Report by the NSW State Coroner

into deaths in custody/police operations.

2011

(Coroner 's Act 2009, Section 23.)

NSW Office of the State Coroner
NSW Attorney General's Department
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The Honourable Gregory Smith
Attorney General of New South Wales
Parliament House
Macquarie Street
SYDNEY NSW 2000

31 March 2011

Dear Attorney,

Pursuant to *Section 37 (1) of the Coroner's Act 2009,* I respectfully submit to you a summary of all *Section 23* deaths reported and inquests held by the State Coroner or a Deputy State Coroner during the year 2011.

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):

- while in the custody of a police officer or in other lawful custody, or
- while escaping, or attempting to escape, from the custody of a police officer or other lawful custody, or
- as a result of, or in the course of, police operations, or
- 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 also 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 during the course of a 'Police Operation' can include shootings *by* police officers, shootings of police officers, suicide and other unnatural deaths.

Deaths occasioned during the course of a police operation are always of concern and have also been subject to 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 2011 there were twenty-nine *Section 23* deaths reported. Thirty matters were completed by way of inquest.

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

Sixty-two cases await inquest and many of these matters are in the investigative stage or set down for inquest in 2012.

I submit for your consideration the State Coroner 's Report, 2011.

Yours faithfully,

Insert signature

Magistrate Mary Jerram
(State Coroner NSW)

STATUTORY APPOINTMENTS

Pursuant to *Section 22 (2) of the Coroner's 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, the subject of this report, were conducted before the following Senior Coroner's:

NSW State and Deputy Coroner's 2011

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.

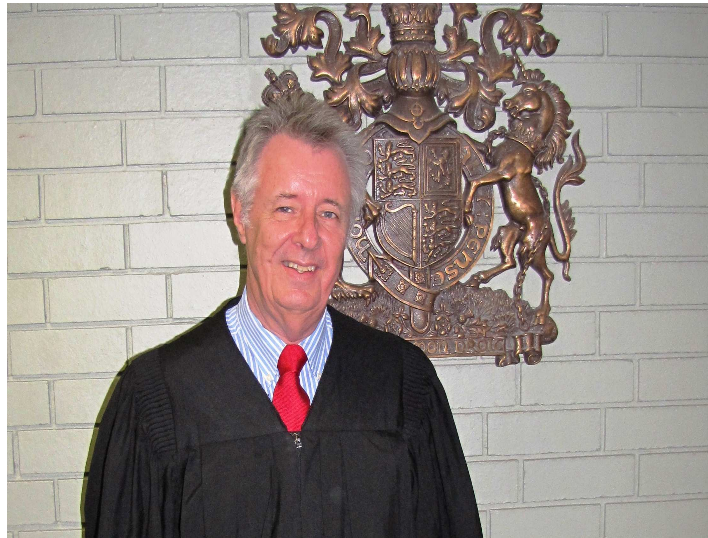
1995 Children's Court Magistrate.

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.
1986-96	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

1985 Admitted as a Solicitor of the Supreme Court of NSW.

1986-7 Solicitor for Department of Motor Transport.

1987-92 Solicitor in private practice.

1992-8 Solicitor for Legal Aid Commission.

1998-01 Solicitor in private practice.

2001 Appointed a Magistrate.

2011 Appointed a Deputy State Coroner.

Her Honour Magistrate HELEN BARRY

Deputy State Coroner

1976 Admitted as a Solicitor of the Supreme Court of NSW.

1977 Solicitor in private practice.

1977-90 Solicitor for Legal Aid Commission.

2001 Various State and Federal Tribunals.

2001 Appointed a Magistrate.

2012 Appointed a Deputy State Coroner.

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Appendix 1

Summary of deaths in custody/police operations before the State Coroner in 2011 for which inquests are not yet completed.

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 the Royal Commission into Aboriginal Deaths in Custody recommendations, 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, *Coroner's Act* expands this definition to include circumstances where the death occurred:

- while temporarily absent from a detention centre, a prison or a lock-up; as well as,
- 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 respect of those cases where an inquest has yet to be heard and completed, no conclusion should be drawn that the death necessarily occurred in custody or during the course of police operations.

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

Intensive Correction Order

The NSW State Coroner has advised Corrective Services that she considers the death of a person whilst serving an Intensive Community Order to be a death in custody pursuant Section *23 of the Coroner's Act 2009*.

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

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 as a result of or in the course of a police operation is not defined in the *Coroner's* Act. Following the commencement of the 1993 amendments to the *Coroner's Act 1980*, New South Wales *State Coroner's Circular No. 24* sort to set out 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 Act, 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 set out above 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 Coroner's 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 Service, and the public generally have the opportunity to become 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 was found not to warrant criticism by the Coroner's.

We will continue to remind both the Police Service 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?

I agree with the answer given to that question by former New South Wales Coroner, Mr Kevin Waller.

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. 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.

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

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

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 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.

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, *Coroner's Act 2009* provides:

Findings of Coroner or jury verdict to be recorded

(cf *Coroner's Act 2009*, s 81)

(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, Coroners Act 2009 provides:

Procedure at inquest or inquiry involving indictable offence

(cf *Coroner's Act 2009*, s 78)

(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) the 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 Coroner's (and their juries) adding riders to their verdicts has been given statutory authorisation pursuant to *Section 82* of the *Coroner's 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 *(S.82)*.

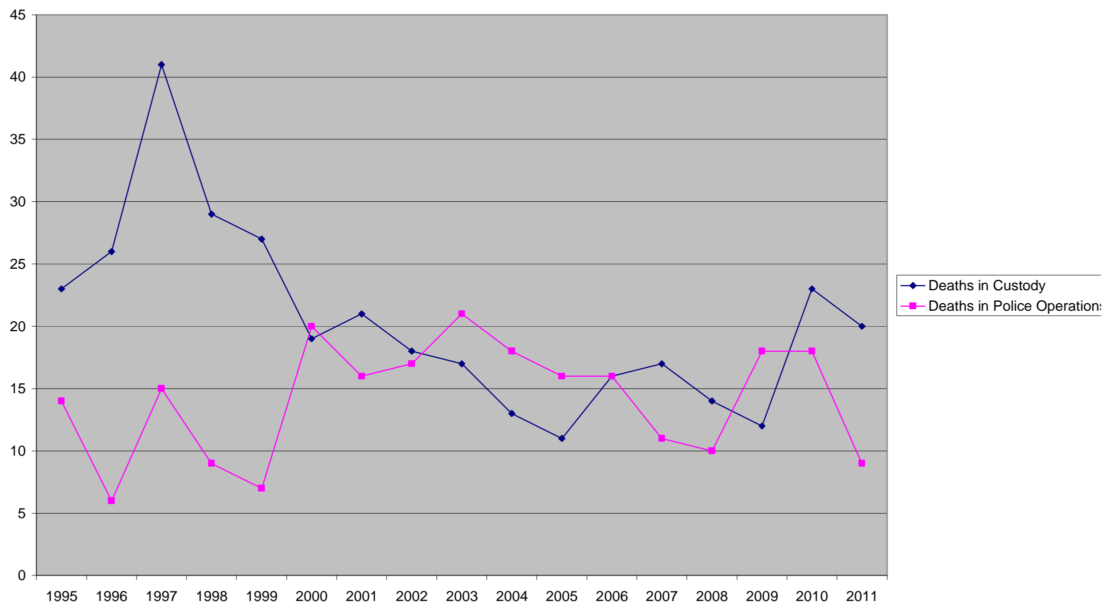
Any statutory recommendations made following an inquest should arise from the facts of the enquiry and be designed to prevent, if possible, a recurrence of the circumstances of the death in question. The Coroner requires, in due course, a reply from the person or body to whom a recommendation is made.

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

OVERVIEW OF DEATHS IN CUSTODY/POLICE OPERATIONS REPORTED TO THE NEW SOUTH WALES STATE CORONER DURING 2011.

Table 1: Deaths in Custody/Police Operations, for the period to 2011.

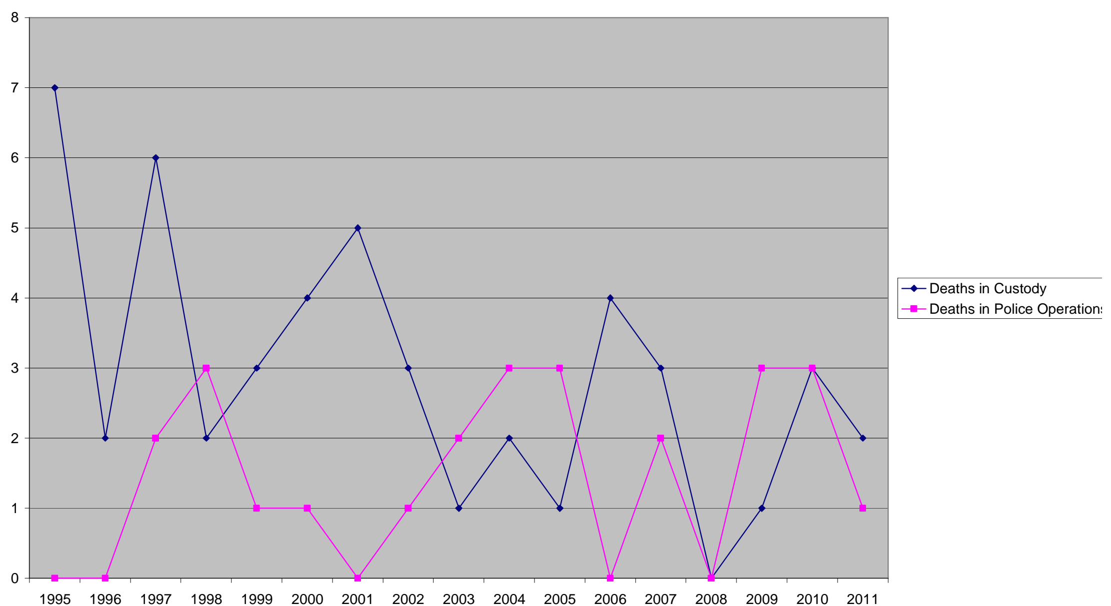
Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	37
1996	26	6	32
1997	41	15	56
1998	29	9	38
1999	27	7	34
2000	19	20	39
2001	21	16	37
2002	18	17	35
2003	17	21	38
2004	13	18	31
2005	11	16	27
2006	16	16	32
2007	17	11	28
2008	14	10	24
2009	12	18	30
2010	23	18	41
2011	20	9	29



Aboriginal deaths which occurred in 2011

Table 2: Aboriginal deaths in custody/police operations for the period to 2011.

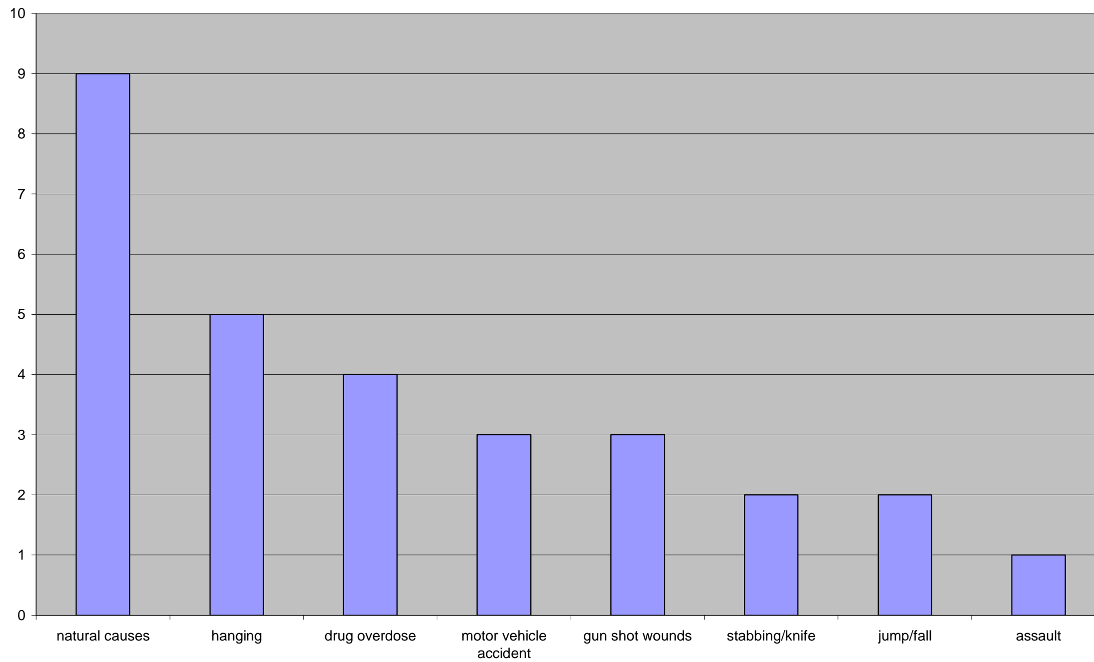
Year	Deaths in Custody	Deaths in Police Operation	Total
1995	7	0	7
1996	2	0	2
1997	6	2	8
1998	2	3	5
1999	3	1	4
2000	4	1	5
2001	5	0	5
2002	3	1	4
2003	1	2	3
2004	2	3	5
2005	1	3	4
2006	4	0	4
2007	3	2	5
2008	0	0	0
2009	1	3	4
2010	3	3	6
2011	2	1	3



Circumstances of deaths of persons who died in Custody/Police Operations in 2011:

9 natural causes
3 motor vehicle accident
3 gun shot wounds
5 hanging
4 Drug overdose

2 stabbing/knife
2 jump/fall
1 assault



Unavoidable delays in hearing cases

In 2011 the State Coroner and the Deputy State Coroner's completed 30 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 2011.

Following are the written findings of each of the cases of deaths in custody/police operations that were heard by the NSW State Coroner, Senior Deputy State Coroner and the Deputy State Coroner's in **2011.** 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 2011

	Case No.	Year	Name	Coroner
1	816	2008	Herve Youdam	DSC Mitchell
2	2474	2008	AA	DSC MacMahon
3	2523	2008	Michael Magro	DSC Mitchell
4	710	2009	AA	DSC MacMahon
5	725	2009	Tut Nyal	DSC MacMahon
6	823	2009	AA	DSC Mitchell
7	847	2009	Maurice Nolan	DSC MacMahon
8	1213	2009	AA	DSC Dillon
9	1221	2009	Mark Milgate	DSC MacMahon
10	1330	2009	Brian Harre	DSC Barry
11	1868	2009	John Helsdingen	SC Jerram
12	2204	2009	Shannon O'Dwyer	DSC Dillon
13	2648	2009	AA	SC Jerram
14	3333	2009	Adam Salter	DSC Mitchell
15	807	2010	AA	DSC Barry
16	835	2010	John Hollingworth	SC Jerram
17	914	2010	Richard Grenfell	SC Jerram
18	959	2010	Robson Pham	SC Jerram
19	1155	2010	Stephen Moore	SC Jerram
20	1305	2010	Lance Johnson	DSC Barry
21	1322	2010	Royce Williams	DSC Forbes
22	1369	2010	Colin Dixon	SC Jerram
23	1374	2010	AA	DSC Forbes
24	1378	2010	AA	DSC Mitchell
25	1753	2010	AA	DSC Mitchell
26	1834	2010	AA	DSC MacMahon
27	1919	2010	Derek Wales	DSC Mitchell
28	2460	2010	Ba Thinh Le	SC Jerram
29	2490	2010	AA	DSC MacMahon
30	3169	2010	Wesley Johns	DSC MacPherson

1. 816 of 2008

Inquest into the death of Herve Youdom at Silverwater. Finding handed down by Deputy State Coroner Mitchell at Parramatta on the 26 August 2010.

Herve Youdom, born 26 October 1980 was a French national who arrived in Australia on 18 June 2008. He died in the custody of *Corrective Services NSW* on 22 July 2008.

The arrest

In her report of the autopsy, which she undertook at Westmead Hospital on 24 July 2008, Dr Dianne Little of the Department of Forensic Medicine indicated that Mr Youdom died of *peritonitis* resulting from a *perforated duodenal ulcer*.

It is not clear what brought Mr Youdom to Australia but he passed through Immigration Control at *Kingsford Smith International Airport*, Sydney on 18 June 2008. Two days later, two previously misplaced bags belonging to Mr Youdom were examined by *Australian Customs* and found to contain two vials of *testosterone.*

One month later, at about 2.15pm, on 18 July 2008, Mr Youdom was found by police standing naked on the grassed area near Circular Quay and as police approached him, he swung his arm toward the head of a police officer and yelled repeatedly *"Leave me alone, Leave me alone."* He began thrashing around violently, spitting and screaming as police sought to restrain him.

Finally he was arrested and taken to *The Rocks Police Station* in George Street. At about 3pm, he was transferred from the Rocks Police Station to *Sydney Police Centre* and charged with *Assault Police* (two counts), *Resist Police, Destroy or Damage Property*, less than $2,000.00, and *Willful and Obscene Exposure.*

Police who received Mr Youdom at the *Sydney Police Centre* at Goulburn Street marked his papers *"Warning Possible Risk of Self Harm."* To the question *"Does the person appear irrational or mentally disturbed?"* police answered, *"Yes"* and added a note *"appears irrational, aggressive and suffering from mental illness or Drug intoxication. Speaking and chanting in a foreign language. Spitting on the floor and in faces of police."* Wisely, police referred Mr Youdom to *St. Vincent's Hospital,* Darlinghurst for assessment and treatment.

St. Vincent's Hospital

At about 7.30pm on 18 July 2009, Dr Zizzo of St.Vincent's Hospital, accompanied by *RN* Colebrook. A psychiatric nurse, who gave evidence before me, carried out a mental state examination of Mr Youdom. This examination was carried out in the back of a police *paddy wagon*. Dr Zizzo's surprising and almost certainly mistaken assessment was that Mr Youdom was *"not a threat to himself or the community, deemed medically fit for discharge"* and he was returned to the

Sydney Police Centre a short time later. Police notes record that, on his return, he appeared very calm, rational and friendly.

There are several aspects of Dr Zizzo's assessment of Youdom, which deserve comment. In the first place, it is unacceptable and probably non-compliant with law that such a mental state examination be conducted in a police *paddy wagon* whether parked in a hospital parking bay or not.

Secondly, the law requires that, in the circumstances, which applied to Mr Youdom, the assessment that a patient is not mentally ill and should be discharged is to be confirmed by a specialist such as a psychiatric registrar. In this case, the psychiatric registrar concerned was Dr Letitia Adios who was advised of Dr Zizzo's assessment and his decision to discharge only after Mr Youdom had been returned to Sydney Police Centre.

That was irresponsible and did not comply with the law.

Thirdly, I am not at all satisfied that Dr Zizzo's assessment was competent and, as events amply demonstrated, it was almost certainly wrong. Dr Zizzo is currently travelling in Europe and unavailable to appear at the inquest but I heard evidence from *RN* Colebrook who was present at the assessment. According to *RN* Colebrook, Mr Youdom had fluent if accented English and seemed to have no language-based difficulty in understanding what was being said to him or in expressing himself.

Mr Colebrook told the inquest that, during the assessment, Mr Youdom had appeared calm and rational and had properly engaged with Dr Zizzo while being angered by and avoidant of police. This description certainly does not accord with the police description of the patient and his affect and behaviour and neither is it easy to reconcile with his behaviour at Circular Quay or his affect and behaviour some few hours later at Sydney Police Centre. According to *RN* Colebrook, Dr Zizzo had assessed Mr Youdom's behaviour and affect as displayed at Circular Quay and in the *paddy wagon* not as psychotic but as behavioural and, possibly, influenced by Drugs.

He also took the view, and perhaps Dr Zizzo did too, that, if the assessment proved incorrect, then police or corrections officers or the judge before whom Mr Youdom was due to appear next morning would have the option of sending him back to St, Vincent's where they could have another go. That latter consideration is a dangerous and quite inappropriate consideration as events tragically demonstrated.

There is a statement of a Dr Ian John Verry, Business Services Manager of Mental Health, St. Vincent's Hospital explaining various Emergency Department and Mental Health procedures adopted by the hospital since Mr Youdom's death.

It is fair to say that they are impressive and have addressed issues, which I think Mr Youdom's raises. It is difficult to see those issues arising at St. Vincent's Hospital again.

Sydney Police Centre

Mr Youdom left St. Vincent's Hospital in custody and was taken back to the Sydney Police Centre. Then, at about 11.50pm that night he was transferred from police custody into the custody of *Corrective Services NSW*.

That transfer relieved police of responsibility for Mr Youdom and *Corrective Services NSW* assumed responsibility for him. As a consequence of that transfer, he was moved out of a police cell and into a cell administered by *Corrective Services NSW*, although situated within Sydney Police Centre.

As he was being moved from one cell to another, he ran away and was tackled to the ground, handcuffed and then placed in the cell. This was the first use of force on Mr Youdom and it was not witnessed by anybody other than corrections officers and was not caught on *CCTV*.

Mr Youdom spent the night in the cells and, next morning, 19 July 2008, he appeared at Parramatta Court via *AVL* and was refused bail.

I have not seen a video recording of his appearance but it is reported that, on that occasion, he seemed relatively composed and was neither shouting nor screaming although he was seen to be muttering to himself.

Later that day, 19 July, 2008, Mr Youdom was seen in his cell, completely naked but for a restraining belt which corrections officers had placed around his waist, standing on the toilet seat having blocked the *WC* with his clothes His foot was on the *"flush"* button, which he was continuously depressing, causing water to overflow the toilet bowl, flood the floor of the cell and escape under the cell door into a corridor. Corrections officers entered the cell and, when Mr Youdom refused to speak to them and failed to respond to their direction that he climb down off the toilet, took him down and, after something of a struggle during which he continually resisted and was spitting at officers, pulled him out of the cell. The water was turned off. A few moments later a *Justice Health* nurse, Mr Subramanian attended but was unable to make contact with Mr Youdom who spat at him, continued shouting and refused to be touched or to answer any questions.

The action of corrections officers in retrieving Mr Youdom from his flooded cell is the second show of force towards him. It was captured on *CCTV* and a *DVD* of the incident is part of the Coronial Brief. The opinion of the Officer in Charge, which I share, is that no inappropriate force was employed on this occasion.

MRRC

Then, later on 19 July, Mr Youdom was moved to the *Metropolitan Reception and Remand Centre (MRRC)* at Silverwater. He arrived there, quite naked, at about 6.30pm.

He was *"totally incoherent"* on his arrival, yelling and spitting and, according to one officer, Mr Kelly, possibly *"spitting blood."*

He was issued with clothing which he took off and tried to flush down the *WC* and he was hurriedly picked up by officers and forcibly moved to the Darcy Pod which is the area at the *MRRC* where problematic prisoners can more conveniently be observed and classified.

This was the third show of force to Mr Youdom and, once again, it was recorded on *CCTV* and the *DVD* of this recording is part of the Coronial brief. Having viewed that *DVD*, it does not appear to me that officers acted inappropriately in deciding to move him to Darcy Pod even before his *Reception Medical Assessment* had been undertaken or in the manner in which Mr Youdom was moved.

Some time on 19 July, a *"New Health Problem Notification Form"* regarding Mr Youdom was completed by a *Justice Health* officer, which described Mr Youdom as *"totally uncooperative… …unable to be assessed… …spitting, shouting, hyperventilating…"* and at least one corrections officer saw him washing himself in toilet water, drinking from, the toilet bowl, dancing around his cell, talking to the cameras and continually hitting the duress alarm button in his cell and the *"OMS General Alert Registration Details"* form completed by corrections officer notes *"irrational behaviour… …totally uncooperative… …at risk of self harm, safe cell until cleared by RAIT."*

Mr Youdom was placed in a *safe cell* which as Assistant Superintendent Ritchie explained is a cell from which all hanging points, sharp edges, blind spots and other architectural features with which one might hurt oneself have been eliminated and which has a perspex front and a *CCTV* camera for viewing by officers. He explained, too, that *RAIT* is a *Risk Assessment and Intervention Team*, convened to assess a prisoner's needs and, particularly his care and protection needs. In this instance, the *RAIT* consisted of Mr Ritchie, a psychologist, Alita Caon, employed by *Corrective Services NSW* and a *Justice Health* nurse, Catherine Hancock.

Mr Youdom was away from his cell from early morning on 20 July 2008 until about 2.30 while he was appearing, at court via *AVL*. Next morning, at about 10.50am, he was interviewed by the *RAIT* in the common area of the Darcy Pod and, according to Mr Ritchie, Mr Youdom was calm and polite and was prepared to speak with them but what he told them may not have made much sense. He told the *RAIT* that he had a bad spirit inside him, which his family had placed there by feeding him. He told them that he had had the spirit for more than a year. When he spoke of the spirit, which he described as a bad spirit, Mr Youdom hugged his upper body. *RN* Hancock's recollection is that the spirit was Mr Youdom's recurring theme during the *RAIT* meeting.

Mr Youdom told the *RAIT* that God had come to observe him at the *World Youth Day* celebrations in Sydney and had told him to take his clothes off and he responded to questions about self-harm by assuring the panel that *"I love my body. I love me"* which may have been more reassuring had he not repeatedly asked for a spirit doctor.

Mr Ritchie's recollection is that Mr Youdom seemed extremely thirsty and continually asked for and drank copious quantities of water. He told the *RAIT* that the spirit didn't like him drinking water and, according to all three *RAIT* members, when he did drink water, his head bent back and his eyes appeared to roll in his head. *RN* Hancock added that, on those occasions, Mr Youdom seemed to gag.

According to Mr Ritchie, when Mr Youdom drank water, he exhibited signs of reflux but, when asked if he was OK, he said that he was. Mr Youdom told the *RAIT* that he had taken cannabis on a daily basis but that he ate only fruit in accordance with the demands of the spirit.

Leaving aside the evidence of Dr Than, there is no evidence that on this or on any other occasion, Mr Youdom made any complaint of pain or of feeling unwell.

Evidently, the *RAIT* were uncertain as to what to do and decided that Mr Youdom should be *"further screened to determine any physical medical issue,"* that he should be referred to Dr Dong Binh Tran, a psychiatrist retained by the prison, who happened to be French speaking, that he should be housed in a *safe cell* pending Dr Tran's assessment and that *RAIT* should reconvene two days later, on 23 July. At that stage, there still had been no medical examination at all whereas, as *RN* Hancock told the inquest, every new prisoner was required to have one.

She made the referral herself and, later the same day, she mentioned it personally when she visited the primary health care nurse at the clinic.

Ms. Hancock thought that the physical examination was urgent because it hadn't yet happened and, thus, was overdue but was not a matter of emergency because, as she told the inquest, she had seen no sign of any physical condition requiring immediate attention. At any event, a *Reception Medical Examination,* which is undertaken by a nurse, is not a medical examination in the ordinary sense. Largely it consists of a nurse making routine observations and completing a *pro forma* and, except in exceptional cases, does not involve the nursed touching the patient.

Dr Tran

Dr Dong Binh Tran, who, before practicing as a psychiatrist, had served some time in emergency medicine, saw Mr Youdom sometime on the afternoon of 21 July. The interview lasted 30 to 40 minutes and, according to Dr Tran, the patient was *"settled and relatively calm"* and *"delusional but coherent."* The interview was conducted primarily in French, which is a language with which Dr Tran is familiar, but with some English.

Dr Tran's notes include *"believes that his condition (because of the pain caused by spirit) can be cured by morphine."* which suggests to me that Mr Youdom told Dr Tran that he was in pain.

At one point in his evidence, Dr Tran told the inquest that Dr Youdom had made no other mention of pain but it became clear, later in his evidence that Mr Youdom had indeed complained of pain on a number of occasions during his interview with Dr Than. Indeed, Dr Tran thought that Mr Youdom was exaggerating and dramatising his pain.

Further Mr Youdom seems to have behaved in a fashion indicative of pain and Dr Tran told the inquest that he understood that Mr Youdom was complaining of pain but had not been sure whether it was physical or a matter of psychosis. At least in the early stages of the interview, Dr Tran thought that Mr Youdom may have been a drug user simply seeking morphine.

