOPs, which, nevertheless, do not always define terms helpfully. Senior Sergeant Davis further agreed that the criteria in the SOPs do not assist officers in determining whether they are entitled to taser a fleeing subject (although this was something that the training material did appear to authorise), and that multiple applications of a taser cannot be justified solely on the grounds that the person fails to comply with a command, in the absence of any other indication that the subject is about to flee or poses any immediate threat, particularly when more than one officer is present to assist in controlling a situation.

Despite that evidence, when asked to apply that opinion to the reasonableness of the use of both tasers and spray, and of the degree of force used by officers against Roberto, he was considerably less objective. It was put to him that the criteria which he had described were not met in the overpowering of Roberto. His response was that he believed that Roberto was not under control and was a threat, and that officers were facing violent confrontation and resistance, either occurring or imminent. The propriety of the use of tasers was up to the judgement of the individual officer, and, furthermore, as junior police required experience and exposure to gain knowledge, he believed it to be perfectly appropriate for probationary officers to be trained in, and allowed to carry, Tasers. He did not consider the seven drive stuns applied to Roberto on the ground excessive, and accepted that the purpose of drive stun mode was as a means of ‘pain compliance’ .

However, when it was suggested that someone would require time to recover from the pain in order to comply, he replied that pain was the designed purpose but that recovery from that pain may occur in as little as two seconds. Nevertheless he did express the view of the Taser Executive Committee, of which he is a member, that tasers should predominantly be used in the probe mode. Asked whether there was a risk of police becoming over-dependent on Tasers rather than other tactics, he maintained that that had not been the case with Roberto, even though he accepted that underlying all police procedures is the concept of minimal force. In NSW, that term is replaced by ‘reasonable’ force, which in the view of Davis, met the situation where Roberto was drive stunned seven times within 51 seconds by Barling and Edmondson, and sprayed with at least some of each of three cans of OC spray by Ralph while handcuffed. Davis considered it possible for a similar situation to justifiably recur, as in his opinion those actions were consistent with current NSW Police SOPs and training.

The SOPs provide criteria for the use of Tasers. They include the use of drive stunning only in 'exigent circumstances'. Officers queried about the meaning of those words gave varying answers, and all insisted that this situation met that definition. It is clear that the term is unhelpful. It is too vague and open to misinterpretation. It should, in my view, be removed from the SOPs.

By Audio Visual Link ("AVL"), evidence was taken from Dr Geoffrey Alpert, Professor of Criminology and Criminal Justice at the University of South Carolina, USA, and an expert in police tactics and weapons. His principal area of expertise, publications and research has been in the USA, but he has recently spent a winter at Griffith University, and is knowledgeable about police use of Tasers and other weapons in Australia. He provided a written report which was admitted as part of the coronial brief, and was questioned on AVL for some two hours by all parties. He was a highly helpful, useful witness whose credibility remained unchallenged. The following views were of particular importance:

1. The underlying principle is accepted that where there is a real need, any reasonable weapon of force can be used, but the use of Tasers in drive stun mode is open to abuse, which is why many American states have severe restrictions. Once a person is under control, the use of any force is a form of punishment. Once cuffed, the question must be asked, with foresight not hindsight, if there is a risk of escape; what is the impact if there is an escape, including is the person likely to commit a serious crime and what threat would thereby be posed to police or members of the public? In Roberto's case, were he to escape there was no real threat of him committing a serious crime or any threat of violence to any person. Furthermore, there were a sufficient number of officers to have controlled him without the use of tasers or OC spray once he was on the ground. Professor Alpert said "I can't imagine agreeing with the use of a Taser after someone has [sic] handcuffed on the ground, under control."
2. Given that height, weight and gender requirements are now waived for entry to the NSW Police Force, theoretically Tasers can neutralise any differences between an officer and a subject, but it can also cause 'lazy cop' syndrome, in which police turn to the use of Tasers too easily and too often. There is of course a difference if an officer is alone, rather than, here, one of many against one.
3. Overall, the NSW Police Training Guidelines and SOPs are excellent but there is a need for change, for greater definition in the criteria for use (particularly in drive stun mode), and improvements in training for officers to ensure that they fully understand be very clear on their meaning. Guidelines and SOPs are only useful if communicated to officers.
4. Training must adapt and develop, and each use of Taser should be reviewed by the relevant Committee every time.
5. The use of handcuffs as pain compliance is a very effective technique, but apparently is not taught in NSW.
6. Obviously, Tasers and spray are less injurious overall than firearms, but their use is not thereby reasonable in all situations.
7. Ralph's training was inadequate. The Professor was surprised at his, and others', including Cooper's, lack of knowledge of procedures.

8. He found Cooper's statement that he was unaware of the warning that multiple cycles or prolonged use of Taser may increase the risk of serious injury or death to be particularly shocking.

In summary, Professor Alpert disagreed with the views all officers, including Davis that the police actions during these events, particularly the use of Taser in drive stun mode whilst Roberto was on the ground and handcuffed, were justified, or in accordance with the prevailing SOPs and training.

Detective Sergeant Glen Browne together with Detective Inspector David Laidlaw were the Homicide detectives assigned to investigate this critical incident as required by police protocol. Some criticism was levelled at Detective Sergeant Browne that during directed interviews with some officers, he had questioned them in such a way that their answers were fed to them, and allowed discrepancies, for example in the interview with Cooper, to pass by unchallenged.

I do not accept that Detective Sergeant Browne in any way interviewed officers incorrectly or improperly. On my reading of those interviews, he was at great pains to be fair, to allow the interviewee to give his or her own version of events without interruption, and to return to pertinent facts, omissions or contradictions where necessary. The inconsistencies which remained were clearly a matter for this inquest, and were aired accordingly.

There is a strong feeling in the community that police should not be investigating police incidents. That is ultimately a decision for authorities other than the Coroner. It may be that criticisms of investigations would wane if an independent, outside body took over that role. It is a difficult situation for officers, however senior, to be expected to query or worse the actions of their colleagues. I wish to comment strongly, however, that in this case, both Detective Sergeant Browne and Detective Inspector Laidlaw demonstrated a skill and lack of bias, in my view, in a painstaking and distressing investigation. I thank them for a good job well done under various pressures, including those of time.

CONCLUSIONS RE POLICE ACTIONS

Policing is a difficult and often dangerous job. The public rely on the police for protection and support which is, in the main, provided with professionalism and courage by the members of the NSW Police Force. They are entitled when necessary to use reasonable force, including weapons, to pursue suspects in vehicles at high speed, to arrest citizens and to place them in custody. As well as Tasers, they carry batons, firearms, OC spray and handcuffs. They are trained to use their bodies and appointments to control those who threaten others. These are not entitlements available to almost any other members of our society, and with them come huge responsibilities. Individual officers do not have a licence to act recklessly, carelessly or dangerously or with excessive force.

In the pursuit, tasering (particularly in drive stun mode), tackling, spraying and restraining of Roberto Laudisio Curti, those responsibilities were cast aside, and the actions of a number of the officers were just that: reckless, careless, dangerous, and excessively forceful. They were an abuse of police powers, in some instances even thuggish, as described by Mr Gormly.

Mr Hamill's analogy with the character in Joseph Heller's Catch 22, screaming 'Help, Police!' as a cry for help against police action is searingly apt. Roberto's only foes during his ordeal were the police. There was no victim other than Roberto, no member of the public who suffered an iota from his delusionary fear. Certainly, he had taken an illicit drug, as has become all too common in today's society.

But he was guilty of no serious offence. He was proffering no threat to anyone. There was no attempt by police to consider his mental state. He was, in the words of Mr Alshayeb, "just crazy". Left alone, there is not a shred of evidence that he would have caused any harm, other than to himself.