His notes record *"noted to display signs/expressions of physical discomfort in a rather dramatic way…"* and he thought that, whether as a drug-seeking exercise or for some other reason, Mr Youdom was exaggerating his physical discomfort in his dramatic affect. *"People in severe pain"* he told the inquest, *"are not dramatic at all."* Instead, he attributed all of the patient's difficulties to his psychosis, regarding Mr Youdom's statements that he had a spirit within in him and *"had been tortured by a spirit since birth"* as negativing any suggestion of a physical condition.

Dr Tran told the inquest that he had wondered whether the patient's references to a spirit might be cultural but had dismissed that possibility on the basis that spirits do not form part of French culture.

Dr Tran was confirmed in his view by his reaction to Mr Youdom's *"claim"* that *"the spirit makes him vomit after eating/drinking leading to a loss of at least 20kg in the past 9 months"* which Dr Than thought was ridiculous. And so he diagnosed *schizophrenia*, noting, *"the inmate specifically indicates that he doesn't believe in and doesn't want to take treatment for schizophrenia but wants something to calm spirit."*

Dr Tran noted, *"low risk of self-harm – doesn't require a safe cell."* He undertook no physical examination of Mr Youdom and prescribed nothing for pain, confining himself to *Zyprexa wafer 10mg nocte.*

Even allowing for Mr Youdom's bizarre affect and behaviour and his belief that it was a spirit, which was causing his trouble, it is surprising that Dr Tran so blithely dismissed the possibility that, in the afternoon of 21 July, Mr Youdom was suffering physical pain. As he explained, drug-seeking patients are commonly encountered in his practice and that possibility needed to be excluded but, on the other hand, the patient was relatively clear and insistent that he had pain even if he was wrong about its origin.

I think it prudent medical practice would have been first to exclude the possibility of significant physical illness and, in particular, of acute abdomen and I understand that to be the opinion of Professor John Ham who was called as an expert witness.

RN **Renouf's first intervention**

Mr Youdom was returned to his safe cell and there followed three interventions by *Justice Health* nurse, *RN* Susan Renouf. The first one occurred at about 5.38pm when, accompanied by other nursing staff including the then acting Director of Nursing at *MRRC*, *RN* Mohamad Trad, and *RN* Hellal Hussein, she was called to Mr Youdom's cell.

The senior corrections officer on duty, Wonderfrash Fitwola, who had initiated the *medical call out*, was present. The cell door was opened and Mr Youdom was seen lying or, in *RN* Hussein's recollection, sitting on the cell floor. In Ms. Renouf's opinion, he was *"possibly psychotic,"* yelling about a spirit inside his body having been put there by his family. *RN* Trad remembers that Mr Youdom was *"uncooperative, kicking and thrashing around."*

Mr Fitwola's recollection is that Mr Youdom was holding his stomach. Part of the incident was captured on *CCTV* and, in it, Ms. Renouf can be seen entering the cell where she attended to the patient. She tried to get his pulse but he was too restless to allow her to count so the best she could say was that his pulse was *"regular."* At the same time, the endorsed enrolled nurse who accompanied her took Mr Youdom's blood sugar levels.

RN Renouf was unable to measure his blood pressure and, finally, she decided to withdraw continue her task later when Mr Youdom was more settled although she told the inquest that, in light of his affect and behaviour, she would not have been comfortable re-entering his cell as she had *"safety concerns."* *RN* Renouf completed an *Emergency Response Form* in which she noted *"previous history of ice abuse"* but she told the inquest that she has no recollection of the source of this information and, of course, could not vouch for its truth.

RN **Trad**

On that occasion, it occurred to *RN* Trad that Mr Youdom may have been in physical pain or else that Mr Youdom's behaviour and affect may have been a consequence of a psychosis and he recalls that, as *RN* Renouf left the cell, Mr Youdom was still yelling and kicking and was still *"elevated."*

The *CCTV* footage shows the nurses and corrections officers standing near the cell door talking but it is not clear and Mr Trad does not recall what they were talking about. He does recall, though, that *RN* Hussein asked whether Mr Youdom should be sent out to a hospital to which he replied *"Not at this stage. He might be OK."* Up to that time, Mr Trad does not recall that anybody had asked Mr Youdom whether he was in pain.

RN Trad told the inquest that his decision at that stage not to send Mr Youdom to hospital or even to summon a doctor who was available *on call* was influenced by safety considerations arising from the patient thrashing about and he explained, *"it was not sufficiently clear that Mr Youdom's physical problem would justify the risk to staff."*

Mr Fitwola

Wonderfrash Fitwola is a senior correctional officer at *MRRC* who, from 2pm on 21 July 2008 was the senior officer on duty at Darcy Pod.

His statement, EXHIBIT 4, was signed on 15 August 2011, too late for inclusion in the Coronial Brief. I have no idea why he was so late in preparing his statement but he told the inquest that 15 August 2011 was the day on which he was first approached to make a statement for this inquest or to assist any investigation into Mr Youdom's death.

The delay served neither he nor the coronial process well. It was Mr Fitwola's task to complete the *Wing Journal* being the log of events at Darcy Pod. A photocopy of the relevant page of the document is annexed to his statement and he says that the handwriting appearing on that page is all his. To my untrained eye, the handwriting appeared to have been contributed by at least two and probably three persons but I was urged by all at the Bar Table that the handwriting is indeed Mr Fitwola's and I now accept that it is.

Mr Fitwola says in his statement that *"(Mr Youdom) was crawling around on the floor of his cell so I called the nurses back to see him at least on one occasion sometime between 7pm and 9pm."* He told me that he is a bit vague about the times which he has specified in his statement and that, having seen the *CCTV*, he would accept the times nominated there and I think his mistakes regarding times had to do with a lack of notes and the lengthy time which elapsed between the events and 15 August, 2011 when he was first asked to make a statement. Mr Fitwola gave evidence of twice having observed Mr Youdom in his cell.

On the first occasion, he said, he stood outside the cell looking through the perspex door for about 15 minutes and saw Mr Youdom crawling across the floor of the cell until he reached the door and then stand in front of the door and hold his arms outstretched as if making an appeal. According to Mr Fitwola, he told Mr Youdom to return to his bed, which, he said, he did, quietly walking back to the bed. Then, according to Mr Fitwola, he remained observing the prisoner on his bed for another 8 or 9 minutes until he turned away.

Before he was examined regarding the second occasion on which he told the inquest he had observed Mr Youdom, it had become quite clear that Mr Fitwola's accounts were hopelessly muddled and that, rather than relying on his evidence, recourse should be had to the objective evidence represented by *CCTV* footage.

It is not clear to me how Mr Fitwola could have said what he said to the inquest given what the objective evidence demonstrates but I think he may have been hugely mistaken rather than deliberately misleading.

What the video recordings demonstrate is that, on 21 July 2008, Mr Fitwola went to the door of Mr Youdom's cell on at least four and possibly five occasions. At 3.22pm an officer can be seen approaching the cell door that may have been Mr Fitwola. Then, he is seen at 5.04pm, 5.31pm, 5.38pm and 7.12pm. His appearances at 3.22pm, 5.04pm and 5.31pm appear to have been brief and uncontroversial.

Although the video recordings demonstrate that Mr Fitwola's evidence as to the timing of his observations of Mr Youdom are unreliable, he made it clear that he had been aware of behaviour which might have suggested that Mr Youdom was in great pain as he waited in his cell on 21 July, 2008.

He told the inquest that he had been *"a little bit concerned"* and he described Mr Youdom on the floor of his cell, crawling towards the cell door, and, on other occasions, standing in front of the door with his hands outstretched before him as if he was appealing for help and crawling around the floor of his cell.

On the basis of what he saw at 5.31pm, Mr Fitwola called for a nurse. His appearance at 5.38pm corresponds with *RN* Renouf's first attendance on Mr Youdom and, at 7.12pm. Mr Fitwola is one of three officers close to the open cell engaged in a discussion.

I am aware that there was some hearsay material which may have suggested some gratuitously offensive behaviour towards Mr Youdom on Mr Fitwola's part but the *CCTV* evidence which covers the whole of the relevant period, other that the unexplained gap between 4pm and 8pm on 21 July, 2008, demonstrates that, in the period for which there is video evidence, there was no such impropriety.

At the end of his shift, Mr Fitwola undertook a *handover* in the course of which, he says, he explained to in-coming officers that Mr Youdom had had two medical *call outs* thereby, in his mind at least, alerting them to the possibility of further problems. He made no note in that regard and, indeed, made no note in the *Wing Log* that there had been any *medical call outs* for Mr Youdom. Clearly there had been and they should have been recorded and clearly Mr Fitwola's notes left a great deal to be desired. He explained that it had been a busy shift but his main explanation is that he forgot. That is not satisfactory but Mr Fitwola's attention was Dr awn to a *memo* from the Deputy Commissioner of *Corrective Services NSW* regarding the requirement of taking proper notes as to *"details of unusual occurrences in the physical and mental health of inmates"* and Mr Fitwola assured me that his note taking has improved *out of sight* since Mr Youdom's death.

***RN* Renouf's second intervention**

At about 7.30pm on 21 July, Ms, Renouf returned to the floor of Darcy Pod, conducting her *pill rounds, which* involved handing medication to prisoners for whom it had been prescribed, including a *Zyprexa* wafer for Mr Youdom.

She found him still totally naked and he told her once again about spirits in his body but he accepted the wafer. Mr Fitwola described Mr Youdom, on that occasion, as "*crowding out of his cell"* so that corrections officers had to push him back and he recalled Mr Youdom touching his stomach and saying *"voodoo, voodoo."*

RN Renouf's third intervention

At about 8.30pm on 21 July, 2008, as *CCTV* footage demonstrates, *RN* Renouf returned to Darcy Pod to provide medication to another inmate and, as she passed the monitor in the office, she looked to see Mr Youdom lying on his back on his mattress covered by a safety blanket, his hands across his chest, looking *"very neat."* He seemed settled, very relaxed and, perhaps, asleep and Ms. Renouf was relieved to think that the *Zyprexa* may have had the desired effect of settling him.

The evidence is that *Zyprexa* can have a settling or soporific effect and it seems likely that its unintended effect was to mask for a time Mr Youdom's deteriorating physical condition, thus lulling Ms. Renouf into a false sense that all was well.

According to *RN* Renouf, on none of the occasions when saw him did she understand that Mr Youdom was in physical pain and he made no complaint of that to her. Next day, when she arrived at *MRRC* to start work, she learned that Mr Youdom had died in the night.

Heating

It appears that sensors embedded in the concrete floors of cells ## 33, 38 and 39 were faulty and prevented the thermostats from operating correctly. If I thought that these faults played any part in the death of Mr Youdom, then I would regard the matter, as one of great significance but such is not the case. There is no medical evidence and no reason to think that Mr Youdom was affected by an elevated temperature in his cell and, indeed, the measurements, which Mr Gardner took indicate no significant increase in the ambient temperature of cell # 38 or in the floor or the ledge on which his mattress had been placed.

Moreover, Mr Saidi of Counsel advises me for *Corrective Services NSW* that the fault has been recognised and that steps have been taken, within architectural constraints, to correct or compensate for them. I think that is as far as I should take the matter.

Mr Youdom's death

Overnight, the interior of all the safe cells in Darcy Pod was monitored by corrections officers by way of *CCTV*. Mr Youdom was in cell # *38* and Detective Senior Constable Pratap, the *OIC*, was able to say that he has viewed all the available video material. *CCTV* records between 4pm and 8pm on 21 July are missing without explanation but for the period during which video recordings are available, nothing appears amiss.

Between 3.01 and 3.04am on 22 July, Mr Youdom can be seen lying on his back on his mattress on the cell floor, moving his arms to his head, slightly moving his right foot and bringing his arms back so that his hands were resting on his abdomen. Those are Mr Youdom's only movements seen on *CCTV* and it was in that final position that he was found dead in the morning.

At about 6.15am, a corrections officer, Warren Kelly, conducting the morning *head check,* tapped on the Perspex, then opened the door of Mr Youdom's cell, called *"Youdom morning head checks"* and, he says, was acknowledged by a movement of Mr Youdom's upper torso which he likened to the prisoner taking a breath.

No video material is available to elucidate this evidence and I think Mr Kelly's check may have been pretty perfunctory. I am far from satisfied that Mr Youdom made any acknowledgement of Mr Kelly's presence and, indeed, I think it is likely that, by that time, he was already dead. Supervised by Mr Kelly and another correctional officer, Craig Reynolds, a inmate and *sweeper*, Brad Evans, placed a breakfast tray inside the door of Mr Youdom's cell sometime around 7am but there is no evidence that there was any acknowledgement by Mr Youdom or that he moved or said anything.

Finally at about 9.45am, some three and a half hours after the morning *head check*, while *letting out* the prisoners, Mr Reynolds began the process of releasing a number of prisoners from their cells for exercise and showers. He opened cell #38 and told Mr Youdom to leave the cell but there was no response.

Mr Youdom was lying on his mattress. He appeared to be in the position in which he had been observed at 3.04am. He did not move and did not acknowledge Reynolds. Mr Reynolds tried to rouse him but he appeared not to be breathing. Mr Reynolds called for assistance and Mr Kelly tried to find a pulse while Reynolds called for medical assistance. A senior officer, Jason Quinn, was hurriedly called from the exercise yard. Two *Justice Health* nurses including *RN* Hussain and a prison doctor, Dr Thiraviarajah were in attendance. Anther medical practitioner, Dr Darkin pronounced Mr Youdom dead at about 9.55am.

Dr Little

Dr Diane Little at Westmead undertook the autopsy on 24 July 2008. Her finding was that the direct cause of Mr Youdom's death was *peritonitis due to a perforated duodenal ulcer* and this was unchallenged at the inquest. The other medical witness, Professor John Ham, the professor of surgery at Sydney University had commented that photographs taken at autopsy did not suggest abdominal distension and Dr Little agreed with that but said that, in a slim body, that distension might not be marked. Indeed, she told the inquest that fluid would sometimes percolate around the bowel and other tissues so that its absence is not remarkable.

In any event, there appears to be no doubt as to Dr Little's findings regarding *cause of death, which* were confirmed, if confirmation were necessary, by Professor Ham.

Professor Ham

Professor Ham provided very helpful evidence as to the *mechanics* of death due to *peritonitis* secondary to *perforated duodenal ulcer*.

He went on to discuss the incidence of pain likely to have been experienced by Mr Youdom which he thought, allowing for individual differences in pain tolerance, was likely to have been severe.

He thought that, initially, Mr Youdom would have experienced severe pain as the ulcer *burned* its way through the wall of the *duodenum*. After that, he thought Mr Youdom would have experienced very considerable pain, although perhaps not so severe, in the bacterial stage as gastric contents spilt into the cavity and sepsis developed.

"In the absence of treatment, the patient becomes shocked and may succumb." According to Professor Ham, the prognosis for a young man if treatment is undertaken within 8 to 12 hours is excellent but, if treatment is neglected, death will almost certainly follow. He thought that *"it is highly likely"* that it was at about 11am on 21 July 2008 Mr Youdom's duodenal ulcer perforated.

Summary

Although the evidence does not permit me to say where they are or who may have been responsible, the loss of four hours of video recordings depicting the events in Mr Youdom's cell from 4pm to 8pm on 21 July, 2008 - hours which Ms. England of Counsel rightly described as *"crucial,"* has placed the investigation into his death at a significant disadvantage.

Likewise, the failure to keep proper records of Mr Youdom's use of the *knock up button*, like Mr Fitwola's failure to properly maintain the *Wing Log,* has disadvantaged investigators. As a consequence, it is not possible to know as much as one would have wished to know about Mr Youdom's welfare during that period and, in particular, about indications he may have given as to his level of pain and his need for medical attention.

Nor is it possible fully to explore the quality of care which corrections offices and perhaps even nurses extended to him.

This inquest must do the best it can with the evidence, which is available.

There were times when Mr Youdom was handled with force such as when he was removed from his flooded cell at *Sydney Police Centre* and the time when he was removed from Reception at *MRRC* and moved to Darcy Pod. There were others but I have heard and seen no evidence, which suggests to me that excessive or unnecessary force was ever used towards him.

Although the policy is to provide each inmate with a physical assessment known as a *Reception Medical Assessment* within 24 hours of arrival at the *MRRC*, this did not happen for Mr Youdom.

Evidence of which video recordings form part demonstrates that, so outlandish was Mr Youdom's behaviour on his arrival at Silverwater that it was thought best to transfer him immediately to a safe cell in Darcy Pod where he could be *triaged* and would have a chance to be settled before any further attempt to assess him.

It is important, I think, to bear in mind that a *Reception Medical Assessment* is not a medical examination in the normal sense. It is not conducted by a medical practitioner but by a nurse and it does not include a physical examination.

It is largely an exercise where, with the aid of a *pro forma*, the nurse gathers and notes various matters regarding the prisoner's general physical status. I think Mr Youdom was in urgent need of recognition of his ulcer and of his deteriorating condition but the failure to provide him with his *Reception Medical Assessment* is beside the point and was understandable at any event.

Mr Youdom had psychiatric assessments in the last days of his life. One was the assessment carried out by Dr Zizzo at *St. Vincent's* and the other was Dr Tran's assessment at Darcy Pod on 21 July 2008.

The first assessment was conducted in the back of a *paddy* wagon and that was inappropriate. A qualified psychiatrist did not check the assessment and the decision to send Mr Youdom away and that was inappropriate. And, allowing for the fact that he is absent and has not had an opportunity to express his view, Dr Zizzo's diagnosis was almost certainly mistaken. But he was a junior doctor, no doubt doing his best in very trying circumstances and with a difficult patient. *St. Vincent's Hospital* has now put in place procedures and processes adequately to address the shortcomings, which arose in Mr Youdom's case.

As to Dr Tran's psychiatric assessment, he was initially suspicious that Mr Youdom may have been a drug user seeking morphine and I understand that such behaviour may be not uncommon among prison inmates who made up a large part of his practice. He told me that it was necessary to exclude that behaviour and perhaps it was. Then he diagnosed *schizophrenia* and there is no evidence, which would allow me to disagree. But the mistake, which I think Dr Tran did make, was to allow himself to be distracted by Mr Youdom's bizarre affect and behaviour and to have missed the underlying physical illness.

It might have been reasonable for Dr Trad to have been uncertain as to whether there was an underlying physiological illness but to have missed it entirely or failed to see it as a real possibility was unreasonable.

I respectfully agree with Professor Ham's evidence to the effect that prudent medical practice would have required Dr Tran to accept the *possibility* of a physiological condition, possibly acute abdomen, and to have taken effective steps to investigate.

It was that possibility, even ahead of the possibility of drug-seeking behaviour that needed to be excluded. Had Mr Youdom's behaviour been so unruly as to be too?

Similarly, I think nurses who cared for Mr Youdom in cell #38 also missed his underlying physiological illness. Chief among those, because she had the closest dealings with him, was *RN* Renouf and, because he was the acting Nurse Unit Manager, *RN* Trad. But neither had much opportunity closely to examine him and calmly to consider his case because Mr Youdom's behaviour was so outlandish as to raise safety issues.

They couldn't get close to him in any meaningful way and, not surprisingly, they were distracted from his underlying condition by his affect and behaviour. Further, it seems likely that, when Ms. Renouf saw him on the monitor sometime around 8.30pm, resting calmly and probably sleeping and looking *"very neat."* Mr Youdom's physiological symptoms were being *masked* by the *Zyprexa* he had taken, thus misleading her into thinking that all was well.

For his part, although Mr Trad's belief as expressed to *RN* Hussein that Mr Youdom's condition did not call for hospitalisation *"at this stage"* was almost certainly wrong, he too seems to have been blinded to the underlying physiological condition by the patient's apparently psychotic behaviour. *RN* Trad told the inquest, *"at the time, we made the best decision we could on the basis of the information available."*

When at a few minutes past 3am on 22 July, 2008, Mr Youdom moved his arms and right foot, which may have been the moment when he died, there was no indication apparent on the video recording that these were anything other than movements in his sleep and there was no reason to think that he was in a crisis.

When *RN* Hussein attended Mr Youdom at about 9.45am on 22 July, his body was still, cold and mottled and there was pooling in his hands and *"he had been dead for a little while."* Corrections officers conducting the morning *head check*, serving breakfast and otherwise attending to prisoners may not have been particularly observant and it is sad that Mr Youdom's death had not been noticed until midmorning but, obviously, these matters played no part in his death. Nor, according to Professor Ham, did the faulty heating system in three safe cells including cell #38.

<u>Formal Finding:</u>

I find that Herve Youdom who was born on 26 October, 1980 and arrived in Australia on 18 June, 2008 died at *Metropolitan Reception and Remand Centre*, Silverwater, NSW at about 3.04am on 22 July, 2008 of peritonitis due to a perforated duodenal ulcer.

2. 2474 of 2008

Inquest into the death of AA at Windsor on the 19th December 2008. Finding handed down by Deputy State Coroner MacMahon.

In summary AA was in custody for serious offences. He was sentenced in September 2006 and had an earliest return date in 2012. In April 2008 he was moved to John Moroney CC. He died on 19 December 2008 as a result of hanging. He was not assessed by DCC as being "at risk" of self-harm. I found that he had been properly assessed by DCC. The files showed some 14 assessments.

I was satisfied that his actions were unexpected and attributable to the break up of his relationship with his partner that occurred on 19 December 2008. (She became very annoyed when some intimate photographs of her that she sent to him at his request were not received.

She feared that they were being shown around and she blamed him. She had multiple conversations with him on 19 December 2008 and at the end of them she said that she did not want anything more to do with him and was changing her phone number so that he could not contact her).

I did not make any recommendations.

I authorised the publications of my findings and a report on my findings.

Formal Finding:

AA (born 7 June 1983) died on 19 December 2008 at the John Moroney Correctional Centre, Windsor in the state of New South Wales. The cause of his death was asphyxiation due to hanging which occurred as a result of actions taken by the deceased with the intention of ending his life.

Orders made pursuant to Section 75(5) Coroner's Act 2009

I authorise the publication of these findings together with a report of the proceedings.

3. 2523 of 2008

Inquest into the death of Michael Magro at St Leonard's 27th December 2008. Finding handed down at Glebe by Deputy State Coroner Mitchell on 17th June 2011.

Michael Peter Magro, who was born on 17 October 1968, died at Royal North Shore Hospital at about 6am on 27 December 2008.

Dr Istvan Szentmariay, whose report on the autopsy which he conducted here at Glebe on 30 December, 2008 is before me, described the cause of death as Hypoxic Brain Injury and commented that "the injury is most likely a consequence of cardiac arrest and based on histology is most likely due to a recent and acute ischaemic event (small myocardial infarct).

"As a footnote, Dr Szentmariay drew attention to the relatively minor degree of coronary narrowing and the relative severe cardiac enlargement along with dilation of the cardiac chambers,' and expressed the thought that "these changes may point towards cardiomyopathy (etiology)" Professor Gordian W.O.Fulde, Professor of Emergency Medicine and the Director of the Emergency Department at St. Vincent's Hospital, Darlinghurst who was called by the Coroner as an expert witness has nothing to say about the finding of Hypoxic Brain Injury,

but has some reservations regarding Dr Szentmariay's footnote, noting Mr Magro's history of sub optimal health and suggesting that preexisting heart damage and lung disease is "quite likely" as a contributing factor in his ultimate illness.

Regarding lung disease, professor Fulde observed "the ability of the lung to absorb oxygen and the heart to pump blood to the lungs and the body are closely interrelated. In this case, I believe both were increasingly to severely impaired. A severe viral infection of both the lungs and the heart muscle is a definite possibility."

Looking at the history of sub-optimal health, I note that Mr Magro's Heath Notification Form completed in prison on 16 September 2008, indicates that, when he entered prison, he was on methadone 2.5mls daily, had been a user of IV drugs about five years earlier, was Hepatitis C positive and, in 2003, had been treated for depression as well as agoraphobia. Mr Magro may have believed that he had a gum disease and suffered from mouth cancer. Although it was not recorded on the l6th September, he had a history of asthma, high blood pressure and, perhaps, heart disease.

He had smoked and drank to excess and had recently been a regular user of cannabis. Taking the whole of the scientific evidence into account, I think the best I can do with any real confidence is to find that Mr Magro's fatal Hypoxic Brain Injury was consequent upon cardiac disease, possible viral infection of the lungs and generally sub-optimal health.

Mr Magro was previously married to Linda Magro and there are three children of that marriage. In addition, there is a young daughter, now about four years of age, of his de facto relationship with Adele Sirman, Judging from the tender and affectionate terms of their telephone conversation of 18 December 2008, a recording of which is EXHIBIT 4, that relationship was a strong and ongoing one. From the 16 September 2008 until the time of his death, Mr Magro was an inmate at Mid North coast correctional centre at west Kempsey. Initially bail was refused on charges of contravene prohibition/Restriction in Apprehended Violence Order x 3 and Common Assault, on 15 December 2008, Mr Magro was convicted of those offences and sentenced.

On his arrival at the prison, Michael Magro was screened and seen by a Justice Health Nurse. The intake documents note that, prior to incarceration, he was drinking 10 to 20 longnecks and smoking 20 to 30 cigarettes per day, taking daily methadone and smoking cannabis three times per week. He presented with a normal temperature but with low blood pressure, noticeable tremor and an irregular heartbeat. According to his cellmate, David Cooper, he seemed to be in reasonable health when he arrived at the prison but his health rapidly declined.

Evidently, one of the arrangements in place to allow inmates to access health care at the section of the prison occupied by Mr Magro involved the inmate filling out a Patient Request Form, known as a green form, which is available on request from prison staff. Justice Health witnesses told the inquest that the green form was intended for use only in non-urgent cases but it is not clear that inmates including, Mr Magro was aware of or always appreciated this limitation.

According to Justice Health, an inmate seeking medical attention in an urgent case might either use the knock up button on the wall of his cell or else go to the sick cell which means attending the morning muster and reporting an illness or simply staying in bed and failing to report at muster in which case prison officers would go looking for him.

The shortcomings of the sick in cell procedure in really urgent cases are obvious - an inmate might be left awaiting a muster for up to twelve hours or so before his illness was notified to the authorities. As to the knock up button, despite what photographs tendered in evidence suggest was its prominent position on the cell wall and the accompanying explanatory signage.

One of Mr Magro's cellmates told the inquest that he had not been aware of its existence. It may say something about the other systems, namely the knock up button and the sick RN cell procedure that, on 17 December, 2008. Michael Magro who obviously regarded his need for medical attention as urgent, seems to have preferred the green form as the means of obtaining medical attention even for what he clearly regarded as an urgent matter.

As at December 2008, where the green form was used, the inmate was expected to ask for a form at the prison officers' station, fill it in by outlining the medical issues involved and then place it in a locked box on the prison officer's desk.

That box was to be emptied by a nurse, probably an Enrolled Nurse, each evening and the forms were then endorsed with the date of receipt and placed in a manila folder for examination and triage by a Registered Nurse next morning. The patient would then be seen by a medical practitioner as appropriate and the green form would be further endorsed with the "date seen" which, according to RN Aidridge referred to the date on which the inmate's name was placed on a list awaiting a consultation or, according to her superior, RN Little, the date on which the patient was actually seen by the doctor or nurse.

Mr Magro's green forms related to a wide variety of issues including new prescription spectacles, the onset of depression, insomnia, elbow-finger pain, aching liver and back, HIV therapy, chronic tendonitis, a request for an extra mattress, further supply of methadone, anxiety attacks, agoraphobia, head ache, ear ache and bad tooth ache caused by the recurrence of a dental abscess, infection after a dental procedure, anxiety, analgesia and, subsequently, emergency dental surgery for a broken tooth, swollen hands, sciatic nerve pain and intense and almost immobilising pain in right leg from hip to knee and knee to ankle, further dental abscesses and the perceived need for antibiotic medication to prevent secondary infection and septicemia.

Some of these reports were duly answered by assessments and consultations, the provision of medication and, on at least one instance, by dental surgery and some may have been of greater concern than others but when Dr Clare Skinner, the acting Deputy Director of Medical Services at Royal North Shore Hospital came to write in her statement for the Coroner that Mr Magro was admitted to that hospital "with a three day history of feeling unwell, she was reflecting something which, perhaps, she had been told but which was far from accurate.

When one takes into account not only what Mr Magro wrote in his various green forms and what he told health workers while in custody and, also, what he told his de facto partner in their phone conversation, a recording of which is EXHIBIT 4, and how he appeared to his cell mates, it is clear that he had been very unwell for a great deal longer than three days prior to his admission to hospital.

In light of subsequent tragic events, four green forms submitted by Michael Magro seem particularly significant. On 4 November, 2008, Mr Magro wrote of "severe chest pain over top left breast...and milder pain under left arm”.

Then, on 19 November, 2008, he outlined a complaint of unfair and discriminatory treatment in being denied adequate psychiatric assistance, which, he alleged, had previously caused severe symptoms including sweating and tightness in the stomach and unbearable stress. In his green form he pointed out that such unfair treatment had already prompted a mild heart attack some weeks previously.

On 17 December 2008, Michael Magro's green form reported, “I am having great difficulty breathing, I don't know whether it is related to panic attacks I have been having or a respiratory ailment but I can't breath”.

“I am very concerned and feel very light headed. I don't think I am getting oxygen. I have never suffered asthma before as such but have been prescribed ventolin for a similar condition and, finally, on the same day 17 December, 2008, in his hand-made green form, Mr Magro complained "I can hardly breath, pain when breathing, fever, high heart rate, possible pleurisy or pneumonia. Have had viral pneumonia before, need to see doctor ASAP, URGENT”.

Kenneth Hawkins who shared a cell with Michael Magro for "a couple of days and nights" in December 2008, reports that "the whole time I was with Michael in the cell, his breathing was terrible. He sounded like a fifty year old with emphysema. Anyone who was near Michael could hear him wheezing. His breathing was so loud it would keep us awake at night," Mr Hawkins' recollection is that, during the time they shared a cell, Michael Magro "was struggling to breath whether he was sitting down or standing up."

David Cooper, another cellmate of Michael Magro, recalls him complaining of chest pains about a fortnight before his death.

During the day, according to Mr Cooper, Mr Magro would generally stay in the cell because he couldn't get around much because he was short of breath" and "he couldn't even play (his guitar) much without becoming short of breath and tired. over the last couple of days before Michael left, he kept us awake with his breathing. It was like a loud snoring sound then he would stop and wouldn't be breathing (and) I would get out of bed and push him to wake up and breath again."

The witness Kenneth Hawkins recalls that prisoners were required to go to the "screws” counter in order to get a green form.

Although it was not his personal experience, he says his understanding is that "sometimes they would give you a form straight away and other times they would tell you they were too busy and to come back in an hour or so."

He recalls Michael Magro handing prison officers a form on the 16 or 17 December but he is not sure whether it was a green form or what kind of form it may have been. David Cooper, on the other hand, is clearer in his recollection of Mr Magro filling in a number of green forms citing a number of complaints and handing them to prison officers on a number of occasions.

His evidence is that Michael Magro varied the terms of these forms "because if you keep fitting out the green forms with the same complaint, they wouldn't see you." According to Mr Cooper, he was present a few days before Michael Magro was taken to hospital and heard Mr Magro at the prison officers' station asking a prison officer for a green form only to be told "the clinic told us not to give you any green forms because you are a serial pest".

On 17 December, 2008, Mr Cooper watched Michael Magro walk back to his cell and, later, Mr, Cooper obtained a green form for him and put it in the box after the latter had filled it out. Mr Cooper says that, later on the same day, he watched Michael Magro preparing a handmade form and explaining that.

'They aren't giving me any green forms so I'll make my own fucking forms'. He was present, too, when, on the evening of 17 December 2008, Mr Magro handed the handmade form to a male nurse, described as, 'middle aged with grey hair, about 6 foot tall, thin build' who turns out to have been an Endorsed Enrolled Nurse Anthony McMahon. Mr McMahon, accompanied by three prison officers, had come to the door of the cell to administer medication to Mr Cooper and was told that, "Michael is really sick and needs to see someone".

Mr Cooper says he watched as EEN McMahon read the form, laughed and walked away. There is no doubt that it was Mr McMahon who received Mr Magro's handmade form because he admits that and, for some reason, he signed the document but, as to Mr Cooper's allegation of reading the form and laughing or chortling as he walked away, Mr McMahon told the inquest that he has no recollection of that.

EEN McMahon says that he was "shocked" at having been handed the form and, in court, despite the evidence of Mr Cooper and Mr Hawkins as to Michael Magro's dire appearance and affect, he questioned, whether Mr Magro's appearance was consistent with what was on the form.

Nevertheless, Mr McMahon told the inquest that he was not aware of anybody having characterised Mr Magro as a serial pest. He told the inquest that he would have read the handmade green form only when he got back to his desk and that he would have referred it to the nurse in charge, Kay Aidridge but Mr Cooper was clear that Mr McMahon "looked at the form quickly, said something and then laughed" and RN Aidridge denies speaking to Mr McMahon when he returned from his rounds bearing the handmade green form and denies that the green form was ever brought to her attention.

In the circumstances I have recited, I think it is more likely than not that EEN McMahon was aware, at least in general terms, of the contents of the form and, rather than bringing it to RN Aidridge's attention, merely filed it away for attention by a registered nurse on the following morning.

Mr Cooper says, inaccurately I think, that later that evening, he pressed the knock up alarm and that "about an hour later, a nurse and screws came and looked at him (Michael Magro) before they took him away" to the prison Health Centre. I don't know whether on some other occasion Mr Cooper pressed the knock up button on Michael Magro's behalf but there is excellent evidence in the shape of the recording of his phone conversation with Ms. Sirman that it was not until shortly after 9am on 18 December that Michael Magro was summoned to the clinic to see Dr Strain. He spent the night of the 17 December, 2008 in his cell without medical attention.

At about 11am on 18 December,2008, when Mr Magro was seen by Dr Strain, the visiting medical officer at Mid North Coast Correctional Centre, the patient "looked anxious and was breathing at a faster rate than normal. He appeared sweaty and was restless." Dr Strain was made aware that there was a history of anxiety. Dr Strain examined Mr Magro, found blood pressure of 107/70,at the lower end of the normal range," and noted that the patient,' was breathing at a faster rate than normal." He found no palpable thyroid abnormality but Mr Magro was tender to palpation of the right upper quadrant of his abdomen. It was then that an ECG was undertaken.

The ECG revealed a pulse rate of 185 bpm, very much faster than Dr Strain had been able to feel, together with "a dissociation between the P waves and the QRS complexes" Dr Strain says that, in light of the ECG readings, "a warning bell" sounded and he "suspected that Mr Magro may have had a rhythm abnormality such as atrial fibrillation with a very fast ventricular response rate and that he may have been thyrotoxic." In those circumstances, sensing 'the possibility of a serious cardiac problem requiring management at a tertiary level", he asked that Mr Magro be transferred to the Accident and Emergency Department of Kempsey District Hospital.

Michael Magro arrived by ambulance at the Emergency Department of Kempsey District Hospital shortly after 11.47am on 18 December 2008. Registered Nurse Katie Marie Croad was on duty there and recalls that Mr Magro became agitated and restless while being treated. Registered Nurse Kerryn Bullivant describes him as looking "critically unstable," struggling and "very frightened". "She recalls that he was medicated with adenosine, amiodarone and digoxin, "all designed to regulate and slow the heart rate." Ms. Bullivant tried to pacify Mr Magro, holding his hand, talking to him and trying to calm him down. When this was not successful, she recommended at 1.20pm that he be given Valium. Finally, when that was not successful, Nurses Croad and Bullivant decided to move Mr Magro out of ED and into Intensive Care.

RN Sarah George who was in the ICU that afternoon states that Michael Magro was admitted there at 2.45pm. He was "anxious, clammy and complaining of pain in the left arm and shortness of breath."

Dr Muhammad Hussein was the physician involved in Michael Magro's care in the ICU at Kempsey District Hospital. He reports that, once the heart rate was slowed by medication, atrial fibrillation became apparent. Describing the patient's condition, Dr Hussein wrote "Initial Troponin and D-dimers were negative, TCO2 was 21 indicating acidosis. Chest x-ray showed pulmonary oedema.

He was given a subcutaneous enoxaparin 80mg and IV Furosemide 100m9. Morphine and Diazepam were given for pulmonary oedema and anxiety." Dr, Hussein explained that enoxaerin was administered in order to thin the blood and furosemide as a diuretic in the hope of expelling fluid from the lungs.

Dr Hussein went on to report that Mr Magro "was transferred to ICU for further management. There he still had dyspnea (breathlessness) and he complained of cough. Bilateral crepitation and vesicular breathing were noticed. Amiodarone was stopped and IV Digoxin was given. Patient was still hypoxic. X-ray showed left lower lobe infiltrate in addition to bilateral hilar prominence and smaller diffuse infiltrates."

The notes record that, at 2.45pm, Mr Magro's saturated oxygen level stood at 7 5o/o in room air (via NRM B5%) which, Dr Hussein says, constituted a medical emergency indicative of significantly impaired lungs, the norm being about 97o/o. Because of his hypoxia and respiratory distress, it was decided to transfer Mr Magro to Port Macquarie Base Hospital.

Mr Magro was intubated, stabilized and accompanied in the ambulance by Dr Vincent Lee, the anesthetist at Kempsey District Hospital but, about 1b minutes out, the patient was seen to suffer a bradycardiac arrest with no palpable cardiac output and the transfer was aborted, Dr Lee judging that continuing on to Port Macquarie was too perilous. In their statements, both Dr Lee and Paramedic Richard Berry describe the treatment administered in the ambulance while they worked on Michael Magro for about 15 minutes.

Mr Magro responded favourably to the 3'd. dose of adrenaline and other treatment administered by Dr Lee while in the ambulance, then rearrested and was revived by a 4th. dose and Dr Lee reports that, on arrival back at Kempsey District Hospital, he had a pulse 100/minute and good peripheral cardiac output and BP '130/80.

But he was gravely ill and Dr Hussein told the inquest that a chest x-ray disclosed that Mr Magro's heart was enlarged and misshapen. It was unclear whether it was the heart which was dilated or whether the picture was the result of increased fluid in the sack surrounding the heart but Dr Hussein thought that it was more likely than not that the heart itself was swelling.

The decision was taken to airlift Mr Magro to Royal North Shore Hospital once he had been stabilised, because the proper management of his condition - severe pneumonia (probably viral), cardiomyopathy (probably stress related but, perhaps, viral in origin), acute pulmonary oedema, atrial fibrillation and consequential respiratory failure - required resources beyond those available at Kempsey District Hospital or even at Port Macquarie Base Hospital.

Dr Hussein told the inquest that he had believed Mr Magro to be suffering from Skess (Takotsubo) Cardiomyopathy but, evidently, it was later suggested at Royal North Shore Hospital that the cardiomyopathy might have been of viral origin. The Cardiac Catheterisation Report prepared by professor Helge Rasmussen at Royal North Shore Hospital on 21 December,2008 shows that the dominant right coronary artery and its branches, the left main coronary artery and the left anterior descending coronary artery and its branches as normal. Further, the report notes "Cardiogenic shock of unknown cause. No infarct pattern on ECG."

It may be that the aetiology of Mr Magro's heart condition will remain uncertain, no tests for the presence of a virus having been undertaken, but Dr Hussein is confident that, in the selection of appropriate therapy for Mr Magro, whether the condition was stress related or viral was not the issue. The statement of Dr Clare Skinner records that Michael Magro arrived at the Intensive Care Unit of RNSH at 6.46am on 19 December 2008. Dr Skinner notes his presenting problems as follows:-

- septic shock (cause unknown)
- respiratory failure due to pulmonary oedema
- paroxysmal atrial fibrillation
- poor dentition and recent tooth abscess
- ischaemic hepatitis and
- hepatitis C positive secondary to previous IV drug use.

According to Dr Skinner, subsequent examinations demonstrated that while Michael Magro's coronary arteries were normal, he had grossly deranged liver function, renal failure, myocarditis, cardiogenic shock (with ejection fraction 15%) and sepsis. Additionally, a brain scan demonstrated generalised low density within the supratentorial brain parenchyma with loss of normal grey/while matter differentiation and Dr Skinner notes that "these features were (in) keeping with diffuse hypoxic brain injury."

Management at RNSH consisted of broad-spectrum antibiotics, inotropes (noradrenalin and milirinone), insulin and amiodarone. According to Dr Skinner, there was initial improvement but poor neurological recovery and Mr Magro remained febrile. His condition deteriorated and, with the concurrence of the family, the decision was taken on 26 December to cease active treatment. Comfort measures and supportive treatment were continued until 6pm on 27 December, 2008 when Michael Magro died.

Professor Fulde, as an expert in emergency medicine, was asked to comment on the quality of care and treatment afforded Mr Magro. His view of the treatment afforded to Mr Magro at Kempsey District Hospital is that it was "appropriate and of a peer practiced standard" and he points to that hospital's very prompt attention, diagnoses and treatment.

He is similarly content with the performance of staff at Royal North Shore Hospital and says that it was "appropriate and consistent with the care of a tertiary teaching hospital."

As to the care of Michael Magro during the attempted transfer to Port Macquarie Base Hospital, Professor Fulde believes that it was adequate and appropriate and, indeed, he goes further to say that "the patient was handed over by a consultant physician to an experienced G.P. anesthetist whose care in a difficult clinical and physical situation (on the road in an ambulance) was good".

In his evidence to the inquest, Dr Lee graphically described something of the severe difficulties involved in managing and resuscitating a patient after a cardiac arrest in an ambulance. Nor does Professor Fulde have any criticism of Mr Magro's management and care during his transfer to Royal North Shore.

The chief areas of concern in this inquest relate not so much to the care and treatment of Mr Magro while in hospital or while being transferred to hospital or between hospitals but, rather, to his care and treatment while in prison and the processes and procedures in place at Mid North Coast Correctional Centre regarding inmates like Mr Magro requiring medical attention and, further, to the processes and procedures relevant the internal investigations conducted by Justice Health and Corrective Services NSW into Michael Magro's care and treatment.

Turning firstly to Mr Magro's care and treatment in prison, there was a gap of about 12 hours between his request to EEN McMahon for assistance and his assessment by Dr Strain and, of course, even longer if one takes into account his first green form of 17 December.

I take into account that the green form system was designed for non-urgent cases and that there was a knock up button available in Mr Magro's cell. RN Aidridge alluded to the efforts, which are made to acquaint inmates with the availability of the knock up button (which include the provision of a DVD) and with the proper means of seeking medical help in emergencies. Nevertheless, Mr Hawkins' evidence is that he was not aware of the existence of the knock up button and had never been instructed in its use.

Mr Magro, of course, was a far more experienced inmate than Mr Hawkins and it is clear that, on 17 December, 2008, he was not merely malingering but perceived that he was in real need of help as later events demonstrated was the case but even he seems to have regarded the green form system as the appropriate means to call for help even in urgent situations. Lam not sure why that should have been the case. Perhaps the prevailing culture pointed to the use of green forms.

Professor Gordian Fulde's evidence is that a complaint of breathlessness is to be taken seriously particularly where the person to whom such a complaint is directed, and this includes EEN McMahon, "did not have the luxury of knowing the patient".

Referring to the terms of the second green form, professor Fulde went on to say that "at face value, I would be worried... ...It would cause me some concern...He should have been seen." Dr Hussain had a similar view. In my opinion, nobody can say - and Professor Fulde does not say, that early attention to Mr Magro's condition would necessarily have changed the ultimate outcome but nobody,

including EEN McMahon, can say that it would not have and it seems to me that where society deprives a person of much of his ability to take care of himself, as in the case of most prisoners, it owes a duty to ensure more watchful and timely care than was afforded Mr Magro who, despite his appeal, had to wait up to twelve hours for medical attention.

Two irregularities were found, one relating to the failure of the officer present at Mr Magro's death to file a timely report and the other to do with a mix up regarding Mr Magro's next of kin. As I understand it, both those matters have been or are being dealt with and they do not concern me here. Other than that, the Commissioner was to be informed that "nothing untoward has been disclosed by investigations into the death in custody”.

In that context, it is important to note, however, firstly that Ms Steel’s investigation is, essentially, a review of the papers and that only very limited, if any, interviews were conducted and that nobody at Justice Health and, particularly, neither RN Little and RN Aidridge nor EEN McMahon was questioned or interviewed and, secondly, that the report is not intended to be a report as to the circumstances of Michael Magro's death.

Mr Walters told me that the commissioner had no authority to question any of the Justice Health nurses so that, as far as Justice Health’s care of Mr Magro is concerned, Ms. Steel's Assessment Report and therefore the Commissioner were entirely dependent on what Justice Health told them.

What Justice Health told them about what had happened to Michael Magro is contained in the 20-paragraph report to the commissioner from Justice Health, which is annexed to Ms. Steel's report. The report, signed by Julie Babineau, the Chief Executive of Justice Health and dated 20 January, 2009 is quite uninformative and, in one critical area, misleading where it purports to detail Justice Health's care of Michael Magro at the critical time of his final illness.

Paragraph 17 of that report reads as follows:-

Mr Magro was reviewed in the health centre in December 2008 reporting shortness of breath and generally feeling very unwell. An ECG was attended which showed a supra ventricular tachycardia (very fast heart beat). Mr Magro was transferred to Kempsey Hospital for further investigation.

The reference to a review on 17 December, 2008 is mistaken and explained as a typo although Ms Hanly, who gave that evidence on behalf of Justice Health, had done nothing to satisfy herself that such was really the case.

The last minute statement of Denise Monkley dated l6 June, 2011 and filed in court on that day, EXHIBIT 9, establishes that the mistake was a typo, albeit a quite misleading one. Until corrected at the hearing, the Babineau report provided no explanation as to when and how Mr Magro had been brought from his cell to the prison health centre to see Dr Strain or what may have been his then medical condition.

Instead, the reader was invited to assume that Mr Magro's transfer to Kempsey District Hospital followed hard on the heels of his appeal for urgent medical attention without any suggestion of the approximately twelve hour delay between Mr Magro handing his note to EEN McMahon and seeing Dr Strain.

There is no mention in the Babineau report of any event which took place between 12 and 18 December and, in particular, there is no mention of Mr Magro's two green forms of 17 December and no mention of his having handed the hand made green form to EEN McMahon. Considering the terms of his green forms and subsequent events, the passage in paragraph 17 Mr Magro was "reporting shortness of breath and generally feeling very unwell" is surely a significant understatement of his condition.

Neither RN Deborah Little, the Nurse Manager for Justice Health's northern cluster and RN Aidridge, the senior nurse on duty on the evening of .17 December, 2008 nor even EEN McMahon, as the nurse to whom Michael Magro's ultimate green form was handed, was ever interviewed or invited to take part in any internal investigative process touching on the care, treatment and death of Michael Magro.

To the extent that Ms. Babineau's report was intended to adequately inform the Commissioner of Corrective Services of what had happened to a prisoner who had been in his care, it cannot possibly have done so. Further, Ms Hanly reminded the inquest that the Root Cause Analysis conducted by Justice Health may not be made available to the Commissioner so that it is not clear how he could be assure a clear and complete picture of what had happened to Mr Magro. But then, it is not easy to see how, in Mr Magro's case, a useful Root Cause Analysis could have been undertaken without Ms. Aidridge's and Mr McMahon's participation.

It seems to me, therefore, that there were real shortcomings in the processes and procedures, which governed the internal investigations of Justice Health and of the Commissioner of Corrective Services Into Mr Magro's care, treatment and ultimate death.

In the case of the Commissioner, those shortcomings originated in the narrow scope of inquiry allowed him, that is, to investigate whether there were any breaches of policy and proper procedure rather than to investigate the circumstances leading to Mr Magro's death. A second shortcoming was the absence of authority in the Commissioner to direct relevant questions to Justice Health staff and, ultimately, his inability to access the Root Cause Analysis.

In the case of Justice Health, the shortcoming was its failure to make proper enquiries, in particular by directing questions to the relevant nursing staff, and the failure to produce a comprehensive and relevant report for the Commissioner. The inquest was informed that there was ample opportunity for the Commissioner to be fully appraised by Justice Health, on an informal level, as the circumstances of the death of Michael Magro. Even if there was – and there is no evidence of such opportunity or of such opportunity having been taken up.

Formal Finding

I find that Michael Peter Magro, who was born on 17 October 1968, died at Royal North Shore Hospital, St. Leonards, NSW on 27 December 2008 of Hypoxic Brain Injury consequent upon cardiac disease, possible viral infection of the lungs and generally suboptimal health.

Formal Recommendations:

To the Minister for Health being the Minister responsible for Justice Health and to the Attorney-General and Minister for Justice as the Minister responsible for corrective services NSW as follows: -

- That in any internal review of a death in custody whether conducted by Justice Health or Corrective Services NSW, the author(s) of such reviews take all appropriate steps to interview and/or obtain information from relevant staff on duty or involved with the deceased person in the forty eight hours prior to that person's death or transfer to an external medical facility and the cellmate(s) of the deceased;

- That if it is not already the case, the Patient Request Forms, known as Green Forms, form part of an inmate's Justice Health medical file;

- That any written communication to Justice Health clinically relevant to an inmate's medical condition should form part of the inmate's Justice Health medical file.

- That in correctional facilities where Patient Request Forms (Green Forms) are in use, these should be reviewed by a Registered Nurse on the day they are submitted by an inmate.

- That Justice Health promptly investigate and seek to devise a policy and procedure or supplement any existing policy and procedure to ensure that any complaint of an inmate regarding breathing difficulty, chest pain and/or respiratory distress to be immediately assessed by a medical professional; and That Death in Custody Reports prepared for Justice Health following the death in custody of an inmate include an endorsement by the person responsible to the Chief Executive for the report confirming that that person has had access to the relevant medical records of the deceased inmate prior to submitting that report to the Chief Executive and enumerating all and any source documents relied upon in the preparation of the report.

4. 710 of 2009

Inquest into the death of AA on the 15th March 2009 at Silverwater. Finding handed down by Deputy State Coroner MacMahon at Glebe.

This has been an inquest into the death of AA who was born on 23 February 1975. The deceased was of Aboriginal descent. He identified himself as transgender and as such was known as AA, AA and by a variety of other names. In this inquest and in these findings, the deceased has been referred to in the feminine and with the name AA. That appears to have been a name, which the deceased identified with more often perhaps than other names and out of respect for that identification I propose to use it in these findings.

The deceased, however, on the evidence available to me had not changed his birth name and as such the formal findings will reflect that formal position.

AA was a person who was engaged in the criminal milieu of society. She had been incarcerated on a number of occasions prior to 2009 for a variety of offences. The circumstances of those incarcerations and the offences are not relevant in these proceedings except to the extent that it is noted that some of those offences involved matters of violence.

On 10 March 2009, AA was arrested by police and charged with a number of serious drug offences. She appeared at the Central Local Court following her arrest and having appeared in court was remanded in custody and had to re-appear at court on 24 April 2009.

She was initially transferred from Central Local Court to the Sydney Police Center and specifically the section of that location which was under the control of the Department of Corrective Services. She remained there until 14 March 2009 when she was transferred to the MRRC at Silverwater.

On arrest and on her presentation at court and to the Department of Corrective Services she was dealt with under the name of AA. At Silverwater she was placed in cell 65 of the Darcy Wing. She was awaiting classification at that time. She was placed one out that is she was placed in a cell by herself. She was last seen alive by Corrective Services Officer Freeman at about 3 o'clock on the afternoon of 15 March 2009 when she was locked in her cell for the night.

At about 6am the next morning, that is 16 March 2009 when her cell was opened by Corrective Services Officer Glenn Clarke, she was found to be deceased.

The apparent cause of her death being hanging, she having been found within the cell hanging with bedding material used as a noose.

It is important to understand what the role of a Coroner is in these circumstances. Section 81 of the Act specifies that a Coroner conducting an inquest is to make certain findings if evidence is available. Those findings deal with the identity of a deceased person, the date and place of their death and the cause and manner thereof. In this case, there is little controversy as to AA's identity.

The evidence is clear as to her birth name and her transgender identification and the various names that she identified with although none of those names were names that she had legally adopted.

The place of her death is also not controversial that being cell 65 of the Darcy Wing of the Metropolitan Remand Center at Silverwater under the administration of the Department of Corrective Services. The time of her death is not exact. As I have already indicated she was last seen alive on the afternoon of 15 March and she was found deceased on the morning of 16 March. She clearly died between those two times.

The cause of her death is also of little controversy. Following her death, her body was transported to the Department of Forensic Medicine here at Glebe where an autopsy was conducted by Associate Professor Duflou, the director of the centre. Associate Professor Duflou had also attended the cell in which AA was found deceased and observed her body in situ. He identified in his report the direct cause of her death as being hanging.

Importantly, he did not identify any other injuries which either could have resulted in her death or which would have suggested that she had been the subject of a violent attack or abuse prior to her death. There was nothing in his report and in his observations of her body that would suggest that the manner of her death was other than intentional self-harm.

As I have indicated, AA was locked in cell 65 a little around about 3pm on 15 March and she was found deceased about 6am on 16 March.

There was no evidence that her cell was opened between those two times and there is no evidence that any third party had any involvement in her death. Having regard to the evidence available, I am satisfied that the manner of her death was intentional self harm and that her action was undertaking with the intention of ending her life. Section 23 of the Coroner 's Act is relevant to AA's death that requires that where a person dies in custody that an inquest is undertaken and that such an inquest is undertaken by either the State Coroner or one of the Deputy State Coroner's .

The public policy reason for that is that where a person's liberty has been taken away from them the organisations of state that have responsibility for their care have an obligation to ensure that that care is provided in an appropriate manner and one which does not contribute to a death. That is the general principle and applies to all persons who are in custody.

In AA's case, that general principle is amplified by two factors and those two factors are recognised as placing a person in custody such as AA at perhaps greater risk. Those two factors are her Aboriginality and her transgender identification. In those circumstances, it is recognised that in particular by the Royal Commission into Aboriginal Deaths in Custody that indigenous persons can be subject to greater difficulties whilst in custody and likewise although it has not been the subject of a Royal Commission, it is recognised by the department itself that a person who has a transgender identification has greater risks whilst in custody.

Finally, of relevance in these proceedings is s 82 of the Coroner's Act, which grants the Coroner a discretion to make recommendations if he or she considers it appropriate about any matter, which arises out of the death of the deceased person with whom the inquest is dealing. The purpose or the primary function of the inquest the matters being dealt with under s 81 being subject to little or no controversy has been to ensure that appropriate action was taken in respect of AA's appearance in custody to identify any risks of self harm and if such risks were identified to take appropriate action to overcome or mitigate such risks.

Clearly, a person who is being brought into custody will suffer stressors and anxiety as a result of their change in circumstances. The prospect of a prison term, the loss of freedom, which goes with that, would be stressful and would ordinarily be stressful, however, some persons would react in a different way and may be tempted to take action which would result in their harm.

It is mandatory on the Department of Corrective Services to seek to identify such persons and where identified to take action to mitigate those risks. In this case, I am satisfied that the Department of Corrective Services and the New South Wales Police Service before them did take action to endeavor to identify such risks.

When a person comes into police custody which AA did after she was arrested and brought to the police station to be charged, a custody management record is created and that custody management record shows that at the time of being brought into police custody which was at approximately 11am on 10 March 2009 AA was not agitated; not under the influence of drugs or alcohol; not exceedingly despondent; did not exhibit any signs of previous attempts at self injury; did not make any threat of self injury whilst in custody; did not appear to be mentally disturbed and did not make any complaints.

Indeed, the observation was that she was co-operative. In answer to specific questions, she denied that she had tried to take her life previously; that she had any serious mental medical or mental health problems and was receiving treatment.

It was appropriately identified as being she was appropriately identified as being Aboriginal. On her transfer to Corrective Services' custody, AA underwent a similar screening. The records show among other things in response to a question, "Do you feel that there is hope for the future?" she said, "Yes"; "Since being arrested, have you had any thoughts about harming yourself or taking your own life or harming others?" she denied it; "Do you have any current plans for self harm or taking your own life?" she denied it and "Have you tried to take your own life or harm yourself in the past whether either as a juvenile or as an adult?" she denied it.