It is of concern to me that so many of the involved police were extremely junior and inexperienced, and yet were armed with Tasers. Senior Sergeant Davis did not agree that probationary officers should not be issued with Tasers. That opinion must be queried in light of what happened on March 18, as must current training methods. Tasers are far from toys, and cause serious pain and temporary loss of self-control. Even current SOPs warn against their multiple or prolonged use because of the risk of serious injury or death. If any officers are to be entitled to carry these significant weapons (and I recognise that they were introduced as a far safer option than a firearm), then there is a considerable need for them to be clearly taught the circumstances in which they should or should not be used, and to be educated more deeply in the exact meaning of the SOPs.

Probationary Constable Barling's wild and uncontrolled use of the drive stun mode suggests that he had no such understanding, despite only recently having undertaken the Taser course. A few of the other Constables seem to have thrown themselves into a melee with an ungoverned pack mentality, like the schoolboys in 'Lord of the Flies', with no idea what the problem was, or what threat or crime was supposedly to be averted, or concern for the value of life.

The report regarding Roberto's actions at the convenience store should not have been broadcast as an armed robbery, particularly after it was subsequently corrected on at least two occasions. I accept that its rebroadcast as an armed robbery was a genuine oversight by Sergeant Partridge, but it was a vital one. Police VKG may need to be examined in order to prevent an incident being inaccurately categorised. Partly as a result, what eventuated was a frenzy of officers, most of them very junior and inexperienced, half of whom did not even know what Roberto was suspected of having done, as they joined in the chase, behaving out of control. I have a strong suspicion that some, particularly Barling and Edmondson, were emotional and angry because they had been 'zapped' by other Tasers, and/or sprayed inadvertently.

The lawfulness of the arrest was raised as an issue at the inquest. I am satisfied that there was a proper basis for the arrest in that the officers first attempting to arrest Roberto suspected on reasonable grounds that he was responsible for a robbery, and he immediately fled from them when they attempted to speak to him. To the extent that the initial arrest was required to be justified by legislation, I am satisfied that s. 99(2) of the *Law Enforcement (Powers and Responsibilities) Act 2002*, permitted an arrest.

No thought whatsoever was given to Roberto's mental state. According to the evidence, at no stage did he act aggressively~~,~~ to any member of the public or officer, other than to struggle wildly to escape the pain he was experiencing from being tasered, drive stunned, sprayed and lain upon by 'half a ton' of police officers (as Ralph described it). As all the civilian witnesses, and a few officers, told the court, at all times Roberto was merely trying to get away.

No one had told him he was under arrest, or why. We now know that he was almost certainly in a psychotic state of paranoia and fear, but this did not translate into any violence other than his need to flee. While not all uses of force by Police were excessive, the attempted arrest of Roberto involved ungoverned, excessive police use of force, principally during the final restraint.

The police officers now listed, should in my strong view, be referred for possible disciplinary action in relation to their actions during the pursuit and restraint of Roberto.

Inspector (then Sergeant) Gregory Cooper

Cooper's failure to maintain any objectivity, or sensible leadership, quite apart from the unreliability of his evidence, is abhorrent. His evidence in the main is rejected. The evidence of the AFIDs establishes that Cooper first fired his Taser from the western side of Pitt Street. Apart from being ineffective, it was a random act for no reason, as was his second cycling while Roberto was fleeing. His only purpose in deploying his Taser seems to have been to effect an arrest. His statement that he believed Roberto to have a knife is in stark contrast to every other witness, and hints at deliberate self-justification. Pushing his entire weight on the back of a man prone, who was handcuffed and had just been tasered was hardly the action of an experienced, senior officer. He allowed excessive use of force by junior officers. It appears that Cooper only sought to stop or limit the use of Taser when officers started to be affected.

Senior Constable Chin Aun (Eric) Lim

Lim probably was justified in his first use of his Taser, because he had seen three failed tackles, Roberto was clearly very strong and he was fleeing (something which appears to authorised by the training). His second cycling however was not justified on the evidence. Roberto was on the ground, surrounded by six officers, and had just been handcuffed. Lim's assertion in interview that after he used Taser the first time, Roberto thrashed around and tried to "buck" the officers restraining him off, was inconsistent with the Tasercam footage from his Taser. Lim's evidence, like that of Kim, of being unaware that spray and drive stun was being used on Roberto on the ground cannot be reliable.

Senior Constable Damian Ralph

Ralph's use of OC spray was unnecessary and excessive, and aggravated rather than subdued Roberto. It was also in breach of the recommendation within the SOPs for it not to be sprayed at less than 60cm where practicable, and the prescribed duration of approximately one second.

Probationary Constable Daniel Barling

Barling's two uses of Taser during the chase may have been justified in accordance with the SOPs, but nothing excuses his five subsequent deployments in the drive stun mode. He must, or should, have known that they would cause pain, hence causing more struggling, be unlikely to subdue, and were unnecessary having regard to the number of officers and the level of restraint already imposed upon Roberto. Those five uses of the Taser were inconsistent with the SOPs and training, and were markedly excessive.

Senior Constable Scott Edmondson

Neither of Edmondson's two Taser applications in drive stun mode were justified, and the second was unreasonable. Roberto was on the ground and handcuffed. Like Ralph's use of the spray, not only did it cause Roberto to struggle to escape even more, it seems that rather than control, compliance was being sought.

After Roberto had fallen to the ground and been handcuffed, no further use of Taser or of the OC spray by any officer was justified, consistent with SOPs, or necessary, and in fact worsened the situation.

Constable Nathan Ferguson-Gornalle seems to have been the only police officer who showed care, concern or compassion for Roberto's plight at the time. He is not criticised in any way.

Further, Probationary Constable Devin Bourke, Leading Senior Constable Chad Ansted, Probationary Constable Michael Waugh, Probationary Constable Ernest Chan, Probationary Constable Todd Collison and Constable Nathan Lockett (the officer who first attended the City Convenience Store), do not warrant any adverse criticism. Counsel submitted that Sergeant Craig Partridge and Constable Annalese Ryan also should not be the subject of complaint. I will accept their views.

THE CAUSE OF DEATH

Five independent medical experts gave careful, informed evidence of their various opinions on what in fact caused Roberto to die. We know that the autopsy performed by forensic pathologist Dr Isabella Brouwer at the Department of Forensic Medicine was unable to elicit a direct cause of death. There were no injuries sufficient to have killed him, no signs of prior cardiac disease (despite his having had some unspecified minor heart checks before he left Brazil), no evidence of asphyxia, and his toxicology revealed only a low level of the drug LSD, and no trace of alcohol.

The highly experienced psychiatrist, Dr Jonathan Phillips provided a report, admitted without contention as part of the coronial brief, after receiving the same detailed brief as the other four specialists. He attributed Roberto's disturbed, fearful and paranoid behaviour to a reaction to the LSD, and his non-compliance to fear arising from his drug-induced psychotic state. He rejected as a recognized psychiatric state 'excited delirium'.

In oral evidence, he painted us a picture of a terrified young man running from his 'demons', perhaps with no destination other than to escape, believing that people were out to kill him, and avoiding any attempt to stop or restrain him.

The four other medical specialists gave concurrent evidence, as well as written reports. All agreed that no direct cause of death could be attributed to

The tasering, either in drive stun or probe mode.
Dr Cooper, an eminent cardiologist and electophysiologist, although considering that a Taser can induce a fatal arrhythmia, found no direct evidence of such from the autopsy. There was, he said, insufficient electricity to have caused a heart rhythm disruption in drive stun mode, nor were any pair of probes positioned either side of the heart (as was the case in scholarly articles in which it has been suggested that Taser may have caused ventricular fibrillation).

OC spray
Professor Alison Jones, a toxicologist, advised that it was not capable of causing Roberto's death, and Drs Brouwer and Vinen (the emergency specialist) agreed. Dr Brouwer said that she could not exclude the possibility that the OC spray may have caused some decrease in respiration.

LSD
Dr Cooper said that LSD was extremely unlikely to cause death particularly in a small dose. It was not known as a direct cardiac cause. Professor Jones' evidence concurred with Dr Cooper's, that it was extremely unlikely to cause death by its pharmacological action or its side effects.