The corrective service officer undertook a visual assessment of self-harm and like the police officer previously did not identify any suggestions that there would be self-harm. The comments that were made were that AA was co-operative and again at a later time the interviewer's comments and observations that "She was calm and co-operative, nil suicidal ideation at present, transgender was identified" and "withdrawing from heroin" was also a comment made.

AA subsequently underwent on 11 March a further assessment by Sandra Laycock, a counsellor. Sandra Laycock in her report said, “I found AA (as said) able to converse with me and answer all questions put to her”.

She stated that she had no previous history of self-harm or suicide and no current self harm or suicide ideation and she concluded, that is Sandra Laycock concluded, “I did not see or hear anything to suggest that she was having difficulties being incarcerated”.

On arrival at the Metropolitan Remand Centre, Marilena Bortoli undertook a screening process in respect of AA. Her observation of her was undertaken on 14 March 2009 at about 7.45pm and took approximately half an hour. She was identified as being Aboriginal and given the opportunity of being screened by a person of an Aboriginal background. AA did not object to Ms Bortoli undertaking this screening. Ms Bortoli said that during the course of her interview AA was “smiling, happy and talking”. She was co-operative and polite. She kept good eye contact at all times.

During the conversation, she presented as a happy and smiling. She concluded, that is Ms Bortoli concluded that there were no indicia suggestive that AA was at risk of self-harm.

The situation therefore from the perspective of the Department of Corrective Services on reception of AA into its custody I am satisfied was that AA did not display any indicia which made it likely or foreseeable that she would self-harm. Of course, there is one thing that a person or a front that a person can place before officials which might not necessarily be the same before your peers. The officer-in-charge of the investigation undertook a significant number of interviews with fellow inmates. Contained in the brief are statements from some ten of those inmates.

The general observations made by each of those inmates was that although AA had some concerns about her incarceration and to one appeared to be angry about something there were no indicia that came to their attention which would suggest that she intended to harm herself. This was particularly relevant in the observations of Sheena Tanovich(?) who I will refer to as Sheena - Sheena was an inmate of the Darcy Wing who had known AA since 1994. Sheena was also a person of transgender orientation.

Sheena in her statement said, “I didn’t think that she would do what she did. She did not give me any reason to believe that she was that bad and to take her life”. She spoke to AA on 15 March shortly before AA was locked into her cell. Sheena concluded her statement by saying, “When I spoke with her she did not say anything to me that would cause me to be concerned. She told me nothing about her feelings apart from being anxious about her charges. If I knew she was going to kill herself I would have told the officers straight away to put her in a safe cell. I did not hear anything unusual through the night or the early hours of the morning of the 16th”.

The evidence therefore is that not only in the way in which she approached the police and Corrective Services' officers, also in her dealings with her fellow inmates, AA did not give any indication of an intention to self harm. I am satisfied that on the evidence available there was no relevant evidence that would have suggested that AA was likely to end her life on the evening of 15 March or the morning of 16 March 2009.

There is one issue of concern as to the actions of the Department of Corrective Services in respect of the period between AA being locked up on 15 March and found deceased on the 16th. Within each cell there is what is called a knock up facility.

This is a manner in which inmates who need urgent assistance can communicate with prison officers whilst they are locked in their cells. It is obvious that there must be a need for an inmate to so communicate in the event of a problem occurring such as a medical problem. The evidence is that there was some use of the knock up facility by AA during the relevant period.

Unfortunately, the evidence that has been able to be obtained in preparation for this inquest has not been able to tell us what it was or why it was that AA used that facility because although the use has been identified, it has not been possible or able to identify the officers of the department who responded and not having been able to identify the officers who responded we do not know - there's no evidence available to let us know what it was that she used the facility for.

Now, of course, these knock up facilities can be used for proper purpose or abused. An inmate - and I am not speaking about AA on this occasion, an inmate could use it for the purpose of annoying prison officers or generally speaking for improper purposes. Mr Saidi in his submissions opined the possibility of inmates using it to order pizzas. Now, that is I suppose possible to try and order pizzas but the real use of such a facility is in case of emergencies. We don't know why AA used the knock up.

It may well be that it was for an innocent purpose. It may well be that it was for an important purpose, we just don't know. It seems to me that that is an area in which there is relevant evidence, which could not be provided to the inquest because readily available facilities should be able to identify uses of the knock up even if that is manual.

The department's principal investigator has recommended that the use of the knock up be recorded and that's an obvious solution to the problem.

Had this been recorded on this occasion we would know whether or not AA made any indication that suggested that she had become suicidal. It may well be that she used it for an altogether different purpose and we wouldn't have been any the wiser, we just don't know.

It seems to me that the recommendation of the principal investigator that the use of the knock up facility by inmates be recorded is a proper and commendable one and because the system that was in place by the department did not ensure that relevant evidence was available to the inquest.

I propose to endorse that recommendation and make a recommendation in similar terms in accordance with s 82 of the Coroner 's Act.

A second issue of concern in this matter, of course, is the fact that AA was able to use what was at hand to create the resources necessary to self-harm. She used bedding material to create the ligature and use the bed that she was provided as part of that process. It is acknowledged and I acknowledge it that over the years the Department of Corrective Services have responded to numerous recommendations made by Coroner's that hanging points and the use of Corrective Services' furniture which can become available to be used as hanging points or in other ways used to self harm have been identified and considerable efforts have been taken to ensure that furniture is or cannot be used to self harm.

The furniture in question in this matter was furniture, which was specifically designed to try and overcome those problems, and the previous State Coroner had been involved in that process. Whilst acknowledging that the efforts have been made, it is clear that in this case there has been a flaw identified. The principal investigator's report has made suggestions and those suggestions are further developed in exhibit 4 before me that there be certain modifications of the relevant furniture. I would endorse that recommendation. The identification of the floor is not a criticism of the department because it is acknowledged that even with the best intentions there are situations, which result in equipment being used not in the way that they should, or it should.

I recognise the actions, which are being taken by the department, and I commend them for that but I do not think it is necessary for me to make a recommendation in accordance with s 82 in respect of that issue.

It was acknowledged by Mr McLachlan who appears for the family of AA that there were no matters which identified the possibility of her intentionally self harming but he has submitted and I should make a recommendation that in cases such as AA, that is persons who have a transgender identification when they are brought in to custody and until such time as their classification assessment has been completed they should be placed in an observation cell. Mr Saidi appearing on behalf of the department submits that such a recommendation would not be appropriate.

In this and other inquests, I have become familiar with the environment of an observation cell. The design of such a cell is to ensure that every action of an inmate is able to be and indeed is observed. There is thus as such a total lack of privacy for the inmate. Inmates are men and women who deserve the same privacy that an ordinary member of society is entitled to and that privacy should be limited only when there is good reason to do so.

Mr McLachlan has submitted that in this case the good reason is that the assessment or the classification of AA had not been completed and it may well have been that something more could have been discovered during the classification process that would have identified a possibility of intentional self harm and had she been placed in an observation cell she would have been less able to take the action that I'm satisfied she did.

The approach that I have taken in previous inquests and the recommendations that I have made in this regard is that an inmate should be treated using the same principles that a person who is not in custody is treated, that is where a person has - that a person should not be placed in an observation cell unless they would be placed in a similar situation were they to be admitted to a hospital for mental health reasons.

If a person is identified on admission to a hospital as being at risk of self-harm, a variety of actions can be taken to ensure that the risk is mitigated. A similar principle in my view should be adopted by Department of Corrective Services and in previous inquests I have made that recommendation.

In this case, applying that principle to AA, there was nothing to suggest that she had mental health issues or was at risk of self-harm. In those circumstances, it would seem to me inappropriate for the Department of Corrective Services to simply because she was transgender to place her in an observation cell with the consequent loss of her privacy.

In those circumstances, I do not consider it appropriate to make the recommendation that has been sought.

One of the issues which must be identified an examined is the manner in which the department had responded to AA's transgender identification. The evidence before me is that at the time of AA's being brought into custody the Department of Corrective Services had a policy as to the management of transgender inmates and I am satisfied that there was substantial compliance with that policy. I also note the evidence before me that that policy is currently the subject of review, however, noting that, it appears to me appropriate not to make recommendations concerning that policy and I do not intend to contribute towards the review of that policy.

On the evidence available to me, as I have said, there was substantial compliance with the policy by the department in dealing with AA and there is nothing before me to suggest that any failure of the department in this regard in any way contributed to her death.

The loss of any person to suicide is a tragedy. It is a tragedy for, of course, the person who has died. They lose their life, they lose the opportunity of their future contributions to society and their future well-being. It is also a tragedy for those who they leave behind and society in general. It must be regretted but it also must be acknowledged that some persons in some circumstances form the view that suicide is the only way in which they can respond to the situations that they find themselves in.

Clearly, AA reached that position. On the evidence available to me, it would seem that either she reached that position and then in a relatively calculated way set about acting to end her life or did so on the spur of the moment having reached a point where she was unable to cope with the situation that she was in.

I do not think that there was anything, which the Department of Corrective Services could have reasonably done which would have prevented this tragedy occurring.

There is one issue, which needs to be dealt with in conclusion, and that is in the interviewing of a number of the fellow inmates one of them suggested that the prison officers acted too slowly in trying to protect or seek to revive her. The evidence does not support the suggestion that faster action would have made a difference. The evidence is that at the time the cell was opened, AA was deceased and had been for some time. That allegation appears to be not substantiated.

Formal finding:

I find that AA born 23 February 1975 died between 3.30pm on the 15th March 2009 and 6am on the 16th March 2009 at Silverwater Correctional Centre, Silverwater the cause of his death asphyxiation whish occurred as a result of him hanging himself with the intention of ending his life.

Recommendations:

I make the following recommendation in accordance with s 82 of the Coroner 's Act (2009) to the Commissioner of Corrective Services that where an inmate uses a knock up facility such use and the Corrective Services' officer response thereto be recorded and such recordings thereof be retained for an appropriate period.

5. 725 of 2009

Inquest into the death of Tut Nyal at Silverwater Correctional Centre on the 17th March 2009. Findings handed down by Deputy State Coroner MacMahon at Glebe on the 8th September 2011.

Tut Nyal was born in South Africa on 1 January 1985. On 9 February 2009 the Parramatta Local Court refused him bail following him being charged with the offence of robbery armed with an offensive weapon.

Following his bail refusal he came into the custody of the Department of Corrective Services (DCS). He arrived at the DCS Metropolitan Reception and Remand Centre (MRRC) at Silverwater at about 7.40pm on 9 February 2009.

On 17 March 2009 at the midday 'lock in' in Pod 2 D Block at the MRRC Mr Nyal was reported missing. A search ensued and some ten minutes later he was found in cell 68 of D Block Pod 2 hanging from a piece of torn sheet which was connected to a fire sprinkler located in the ceiling of the cell.

Mr Nyal was placed on the floor and cardiopulmonary resuscitation (CPR) was commenced. Justice Health and Ambulance Paramedics were called and provided assistance however Mr Nyal was unable to be revived. He was subsequently declared deceased.

Jurisdiction and function of the Coroner

Section 81(1), Coroner's Act 2009 (the Act) sets out the primary function of the Coroner . 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 that a Coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate 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. It is not the role of the Coroner to attribute blame.

Because Mr Nyal was in the custody of DCS at the time of his death sections 22, 23 and 27 of the Act are also applicable.

The effect of these sections is 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 former State Coroner, Magistrate Kevin Waller, has explained the reason why an inquest is mandatory in the case of such deaths in the following terms:

"The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached the laws, owes a duty to those persons of ensuring that their punishment is restricted to this loss of liberty, and is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentence. The rational 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 satisfied the community that deaths in such places are properly investigated."

Section 81(1) Findings:

The findings to be made in accordance with Section 81(1) of the Act were not matters of contention in the inquest.

Dr Condon declared Mr Nyal deceased at the MRRC at 12.25pm on 17 March 2009 and his brother-in-law, Daniel Nyal, identified his body on 18 March 2009. Following his death Dr Van Vuuren, a forensic pathologist, undertook an autopsy and she found that the cause of his death was consistent with hanging.

During the course of the inquest evidence from CCTV was available that showed Mr Nyal was locked into cell 68 at 10.26am on 17 March 2009 and that no one entered or left the cell until 11.41am when Corrections Officer Sutherland entered the cell and found Mr Nyal.

Having regard to the evidence available I am satisfied that I am able to make the following findings in accordance with Section 81(1) of the Act:

Section 75(6) Order:

I have found that Mr Nyal's death was self-inflicted. The provisions of Section 75(5) therefore apply. That section prohibits the publication of a report of the proceedings unless (and to the extent that) the Coroner holding the inquest makes an order permitting the publication of such report.

In this case there are two competing public interests. The first, recognised by the Parliament in enacting the prohibition on the publication, is the need to be sensitive to the pain that a family will experience when a loved one takes action that results in the ending of their life.

The second public interest, recognised by the Parliament in requiring all deaths in custody to be the subject of an inquest conducted by the State Coroner or a Deputy State Coroner, is the need to ensure that persons in custody are not, as Magistrate Waller described, the subject of *"ill-treatment or privation"* and that the cause of their death is not contributed to by the conditions of their custody.

In this case the family of Mr Nyal recognised the importance of the public interest in the public examination of his death and did not object to the publication of a report of the proceedings. In the circumstances I am satisfied that a report of the proceedings should be allowed without restriction and in accordance with Section 75(6) of the Act I make an order allowing the publication of a report of the proceedings without restriction.

Issues examined at Inquest.

As outlined above the reason why the Parliament requires that an inquest be conducted into all deaths that occur whilst the deceased is in custody is to ensure that the punishment that a prisoner receives is the loss of their liberty and is *"not exacerbated by ill-treatment or privation"*.

The police investigation of the death therefore examines the circumstances thereof and the history of the incarceration so as to determine whether or not this is the case. In Mr Nyal's case although it was clear that his death was due to his own action the investigation identified a number of issues that became the subject of close examination at inquest.

It was necessary to determine whether or not the issues identified contributed to the occurrence of Mr Nyal's death when it occurred and whether or not the circumstances gave rise to the need to make recommendations pursuant to section 82 of the Act.

Those matters can be summarized as follows:

Was it appropriate to allow Mr Nyal to be released from the occupation of a safe cell on 17 March 2009, and did his being placed in cell 68 rather than cell 81 of Darcy Pod 2 contribute to his death in any way?

Appropriateness of release from safe cell:

It is without doubt that Mr Nyal was a man who suffered from serious mental health issues. It is not necessary for me to outline the details of his mental health history other than to note that before entering custody he had been the subject of multiple hospital admissions for mental health reasons and that there was a history of intentional self-harm.

In addition, in 2003 and 2004, whilst in custody, Mr Nyal was identified as being a person at risk of self-harm and at times found to be delusional and suffering from psychosis. On 19 December 2003 also whilst in custody Mr Nyal attempted to harm himself by hanging.

On 2 June 2004 Dr Andrew Ellis, a forensic psychiatrist, assessed Mr Nyal and concluded that at that time he met the diagnostic criteria for Schizophrenia Paranoid Type.

On 9 February 2009 when Mr Nyal re-entered custody he was still experiencing mental health difficulties and the subject of a Community Treatment Order.

In accordance with normal procedures Justice Health undertook a mental state assessment assessed and having regard to his mental health history and his circumstances at the time identified him as being at risk of self-harm. As a result of this initial assessment Mr Nyal was required to be placed in a safe-cell until cleared.

On 11 February 2009 Dr A. L. Martin, a psychiatric registrar attached to Justice Health, undertook a full psychiatric assessment of Mr Nyal. Following that assessment Mr Nyal was transferred from the safe-cell to a cell in the Hamden Wing – a mental health wing.

On 15 February 2009Mr Nyal refused to take his medications as prescribed and threatened to slash himself if he could not smoke. He also said that he had a razor. As a result he was once again returned to a safe cell.

On 16 February 2009 Dr Martin reassessed Mr Nyal again. Dr Martin recorded that Mr Nyal's mental state had remained unchanged since his admission and that there was *"some evidence of delusional thinking but that he was not acting on it currently".* He was once again cleared from remaining in the safe cell.

Subsequently Mr Nyal's behaviour was the subject of some difficulty. He constantly used the "knock up" system to ask that he come out of his cell for a cigarette. This led, on 17 February 2009, to a conference between Dr Martin and Senior Assistant Superintendent Woods, the Area Manager of Mental Health Services.

Mr Woods had concerns for Mr Nyal's safety if he were to be transferred to the main gaol. Mr Woods' concerns were described in the following terms: *"if he gets transferred to the main gaol because of his annoying behaviour he is likely to be at risk of harm from other inmates."*

Following this conference Mr Nyal was approved for placement in the Darcy Pod whilst awaiting a bed in the Hamden Unit, as already mentioned, was a mental health facility within the MRRC. He was subsequently transferred to the Hamden 17 Pod of cells.

The above outline is not meant to be a detailed analysis of Mr Nyal's mental health state or the interaction between Mr Nyal and those responsible for his mental health care whilst in custody. It is sufficient however to show that Mr Nyal was a vulnerable person who was at risk of self-harm and that if, his time in custody was not going to be classed as *"ill-treatment or privation,"* it was necessary for DCS and Justice Health services to recognise and respond to his identified vulnerability.

At about 7.20pm on 13 March 2009 whilst in his cell in the Hamden 17 Mr Nyal contacted the correctional officer on duty through the "knock up." I accept that the following conversation then occurred. Mr Nyal said*: "Chief, I am feeling suicidal. I don't feel right in the head, I want to go to Darcy."* As a result of this he was approached in his cell and asked: *" Why do you want to hurt yourself?"* He replied: *" I don't feel right in the head, if I can't go to a safe cell in Darcy, then I am going to set my cell on fire."* Mr Nyal was subsequently transferred to a safe cell in the Darcy wing of the MRRC.

Once an inmate is identified as being at risk and transferred he is required to be assessed by the Risk Assessment Intervention Team (RAIT). The RAIT is required to review the inmates' circumstances and the inmate is required to remain in the safe cell until cleared by the RAIT.

The RAIT consists of three members. The Justice Health member is required to be a qualified mental health nurse. There is also a DCS correctional officer at or above the rank of Assistant Superintendent and another person from what could be identified as being DCS welfare services. That person can have a variety of qualifications relating to psychology, welfare or drug and alcohol issues.

Following Mr Nyal being returned to the safe cell a RAIT was formed to assess his risk of self-harm and prepare a plan for his future. That team consisted of Acting Assistant Superintendent Trevor Clarke, Specialist Psychologist Amanda Cutajar and Mental Health Nurse Lynn Keast. The record of the RAIT's consideration was available during the inquest and Ms Cutajar and Ms Keast each gave evidence.

Ms Cutajar and Ms Keast in giving their evidence outlined their qualifications training and experience. They were both highly qualified and experienced in their respective fields. They both had extensive experience in assessing inmate risk of self-harm.

Ms Cutajar's evidence was that the RAIT first reviewed the information that was available from the DCS and the Justice Health files. After that Mr Nyal was interviewed. Ms Cutajar's conclusion was that during the course of the interview and the examination of risk factors evident at the time Mr Nyal presented stable in mental state.

She said that he engaged well, was communicative and cooperative and was logical and sequential throughout the interview.

Mr Nyal also stated that he had no intention to self-harm. Ms Cutajar did not consider that it was necessary for Mr Nyal to remain in a safe cell.

Ms Keast's evidence was similar to that of Ms Cutajar. Ms Keast in her assessment of Mr Nyal did not find any evidence of psychotic symptoms. She also did not consider that it was necessary for Mr Nyal to remain in a safe cell. Ms Keast was most definite in her evidence that if there was any concern by team members as to whether or not a person should be released from safe cells the approach was to err on the side of caution. In Mr Nyal's case in her opinion there was no such doubt.

Following the interview the RAIT recommended that Mr Nyal be released from the safe cell, that he be returned to the Hamden Pod when a cell became available there and that he be placed in a cell by himself. Mr Nyal remained in the safe cell until 17 March 2009 when he was transferred to a cell in the Darcy Pod awaiting a cell in the Hamden Pod. I accept, and it was not a matter of controversy, that cells in the Darcy Pod were of similar design to those in the Hamden Pod.

Counsel for the family of Mr Nyal criticised the decision of the RAIT to allow Mr Nyal to be released from the safe cell. It was suggested that the RAIT process failed Mr Nyal. Before dealing with this submission it is necessary to have some understanding of conditions of the safe cell.

The purpose of the safe cell is to ensure that an inmate who is at risk of self-harm is inhibited from doing so. As a consequence the inmate is restricted in the personal possessions that he is allowed to retain, has limited clothing, is provided with limited cell furniture and is the subject of regular visual monitoring. The facility is designed to ensure that the inmate does not have available to them material that may be used to self-harm and that if they take other action to hurt themselves it is discovered and prevented. Extended occupation of the safe cell would be, in itself, counter productive to a persons' mental health and thus must be used only when it is necessary in the interest of the inmate.

There is no evidence to suggest that the RAIT assessment on 15 March 2009 was in any way defective. The members of the team undertook their task in a considered fashion using their considerable qualifications and experience. Having come to the conclusion that they had they had no choice but to recommend that Mr Nyal be removed from the safe cell. To have not done so would have been completely inappropriate.

To suggest that the RAIT process failed Mr Nyal simply on the basis that he subsequently self-harmed cannot be sustained.

I am satisfied that the members of the RAIT team undertook their duties in a professional and competent fashion and any criticism of them is unjustified. I am further satisfied that it was appropriate to transfer Mr Nyal from the safe cell when that occurred.

Significance of placement in Cell 68:

Mr Nyal was found deceased in cell 68 of Darcy Pod 2 at 11.41am. This was after he was found to be missing during the lunchtime lock-in of inmates that had commenced at 11.23am. As I have already mentioned the CCTV evidence shows that Mr Nyal was locked in that cell by SCO Loloa at 10.26 am.

SCO D'Costa was the officer in charge of Darcy Pod 2. It was his evidence that in his discussion with SCO Loloa that morning he directed that Mr Nyal be placed in cell 81 of the Pod. Mr Nyal being declared missing appears, in part, to have resulted in him being locked in cell 68 and not cell 81. Both SCO Loloa and SCO D'Costa gave evidence at inquest. Both gave their evidence in a straightforward way and I have no reason to think that each were not doing so in a truthful way or were not were seeking to assist the inquest.

SCO Loloa's evidence was that in his discussion with SCO D'Costa he was told to place Mr Nyal in cell 68 and that is what he did. SCO D'Costa's evidence was that he told SCO Loloa to place him in cell 81 and not cell 68. The CCTV evidence that shows SCO Loloa entering the Pod and taking Mr Nyal directly to cell 68 would support SCO Loloa's version. The fact that the OIMS records were updated to show that Mr Nyal was in cell 81 would support SCO D'Costa's intention to place Mr Nyal in cell 81.

On balance I am satisfied that it is more likely that SCO Loloa is correct and that SCO D'Costa was mistaken. SCO D'Costa was short staffed on 17 March 2009 and it is likely that the additional work that he was responsible for may have resulted in his confusion. The more important question that arises from this however is whether or not the fact that Mr Nyal was locked in cell 68 rather than cell 81 in any way contributed to his death?

The evidence of the DCS investigator Peter Wallace was that the difference between cell 68 and cell 81 was that cell 68 was designed to accommodate two inmates whilst cell 81 was designed to accommodate one inmate. Apart from this they were similar and relevantly each had fire sprinklers installed in the cell. It was the fire sprinkler that Mr Nyal used as a hanging point. Indeed it was Mr Wallace's evidence that having examined the two cells it was his opinion that cell 81 in fact had more hanging points than did cell 68. In terms of the availability of a hanging point for an inmate to use I am satisfied that placing Mr Nyal in cell 68 rather than cell 81 was not materially contribute to his death.

The further question that arises from Mr Nyal's cell placement is whether or not if he had been placed in cell 81 might he might have been located sooner and might his death have been prevented?

I do not think that this question can be answered one way or another. On the evidence available it is not possible to establish when Mr Nyal took the action that resulted in his death. As mentioned he was locked in the cell at 10.26am and he was found at 11.41am. His actions occurred at sometime during that 75-minute period. It was not until after the lunchtime lock-in commenced that it was noticed that Mr Nyal was missing. That commenced at 11.23am.

By that time Mr Nyal had been in the cell for 57 minutes. It may have made a difference but equally it may be that Mr Nyal's actions occurred well before that time.

17 March 2009:

Following the recommendation of the RAIT on 15 March 2009 that Mr Nyal return to the Hamden Pod he remained in that cell until the morning of 17 March 2009. There is no evidence to suggest that anything occurred during the intervening period that would have suggested his risk of self-harm had returned.

On 17 March 2009 Mr Nyal was transferred from the safe cell-to-cell 68. To a very considerable extent by the use of CCTV records we were able to observe Mr Nyal's actions that morning. There is nothing in his observed actions that would suggest concern. All inmate telephone calls are recorded. Mr Nyal made a telephone call to his family on the morning of 17 March 2009. That call was recorded and played during the inquest.

There was nothing in the subject of the conversation or the tone of that call that suggested any concern for Mr Nyal's well being. Indeed it was the evidence of his family that Mr Nyal's actions were unexpected. I agree with his family and am satisfied that Mr Nyal's death at the time it occurred was unexpected. On balance it seems to be more likely that once Mr Nyal was locked in cell 68 Darcy Pod 2 on 17 March 2009 something happened that resulted in an impulsive action by him that led to his death.

I am satisfied that there is no evidence available that would suggest Mr Nyal's death was contributed to by the actions or inactions or DCS or Justice Health staff or the conditions of his incarceration. His death, nonetheless, is a tragedy.

Section 82 Recommendations:

I have already outlined the circumstances in which a Coroner has jurisdiction to make recommendations. In this case as, already mentioned, Mr Nyal used the fire sprinkler that was in the cell in which he was placed as a hanging point. Its availability was thus a contributing factor to his death. Coroner's, including myself, in previous inquests have identified that the availability of hanging points in prison cells is a significant issue for persons in prison who are vulnerable and may take impulsive actions that can lead to their death or injury.

Available at inquest was evidence of the actions of DCS following coronial recommendations made following the inquest touching the death of Stephen Robert Allan.

That evidence, which I accept, was that since 1997 no correctional centre has been built or been the subject of refurbishment that fit fire sprinklers in cells. The DCS is to be commended for this decision.

The removal of fire sprinklers in cells would, of course, be of benefit to future inmates who are at risk of self-harm. It appears to be the policy of DCS that over time this will occur. It is therefore unnecessary for me to recommend that this occur.

Counsel for the family of Mr Nyal have submitted that I should make a number of other recommendations arising from the examination of the circumstances of Mr Nyal's death.

A Coroner in deciding whether or not to exercise his or her discretion to make a recommendation in accordance with Section 82 of the Act has to take into account the circumstances of the death that is the subject of the inquest and the evidence available as to the response of the government department or agency to whom the recommendation may be directed. In the case of Mr Nyal I have had the benefit of the report and recommendations of the DCS investigator Peter Wallace.

Mr Wallace undertook a detailed investigation of the circumstances of Mr Nyal's death from the perspective of the DCS. That perspective, because it deals with organisational and other matters internal to the DCS, can in some ways be wider than the matters that the police investigation on behalf of the Coroner would examine. Nonetheless the recommendations of Mr Wallace were helpful in determining if recommendations ought be made by me.

Counsel submitted that a recommendation should be made that the composition of the RAIT be reviewed. The making of such recommendation was opposed by DCS. Counsel for the family suggested that having a DCS officer on the team who was not mental health trained meant that inmates were not receiving a mental health treatment regime that was equivalent to that which would apply in the community.

As I have previously made clear it is my view that the mental health care of inmates ought, subject to the characteristics of the corrections environment, be equivalent to that available in the community.

In this case however there is no evidence available to suggest that on 15 March 2009 the presence of a DCS officer on the RAIT who was not mental health trained in any way affected the decision of those members of the team who were qualified to make the decision as to whether or not Mr Nyal was at risk of self-harm. In such circumstances I do not consider that there is a basis for me to make such a recommendation.