Excited delirium
Dr Vinen described it as a series of behavioural events linked with illness, seizures and drug ingestion rather than a cause of death. Dr Brouwer did not rule out that Roberto exhibited signs of excited delirium but did not postulate it as a cause of death so much as being associated with death temporally. Professor Jones and Dr Cooper offered no comment.

Anatomical causes.
Dr Brouwer found no evidence enabling anatomical diagnosis or structural abnormality and the others agreed. Dr Cooper was of the view that the minor heart rhythm abnormality he noted from the ECG conducted in Brazil prior to his death was not contributory to his death.

Dr Cooper saw three possibilities, none of which he could be confident to pinpoint as the cause of death:

a) positional asphyxia causing the heart to stop within a minute of respiration ceasing;
b) a cardiac arrhythmia, such as ventricular fibrillation induced by an excited delirium state;
c) a neurological effect, from an outpouring of catecholamines affecting brain function.

Dr Vinen was alone in giving a definite opinion that Roberto's death was due to positional asphyxia caused by the weight of a number of officers on his body preventing respiration. He saw it as the terminal event in a series of multifactorial events.

Dr Brouwer did not accept his view that there is a scientifically established basis for finding positional asphyxia as a single cause of death. She posed two options, a) undetermined or b) sudden unexpected death in a young man with LSD-induced psychosis, associated with police restraint and simultaneous use of OC spray and taser. She also noted the temporal relationship between excited delirium and physical restraint, taser and OC and sudden death.

Professor Jones could not suggest a predominant cause of death, other than to confirm her exclusion of the pharmalogical action of OC spray and LSD, although not excluding that LSD probably caused an acute psychotic reaction with downstream consequences.

I note that Dr Dawes provided a Report in which he gave his view that 'excited delirium' was the likely cause of death. The report was useful in further explaining the technical aspect of Taser operation, but Dr Dawes cannot be considered completely independent, because of his acknowledged links to the Taser International Company.

Roberto's death clearly arose from complex and multi-factorial causes, with no confirmed single identifiable cause. Nevertheless, it is impossible to believe that he would have died but for the actions of police. All of the medical experts agreed that his death was not coincidental. I will make an open finding as to the cause of death, with comment as to its manner accordingly.

THE QUESTION OF REFERRAL UNDER S 78 OF THE ACT.,AND OR OF THE WORKPLACE SAFETY ACT.

Mr Hamill for the family made strong submissions both oral and written, that the evidence satisfied the criteria in s. 78 of the *Coroner's Act 2009*, in that it was capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence in connection with Roberto's death, there is a reasonable prospect that a jury would convict the known person of the indictable offence , and that that the offence had lead to the death. His submission was that I should therefore suspend the inquest and refer this matter to the Director of Public Prosecutions for consideration of charges being laid. He based those submissions on the VKG recording, the CCTV footage, the independent witnesses, the Tasercam footage and logs, and the apparent breaching of the SOPs. Dr Vinen's view that positional asphyxia should be found to be the cause was also heavily relied upon. It was argued that whether the actions of police were grossly and criminally negligent should be a question for a jury. However, it was conceded that causation would be a problem for any prosecutor or jury.

Other Counsel, including Mr Gormly and Mr Hodgkinson, submitted otherwise, while Mr Zillman on behalf of Taser International pointed out that there was no medical evidence that a Taser was directly responsible for the death. I concur with those submissions.

I disagree that the admissible evidence reaches the standard required by s. 78. Much of what was heard by this court would be inadmissible in a criminal court. Vitally, there is insufficient evidence to establish a clear cause of death, and no specific administration(s) of force could be said in themselves to be lethal.

While it is probable that those combined actions were the primary factors leading to Roberto's death, without a clear finding as to cause, the death could not be sheeted home to any or all of those actions. Mr Hamill also submitted that I should refer to this matter to Workcover for investigation. I do not intend to do so as I view the issues raised by the evidence as being policing issues warranting investigation and review by policing bodies as opposed to a Workcover investigation.