Counsel for the family submitted that a recommendation ought be made in accordance with Section 82 (2) (b) referring the actions of a number of named DCS officers to the Commissioner to consider disciplinary action. Such a recommendation, although available to a Coroner, should be used sparingly. Disciplinary action of employees is a matter for an employer not a Coroner.

During the course of an inquest however evidence may become available that ought be brought to the attention of an employer that may give rise to such consideration. In my view there is nothing that arose in the evidence in this matter that would suggest that such action be taken.

Counsel for the family also submitted that a number of other recommendations be made. Having considered the matters suggested I am not convinced that it would be appropriate to make the recommendations suggested. In the circumstances I do not propose to make any recommendations pursuant to Section 82 of the Act.

Formal Finding:

Tut NYAL (born 1 January 1985) died on 17 March 2009 in cell 68 Darcy Pod 2 at the Metropolitan Remand and Reception Centre, Silverwater in the State of New South Wales. The cause of his death was hanging which occurred as a result of actions taken by him with the intention of ending his life.

6. 832 of 2009

Inquest into the death of AA at Malabar on the 27th March 2009. Finding handed down by Deputy State Coroner Mitchell at Glebe.

AA lived with his parents at Little Bay. He grew up in the area and joined the NSW Police Force on 29 April 2005. He was attached to Eastern Suburbs Local Area Command. He was popular with his commanders and superiors and also with his fellow junior officers and the extensive evidence, which has been gathered, describes him as gentle, sensitive, honest and intelligent. Almost all the witnesses who worked with him describe him as a proud and private person but, clearly, he had an ability to endear himself to his colleagues, particularly with female staff members, some a little older than he, such as Patricia Bulpit and Sergeant Jennifer Cracknell who told the inquest that they had been very fond of him. Several of his superior officers such as Sergeant Craig Hansen, his extremely experienced team leader, had quite a bit of time for him.

AA seems to have had a particular ability to make friends, both police and civilian, and his closest male friend was his first cousin, XX whom, in his final text, he described as *"…my brother and the best mate I've ever had..."*

Mrs. AA, his mother, told the inquest that AA was a sensitive, thoughtful young man, very articulate with good communications skills. He made good friends easily and people liked him. Mrs. AA said AA was a very engaging person. Evidently he was highly intelligent having been Dux as well as Vice-Captain of his secondary school and Captain of his primary school. In his final year at school, he won a number of academic prizes including the *Archbishop of Sydney's Prize for Student Excellence. AA* enjoyed swimming, football and, perhaps especially, golf and he and BB were passionate about repairing and racing cars. At school he had been a debating champion.

AA's mother told the inquest that he had a strong sense of loyalty, integrity and of self-worth and among the best compliment she could pay him was that he had an ability and a strong desire to serve others and she sees that as one of the reasons, perhaps the principal reason, he joined the Police Force.

AA had been in a long-term relationship with a woman by the name of AA girlfriend and that relationship ended in about December 2007 or early January 2008 leaving him feeling a bit sore and sorry.

In about March or April, 2008 he and Cst X, then a probationary constable, realised that they were attracted to each other and commenced a relationship, characterised by some hesitations and false starts as each tried to be honest and open with the other, which continued, at least in terms of mutual care and affection, right up until his death. AA's relationship with Cst X seems to me to have been supportive, truthful and affectionate.

I agree with Dr Barron that, if AA found some frustration in sometimes being unable to further the relationship as far and as fast as he might have liked, she remained supportive and an important source of solace for him. AA loved his job, loved the police, loved his family – parents, sisters, nieces and nephews and he loved his friends and, not surprisingly, he was greatly loved in return. Clearly, he will not be forgotten.

Stigma

Detective Sergeant Graham, the *Officer in Charge* is a police officer of over twenty five years service, a former executive officer in the *Police Association* and an extremely thoughtful and perceptive policeman. His lengthy statement in the Coronial Brief, like his *Critical Incident Investigation Report* is thorough, detailed and enlightened.

And his evidence given at the inquest, particularly when commenting on the recommendations he made in that report and when dealing with predicament presented to the *NSW Police* by officers, particularly young officers, vulnerable to a mental health issue, was very helpful indeed. Mr Graham spoke of *stigma, which* is a long-standing and deeply entrenched factor in the attitude of many police officers, young and old, in many police forces here and overseas. *Stigma* may attach to a number of matters including sexual orientation, racial background and, relevantly to this inquest, mental ill health.

Mr Graham believes that the phenomenon of *stigma* in police forces has its origin in the stressful nature of police work, the fact that, in many cases, a police officer finds himself/herself with no other potential employer than the police force of which he or she is already a member and, I think, the close, collegial nature of the police force and the degree to which police officers are set apart from their fellows in the general community.

In her statement on behalf of the police Association, EXHIBIT 7, Julie Carroll dealt with the phenomenon of *stigma, which* she sees as endemic in the police community.

She wrote, *"There have been many improvements… …The prevalence of psychological injury and the need to seek help has been acknowledged within the NSW Police Force however the stigma attached to psychological illness continues."*

Mr Graham told the inquest that these are the very factors – danger, isolation and exposure to sometimes dreadful human misery, which, in some instances, are inclined to prompt mental health problems and he said that police *culture* had long expected that police men and women will be or, at least, ought to be impervious to such things.

And so, he told Mr Gormly, many police officers will go to great lengths to hide mental health problems or emotional distress. A police officer, feeling seriously damaged, may decline to disclose his distress to anybody – friends, spouse, doctor, counsellor or superior officer. Some may find solace in alcohol and others will prefer to shoulder the burden silently and sadly while it weighs them down and sometimes destroys their careers, their effectiveness, their happiness and even their lives.

According to Mr Graham, the *culture* is changing and things are improving. It seems to me that very impressive progress has been made in this area but still many officers struggling to cope will prefer to keep silent rather than disclose their predicament to those who might help them – medicos, psychologists, Counsellors or colleagues who might be required to report the matter to police commanders. But, he agreed with Mr Gormly, this constitutes a huge problem for police forces because it increases their difficulty in identifying who has a problem and who needs help.

Privacy and *pastoral care*

Those who command *NSW Police* rightly recognise that *"mental illness and guns are a poor mix"* but, for the reasons I have outlined, there is only limited value in relying on a policy-imposed obligation of police officers to disclose any condition or medication likely to impact on their work performance or on relying on them voluntarily to disclose their difficulties to their superiors and so, as Mr Graham explained, if an officer is suspected of having a mental illness, senior officers will separate that officer from his/her gun which means placing the officer on restricted duties – at least to allow the position to be clarified and an assessment to be undertaken.

To do otherwise would be to threaten the public, the police officer involved and other members of the police service. Mr Graham told the inquest that what threatens that process is the issue of privacy.

The issue is obvious. People, including people who happen to be police officers, are entitled to feel that a range of issues - family issues, issues of sexual orientation, financial issues and health issues among them, will remain private. But the rational administration of a big employer such as a police service will struggle to reconcile the right to privacy with the need for proper administration and Mr Graham provided the inquest with a pointed example.

Evidently, it used to be the rule that, in order to protect the privacy of a frequently absent police officer, when medical certificates were called for in order to explain absences from work, those certificates were required not to disclose the *reasons* for the absence from work. It was sufficient that a medical practitioner certify that there *was* a reason. But this proved to be unsatisfactory so that, since 15 December 2009, privacy considerations have deferred to efficient administration and reasons must be disclosed. But, Mr Graham reported, this change has had the effect of dissuading some officers from seeking medical advice and assistance for conditions whose existence they would prefer to remain confidential.

So, again, privacy considerations, important in themselves, have proven to be an obstacle to senior police officers in exercising *pastoral care* of officers needing help.

Early signs of trouble

In AA's case, the evidence demonstrates that, in the period July, 2007 until March, 2009, there were signs and indications that he had been experiencing difficulties with depression and that, as such, his mental health was deteriorating although, as Mr Graham pointed out, few people could have seen the whole picture. By late July 2007, there were absenteeism issues although laziness or lack of interest in his work seems to have been quite inconsistent with what I now know of AA.

That he was a good worker, respectful of and respected by his superiors, good to work with, good at his at job and very proud to be a policeman is widely recognised.

On 15 October 2007, AA was spoken to about his absences from work so it is clear that his superiors had noticed them. Then, on 26 June 2008, Inspector Christine George put him on *mandatory certificates* for 3 months. That meant that, for the next three months, AA would not be entitled to any sick leave (as opposed to recreational leave) without a medical certificate.

While Mr Graham describes Inspector George's action in this regard as *"giving AA a soft option,"* it is reasonable to see the event as another indication that AA's difficulties were accelerating and increasingly being noticed by his superiors. But, as Mr Graham acknowledged in answer to Mr Gormly, even at that point AA was careful not to be too frank about his problems and, in doing so, he was acting quite normally given police *culture* at the time. Indeed, Mr Graham pointed out that AA would have been quite right to feel that, were he to admit to mental health problems, he might be disadvantaged, stigmatised by his peers and his career put at risk.

Inspector Malcolm Smith

Within days of taking over as the commander of *Eastern Suburbs Local Area Command* in December, 2008, Superintendent Jenny Hayes initiated a detailed assessment of the health and welfare and the effectiveness of those under her command and AA,

who had been identified as somebody whose absences from work – 13 days off over a twelve month period including 8 days for which no medical certificates had been presented, was suggested as a person worthy of enquiry.

By direction of the commander, AA was interviewed by Inspector Malcolm Smith, the *human resources manager* for the *ESLAC* on 3 December 2008. Mr Smith described him as *“avoiding”* and *“defensive.”* Mr Smith reported that when asked, *“Is there anything troubling you?”*

AA had taken offence and answered that he didn’t need any help. Sgt. Graham’s view is that AA’s response to Mr Smith’s inquiry, if correctly reported, was *“pretty typical”* of young officers in similar situations and, whether prompted by a sense of vulnerability lest his *secret* be disclosed or by lack of insight into the nature of his predicament, exemplifies a difficulty of the police service in keeping an eye on the health and welfare and fitness for duty of its officers.

Sometimes, high absenteeism will indicate laziness or a lack of interest in the job but sometimes, as in AA’s case, it may be the only outward sign of a mental illness available to superior officers – until a catastrophic event. In AA’s case there were other signs of depression, arguably many other signs, but as Mr Graham put it, nobody was privy to the *whole* of the picture so nobody was able to prevent the catastrophe.

Inspector Smith ordered AA to see the *Police Medical Officer* and put him on *mandatory certificates* for 6 months. Sadly, for the reasons I have expressed above, it is likely that this action did little to prompt AA to *open up* and seek help regarding his depression. Instead he may well have regarded Mr Smith’s intervention as harsh and punitive, reinforcing his resolve to keep his problems to himself. After all, as Mr Graham said, to risk *stigma* and the possibility of career disadvantage *“is a big unknown for a young fella.”*

But it is difficult to know what else Mr Smith could have done. AA’s unexplained absences from work indicated a problem and were of an order that suggested the problem might have been a serious one. AA himself was unwilling to disclose his difficulties and kept his own counsel and Mr Smith’s choices were to ignore the problem or to seek medical advice, which might give him some idea as to what was wrong and what might be done to assist. I accept that he had AA’s best interests very much in mind.

Dr Verma

So, on 22 January 2009, AA was reviewed by the *PMO* and cleared for full operational duties. This involved the restoration of his gun. Dr Verma is the police medical officer who saw AA on 22 January 2009. Dr Verma told the inquest that his only recollection of the event was that AA was *“quite good looking, quite tall and not prepared to give consent”* to Dr Verma providing a detailed report to superior officers.

AA explained his absences from work as largely the result of some minor ailments but he told Dr Verma that he *“felt a bit down at times.”*

He disclosed the break-up of his relationship with XX in early 2008 and mentioned some other family-related sources of stress including the suicide of a cousin, a sister's self-harm and the estrangement of another sister from the family. Dr Verma thought that AA's absences from work had probably been related to these stresses.

He took AA through a number of *screens* - checklists of factors designed to elucidate a patient's psychological and emotional well being, and conducted a clinical interview. The notes, which he took, are contained in the Coronial Brief. He found no psychotic features.

Dr Verma reported to Superintendent Hayes that AA was fit for operational duties and would be into the foreseeable future. Dr Verma told the inquest that, since the patient's consent to disclose details of his mental state to a superior officer was not forthcoming, he was entitled to provide police commanders with his finding that AA was fit or unfit to return to full operational duties or to some restricted duties, whether on conditions or unconditionally, but, other than that, he was authorised to disclose no information. And that is what he did.

The Coronial Brief contains a copy of the advice which Dr Verma would have provided had AA's consent been forthcoming but, essentially, it would have added little that was new. Dr Verma's draft report, dated 29 January noted his finding that AA did not suffer from any psychological illness and was fit to resume full operational duties and to be restored to his firearm and, although the report added advice that AA should *"use EAP services and seek treatment from his GP as needed"* and *"was encouraged"* to discuss matters with superior officers, the finding was unequivocal and not contingent on that advice being taken. Dr Verma didn't feel that AA had *"a psychological illness"* and, therefore, didn't feel that he had a need to consult a psychologist. Instead, he thought that, during 2008, AA had experienced *"adjustment reactions"* from which, on each occasion, he had made a good recovery.

Dr Verma could find neither a history nor any affect related to depression and he thought that Dr Cotton, AA's previous *GP* might have been mistaken in prescribing antidepressants. So confident was he of that view that he saw no reason to speak to AA's *GP* and would not have done so even had AA had given the necessary consent.

The consent form which was handed to AA at the commencement of his interview with Dr Verma but which he declined to sign recites that "the purpose of this assessment is to determine your physical and/or psychological fitness to work safely as a police officer with regard to yourself, your fellow officers and the public" and Dr Verma confirmed the limited nature of the service provided by the PMO which was to assess but not to treat. Dr Verma, an occupational physician, works only two days per week for NSW Police and the rest of his professional week is taken up within the NSW Fire Brigades where, again, he is restricted to making assessments rather than providing therapy. Indeed, it was in 2007 that he was last engaged in therapeutic medicine when he worked at a rehabilitation clinic. There he dealt primarily with persons physically injured at work although there were some cases of work-related psychological illness.

Even then, Dr Verma was not routinely engaged in prescribing anti-depressant medication. Nevertheless, he told the inquest that he has a "general understanding of the range of anti-depressants on the market."

As a police medical officer, the bulk of his assessments relate to psychological injury and Dr Verma confirmed that he has no qualifications as a psychiatrist or a psychologist. He has never administered the MMPI-2 test and, indeed, would be unqualified to do so. Nor has he studied the test although he has observed other people administering it.

He has never analysed the raw data derived from such a test and, again, he is not trained to do so. As *police medical officers*, Dr Verma and his colleague Dr William Kirby perform much the same duties although Dr Kirby may attend to some additional administrative duties.

When Dr Verma commenced his appointment, Dr Kirby gave him an informal orientation, explaining some of the work a *PMO* is required to perform, but there was no written instruction either from Dr Kirby or from *NSW Police*.

His orientation extended to two days at *City Central Local Area Command* where he observed what was going on and *"some time"* at the *Bomb and Riot Squad* where he observed the highly stressful work there.

In addition, Dr Verma observed a *"Psych Shoot"* which is an exercise in the nature of a *walkthrough* where an officer has fired his/her gun, an object of the exercise being to monitor the reaction under stress of the particular officer. Apart from those matters, I think Dr Verma would agree that most of his experience has been gathered on the job and in his office.

A very large part of Dr Verma's work is assessing whether individual police officers are fit to hold a firearm and whether they should be on full operational duties with a gun or restricted duties without one. To make these assessments, he routinely relies on his clinical interview with the individual officer, the *questionnaire* that he administers to the officer and, where a test such as the *MMPI-2* test is undertaken, the analysis of the test result by the psychologist administering the test. In AA's case, there was no psychological test and no psychologist's advice to inform Dr Verma's findings.

A difficulty under which I perceive a *PMO* labours is that there is no objective standard against which to measure findings and no guidelines as to what *NSW Police* sees as fitness or unfitness and, as far as Dr Verma was able to say, there are no policies in that regard. It is clear and Dr Verma accepts that merely because a police officer experiences some psychological difficulties or exhibits some psychological deficits, one cannot say that he or she is necessarily unfit but there appears to be no guidance as to how tolerant of imperfection the *PMO* should be in passing judgment on an officer's fitness.

Dr Verma said that, should an officer show signs of a psychiatric condition which may or may not be inconsistent with fitness, then the *PMO* will make a decision by taking into account the seriousness of the symptoms, the social context of the officer and whether he has effective supports,

the incidence of alcohol and/or drugs, the officer's engagement with a *GP* or psychologist or other relevant health professional, his or her degree of insight, the impact which medication has had and is likely to have and the likelihood of compliance with a regime of medication.

The fact remains that these are extremely subjective matters and I think there is a need for clear-cut policies and guidelines to assist the *PMO*. As it is, Dr Verna seemed quite unclear as to what were the criteria for the assessment he was called upon to make and seemed to believe that the predominant issue was the presence or absence of a *"diagnosable psychiatric condition."*

The form, which Dr Verma used when he interviewed AA, explores some matters, which I would have thought were likely to be relevant in making the assessment, but omits many others. For instance, there is no reference in the form to whether there has been any change in the officer's attitude towards his firearm and/or his duties and, if there has, why. If an officer shows a disinclination to wear his gun, which Dr Verma suggests is not uncommon, one would want to know what had happened on the last occasion on which he or she had worn it. But matters of this type are missing from the form and indeed, there is only the most oblique reference to guns at all – whether one owns a weapon and whether one goes hunting or causes harm to animals.

The form asks nothing about the officer's use of guns at work and Dr Verma admitted that, in his interview with AA, the matters of guns and of his attitude to his gun and to guns in general were not mentioned. It seems then that, in assessing AA's fitness, Dr Verma was at a considerable disadvantage. He was aware that many young men might tend to down play their emotional problems.

Often they will be too young and inexperienced to recognise that they have a problem or, if they are aware of it, too young and inexperienced to know how serious it may be.

Or they may be brave and resolved to *soldier on*. If they work in an organisation like the police force, they may well be fearful of stigmatization and that their careers may be damaged. Dr Verma agreed that all these factors have a tendency to interfere with the quality of the history presented to the doctor and so it may have been with AA.

The *PMO* can expect to receive some but, if Superintendent Hayes' referrals of AA are an indication, not very detailed information from the senior officer making the referral and, essentially, what the *PMO* gets is largely based on self reporting in interview and, where a psychological test is administered, the police officer's self-reports to the person administering the test. Dr Verma agreed that a *PMO* would be advantaged by receiving input from the officer's *GP*, his work colleagues, superiors, parents, family and friends and from having access to the *GP*'s treatment plan and the officer's sick leave record. But none of these was provided to him.

Dr Verma did not consult a psychiatrist when assessing AA. No psychiatrist is on the staff of *NSW Police* and, although it is not unheard of that a *PMO* will refer an officer to a psychiatrist in private practice, that did not happen in AA's case.

I think a reference by a *PMO* to an outside psychiatrist in the context of a fitness assessment is the exception rather than the norm. Dr Verma made his assessment of AA's fitness with very little personal knowledge of AA and relying largely on his own medical assessment of *no diagnosable psychiatric condition* and, thus, in an area of medicine in which he was a stranger and which is usually the preserve of psychiatrists.

Dr Verma was aware that AA had seen a *GP* at *Malabar Medical Centre*, Dr Cotton in March 2008 and had discussed depression.

Dr Cotton had prescribed *Mirtazon, which* AA discontinued in May 2008. When asked what impact a regime of medication might have on an assessment process, Dr Verma told the inquest that, while the use of anti-depressants is not necessarily inconsistent with fitness to hold a firearm, the use of some medications – particularly psychotropic medications as distinct from anti-depressants, is inconsistent with fitness but he struggled to distinguish anti-depressants from psychotropic medications and to categorise *Efexor* (venlofaxine) as one or the other and he admitted that these matters are really the province of a psychiatrist rather than an occupational physician such as himself.

Having seen and assessed AA, Dr Verma prepared a draft report for Superintendent Hayes, which, for want of consent, he never sent. In that report he described AA as *"fit for operational duties and is unlikely to need any extended periods of absence."* Dr Verma expressed the view that AA was *"likely to have had adjustment reactions in the past from which he appears to have made a good recovery each time"* and that *"the officer does not suffer from any current psychological or chronic physical illness."* In the report he went on to say that AA should *"use EAP services and seek treatment from his GP as needed"* and he was encouraged to discuss any problems he might encounter with superior officers but Dr Verma told the inquest that his opinion as to fitness had not been contingent on that advice being accepted.

Because Dr Verma believed that, for privacy reasons, that report could not be issued, he sent an e-mail to Superintendent Hayes on 22 January 2009 stating in bald terms and without explanation or qualification *"I can advise that (AA) is fit for operational duties and will be into the foreseeable future."*

It is worthwhile to pause and consider the advice, which Dr Verma might have offered Superintendent Hayes.

This was not only that AA was not suffering from any psychological illness but also that he had never suffered from such – merely having encountered some *"adjustment reactions."* As it was, he certified that AA was fit and *"will be fit into the foreseeable future."*

He formed these opinions and made these pronouncements without having spoken to AA's *GP*, his family members, his work colleagues or his superiors, in the face of long standing sick leave issues and in the face of AA's unwillingness to allow him to contact the *GP* and unwillingness to consent to a detailed report being sent to the Commander and in circumstances where he knew AA had faced

and might still face significant stressors. Further, Dr Verma was aware that AA's police superiors did not suspect him of malingering so that they suspected his excessive sick leave as pointing to a medical problem.

And he was aware that his expertise in psychiatric matters was minimal and that the bulk of his data was based on AA's self-reports. His time spent with AA amounted to about one hour and the information, which had been provided by Ms. Hayes, had necessarily been very sketchy. Having those matters in mind, it is not clear to me how Dr Verma could have reached his conclusions and, particularly his prognosis.
Dr Verma told the inquest that a basis of his conclusions had been that he had failed to find a *"diagnosable psychiatric condition."* Quite apart from the paucity of information with which he was working in a field of medicine in which he was a comparative stranger, it is not clear to me that the presence or absence of a diagnosable psychiatric condition is a helpful concept in making the assessment. He admitted to Mr Gormly that there is an array of debilitating conditions falling short of diagnosable psychiatric conditions where officers might still be unfit and may need significant help by way of advice, support, counselling and perhaps medication.

Some of these people might be described as psychologically vulnerable and, as such, may well be unfit to carry a firearm. Dr Verma admitted that, when he assessed AA, it was clear that he had a variety of such debilitating conditions. And yet, in the report he wanted to send to Superintendent Hayes and in the e-mail which he did send her, Dr Verma made no mention of any of these and his assessment that AA was *fit* and would remain fit hardly takes any of those debilitating conditions into account. He told the inquest that he described as AA as *"fit"* not only because he couldn't find a diagnosable psychiatric condition but also because it seemed to him that AA could rely on significant supports.

I think that two things need to be said about that - firstly that Dr Verma didn't really know very much about the quality of those supports and the awareness of such support persons that their support might be sought or might be needed and secondly that he didn't know whether AA would be prepared to enlist those supports and he had good reason to fear that he might not. To the extent that Dr Verma thought that AA might need monitoring, that was surely inconsistent with the prognosis about fitness into the foreseeable future.

Gathering Difficulties

Between December 2008 and March, 2009, AA took five days sick leave, with a medical certificate, and, on 2 December, 2008, one day of recreation leave for which no certificate was necessary and, otherwise, worked in accordance with his roster.

During that period, his mother was ill and a sister was admitted to *Royal North Shore Hospital* after an apparent attempt at self-harm. There were indications to those close to him that he was facing challenges but outwardly he was coping.

He shed a lot of weight, grew his hair longer and took more care than usual with his dress and appearance but some thought these were good signs that he was taking care of himself. He was smoking heavily – not a good sign, and drinking more than he usually did but these things happen with young men and don't always indicate a serious problem. Occasionally he said things, which, with the wisdom of hindsight, may now be seen as significant – telling his sister "*…nothing is going well for me, my work, family and personal life. I'm so sick of not being happy"* and, again, telling XX *"Everybody thinks about doing it (suicide). I've thought about it…"* but none of these statements seemed as significant then as they do now.

Dr Thew

Dr Thew, AA's general practitioner, has practiced at *Malabar Medical Centre* since 2000 and saw AA on 3 March and 25 March 2009 for depression. His practice has seen AA on various other occasions and he has seen each of AA's parents and three of his sisters and is familiar with the family. He was aware that AA was a police officer and, when he saw him in March 2009, was aware that AA had previously seen a partner in the practice, Dr Chris Cotton, in February 2008 regarding depression. Dr Cotton had prescribed *Mirtazon* and it unclear for how long AA used that medication.

When on 3 March, 2009 AA visited him, Dr Thew had not been aware that had been referred to the *Police Medical Office* and assessed by Dr Verma and, of course, neither could he have known that, on the very next day, 4 March, AA would be sent back to the *PMO* for further assessment. On 3 March, it was clear to Dr Thew that AA was not suffering from a *bipolar* condition. Dr Thew saw nothing to suggest the presence of *mania* and he thought AA was suffering from *melancholic depression*. Dr Thew made that diagnosis having regard to what he saw as a flattened affect with no highs, his view (not necessarily shared by AA's parents) of *"a strong family history"* and AA's reports of diminished performance at work. AA told him that work colleagues had noticed a change in his mood.

Dr Thew was prepared to accept that there may have been reactive features to the depression and he pointed to AA having mentioned the breakdown of his relationship with XX and his sister's illness as *"trigger events"* but he maintained his view that the condition was essentially endogenous. This is a view disputed by the family and, as Mr Gormly of Counsel submitted, *"we just don't know."*

Dr Thew thought that AA's depression was *"significant"* and he prescribed *Efexor XR 37.5mg*, gave him a certificate excusing his absence from work for five days from 3 to 8 March, arranged an appointment for AA to see a psychiatrist, Dr Olav Nielssen (which, in the event, never happened) and asked him to return in a week which he failed to do.

In fact, AA called on Dr Thew for a follow up on 25 March only after Dr Thew had telephoned him to find out how he was getting on. While Dr Thew thought that AA's depression was *"significant,"* he believed, even as late as 25 March, that he was functioning with good supports both at home and at work.

Given his diagnosis, Dr Thew thought that *Efexor* was a more apt medication than *Mirtazon* or *Zoloft* and he was more familiar with it at any event. The reference to *Efexor* in *MIMS* and the product information accompanying the drug contains the warning to *monitor for suicide.* An accompanying risk of suicide is an unwelcome feature of *Efexor* and this is and was quite well known in the community although I have no way of telling AA's state of knowledge on the matter. At any event, Dr Thew seems to have been well versed on the topic and, very cautiously, he prescribed just one half of the minimum dose intending to gauge AA's tolerance before increasing the dose to the suggested minimum dose of 75mg.

Dr Thew admitted that he did not expressly warn AA about the heightened risk of suicidality involved in *Efexor* use although he says that he did counsel him generally about potential side effects.

In his statement, he says that *"I always arrange a follow up consultation and I tell my patients to contact me or another medical practitioner, immediately, if they encounter adverse symptoms from medication or a clinical deterioration."* He told the inquest that, if he did not mention that, on taking *Efexor*, AA might feel suicidal, *"it was implicit."* I doubt that an implicit warning was a satisfactory recognition of the catastrophic side effects which sometimes accompany *Efexor* and it would have been preferable had he given AA a specific and detailed warning regarding suicidality. Dr Thew admitted that, with the wisdom of hindsight, he should have done more to warn AA about the dangers posed by *Efexor* but, by asking AA to return within a week, he was giving himself the opportunity to observe AA's progress and, by arranging an early appointment with Dr Nielssen, he was putting in place an additional safety net.

Perhaps a useful further safety net might have been to warn AA's family that he had been prescribed *Efexor* but that would have required AA's consent, which he might well have withheld. At any event, Dr Thew did not think that the risk were such as to necessitate that course and, as he told the inquest, *"plenty of people on anti-depressants live alone."* And I think he was entitled to place considerable reliance on AA's good sense and apparent willingness to cooperate in therapy.

Superintendent Hayes

On 3 March, 2009, Superintendent Hayes learned that AA had unexpectedly terminated his shift and the duty officer, Inspector George, a friend of the AA family, disclosed to her that AA *"had not been himself lately,"* that a family member had recently died, that he had been losing weight and that *"people were concerned about him."* Ms George impounded his firearm, which was later endorsed by Superintendent Hayes. Another Duty Officer, Inspector Flood, told Ms. Hayes that AA had been depressed.

Accordingly, on 4 March, Superintendent Hayes *"spoke to AA… …about her concerns for his welfare and psychological and emotional ability to carry out his functions as a fully operational police officer"* and she indicated the need to restrict his access to his firearm. AA was distressed but even then was prepared to make only a partial disclosure to Ms. Hayes.

He told her he had been distressed by the attempted suicide of his younger sister and a relationship breakdown with a work colleague and he told her that he had *"other personal issues."*

He told her that he was being treated by his own doctor who had prescribed anti-depressants and that he had made an appointment to see a psychiatrist, Dr Olav Nielssen, and he reminded her that he had been cleared by the *PMO* only a month or so before. But he declined to identify the anti-depressant medication which had been prescribed by Dr Thew or to tell her what those *"other personal issues"* were, failed to provide authority for his *GP* to discuss his situation with her. AA declined his consent to Ms. Hayes discussing his situation with the *PMO* and maintained his stance that he was not comfortable availing himself of counselling from the *Employee Assistance Program*.

In other words, AA was very guarded in what he told Superintendent Hayes and she, in turn, was quite limited in the information she had as to the true nature of his situation.

Doing the best she could, Superintendent Hayes referred AA to the *police medical officer* and removed his firearm but she softened the blow by allowing him to take recreational rather than sick leave until 23 March, 2009 and, to spare him embarrassment, she allowed his firearm to remain in the locker, secured by Inspector Bonello's padlock.

By that means, it was thought, police officers using the locker might not realise that AA's gun had been taken away from him.

Lest it be thought that Superintendent Hayes' actions in removing AA's gun, referring him to the *PMO* and insisting that he take some leave were punitive actions, I am satisfied that on this occasion as on the occasion in December, 2008 Ms Hayes saw her function as not so much to monitor sick leave as to monitor a junior officer's welfare and that she was concerned, not merely to reduce AA's sick leave but to find out what was wrong and to make sure AA got the help he needed. It was not in her mind that AA was taking sick leave when he was not sick or that he was merely shirking.

Having heard her evidence, I do not see Ms Hayes attitude towards AA as punitive. I accept, too, that the primary factor in Superintendent Hayes' decisions to remove his gun and send him back to the *PMO* was, as she assured the inquest, *"for AA's safety and welfare."*

Superintendent Hayes told the inquest that in deciding to remove AA's gun, she believed she had been acting prudently and in his interests. She had suspected a medical problem, which he confirmed during their interview. She sent him off to the *PMO* in the hope that his problem would be identified. She was looking for a way to help him and she told the inquest that, at the time of the referral, she had certainly not decided to put him off work. On the other hand, his separation from his firearm was standard in the circumstances.

Superintendent Hayes' evidence is that the decision as to whether AA should be restored to full operational duties or to restricted duties was a decision for herself as the Local Area Commander. She expected from the *PMO* a purely medical opinion on the basis of which, she would be required to make her decision. She would have wished for more and clearer information from AA himself, from those caring for him including Dr Thew and from the *PMO* but her understanding was that, absent AA's consent, she could not have that and would have to make her decisions as best she could on limited information. She told the inquest that she favors a regime where better and clearer information is available to those who must make the decisions.

When he gave his evidence, Dr Stephen Barron suggested that a police medical officer should make a decision like this but Ms. Hayes maintained that the decision she had to make was properly one for herself as commander. Having in mind the need to respect the chain of command and the diversity of matters to be considered in coming to such a decision, some of which relate to the welfare of others, I respectfully agree with her.

AA went on leave in accordance with Ms. Hayes' proposal. He spent some of his leave in the Blue Mountains visiting his cousin. It is not clear whether he or Dr Neilssen failed to keep their appointment but somehow the appointment was missed.

AA reported to the *PMO* on 11 and 18 March. He may or may not have been entirely frank with Dr Kirby and with the police psychologist, Dr Natalie Shavit, but they pronounced him as fit to return to full operational duties and to have his gun restored to him.

The psychological testing

Natalie Shavit is a psychologist employed by *NSW Police* in the *Health and Wellbeing Unit* of *Workforce Safety Command*. She holds high academic qualifications including Science/Law bachelor's degrees, a master's degree in Counselling Psychology and a doctorate in Clinical Psychology. On 11 and 18 March 2009, AA was interviewed by *PMO* Dr Kirby who, on the second of those occasions, referred him to Dr Shavit. According to Dr Kirby, he spoke to Dr Shavit before hand and *"briefed her on the essentials of the case and my opinion that I felt he was of a stable mental state and suitable for full operational duties."*

Whether sharing his opinion with Dr Shavit before she administered her test is *best practice* is open to doubt. Professor Hayes expressed concern regarding the practice of the *PMO* briefing the psychologist *before* the administration of the test and stressed *"to ensure that the opinions of the two professionals remain independent, especially as the PMO in this case was an occupational physician rather than a psychiatrist."*

In that context, Dr Kirby's evidence as to the closeness with which he and Dr Shavit worked is not reassuring. Dr Shavit then administered the *Minnesota Multiphasic Personality Inventory Test 2 (MMPI-2)* in which AA was faced with over 500 propositions and asked to say whether they were true or false.

Professor Hayes is skeptical as to whether the *MMPI-2* test is the most appropriate test at any event and she sees the test as particularly susceptible to *faking*. In her view, *"faking is most likely to arise in situations where there are substantial incentives for distortion"* which was certainly the case here.

According to Professor Hayes, it is important to administer the test "*in a clinical setting."* The test appears to have been administered without Dr Shavit and AA having had much opportunity to establish a *rapport* which, Professor Hayes says is important *"in order to deflect any supposition that the psychologists was more interested in administering a computer test than understanding a client's needs through face to face interaction."*

AA is said to have telephoned his friend and to have told her that the test was *"crap"* and that he had finished it in 20 minutes but, according to Dr Shavit, it would ordinarily have taken between 60 and 90 minutes to complete and I think AA may have been indulging in a bit of bravado here. The point, though, is that he completed the test and a record of the answers he gave is included in the Coronial Brief.

The *MMPI-2* test includes an instrument designed to enable Dr Shavit to *"validate' AA's* responses which means to check them for internal inconsistencies and, to the extent that they really could be *validated* in that fashion, she did so. Later, Dr Shavit conducted a clinical interview with AA, the principal purpose of which was to corroborate the accuracy of the test results.

Although Dr Shavit agreed with me that no test of this nature is infallible, she satisfied herself on the basis of the validation instrument and her interview that the test results were accurate and she came to the conclusion that, as far as she could tell, AA, while not in perfect psychological health, was essentially *fit*.

By contrast, Professor Hayes' opinion is that *"the MMPI-2 test should be administered as part of a battery of tests rather than as an isolated assessment instrument."*

She does not see the *MMPI-2* test, no matter how faithfully administered and carefully validated, as capable of providing anything more than an indication which would need corroboration in the form of further tests as well as professional assessments before producing a reliable result and she was not convinced that the *MMPI-2* test was the most apposite instrument in an assessment if *fitness* at any event.

Dr Shavit went further and pronounced AA fit to resume his police duties and to have his firearm restored to him. That she did this is a testament to her confidence in the utility of the *MMPI- 2* test and the validity of the test results.

A confidence which it is not necessary to share and seems to ignore her very sketchy knowledge of what is involved in operational policing duties and in the possession of a gun and of what AA might face on his return to work. She told the inquest that she had been aware that AA was a *general duties* officer but that she had only an imperfect understanding of what that meant.

She admitted that she knew little about the rules and regulations regarding the use of firearms by general duties officers and did not know the degree to which, while in service, AA was likely to be exposed to stressful sights and situations and difficult decisions relating to his possession and use of a firearm. Nor could she have known much about the particular stresses and strains, which AA might experience in the context of his work in a busy suburban police station.

At the same time, Dr Shavit, in making her recommendation, did not know the views of AA's *GP* or his parents or those who were close to him. She was aware that he was taking *Efexor* but could not have been sure how he was tolerating it and she was not to know the extent of psychiatric services available to him.

To the extent that her views were based on test results and her clinical interview, their origin was largely in AA's *self-reporting* whereas she knew that young men will often be less than reliable when discussing their own emotional frailty, the more so if they happen to be serving officers in a police force where stigmatization is still a fact of life albeit a diminishing one and where AA was entitled to see a risk to his career prospects. Further, I think Dr Shavit might have done well to refrain from pronouncing AA fit for a return to full operational duties, which she did not clearly understand.

Dr Kirby

Dr William Kirby the senior police medical officer is an occupational physician. It was he who undertook the assessment of AA in March 2009 and he saw him on 11 and 18 March. He estimates that, as a *PMO*, 90% of the matters referred to him relate to psychological/mental health issues. Dr Kirby reiterated that a *PMO* has no therapeutic role and, instead, his principal task is to provide police commanders with assessments of officers' fitness for work.

Dr Kirby told the inquest that, in preparing assessments, his principal focus is not the potential for self-harm but, rather, the officer's ability to function as a police officer in accordance with his/her training. Risk of self-harm is of professional interest to him only insofar as it impacts on the subject officer's ability to do his job and is more appropriately the province of the officer's own clinician.

So too is therapy. According to Dr Kirby, there is no objective criteria to be applied and no set benchmark standards against which to measure an officer's fitness and, he said, it is largely a matter of gaining a degree of empathy with the officer so as to gather information – in large part from the officer him/herself, and assessing whether the officer, when faced with a critical situation – one in which there is a degree of danger when a quick response is demanded, will be able to respond in accordance with his/her training. As he explained, *"I need to assess whether the actions of the officer in question are likely to be sufficiently within the norm."*

Dr Kirby provided an *interim* advice to Superintendent Hayes on 19 March 2009 in which he certified AA as fit for full operational duties and fit to have a firearm.

He advised Ms. Hayes that a full written report was to follow but that the report *"will not detract from their (sic) immediate return to full duties given the LAC has no other concerns other than those noted in the referral."*

Dr Kirby explained to the inquest that, on 11 March, he had undertaken a mental state examination and that, so far as his ability to carry out his duties in accordance with his training was concerned, *"there was no need to make a statement concerning his operability as a police officer as he had elected to have two weeks leave and I was satisfied with his professional, family and peer support."*

Dr Kirby told the inquest that, when first seen, AA was very early in his therapy and there was a lot going on in his life so that, instead of being immediately restored, he should take some leave and return in a week or so for a follow up assessment.

Dr Kirby wanted to give the *Efexor* time to take effect. Dr Kirby's evidence is that he had thought that the follow up assessment would probably be favourable and that he had anticipated that AA would then return to work but if AA told his commander on 11 March that he had been pronounced fit that was probably something of an exaggeration. Then, on 19 March, 2009, after his second interview with a *"much improved" AA*, when both he and Dr Shavit found *"his mental state and mood satisfactory,"* Dr Kirby sent his interim advice which cleared AA for work and commenced the preparation of the *final* report which, in the event, he never completed and sent.

Having in mind the terms of his *interim* report where no terms or conditions were recommended or noted, it is clear that Dr Kirby had not been minded, when preparing his *final* report, to recommend the imposition of any conditions on AA's return to full operational duties. Instead, the final report would almost certainly have confirmed what Dr Kirby had seen as AA's stable mental state and consequently his fitness to have a gun. At most, Dr Kirby's *final* report might have accompanied his certification of AA as fit with a *plan* which may have included a suggestion that there be some monitoring.

Now Dr Kirby knew little of Dr Thew's plans for AA. He didn't know what Dr Thew thought about AA's mental state. He didn't know the dosage of *Efexor* prescribed or the period during which Dr Thew expected AA to use the medication. He certainly didn't know that Dr Thew had prescribed such a low dose with the expectation that it might be doubled once AA's tolerance was established.

He didn't know the identity of the AA's psychiatrist nor whether AA had contacted or would contact him and he didn't know what if anything the psychiatrist might propose with regard to psychotherapy. Nor did he know whether it was Dr Thew or the psychiatrist who had prescribed the *Efexor*. Further Dr Kirby had no therapeutic role to play and therefore could hardly have varied another clinician's plan even if he had known what that plan was or how the clinicians might vary it from time to time. For those reasons, it is hard to see how he could have provided a useful plan for AA.

Dr Kirby told the inquest that, although the decision to return AA to full operational duties was one for the commander, he had been aware that she would be influenced by his advice and he had anticipated that she would follow it. He had not spoken to the *GP*, had not spoken to AA's parents and had not spoken to the Commander. The only information he had was *very sketchy* information from XX and AA's not necessarily reliable self-report and the view of the psychologist which he himself may have influenced.

Although it might have been prudent to await a report from the psychiatrist which he understood was likely to become available, he went ahead and *cleared AA*.

It is not clear to me that, in assessing AA's fitness, Dr Kirby was not in danger of falling into much the same error as Dr Verma in equating fitness for duty with the absence of a mental illness. He spoke of an officer as unfit to carry a weapon when prescribed *benzodiazepine* or frankly *psychotic* or *Bipolar 1* or *2.*

This standard is not dissimilar to the standard apparently applied by Dr Verma who spoke of a *"diagnosable psychiatric condition."* and it seems to me, on the basis of what happened to AA, that if such are the standards applied in the assessment of the fitness of police officers for full operational duty and to carry a firearm, then those standards are unhelpful.

Both Dr Kirby and Dr Verma were clear that, in about 90% of the cases where an assessment of fitness is required, the issue is the mental or psychological health of the police officer involved. In those circumstances, it is surprising that none of the *PMO*s is a psychiatrist. Dr Kirby himself, although a highly experienced occupational physician, has no formal training in either psychiatry or psychology other than some *mental health elements* which he said arose in the course of his studies leading to his fellowship of the *Royal Australian College of General Practitioners* and, of course, in his studies as an undergraduate.

Dr Kirby told the inquest that *"we can refer somebody to a psychiatrist any time we want to"* and he gave me to understand that a referral to a psychiatrist is more likely to be made by a *PMO* where it is clear that therapy is indicated rather than in the preparation of assessments. Where an assessment of fitness is the issue, access to a psychiatrist is not so simple and Dr Kirby said that, only when he is in doubt will he refer to a psychiatrist to assist in the preparation of an assessment.

I think that a difficulty with that policy may be that a *PMO* looking for *frank psychosis* or *bipolar* or, as in Dr Verma's case, a *"diagnosable psychiatric condition"* may fail to see what a psychiatrist would see and so mistakenly certify as fit an officer who manifestly is not. In that connection, I note that Dr Kirby is unprepared to accept, even with the wisdom of hindsight, that on the day on which he cleared him, AA was not fit. He told Mr Gormly of Senior Counsel for the family that, on 18 March 2009, AA was not mentally ill. Instead, Dr Kirby maintains that, on the days when he saw him, AA had a *"mental condition"* but, nevertheless, *"was functioning well."*

He was not able to say what may have happened to alter the position between 18 March 2009 when he cleared him as fit and 27 March when AA died. Dr Kirby conceded that to have a psychiatrist *"on tap,"* whether as an employee of *NSW.*

Police attached to the *police medical officer's* unit or as a private practitioner available to be consulted by *PMO*s and to see police officers in the day-to-day business of preparing fitness reports, *"would be very helpful."* I think it is essential. Mr Gormly of Senior Counsel for the family submitted that the *PMO'*s section of the *Health and Wellbeing Unit* is *"dysfunctional."* It certainly exhibits some fundamental flaws.

In the first place, although a great deal of its work relates to matters of mental health, it employs no psychiatrist and access to psychiatrists in private practice, except where a *PMO* recommends therapy, is far from certain.
And thus, Dr's Kirby and Verma are routinely engaged in making judgments appropriately within the province of psychiatrists – something for which they are not trained. Secondly, there appears to be no clear criteria as to what is meant as *fitness* and what the *PMO* is being asked to assess and the evidence demonstrates significant confusion between the two *PMO*s in this regard.

Thirdly, there is confusion among *PMO*s regarding the vital matter of privacy and confidentiality and what information can and should be disclosed by the *PMO* to superior officers and whether consent of the police officer being assessed is required.

And, fourthly, to the extent that psychologists are employed to assist in assessments by administering a test – in AA's case the *MMPI-2*, there may be considerable doubt as to their independence of the *PMO,* their understanding of what is involved for police officers in *full operation duties* and in the responsible possession and use of firearms and, particularly given the absence of psychiatric oversight, their selection of the particular test to be employed and the mode of its administration.

Privacy

Superintendent Hayes told the inquest that a great concern for her in AA's case was the difficulty in obtaining a clear picture as to what may have been troubling him and the degree of his distress. It was her evidence that, when she sent him to the *police medical officer*, the primary issue had been his welfare.

His record of absences from work and, then, what she had heard from various people, police officers and civilians, about apparent changes in his mood, personality and performance at work all suggested that he was in distress and struggling. When she spoke to him, he was not very forthcoming and she felt that, for his good and the good of his work mates, she needed to know what was wrong and what could be done to assist him. Inspector Smith was similarly motivated.

Evidently, AA was reluctant to disclose to Superintendent Hayes or Inspector Smith or even to Sergeant Hansen or anybody else a good deal of what we can now see was vital information as to how he was feeling, who he was seeing or not seeing and what treatment he was receiving.

Further, privacy considerations hampered those who had a concern for his welfare in gathering a clear and complete picture of what was happening to him.

His superiors felt that he could not be required to provide information and, evidently, he did not feel inclined to give his consent to his superiors or to the *PMO* gathering information from his *GP.* When he saw Dr Verma, AA withheld his consent to Dr Verma providing to the commander other than the most basic information about his condition. AA appears to have given his consent to Dr Kirby making a disclosure to Superintendent Hayes although it is clear that he did not authorise his *GP* to divulge information were he to be approached by Dr Kirby and he wasn't asked to tell Dr Kirby or Dr Verma the name and address of Dr Thew let alone of Dr Nielssen.

When it came to his interviews with Dr Kirby, AA did sign the consent form which was presented to him and I am not sure why. Perhaps his decision was influenced by Dr Kirby's policy, which is to refuse to interview an officer where consent is withheld and to refer the matter back to the commander with reasons. Perhaps he was persuaded by Dr Kirby of the wisdom of sharing the information. Or perhaps, by that time, he was passed caring so difficult was his situation.

It is quite clear that, except in extraordinary circumstances, a private practitioner like Dr Thew or Dr Nielssen is bound by the duty of confidentiality and may not divulge confidential information provided by a police officer/patient to that officer's superior officers or anybody else. It seems not to have been so clear whether *police medical officers* were in the same category.

Dr Verma thought that they were and evidently still thinks that they are and he felt bound to withhold all but the sketchiest information to Superintendent Hayes. Superintendent Hayes believed and may still believe that she was entitled only to such information from the *PMO* as AA was prepared to allow her. Dr Kirby's attitude is harder to gauge. On the one hand, he told the inquest that he avoids what he sees as a problem by refusing to commence the assessment process unless consent is provided either expressly or impliedly.

But he also said that, when he is provided with confidential information by a police officer who he is assessing, he will pass that on to the officer's commander, irrespective of consent, provided the information is relevant and within the scope of the referral. Evidently, this remains his position and it is his practice to advise the police officer of this position at the commencement of an interview.

Fundamentally, Dr Kirby's view is twofold – firstly that, by attending on the *PMO*, the police officer is tacitly providing consent to the provision of relevant confidential information to the superior officer who made the referral and, secondly, that, as an employee of *NSW Police,* Dr Kirby himself is under a duty to pass on the information irrespective of his fellow employee's wishes. He was unaware that this was not Dr Verma's view.

The *Health Records and Information Privacy Act 2002* deals with the collection, use, storage and disclosure of health information by both public and private institutions. I know of no reason why it might be thought not apply to *NSW Police*.

The Act would permit the exchange of otherwise confidential information between various police officers and employees of *NSW Police* and, thus, between a *PMO* and a commander referring an officer to the *PMO,* irrespective of the officer's refusal to consent and irrespective of the source of that information, whether reported to the *PMO* by the officer or by a third party such as the officer's medical practitioner so long as the information was lawfully obtained.

Ordinarily, the information exchanged between one person, in this instance the *PMO*, and the other, in this case the commander, must be required for the same purpose as it was originally acquired and may not be used for a secondary purpose except with consent or where the primary and the secondary purposes are so closely aligned that its use for a secondary purpose is to be reasonably expected or in cases of imminent risk to the life, health and safety of an individual.

In AA's case, I would have thought that, under the Act, both Dr Verma and Dr Kirby were entitled to provide to Superintendent Hayes such information on his mental health status as AA had given them whether he consented or not. I think that the *consent form* employed by Dr Kirby should be scrapped in favour of a clear and frank explanation of the rights of the police officer and as to what can be disclosed by the *PMO* and what cannot. To the extent that police medical officers and senior police officers may be unaware as to what information should and what may not be passed from the former to the latter, it is important that *NSW Police* clarify the true position for them and ensure that they are aware it.

The position is quite different, though, when it comes to obtaining information regarding the health of police officers from outside sources. In AA's case, Dr Thew was bound to maintain AA's confidences and, absent an emergency, was not permitted to make disclosures to his family or to police without AA's consent and the *Health Records and Information Privacy Act* does nothing to affect that situation. Had he, with AA's consent, provided information to the *PMO*, and then it seems likely that the *PMO* would have been at liberty to pass that on to the commander.

There is a third situation which relates to AA's entitlement to decline to make disclosures and give consent to outsiders such as private medical practitioners to provide information to his superiors and to the police medical officers. As I understand it, he might have been required to disclose his use of *Efexor* but, in general terms, he could not be required to make further disclosure.

Whether there should be further erosion of a police officer's right to privacy by requiring him or her to disclose to a commander or to a *PMO* details of his health or mental health status or requiring him or her to authorise his/her private medical practitioner to provide such details is a vexed question. It is submitted on behalf of the family that such should be the case and the arguments in favour of that proposition have to do, ultimately, with providing senior officers with better information when deciding to return an officer to full operational or restricted duties and restoring or retaining his/her firearm. In his evidence, Dr Barron was a strong advocate of such *"reform."*

The opposite view was perhaps best represented by Ms. Carroll of the Police Association of New South Wales who reported "within the current culture, compulsory access to medical information… …will require in officers either not seeking treatment or failing to disclose that they are in treatment. They may also edit within the context of a treatment environment. Confidentiality and control over access to medical information is a critical theme that is raised by our members. Unfortunately, too often we see confidentiality breached and damaging rumours spread throughout commands.

Officers are well aware of the difficulties that are experienced around maintaining confidentiality and this factor will act as a major barrier to disclosure and reporting…

Even within the context of injuries that are clearly work related in nature, there is reluctance in some officers to make a claim for compensation due to the access to medical information that is part of the normal claims process. Often officers avail themselves of other forms of leave in an effort to allow themselves an opportunity of seeking treatment and recovery … "rather than pursuing remedies which will involve the sacrifice of privacy".

Ms. Carroll's comments seem to me to illustrate the degree of reluctance among many police officers to abandon their entitlement to privacy and the heightened risk of *"driving officers underground."*

The *OIC*, Sgt Graham, agreed with Mr Gormly that, in assessing the mental health of a police officer, mere reliance on what that officer has to say is unwise. For reasons to do with *stigma* and fear that their professional reputation and careers may be damaged, police officers suffering a mental health deficit are likely to be unreliable reporters of their own condition. Rather, in devising a system of assessing the mental health of officers, it is wise to provide for and encourage the input of third parties. Further, Mr Graham thought that, in designing a system to assist a mentally ill officer, it is not useful to rely on that officer's ability or willingness to comply voluntarily with directions.

Rather it might be desirable to design a system of directions, which carry obligations of compliance by the officer in question. But, having in mind privacy issues, Mr Graham was not so sure that he agreed with Mr Gormly's suggestion that it would be useful were *NSW Police* to consider requiring officers to provide management with authority to access relevant medical and psychological and other information relevant to the safety and welfare of those officers.

Presently the requirement of police officers to provide to their superior officers private information as to their mental health condition is limited to reporting the use of prescription medication, which would impair functioning. This is of limited utility since it is difficult to enforce compliance and because *impairment of functioning* is a very inexact and subjective term. Those whose functioning is impaired are precisely those least likely to recognise that condition and report it. But Mr Graham's attitude is that, in considering any change to the existing arrangements, close consideration would have to be given to protecting the privacy of officers.

Mr Graham told the inquest that a police officer is required to report to his or her superior any information which suggests that a colleague is unfit for duty whether that unfitness proceeds from drugs or alcohol or from some other impairment including a mental illness or disorder.

Mr Gormly asked whether such policy might usefully be varied to provide that such reports be made instead to the *police medical officer* but, in Mr Graham's view, it is properly a matter relating to the *chain of command* so that the present policy should not be altered.

It seems to me that the prospect of wholesale opposition among the very group of people best informed on these issues in the event of a diminution of a police officer's right to privacy is very real and that any such change would be likely to have the adverse effect of driving *underground* the officers most in need of help.

Mr Gormly of Senior Counsel for the family acknowledged the problem of driving police officers *underground* and submitted that, even if a further erosion of a police officer's rights to privacy is impractical, some significant benefit might result from a robust approach to opening the paths of communication between police officers and their superiors, particular regarding their health, welfare and fitness. Perhaps a system of assigning new officers to the oversight of a mentor, a role such as Sgt. Hansen seems informally to have adopted with regard to AA would be of assistance in this regard although the sad fact is that such *mentoring* was ultimately ineffective in AA's case.

The last days

AA returned to work on 23 March 2009. Although he ultimately retrieved his gun by means of bolt cutters, it was not until after he had been cleared by the *PMO* as *"fit for work and to carry a gun"* and he was authorised to have it back. On 25 March, Dr Thew phoned him to find out why he had not returned to see him and AA called in at the surgery where his was given a prescription for *Efexor – XR 75mg*, the recommended minimum dose.

Next morning, he went off to work and his mother noticed his police badge lying open on his computer desk alongside a photo taken when he was a baby. AA spent the night of 26 March 2009 with XX at her place where he seemed, in turn, vulnerable, needy, and then cheerful and his old self.

He complained to XX *"I don't think the medication is working… …everybody thinks I'm happy now but I feel so empty on the inside, it's like there's nothing there and I don't know how to make it go away. This is going to sound really silly but I can't cry."*

Some of these matters, which seem so significant, now, seemed not so significant at the time. Next morning, AA had breakfast with his family, spent a short time speaking with his mother and hit some balls with his father at a local driving range.

Later he had a conversation with his sister when he told her *“the depression is back.”* He exchanged some text messages with his cousin and, although he was not due to commence work until 8pm, left home for Waverley Police Station at about 6 or 6.30pm. Sometime around 4pm he had composed a suicide note, which he left on his computer.

It read: -

“I know you will never fully understand my decision and that you’re going to be left feeling very upset and hurt. For that, I’m sorry. Being selfish like this is not how I want to be remembered but things are just too painful to go on living like this. And I can’t see my life getting better or easier for me. It’s nothing specific, just one shit thing happening after another. I’ve had enough of being unhappy, feeling lonely and living clouded in darkness. I know there are other people with worse problems than I have, but I guess I’m just not strong enough to deal with things. This is no one’s fault but my own. .. can have any of my property that he wants. Everything else is for Mum and Dad to decide what to do with.”

At 7.28pm, XX received a text message from AA, which read, “Dude, you’re my brother and the best mate, *I’ve ever had. There is a .txt file on my computer desktop. I want you to read it when you get the chance, or tell my dad about it. Its important.”*

XX tried desperately to raise AA by phone but it seemed to him that AA was deliberately terminating his calls. He phoned AA but XX was unable to gain access so, as soon as he could get there, he booted up, saw an icon *Tone.txt* that was a nickname AA used to use for him, and opened up the *suicide note*.