After the evidence completed the court heard from Ana Laudisio De Lucca Roberto's sister, and from Domingos Laudisio , his Uncle. They have been, and remain, extremely distressed, angry and grief-stricken by Roberto's death. They painted a picture of Roberto which none of us will forget, from childhood in Brazil to his death as an adult in Sydney. He was plainly a much loved young man. The family and his friends will miss him forever. While no words from others will comfort them, I do express my deepest personal sympathies to them all, and hope that at the very least some of their questions about this tragedy have been answered by these proceedings.

As I cannot be comfortably satisfied of the cause of death, I make the following formal finding according to s 81 of the Act:

Formal Finding:

That Roberto Laudisio Curti died shortly after 6am on March 18, 2012, in Pitt Street, Sydney, in the State of New South Wales, of undetermined causes, in the course of being restrained by members of the New South Wales Police Force.

Recommendations: s 82 Coroners Act 2009

To the Commissioner of Police

1. That the conduct of Officers Barling, Cooper, Lim, Edmondson and Ralph in their actions during the pursuit and restraint of Roberto Laudisio Curti be considered for disciplinary charges.

2. That the actions of police during the pursuit and restraint of Roberto Laudisio Curti be referred to the Police Integrity Commission.

3. That there be an immediate review of the contents of the relevant NSW Police Standard Operating Procedures and associated training relating to the use of Taser, OC spray, handcuffing, restraint and positional asphyxia to:
    a. ensure that officers are aware of the dangers of a
        i. positional asphyxia;

   ii. the multiple use of Tasers and their use in drive stun mode;
   iii. the multiple use of OC spray;
   b. ensure that guidance provided to officers is clear and consistent, in particular removing the term “exigent circumstances”;
   c. review the criteria for the use of Tasers;
   d. consider imposing limitations on the use of Taser in certain circumstances;
   e. consider prohibiting the use of Tasers drive stun mode, other than where officers are defending themselves from attack;
   f. improve training techniques and education in the appropriate and/or prohibited use of all the above.
   g. consider whether Probationary officers should continue to be authorised to carry Tasers.
   h. ensure that the safe management of risks of asphyxia by crush, restraint or position are included not only in the SOPs for the use of OC spray but wherever use of force must be applied to a person by a police officer.

4. That there be a review of communication procedures to ensure that signs of mental disturbance in any person the subject of a police report be communicated, and officers trained further to respond accordingly.

5. That there be an examination of NSW Police VKG procedures to ensure accurate categorisation of any incident reported.

39. 100930 of 2012

Inquest into the death of Kaniappa Raju at Randwick on the 29th June 2012. Finding handed down by Deputy State Coroner MacMahon.

Mr Raju was in custody for murder of his wife in 2002. He received a sentence of 21 years with non-parole of 16 years. In June 2011 he was at Wellington Correctional Centre when he experienced symptoms. He was taken to Dubbo Base Hospital where on 2 July 2011 he received a preliminary diagnosis of Metastatic Glioblastoma Multiform.

He was then taken to Long Bay Hospital POW Annex where the diagnosis was confirmed by specialist Dr Elizabeth Hovey. Dr Hovey advised that the condition was an incurable high grade cancer of the brain and that he had between 12 and 14 months to live. He remained in the Long Bay Hospital thereafter. On 27 February 2012 he was readmitted to the POW Annex.

On 14 and 15 March 2012 he confirmed a not for resuscitation order and was treated on a palliative care basis thereafter. Between 22 March 2012 and 28 March 2012 his condition deteriorated into unconsciousness and on 29 June 2012 he died.

The evidence available satisfied me that he had received all appropriate medical care and treatment. Indeed the files contained a note from him thanking (indeed praising) the nursing staff for their care of him. I made no recommendations or non-publication orders.

Formal Finding:

That Kaniappa Raju (born 12 July 1960) died on 29 March 2012 at the Long Bay Correctional Centre Hospital – Prince of Wales Hospital Annex, Randwick in the State of New South Wales. The cause of his death was Metastatic Glioblastoma Multiform. The manner of his death was natural cause.

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 2012.