By this time, AA had already, recovered his *Glock* 40-calibre service firearm from the gun safe, signed out a portable radio and, thus armed and dressed in his Court uniform, left Waverley Police Station. He sent a number of text messages to XX but she was on duty at Glebe morgue and unable to do much more than simply acknowledge his messages but one of those messages read *“I love you and what I’m about to do is not your fault”* so she was extremely worried. She immediately sent a message for the Duty Officer at Waverley, Sgt. Russell Brown, which he recalls as a warning that AA was *“very depressed –talking of suicide.”*

He noted that AA was *“was crying and sounded very upset”* and he indicated at the inquest that, at this stage, he was not sure what to make of it all. But, at about the same time, XX was informed that Mrs. AA had telephoned to say that *“she was very frightened for AA’s welfare and thought he might be very depressed and suicidal”* and then discovered that AA was armed and was absent from the station so that he was in no doubt that an extremely serious situation had arisen.

At 7.52pm, XX sent a text *“Don’t do anything silly”* to AA who telephoned her but then hung up before she could answer.

She phoned her friend, Constable XX at home, explained the situation and asked her to drive over to Little Bay and see if AA was there.

As XX and her boyfriend drove towards Little Bay, she managed to raise AA by phone and he told her that he was at Clovelly. It was obvious that he was in trouble and when she told him that she could phone the police, he said, *"What are the cops going to do,? Triangulation on my phone will take 3 hours."*

That was an exaggeration but AA was right to believe that, right along the coastline, triangulation would be a difficult and possibly prolonged process.

There was a search of Waverley Police Station, which established that AA was nowhere to be found and Constable Carey was sent up the street to find that AA's vehicle was gone. As soon as AA terminated the call to XX, she phoned Waverley Police Station to be told that police were already *"doing a triangulation on AA's phone* (initiated by Sgt. Brown) *and that (like her) they were heading out to look as well."*

The portable radio in AA's possession was deactivated by police so that he would not be able to monitor the police response to his situation and, shortly after 8pm, Superintendent Hayes was first advised on the matter when she received Sergeant Brown's phone call. She then briefed the Regional Commander by telephone. At about 8.07pm he spoke to his sister by phone and he sounded very drowsy and was slurring his words and, eventually he told her *"I'm sorry, I have to go"* and terminated the call. Then XX called him back and he told her *" it's too hard. Everyone says it will get easier but it's not getting easier."*

According to XX, AA terminated the call at about 8.25pm. *XX* has little recollection of the precise timing of events on that evening but it appears that triangulation suggested that AA's vehicle was situated within a 1 km radius of a certain intersection in Malabar and that the *first callout* occurred at 8.25.43 when he and A/Sgt Capon drove to Malabar in *ES14* on *urgent duty* response and simultaneously, several other police vehicles responded to the call.

Although it appears that the gravity of the situation had only gradually become apparent, it is clear that by this stage the enormity of what was happening and the urgency were clear to everybody. Before XX's vehicle arrived at the western end of Fisherman's Road, Malabar where a roadblock had been installed, he heard *EB14* state that a shot had been fired.

The occupant of *EB14* was Senior Constable Petah Condie who was *"only a couple of minutes away"* when she heard the call to proceed to the vicinity of Victoria Lane, Malabar. Initially, the details provided in the radio call were quite wrong but mention of urgency, the possibility of self harm, a male police officer in part uniform and a loaded firearm were sufficient to alert listening police. The *DOI*'s instructions were *"no lights and sirens and to proceed as quickly as possible."*

Failing to find AA's vehicle in Victoria Lane, Ms. Condie drove along Ragan Street when she heard *EB104* announce, *"We've located the vehicle. It's on Fisherman's Parade, opposite the sewerage works."* Detective Senior Constable Todd Mathers and Plain Clothes Constable Graham McGinty, both of Maroubra Police Station, staffed EB104.

Senior Constable Condie drove carefully along Fisherman's Road but came across AA's vehicle unexpectedly parked on the southern curb of the road-facing west. She had expected he would be parked further out towards the coastline, closer to the sewerage works.

She drove past and her description of what she saw underlines, I think, AA's pain, her own bravery in facing a terrifying situation and the overwhelming tragedy of what was happening. Ms. Condie *"couldn't even make out if it was a male or female or any facial features. All I could see were big eyes starring like a rabbit in headlights. He wasn't looking at me as police, he was just staring. I would say he was in a zone, like he was looking through me."*

Ms. Condie drove a little further down the road when she came across *EB104*. She stopped, alighted and took control. She directed Messrs Mathers and McGinty to don their bulletproof vests.

She was particularly concerned because she was facing an unknown situation with the driver in the stationary vehicle armed, probably desperate and aware of on-coming police. There was no shelter and no capacity to go into the bushes and surprise him. She intended to perform a *"dangerous vehicle stop."* She told Messrs Mathers and McGinty but *'didn't give him a chance to respond as I was thinking 'I'm the supervisor and I have made the decision.' I thought we have to be safe and this is the safest way so that he didn't drive off and couldn't possibly injure someone else. In my mind he was contained in that area and I believed that I had to act quickly'.*

Ms. Condie drive a little closer and then got out of *EB14* and approached AA's car on foot, accompanied by Mathers and McGinty.

Mr Mathers covered her behind a telegraph pole as she crept around her car in an attempt to gain access and fetch a loud hailer. *EB10* was on the air and Ms. Condie reported, "We're going to approach the vehicle."

Ms. Condie then repeated her instruction to Mr Mathers to keep them covered from behind the telegraph pole while she and Mr McGinty went ahead. Her instructions were that she would make straight for AA's vehicle and McGinty *"would curve around* (from the other side of the road) *and be at the driver's side of the vehicle."* She started yelling *"AA, It's the police. We're going to help you."*

There was no answer and, after checking that Mathers and McGinty were in place and knew what they were supposed to be doing, Ms. Condie approached AA's vehicle with her firearm in one hand and a torch in the other. She used his vehicle to afford her a degree of cover.

She was about a metre away from AA's vehicle when she heard a very loud bang. She started yelling, *"shots fired, shots fired"* into the radio and she thinks that she heard Graham McGinty do the same thing. She was lying on the ground, up against the gutter and facing AA's vehicle and she *"started doing a commando crawl but going backwards."*

Gradually it became clear that the shot, which had been fired, had been AA shooting himself and that he was incapacitated and possibly dead. His head was against the window and, although Ms. Condie knew that *"he could be faking it,"* she went right up to the car, tried the door and discovered that it was locked.

She could see through the window there was *"a huge amount of blood coming from his mouth and coming down his neck"* and that his firearm seemed to have fallen onto his left hand rather than being held by him. Police put down their firearms and Ms. Condie *"got on the radio and said 'Eastern Beaches 14. It appears that this officer is deceased.'"*

Although there was an attempt at *CPR*, it is clear, I think, that Ms. Condie was correct and that AA had died. Police officers including Sgt. Brown, Detective Chief Inspector Abel and the *OIC* were examined in relation to the police operation on 27 March 2009.

It was important to establish whether there was any significant delay in *raising the alarm* when AA first went missing but, allowing for the fact that the full appreciation of what was afoot came only gradually, I think there was not.

It was important, too, to consider whether Ms. Condie's actions were appropriate and I think that she did all that could have been done and that she acted responsibly, compassionately and extremely bravely.

It was deemed necessary to question whether there was any undue delay in *triangulation* but the evidence suggests that this proceeded efficiently and promptly – far more promptly than AA had anticipated.

Further, there was concern that, although brave, Constable Condie's method of approaching AA's vehicle was unwise, may have prompted him to take an unwise step and may have exposed her and her two companions to unnecessary danger.

Sergeant Graham's attention was drawn to the *Memorandum of Understanding* between Police, the NSW Ambulance Service `and NSW Health. EXHIBIT 3.

At page 23 of that document one can find a protocol, the *Mental Health Emergency Response,* regarding the preferred method of dealing with a high risk situation involving an armed and apparently mentally ill person posing real or impending violence or threat to an individual (including an individual police officer) or the public or where it is suspected that the person may attempt to take his own life.

This protocol places police in the front line to deal with the situation and their task is *"to attend the scene, gather, analyse and disseminate relevant intelligence and assess support needed from other agencies."*

Police are then enjoined to *"respond by containment and negotiation and, if any doubt exists as to whether the situation is high risk, the Tactical Operations Unit should be contacted via the Duty Operations Inspector at any hour."* As the events of 27 March 2009 played out, that was impossible.

The incident commencing with the location of AA's car at Fisherman's Road, Malabar until his death certainly posed a high risk to AA himself and nobody could have been sure that Const.

Petah Condie and her companions were not similarly at high risk as they emerged from their car and approached AA and her recollection is that she called *"AA. It's the police. We're here to help you."* If Ms. Condie is mistaken about some of the detail, I think it is clear that she was aware of a fellow police officer in trouble and was doing her best in all the circumstances to help.

Chief Inspector Abel who is the police negotiation commander pointed out that the *"Mental Health Emergency Response"* protocol is no more than an agreement between three agencies and is not a police operational protocol. It allows each of the three agencies to do perform their individual function in accordance with their own practices and protocols.

In the case of *NSW Police,* as of March, 2009 the appropriate protocol was called *"Responding to High Risk Incidents"* and Mr Abel's evidence is that, effectively, Constable Condie and her companions complied with it. Mr Able went on to say that, in his opinion, it would have been inappropriate and premature to call in the police negotiators until first attending officers had arrived at the scene and assessed the situation. In the event, there was no time for that because AA fired the shot only one and a half minutes after being located at the scene.

Const. Condie and her two companions, Detective Todd Mathers and Detective Graham McGinty followed orders and acted with speed, bravery and compassion.

To the extent that any particular protocol applied and was ignored, as Mr Gormly suggested it might have been the case, it was because there was simply no time to invoke it. Instead, Ms. Condie appropriately adopted a mode of behaviour characterised by *"containment and negotiation".*

Sgt. Graham was closely questioned about all this by Mr Gormly of Senior Counsel. He thought that, had the incident been prolonged, the *"Responding to High Risk Incidents"* policy might have been invoked but that, in the event, matters moved so quickly that there was no time to do that. He reminded the inquest that these sad events happened very quickly and he pointed to the undoubted bravery of the three officers involved and the peculiarly sad nature of AA's death.

In his submissions, Mr Gormly opined that if what was dubbed *"a mental health response"* had been implemented on 27 March, 2009, *"the outcome might have been different."* So it might but equally I think, it might have been worse.

Nobody could have been sure what was happening to AA. Nobody knew whether he was accompanied or alone. Certainly, Ms. Condie did not know that. Nobody could have known whether another person might have been in danger or whether delay might lead to de-escalation or might serve to heighten risk. A *stand back* tactic might sometimes work to advantage but a policy of *stand back* is another thing entirely.

In those circumstances, it would be brave indeed to disagree with the sober consideration of experienced senior police officers such as Messrs. Abel and Graham.

AA was a very fine young man of whom his family has every right to be extremely proud. He death is a real tragedy for his family and his friends and a loss for the police service and community generally. Clearly he will not be forgotten.

Formal Finding:

I find that AA who was born on 25 January 1983 died at Fisherman's Road, Malabar, *NSW* at about 8.39pm on 27 March, 2009 of a gunshot wound to the head, self-inflicted while suffering severe depression.

Recommendations

I make the following recommendations to the Commissioner of Police: -

- **That a psychiatrist or psychiatrists be employed in the *Health and Well-being Unit* of *Welfare Safety Command* or retained so as to ensure qualified psychiatric oversight of all police fitness assessments where mental health or emotional stability are an issue;**

- **That appropriate criteria be developed and established to guide and inform *police medical officers* in assessing the fitness of police officers for various duties within the police force and the fitness of police officers to have possession of a firearm;**

- **In particular, that the criteria so developed and established provide that fitness for duty and to carry a firearm is not merely a matter of the absence of a *diagnosable psychiatric condition* or mental illness;**

- **That *police medical officers* be encouraged to explore with police officers referred by commanders for a fitness assessment the history of that officer and any current or recent medical diagnoses and treatment plan or plans and the identity of that officer's medical practitioner and to seek the consent of the police officer to that medical practitioner providing appropriate medical information to the *police medical officer* and that unwillingness to provide that consent be among the matters to be reported to the referring commander;**

- **That psychologists assisting in the preparation of fitness assessments be accorded independence from *police medical officers*;**

- **That *police medical officers* be reminded of the provisions of the *Health Records and Information Privacy Act 2002* and, so far as the provision of information to commanding officers is concerned, be encouraged to act in accordance with its terms;**

- **That the practice of placing reliance on psychological tests in the preparation of fitness assessments be reviewed by an independent expert;**

- **That the freedom of commanding officers to make their decisions as to the removal or restoration of firearms informed by considerations other than those dealt with by *police medical officers* be encouraged;**

- **That commanding officers be reminded of their entitlement to the provision of information pursuant to the *Health Records and Information Privacy Act 2002*;**

- **That consideration is given to the establishment of a mentoring system of young officers by more senior officers with a view to the guidance, support and oversight of the performance of those young officers.**

7. 847 of 2009

Inquest into the Death of Maurice Nolan on the 17th February 2009 at Yowie Bay. Inquest held by Deputy State Coroner MacMahon at Glebe.

This has been an inquest into the death of Maurice Edward Nolan. Mr Nolan was born on 19 March 1941 and on 17 February 2009 he was aged 67 years.

On that day he was residing at 1/247 Attunga Road, Yowie Bay.

At the relevant time Mr Nolan was serving a sentence of home detention. The evidence is that Mr Nolan's wife saw him in the earlier part of the morning. Arranged for the purchase of a newspaper for him and some bread rolls and then Mrs Nolan left the family home to visit her son, Paul.

Some short time later, a Mr Jimmy Zandos observed a person lying on the 10 concrete driveway to the property. Mr Zandos was working at a nearby house.

He attended on the person who he observed lying on the ground. Realising that there was a need for medical services and called triple-0. Ambulance officers attended and the assistance that was provided was not able to revive Mr Nolan. Police were called. Police contacted Mr Nolan's doctor, Dr Weeks. Dr Weeks had been treating Mr Nolan for some time and issued an invalid death certificate advising that the cause of death was a myocardial infarction on an underlying medical condition of alchemic heart disease.

Mrs Nolan said that when she left home at about 8.15 that morning, Mr Nolan "was in good spirits. He was his normal self and appeared to be fine. He was talking and just being himself." The history of evidence that came from Dr Weeks was that Mr Nolan had a history of heart attacks and heart conditions over a period of some eight years and had previously undergone a triple by-pass. Dr Weeks had known Mr Nolan for some twenty years.

Had last seen him on 24 November 2008 and as I have already said Mr Nolan had a long history of cardiovascular disease.

The medical evidence available from Dr Weeks and other sources was reviewed by the Director of the Department of Forensic Medicine, Dr Jo Duflou and having undertaken that review Dr Duflou's opinion was that the cause of death formulated by Dr Weeks was entirely reasonable.

But for the fact that Mr Nolan was at the time serving a sentence of home detention, I have no doubt that an inquest in this matter would have been dispensed with. However, the Coroner 's Act (2009) requires that where a person is in custody and dies, an inquest is mandatory and the conduct of such inquest is part of the exclusive jurisdiction of the State Coroner or a Deputy State Coroner .

The reason why such a death in custody inquest is mandatory is set out by the former State Coroner, Magistrate Waller. He says, "The rationale is that by making an inquest mandatory a full and public inquiry into deaths in prisons and police cells in a government provides a positive incentive to custodians to treat their prisoners in a humane fashion and satisfies the community that the deaths in such places are properly investigated." It is to ensure that where the loss of liberty is the sentence, that loss of liberty is not exacerbated by ill treatment or probation on the part of the individual.

In this case Mr Nolan such circumstances do not apply and Mr Nolan whilst his liberty was inhibited by the fact that he was on home detention, other characteristics of liberty were afforded him. The cause of his death is clearly that of a natural cause, the outcome of a longstanding medical condition from which he suffered.

In those circumstances, the issues relating to him serving his sentence are not relevant or do not affect the fact of his death. Section 81(1) of the Coroner 's Act requires that at the end of an inquest the Coroner is to make a determination as to the identity of the deceased person, the date and place of their death and the manner and cause thereof. In this case Paul Nolan, the deceased's son, identified the deceased. I accept that identification. It is clear from the evidence of Mr Zandos and the evidence of the police as to the location of Mr Nolan's death. I accept the cause of death formulated by Dr Weeks and supported by Dr Duflou of myocardial infarction due to ischaemic heart disease and I am satisfied that the manner of Mr Nolan's death was a natural cause.

I, therefore, make findings in accordance with Section 81(1) of the Coroner 's Act (2009) as follows:

Formal Finding:

That Maurice Edward Nolan born on the 19th March 1941 died on the 17th February 2009 at 247 Attunga Road, Yowie Bay in the state of New South Wales. The cause of death was myocardial infarction due to ischemic heart disease and the manner of his death is natural causes.

8. 1213 of 2009

Inquest into the death of AA on the 4th May 2009 at Penrith. Inquest conducted by Deputy State Coroner Dillon at on the 12th April 2011.

Introduction

Deaths by suicide in custody are preventable deaths. Regardless of the nature of any crimes committed by persons in custody or their characters, it is a statement of the obvious that our society, through it agencies, such as the Police Force and the Department of Corrective Services, owes prisoners a duty of care. Prisons and lock-ups should be safe environments for inmates.

As easy as it is to enunciate such general statements from the Bench, in practice the day-to-day task of ensuring prisoner safety in a gaol or cell complex is difficult. It is difficult not least because the workings of the human mind can be hidden, sometimes even from a person him - or herself, as well as from others.

Nevertheless, it is well-known that reducing the availability of opportunities for spontaneous or impulsive suicides can cut suicide rates. Where suicides occur in prisons, it is usually because either a good system has not been established or, if it has, the system has failed in some way.

AA was a young man of 32 when he died of a hypoxic brain injury suffered as result of hanging himself in the cells at Penrith Courthouse on 3 May 2009 with the drawstring cord from the waistband of his shorts. This is a case of systems failure.

An inquest is an independent judicial inquiry or investigation. In this case, the primary questions have been “How did the death come about?” and “What can we do to prevent similar deaths occurring in future?”

Background

AA was arrested on 2 May 2009 and charged with Possession of Prohibited drug [heroin] and Escape Lawful Custody. He was then a prisoner on parole and was facing serving a further approximately 11 months in prison for the balance of his parole period. AA had a long history of educational difficulties, family dysfunction and drug-related criminal offences.

Despite these enormous personal disadvantages, it is noteworthy that the police officers who arrested AA and who held him in custody at Parramatta Police Station pending his transfer to the custody of the Department of Corrective Services – in particular, Detective Nathan Marlin and Sergeant Dane Sinclair – took a relatively benign view of him. Those officers saw in him a young man who was struggling against an addiction that he was unable to manage but who wished to make a better life for himself and his young son. Detective Marlin thought that he had made a decision to use the time he would spend in custody to rehabilitate himself.

As a boy, AA was hyperactive at school and found the school environment difficult. He was, however, a talented Rugby League player and played under-age representative football.

Unfortunately, while playing football he met people who introduced him to drugs and he gradually became addicted with all the self-destructive consequences that frequently follow. Despite all that, he became a devoted and loving father of his son. His addiction and other circumstances fractured and fragmented what might otherwise have been a stabilising and fulfilling aspect of his life.

The real tragedy of this case is that AA fundamentally decent instincts and aspirations were snuffed out by his despair – perhaps triggered by the realisation that he was once again to be separated from his young son because of his drug addiction and drug-related offences – and by failures in the correctional system that owed him a duty of care.

The issues

The first duty of a Coroner is, if possible, to make findings concerning the identity of a person who has died suddenly or unexpectedly, the date and place of death and the cause and manner of death. By "manner of death" I refer to the circumstances of a person's death: here the question is, "How did the person die?"

In this case, the only difficult question is that last one. It raises further questions that were outlined by Counsel Assisting in his opening address:

- Why was the cord not removed from AA's pants by Police or Corrective Services officers?
- Were the procedures and the facilities at the Penrith Court Cells complex safe for a prisoner at risk, and in particular?
- Why was AA not searched again by Corrective Services officers when received into custody at the Penrith Court Cells complex?
- Why was AA not identified as a prisoner at risk?
- Was AA being properly monitored by Corrective Services officers at the Penrith Court Cells complex in the lead up to his death, whether by CCTV or otherwise?

This is a mandatory inquest under the *Coroner's Act 2009*. Parliament has decided to require an inquest into all deaths in custody, as our society owes a duty of care to citizens (and others) deprived of their liberty because of legal process. It has recognised that it is desirable to hold government agencies responsible for safeguarding such people in custody to account for the ways they conduct their administrative duties relating to the custody of prisoners. It is also desirable, when things go wrong in the custodial system, to learn the lessons of experience and to rectify faults or systemic failures. An inquest can serve the purpose of highlighting those systemic failures and lessons learned.

The facts in summary

After his arrest on Saturday 2 May 2009, AA was searched by police and held in the charge room at the Parramatta Police Station. A foil of heroin was removed from him and, as previously, noted, he was charged with Possession of Prohibited drug.

At that stage, his shoelaces were removed. He was wearing a pair of rugby shorts with a drawstring cord in the waistband. Police officers did not remove it. He was refused police bail and transferred to the custody of DCS at Parramatta Courthouse that evening.

At the Parramatta court cells, DCS officers received the Custody Management Record and a Prisoner/Intoxicated Persons Transfer Note (or “Prisoner Transfer Docket”). The Prisoner Transfer Docket included a warning that AA had a previous history of self-harm. The Prisoner Transfer Docket was filed in a DCS file at the Parramatta court cells and was not placed on AA’s personal “warrant” or file that travelled with him in DCS custody. The practice of filing the Prisoner Transfer Docket in the place where the prisoner was received, although apparently common in many DCS facilities, was contrary to established Departmental procedure.

At Parramatta court cells, the senior officer managed the paperwork received from police while another officer conducted a strip-search of the prisoner and examined his or her clothing for contraband. When AA was received, he was searched by a relatively junior officer, Mr George Denton, who stated to police after AA had died that he had found the drawstring cord in AA’s shorts but had been unable to remove it because it was sewn into the shorts. He also stated that he had checked with his supervisor, Officer Melanie Bell, who had approved him leaving the cord in the shorts.

AA stayed overnight at the Parramatta court cells and was transferred to Penrith court cells early the following day to appear before court in a bail hearing by Audio-visual link. He was not further searched upon reception at Penrith and no one examined his shorts. He was, however, interviewed and assessed by Justice Health Registered Nurse Joanne Locke who appears to have spent about one-and-a-half hours conducting her assessment. She applied a number of standards tests as well as observing AA and applying her own 17 years of experience. The interview took place at about 10 am. She concluded that he was suitable for normal cell placement but noted on a document entitled a “Health Problem Notification” that he was suffering withdrawal symptoms, which she assessed at that time as “mild”. She gave him medication for those symptoms and prescribed further doses that were to be given in the evening. She also gave him a Ventolin puffer for asthma.

There is a considerable quantity of evidence from police and correctional officers, as well as from AA’s mother, Mrs X, suggesting that at least until the late afternoon of 3 May 2009, AA appeared well and in good spirits and was not an apparent or obvious suicide or self-harm risk. Nevertheless, he had had a long history of self-harm documented in police and DCS records.

That information was apparently unknown to the DCS officers who held AA in custody at Penrith on 3 May, although an alert had been posted on the Prisoner Transfer Docket received from police at Parramatta court cells.

When he appeared before the court, AA was refused bail and remanded to appear the following Tuesday at Central Local Court by AVL. Ordinarily, if a place is available, remanded prisoners are moved from Penrith cells to a correctional centre once their bail hearings are finished.

These movements are managed by the Placements section of the department according to a priority list they develop during each day's activities. Sometimes remand prisoners cannot be placed immediately and are kept in court cells overnight. In AA's case it appears that a place was not available in a correctional centre according to the Placement section's priorities and he remained at the Penrith court cells until he was found hanging by the cord of his shorts at about 7pm.

His condition was discovered by officers delivering dinners to cells. He was cut down by correctional officers and attempts were made to resuscitate him. An ambulance attended and he was removed to Nepean Hospital still alive but as became clear at the hospital, having suffered irreversible and fatal brain damage due to oxygen starvation. He was maintained on life support until the following day when he was removed from the system and died.

Withdrawal from heroin runs its course over a period of 7-10 days but tends to peak at 24-48 hours after the last dose. AA's last dose had been on the afternoon of 2 May. It is likely that his withdrawal symptoms were therefore beginning to peak or at their peak in the late afternoon of 3 May. At some point during the afternoon of 3 May, AA spoke to Correctional Officer Guy Eagleton about his medication. Mr Eagleton gave evidence that he had told AA that he would receive his medication with dinner.

A prisoner, Mr Mustafa Zikria, gave a statement to police on the day of AA's death to the effect that no more than 30 minutes before he was found hanging AA had been pleading with officers for medication. Mr Eagleton's account was that AA appeared calm and co-operative and did not display any unusual signs indicative of severe withdrawal symptoms. Regardless of which account is correct, it is common knowledge that withdrawal symptoms are painful and disturbing for addicts unless mitigated by other medications. Hence RN Locke's prescription for medications designed to relieve those symptoms.

What were the circumstances of AA's death?

In one sense, AA's death came about because he chose to die. He reported to RN Locke during his assessment interview that he felt worthless "all the time". In such a frame of mind he probably could not conceive of the fact that, despite his own low evaluation of his life, he was valued and loved by others.

To close the inquiry there would reduce the meaning of AA's death to his subjective appraisal and would provide no satisfactory answer to the difficult questions his death presents about the management of persons with a high potential for self-harm in custody.

Mrs X, when she gave evidence, stated that she had been relieved when AA had been arrested because she felt that he would be kept safe, whereas out on the streets taking drugs she knew he was in danger. As it turned out, the system was unsafe for AA.

The "Swiss Cheese" model of accident causation is a model used in the risk analysis and risk management of human systems. It likens human systems to multiple slices of Swiss cheese, stacked together, side by side.

It was originally propounded by British psychologist Professor James Reason in 1990, and has since gained widespread acceptance and use in healthcare, in the aviation safety industry, and in emergency service organizations. It is sometimes called the “cumulative act” effect.