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	1107/10	20/03/10	Canberra	23	Police Op
2	1108/10	20/03/10	Canberra	33	Police Op
3	1109/10	20/03/10	Canberra	29	Police Op
4	1110/10	20/03/10	Canberra	3m	Police Op
5	2523/10	11/10/10	Randwick	49	In Custody
6	2794/10	11/11/10	Collarenabri	44	Police Op
7	2860/10	22/11/10	Bankstown	19	Police Op
8	2863/10	22/11/10	Parramatta	56	In Custody
9	43/11	09/01/11	Randwick	54	In Custody
10	85/11	15/01/11	Westmead	51	Police Op
11	962/11	29/04/11	Orange	31	In Custody
12	1029/11	07/05/11	Junee	28	In Custody
13	1074/11	15/05/11	Berkshire Park	23	In Custody
14	1187/11	28/05/11	Surry Hills	33	In Custody
15	1388/11	21/06/11	Silverwater	39	In Custody
16	1567/11	11/07/11	Smithfield	32	In Custody
17	1905/11	14/08/11	Wagga Wagga	37	Police Op
18	2126/11	03/09/11	Wellington	59	In Custody
19	2235/11	18/09/11	Watsons Bay	40	Police Op
20	2305/11	26/09/11	Silverwater	38	In Custody
21	2486/11	15/10/11	Malabar	31	In Custody
22	2573/11	26/10/11	Villawood Immi	27	InCustody (Fed)
23	2638/11	04/11/11	Sydney	47	Police Op
24	407907/11	19/12/11	Parklea	30	In Custody
25	12332/12	11/01/12	Silverwater	71	In Custody
26	15861/12	16/01/12	Kingswood	68	In Custody
27	34766/12	01/02/12	Colyton	47	Police Op
28	46111/12	12/02/12	Darling Harbour	19	Police Op
29	47897/12	13/02/12	Malabar	50	In Custody
30	49722/12	13/02/12	Bathurst	22	In Custody
31	58625/12	22/02/12	Westmead	21	Police Op
32	65200/12	27/02/12	Liverpool	44	In Custody
33	69319/12	01/03/12	Avalon	32	Police Op
34	71675/12	02/03/12	Tamworth	40	Police Op
35	71862/12	03/03/12	Possum Brush	55	Police Op
36	83234/12	14/03/12	West Ryde	33	Police Op
37	86730/12	18/03/12	Nabiac	27	Police Op

No	File No.	Date of Death	Place of Death	Age	Circumstances
39	44977/12	20/03/12	Randwick	85	In Custody
40	89735/12	20/03/12	Malabar	70	In Custody
41	91010/12	21/03/12	Bankstown	79	Police Op
42	94483/12	25/03/12	Parramatta	34	Police Op
43	100399/12	29/03/12	Randwick	51	In Custody
44	102820/12	30/03/12	Malabar	31	In Custody
45	121233/12	15/04/12	Tenterfield	33	Police Op
46	128835/12	21/04/12	Nowra	40	Police Op
47	128570/12	22/04/12	Malabar	86	In Custody
48	173536/12	30/05/12	Tamworth	22	Police Op
49	189678/12	16/06/12	Emu Plains	22	In Custody
50	192526/12	19/06/12	Randwick	27	In Custody
51	259122/12	18/08/12	Malabar	40	In Custody
52	247660/12	08/08/12	Cessnock	60	In Custody
53	273783/12	01/09/12	Silverwater	49	In Custody
54	305904/12	21/09/12	Kundabung	25	Police Op
55	302011/12	27/09/12	Blackalls Park	29	Police Op
56	310066/12	05/10/12	Randwick	69	In Custody
57	314507/12	10/10/12	Camperdown	48	Police Op
58	32345/12	17/10/12	Tweed Heads	42	Police Op
59	327351/12	21/10/12	Randwick	56	In Custody
60	336265/12	24/10/12	Bathurst	57	In Custody
61	349869/12	08/11/12	Wollongong	34	Police Op
62	366920/12	23/11/12	Redfern	46	Police Op
63	371767/12	27/11/12	Junee	42	In Custody
64	379032/12	05/12/12	Silverwater	40	In Custody
65	379965/12	06/12/12	Windsor	45	Police Op

Report compiled by
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