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. (see Figs 1 and 2 below)

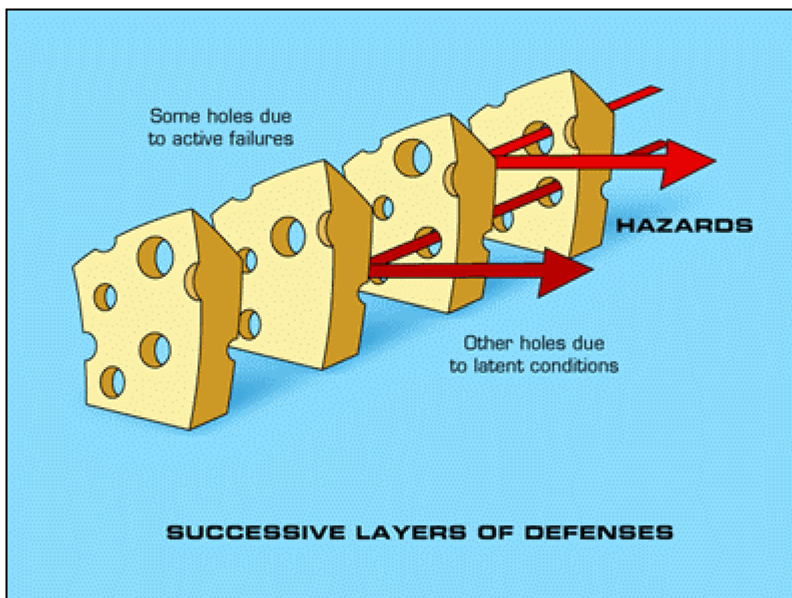


Fig 1. The defence layers work: holes do not line up

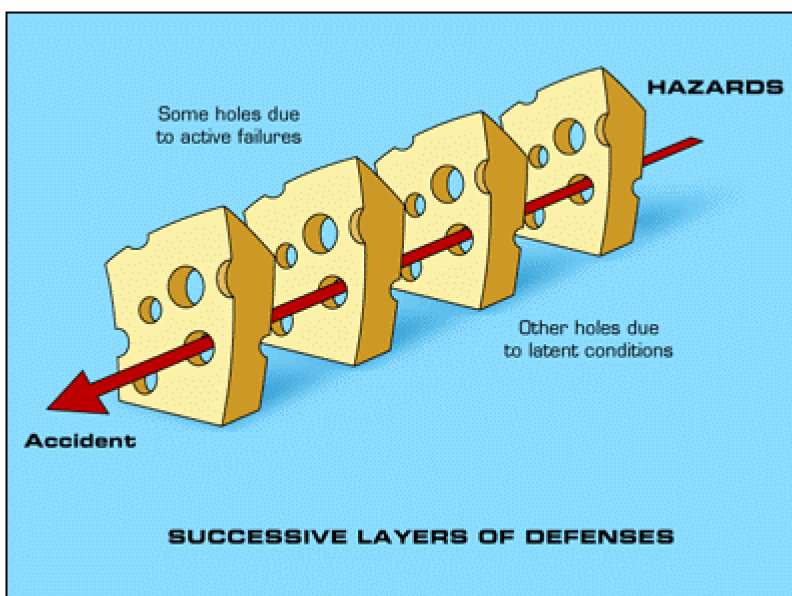


Fig 2. The holes line up: trajectory of accident opportunity[4]

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

In my view, the model is useful for an understanding of how AA came to hang himself in the Penrith cells. There were a number of layers of defence built into the system that was meant to prevent AA from taking his own life. These included searches, warnings about histories of self-harm, assessment by trained Justice Health personnel, medication, CCTV monitoring and the presence of correctional staff trained in dealing with prisoners who were obvious risks to themselves.

Despite them, AA managed to find an opportunity to take his own life and the means of doing it. XX put it very succinctly when she said that if he had not been placed in a cell with a hanging point with the cord from his shorts, he would probably still be alive.

The system failed in a number of ways, some more significant than others but all of which combined, ultimately, to give AA the opportunity of hanging himself.

First, and most obviously, if the cord had been taken from AA, he could not have used it to self-harm. There were a number of opportunities for police and correctional officers to remove the cord. It could have been taken from him by arresting police or the custody manager. It could have been taken from him by correctional officers at Parramatta court cells. It could have been taken from him by correctional officers at Penrith court cells.

The best opportunity to take the cord was probably at the Parramatta cells when AA was received into DCS custody and was thoroughly searched. According to Correctional Officer Denton he thought about taking the cord and attempted to do so.

It is not entirely clear why he attempted to do so because, at that time, DCS operational procedures only required cords to be removed if a prisoner was “detoxing” or was recognised as otherwise being “at risk”. AA was not thought by police or DCS officers to be “at risk” at that time and was not apparently “detoxing”.

Further, it is not clear how vigorous or skilful officer Denton’s efforts to remove the cord actually were.

In his evidence during the inquest, he exhibited a very poor recollection of events and appeared unable to provide any satisfactory explanation of the fact that he had been incapable, he said, of removing the cord but AA had been able to do so in the Penrith cells the next day. I examined the shorts and they appeared to be undamaged.

In any event, the cord was not removed either at Parramatta or at Penrith. Mr Denton ought not be scapegoated or required to shoulder the entire responsibility for this line of defence being penetrated because the rules as they then stood did not require the removal of the cord and other officers could also have removed the cord had they chosen to do so because of the potential risk it posed.

Second, whatever view one takes of officer Denton’s evidence, as I have noted above, DCS policy in May 2009 did not require cords to be removed in these circumstances.

(That policy has now been changed and it is mandatory to remove potential ligatures from all prisoners received into DCS custody.) The flaw in the system was not so much in an individual officer's performance of his duties but in the systemic assumption (at that time) that unless a prisoner showed obvious signs at the time he or she was strip-searched that he or she was at risk, or there was a clear and unambiguous alert given to the searching officer that the prisoner was at risk, there was no need to remove the potential ligature and that the need would not arise later.

Third, the cell into which AA was placed in Penrith had a convenient hanging point.

Fourth, monitoring systems and practices at Penrith cells in 2009 were inadequate for the task of maintaining the safety of more than one "at risk" prisoner at a time. There were only two CCTV monitors in the cell complex, only one of which was able to monitor the cells. At that time, if a prisoner was identified at Penrith cells as being at risk of self-harm[5], he or she was placed in a cell and a watch was kept on that prisoner by CCTV in his or her cell.

The single monitor available to maintain surveillance on the cells was devoted exclusively to that task. Other cells were not monitored by CCTV during the period that prisoner was kept under surveillance. There was no system at that time of switching views on the CCTV monitor from the "RIT" cell to other cells even on an occasional basis although the technology had the facility for this to be done using the remote control.

Nor was there any regular face-to-face inspection of cells and prisoners by officers while the CCTV cell monitor was trained on the "RIT" prisoner. This obviously lent AA an opportunity to pull out the cord from his shorts and to set a noose from the hanging point behind the door of his cell undetected. (To add further complexity to these circumstances, AA also managed, without detection, to blind the CCTV camera in his cell using wet paper before hanging himself. Because the monitor was fixed on another cell, this had no ultimate effect but was another breach of the defences.)

Fifth, although the Justice Health "Health Problem Notification" document filled out by RN Locke and given to DCS highlighted the fact that AA was in withdrawal (although only mildly at 10am), the fact that much worse symptoms were likely to develop later in the day or evening does not seem to have registered with DCS staff at Penrith. Although during the course of submissions I was told that he had resiled from this position, Correctional Officer Jason Charlton suggested during his evidence that the correctional officers were not adequately trained in recognising and managing "detoxing" prisoners although they are generally well-trained in managing "RIT" prisoners. His observation was supported by Mr Brian Bartlett, a senior officer with DCS.

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[5] Such prisoners were called "RIT" or "Risk Intervention Team" prisoners.

Sixth, there were worrying indications that some junior correctional officers may not be adequately trained in important procedures. For example, as I have noted above, we learned that Prisoner Transfer Dockets were routinely filed at a prisoner's place of reception rather than travelling with his or her file. Officers gave evidence that this was how they had been taught to deal with that document by their supervisors.

This suggests that most officers learn from one another rather than by familiarising themselves with operations manuals. Indeed, this is probably the way most people learn to do most things requiring the application of some skill or procedure. While "learning by doing" or on-the-job training is, by and large, a highly effective form of training, it is imperative that the right ways of doing things be taught and learned.

I observed a couple of examples of procedures being followed without apparent thought being given to the rationale for those procedures. As previously noted, the Prisoner Transfer Docket was filed rather in the manner of a receipt rather than being assessed for its potential value as information about a prisoner's potential for self-harm. On AA's docket, the police had provided a warning to DCS that AA had a previous history of self-harm – potentially very important information that may have altered DCS's assessment of him. Yet that warning was effectively ignored.

An officer conducting the "lodgement" process was required to conduct a *visual* assessment of the prisoner. Included in the checklist of matters to be considered was an examination of the prisoner's neck and wrists for scars, indicating previous attempts at self-harm. Officer Chea spoke to AA's through his cell door at Parramatta and asked him whether he had such scars but did not look at his wrists or neck.

This seems to suggest that she had not been adequately trained in the underlying reasons for *looking* at the prisoner. AA told her that he did not have any wrist scars. That was untrue. He had previously scarred them in self-harm attempts but this went unnoticed at Parramatta. As I have previously noted, there was no further search at Penrith and there was no further back-up check for signs of self-harm except by Justice Health.

Seventh, it is also problematic that a prisoner in AA's position – on remand, withdrawing from heroin, serving his balance of parole – was left in courthouse cells for two successive nights without access to medical care once the Justice Health nurse's shift had ended. I accept that there is a resource issue. In raising the issue, I do not criticise individual officers. It is, however, an unsatisfactory situation.

It is no secret that NSW prisons are now largely populated by drug-affected and mentally ill (sometimes both) prisoners. Many of them are, almost by definition, at risk of self-harm especially in the early days of their incarcerations. If we are to expect Justice Health and the DCS to care adequately for these populations, it is a statement of the obvious that they must be adequately resourced by government to do so in the current custodial settings or, alternatively, other less resource-intensive means need to be found to cope with the problems such populations present.

I note that in a recent edition of the ABC program "Lateline", the Attorney-General, Mr Greg Smith SC, expressed grave concerns about the size of the NSW prison population, stating,

'A couple of years ago, Premier Nathan Rees seemed to think it was a badge of honour to have over 10,000 people in jails. I thought it was a disgrace.

And it just reflects either that we've got a lot more crime in this state [than Victoria] or that somehow our policies on sentencing have been skewed… We need to divert as many people as we can from the system, people with problems, such as people with mental issues, and in the case of people with drug addiction, I want to set up a 300-bed, serious drug place where we can rehabilitate them intensively so that we can get them off drugs'.[6]

That is a very wide and deep policy issue which is beyond the scope of this inquest to address except to applaud the Attorney's approach but it is worth observing that the decision to leave AA overnight at the Penrith cells without access to 24-hour medical care in a prison or, even better, a dedicated drug rehabilitation centre of the type being proposed by the Attorney-General, may have increased his vulnerability to suicidal ideation or other tendencies to self-harm as his withdrawal symptoms intensified.

All of these things said, as XX herself recognised, this is in essence a simple case. If AA had had the cord removed from his shorts, it is more than likely that he would still be alive today and, with luck, be undergoing intensive drug rehabilitation.

What has been done to reduce systemic risk?

Evidence was given that considerable efforts had been made by DCS to reduce systemic risk at the Penrith cells and in the wider custodial system. I accept that AA's death was a shock for the police and correctional officers most directly involved with his custody. I also accept that the DCS has learned from the experience and sought to implement some changes as a result of lessons learned from the incident.

It is now mandatory that potential ligatures be removed from all prisoners taken into DCS custody. I should emphasise that this is not a cause for congratulation – and I do not believe that the Department expects it – but a commonsense measure surprisingly not implemented before AA's death.

CCTV monitoring has been improved at the Penrith cells: extra monitors have been installed enabling correctional officers to view prisoners in all cells simultaneously.

What more should be done?

In my opinion, a number of further improvements in the system are called for. First, a scheme of monitoring prisoners on a regular basis by way of visual check would be a significant improvement on the current ad hoc practice.

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[6] Transcript *Lateline* 06/04/11 http://www.abc.net.au/lateline/content/2011/s3184344.htm

I am conscious that correctional officers often have many duties to attend to such as loading and unloading trucks, processing prisoners, serving meals, administering medications and monitoring “RIT” prisoners. I am also conscious that prisoners in cells can be very demanding and attention-seeking and that an officer walking down a corridor in a cell complex can be bombarded with requests and demands for attention to trivial as well as significant issues. It was implicit in officer Cliffe’s evidence that he sought to avoid unnecessary exposure to demands from prisoners.

While that is entirely understandable from one perspective, if there is no reasonable alternative means of maintaining a careful watch over prisoners, a system designed to keep prisoners safe from self-harm is liable to fail.

I have learned from experience conducting inquests into deaths in psychiatric units that one means used by NSW Health to maintain a safe environment for risky patients is for nurses to conduct regular checks on them, in some cases at 15-minute intervals.

As there are similarities between the populations of psychiatric units and many persons in court cells, a system of regular checks on prisoners in cells, especially in the initial stages of being confined in custody, would add an additional layer of defence against self-harm. I propose a recommendation to that effect. I understand that this recommendation is supported by the Department.

A further layer of defence against self-harm could be instituted if prisoners identified in court cells as withdrawing from drugs were given increased priority for placement in a correctional facility to enable them to be given 24-hour medical care if needed. In the light of AA’s experience, in my draft findings I proposed a recommendation that the Commissioner of Corrective Services considers re-ordering priorities for placement of prisoners undergoing drugs withdrawal.

Counsel for the Department of Corrective Services has informed me that the Commissioner has initiated a project to develop strategies to streamline the movement of prisoners from court cells to correctional facilities. It was submitted that the Department would need to be guided by Justice Health in respect of the severity of withdrawal symptoms and that there was no need to reconsider the system beyond that proposed by the Commissioner.

I agree that the primary assessment of drugs withdrawal symptoms is a medical matter for trained clinicians. The general point this case demonstrates is that drug withdrawal is a volatile process in which prisoners may suffer physical and psychological pain of increasing severity and, therefore, that the risk of self-harm is also likely to vary over time. This suggests to me that there is a potential need for such prisoners to be monitored and perhaps treated over a 24-hour period or longer. Hence the need to move them to facilities where such clinical monitoring is available.

I support the Commissioner’s plan but will make the recommendation as drafted.

As mentioned earlier, the new government has promised that it would establish a Metropolitan drug Treatment Facility capable of housing 300 prisoners. This would be in addition to the Parklea facility catering to drug Court referrals.

The Legal Aid Commission has submitted that I should recommend that the DCS ought consider using that facility for “the timely receipt and treatment of inmates from police and court cells” who are in the process of drug withdrawal or who are likely to be withdrawing from drugs shortly after being taken into custody.

As the new centre has not yet been built and may take some time to establish, I do not propose a formal recommendation – by the time it is running, such a proposal may be obsolete. Nevertheless, all other things being equal, this seems to me to be a meritorious proposal worthy of consideration.

I proposed a draft recommendation that the DCS (and, where appropriate, the Commissioner of Police) install systems of recording times and locations of “knock-up” calls from cells, including a system of recording when the knock-up call is answered. This recommendation has been opposed by the Department of Corrective Services as requiring a substantial capital investment that is not justified. It was also submitted that even the exercise of reviewing this proposal would be costly. No estimate of the costs either of upgrading the systems or of reviewing the systems has been offered.

The ultimate point of that proposal is prisoner safety and accountability of the custodians. If prisoners are indeed properly monitored and “knock-up” calls are answered, such a system would ultimately not only provide protection for prisoners but for correctional officers against allegations of neglect or misconduct. I appreciate that substantial costs may be involved in such upgrades and that a cost-benefit analysis is needed: there may be higher priorities for such expenditures.

I therefore propose that a review be conducted and that the Department *consider* upgrading the “knock-up” system as proposed in the context of other measures designed to promote prisoner safety.

A further recommendation I proposed in draft was that the Lodgement form filled in by correctional officers when receiving prisoners from police custody be amended to require the officer undertaking that exercise to acknowledge reading both the Custody Management Record and the Prisoner Transfer Note and any warnings or alerts contained on those records and to note those alerts or warnings on the Lodgement form or in some other attached document. These recommendations have been supported by the Department of Corrective Services.

I further proposed a draft recommendation that the Commissioners of Police and Corrective Service develop a system of integrating recorded histories of self-harm contained in their records (“static self-harm factors”) with any current observations or alerts of risk of self-harm at the time prisoners are transferred from Police to Corrective Services custody. In making this proposal, I do not mean to suggest a method by which this process should be carried out, much less the expenditure of vast capital funds on an integrated computer records system.

Rather, my intention is to suggest that Police custody managers check police records for histories or alerts of self-harm and specify them in the Prisoner Transfer Note or the Custody Management Record as well as noting any other signs or indicators of potential or immediate risk of self-harm by prisoners being transferred to Corrective Services.

Once the prisoner is received, a search of Corrective Services records should also be undertaken for histories or warnings of self-harm. Had officers at Parramatta or Penrith been aware of AA's extensive past history of self-harm, this may have acted as a warning to monitor him carefully.

AA was not identified as a person at risk until he was found hanging in his cell. It is self-evident, however, from the fact that he sought to take his own life that he was either at risk throughout his time in custody or became so some time during the afternoon of 3 May. Yet this was never identified. Mr Spartalis commented at one point during the proceedings that if all drugs-related and mentally ill prisoners were counted as being at risk this might cover 90 per cent of the prison population. Possibly so. (And the Attorney's remarks on Lateline are particular pertinent in this context.)

Yet experience in the coronial jurisdiction and the criminal jurisdiction of the Local Court suggests that suicides and self-harming conduct quite often take place during the early stages of a prisoner's confinement when he or she is undergoing the sudden shock of loss of liberty and may be withdrawing or suffering symptoms of untreated mental illness.

The Commissioner of Police was not identified as an interested party to the proceedings and did not seek leave to appear. This suggested recommendation obviously has implications for the Police Force. The Department of Corrective Services has informed that it "will give consideration to an arrangement between the NSW Police Force and Corrective Services in relation to the transfer of information relating to histories of self-harm subject to the views of the NSW Police Force." I therefore propose that, instead of the draft recommendation, the Commissioner of Police and the Department of Corrective Services develop a system or protocol for the transfer of full histories of prisoner self-harm from the Police Force to the Department when prisoners are transferred from police to DCS custody.

It was submitted to me that I should not make any recommendation concerning training of correctional officers in recognising and managing prisoners withdrawing from drugs because that would increase their level of responsibility without properly equipping them to address the issues. That position was reiterated in the written submissions I received after issuing draft findings and recommendations. It was emphasised that officers already undertake a "Safe Custody" course. It was said, correctly, that the identification and management of drug withdrawal is a medical issue and that correctional officers should be guided by Justice Health officers.

It was also pointed out to me that the training of correctional officers is to call for medical help if they see someone in distress and that therefore it is inappropriate to require that correctional officers be trained in recognising or managing drug withdrawal symptoms.

The Department does not support a recommendation that would lead to correctional officers taking on roles or responsibilities that are the normal domain of clinicians. With respect, this submission appears to me to miss the point.

It is not to unduly load the officers with the responsibility of caring for and treating prisoners but to assist them in recognising when to call for medical help and to take basic steps to prevent harm or further harm until that help arrives.

As Correctional Officer Charlton noted, correctional officers are well-trained in managing prisoners who evidence signs of potential self-harm. It seems to me that there is no difference in principle in training officers to deal with such problems, which are commonplace unfortunately in the system, and training them about the signs to watch out for in prisoners who are or may be suffering withdrawal symptoms, another commonplace problem I would have thought, and the procedures to be adopted when such a prisoner is identified.

Some prisoners may seek to feign or exaggerate symptoms but this is the case at present. RN Locke gave evidence that she would expect such a prisoner to be brought to her for assessment. Such training would, however, only be of use if a previous recommendation that prisoners be regularly visually checked were also implemented.

Ultimately, the better-trained correctional service staff are, the better they will do their jobs and, all other things being equal, the safer will be the prisoners. A number of officers and one ex-officer appeared to me to be upset by AA's death. There can be little doubt that a death in custody places a significant strain on correctional staff, not least because they become the subject of a coronial investigation in the aftermath, but also because decent officers will inevitably feel a sense of responsibility and failure when a prisoner takes his or her life on their watch.

A safer system is therefore of benefit to correctional officers as well as to prisoners. I will make the recommendation as drafted and hope that the Department will reconsider its opposition to the proposal. Training is a key issue. The Legal Aid Commission has submitted that I should recommend that officers posted in 24-hour court cells be given appropriate refresher training in relation to the lodgement and reception process with particular emphasis on;

Obligations in relation to completing Lodgement forms (PDFs) thoroughly

- Checking current and inactive alerts on the OIMS system and noting them on the Lodgement form
- The mandatory requirements in relation to Custody Management Records and Prisoner Transfer Dockets
- The need to take into account police alerts and warnings as well as DCS alerts in considering risk factors.
- Refresher training may also be needed in respect of the proper keeping of cell registers and the procedures relating to movement of prisoners between cells.

There is some overlap here with some of my previous proposals. I am also unaware of how widespread the need for systemic refresher training is now. The need for it could be assessed by DCS management in the light of these findings.

I propose to recommend that DCS review its training of officers in 24-hour court cells as suggested above and to implement refresher training if such a need is identified. This recommendation is supported by the Department.

The Legal Aid Commission made a number of proposals for review of Justice Health's policies and procedures concerning prisoners withdrawing from drugs. These appear to be based in large part on a report it had obtained from Dr Hayllar. While it was served on the interested parties, because it was provided to the court only at a very late stage and may have caused unfairness had it been admitted, I did not admit it into evidence. Dr Hayllar appears to have significant experience and expertise in relation to the management of people withdrawing from drugs.

The cogency of the opinions stated in the report has not been tested and Justice Health's policies and procedures were not the focus of this inquest. I do not, therefore, propose to make the recommendations suggested by the Legal Aid Commission. Nevertheless, the report may be a document useful to Justice Health in assessing its policies and procedures. Without endorsing the report, I propose to recommend that NSW Health consider it and, insofar as it useful, review relevant Justice Health's policies and procedures in the light of the opinions expressed by Dr Hayllar. There has been no opposition to the proposal from NSW Health.

Conclusions

In conclusion, I turn back to the issues raised by Counsel Assisting in opening the inquest:

- Why was the cord not removed from AA's pants by Police or Corrective Services officers?

- Were the procedures and the facilities at the Penrith Court Cells complex safe for a prisoner at risk, and in particular:
- Why was AA not searched again by Corrective Services officers when received into custody at the Penrith Court Cells complex?
- Why was AA not identified as a prisoner at risk?
- Was AA being properly monitored by Corrective Services officers at the Penrith Court Cells complex in the lead up to his death, whether by CCTV or otherwise?

The most plausible answer to question 1 appears to be that no one who had custody of AA at Parramatta Police Station or court cells considered it necessary at that time to remove the cord because AA did not appear to be at risk and because the procedures or instructions then applicable did not require the cord to be removed when AA was received into DCS custody.

The short answer to question 2 is that there were flaws in the procedures operating at Penrith court cells in May 2009 and the cell in which AA was placed was unsafe for a prisoner in possession of a ligature.

It appears that AA was not searched on his reception at Penrith cells because Penrith correctional staff relied on the fact that AA would have been searched at Parramatta cells and they assumed that the search at Parramatta would have removed any items constituting a potential risk of harm from his possession. They also relied on the fact that he did not appear to be at risk and had been assessed by RN Locke as suitable for normal cell placement. To state the obvious, there was simply no procedure at Penrith requiring that prisoners received from other DCS locations be searched again.

The question of why AA was not identified as a prisoner at risk is more complex. Certainly, at a number of steps along AA's path from the time of his arrest, Police, Correctional Services and Justice Health staff took steps to attempt to assess whether AA was in fact at risk of self-harm. It is evident that for most of the time AA was in custody on 2 and 3 May he did not raise an alarm or cause anyone to suspect that he was at genuine and immediate risk of self-harm.

It may be that his decision was made relatively quickly and fairly spontaneously shortly before he hanged himself. On the other hand, given his history of self-harm, perhaps thoughts of suicide were always close to the surface of his mind if not always consciously present. It is possible that as his withdrawal symptoms intensified during the late afternoon of 3 May they brought with them suicidal ideation. If, as Mr Zikria asserted to police, AA had been pleading for medication during the last 30 minutes before he was found hanging, this would certainly suggest he was then at risk, regardless of his situation the day before or earlier during that day.

He was not identified at that stage as being at risk because, among other reasons, he was not monitored in his cell. Even if he had been, the risk may not have been identified. If Mr Eagleton's evidence that he was asking about medication some time before dinner is an indication that his withdrawal symptoms were re-emerging, he was at potential risk. This was not identified at the time by Mr Eagleton because AA did not appear to Mr Eagleton to be in distress and because, although I make no criticism of him, Mr Eagleton was not trained to recognise the request for medication as a possible sign of a prisoner at risk. The same comment applies to all correctional officers at Penrith at that time.

Another possible reason AA was not identified as a prisoner at risk is that, apart from one brief conversation between him and Mr Eagleton and a conversation that led to him being moved from one cell to another.

He appears to have had very little interaction with correctional officers at all because there were no regular checks conducted on prisoners. As I have noted above, the system of monitoring prisoners was significantly flawed.

Headway has been made in improving the safety of prisoners. It is encouraging to note that the Prison Officers' Vocational Branch is a vociferous advocate of improved facilities and procedures and that DCS management has responded to many concerns this case raises. Nevertheless, it is tragic that so high a price has been paid for the lessons learnt.

It has been observed by insiders and observers of our criminal justice system that our prisons now serve the function that once was carried out by psychiatric hospitals: segregating the mentally ill and drug-addicted from the rest of society.

As I have noted above, however, the new Attorney-General has outlined a new approach to sentencing policy and the rehabilitation of prisoners, which seeks to regain a balance between punishment of offences and the rehabilitation of offenders, especially the mentally ill and drug-addicted.

From my perspective as a magistrate of 15 years experience, as well from the perspective I have gained as full-time Coroner presiding over a significant number of deaths in custody inquests, this is a most encouraging policy turn in this field. If fully implemented it may lead to a reduction of deaths in custody, reduced drug-induced crime and the mending of broken lives. It is in this new context that I offer the recommendations that follow my findings.

Finally, it has been said, “for [grief] there is no remedy provided by nature”. I realise that an inquest can provide little comfort for the family who have lost a young man but I hope they will know that the lessons learned in this case will probably save the lives of others. I offer my most sincere respects and condolences to AA’s family.

Formal Finding:

I find that AA died on 4 May 2009 at the Nepean Hospital, Penrith, New South Wales as a result of a hypoxic brain injury suffered when he hanged himself in the cells of the Penrith Local Court.

Recommendations

To the Minister for Corrective Services I make the following recommendations:

- That a system of monitoring prisoners on a regular basis by way of visual check be established in court cells administered by the Department of Corrective Services.
- That the DCS consider giving increased placement priority to prisoners in court cells who are withdrawing from drugs.
- That the DCS review its current “knock-up” systems and, following such a review, consider installing systems or mechanisms of recording times and locations of “knock-up” calls from cells, including a system of recording when “knock-up” calls are answered, in the context of other measures designed to promote prisoner safety.
- That the DCS amend the current Lodgement form to require correctional officers completing the form to acknowledge reading the Custody Management Record and Prisoner/Intoxicated Person Transfer Note received from police custody managers.
- That the DCS note or record any warnings or alerts contained on those police records on the Lodgement form or some other appropriate DCS document.

- That the DCS consider instituting a course of training in the recognition and management of prisoners withdrawing from drugs for correctional officers located in court cells.

- That the DCS review its training of officers in 24-hour court cells and implement refresher training if a need for it is identified.

To the Ministers for Police and Corrective Services I make the following recommendation:

- That the Police Force and the DCS develop a system or protocol for the transfer of full histories of prisoner self-harm from the Police Force to the Department of Corrective Services when prisoners are transferred from police to DCS custody.

To the Minister for Health I make the following recommendation:

- That NSW Health considers the undated report of Dr Hayllar received 11 March 2011 and, insofar as it is useful, review relevant Justice Health policies and procedures in the light of the opinions expressed by him.

9. 1221 of 2009

Inquest into the death of Mark Milgate at Gilgandra on the 30th April 2009. Findings handed down at Dubbo by Deputy State Coroner MacMahon on the 18th March 2011.

Mr Milgate's death was an unfortunate one. He was in a car with others that had had a collision. The police were looking for them. They the police drove past then turned around and came back but by the time they arrived the occupants had disappeared into the bush.

There was no moonlight or any other light available. The police officers waited for some time but none of the occupants emerged from the bush. The car was picked up by a tow truck and taken to the holding yard. Mr Milgate's companions emerged from the bush after the police left and hitched back to town. Mr Milgate however appears to have hidden by laying on the rail track. I suspect but did not find that he went to sleep on the track.

A goods train went past and he was struck on the head by the locomotive's undercarriage. He died as a result of his head wounds. I found that the actions of the police were appropriate and did not contribute to Mr Milgate's death.

<u>Formal Finding:</u>

Mark Andrew Millgate (born 3 September 1975) died on 30 April 2009. The place of his death was on railway tracks beside the Castlereagh Highway about 18 kilometres north of Gilgandra in the State of New South Wales. The cause of his death was a massive head injury that he suffered when he was struck by part of the undercarriage of a passing locomotive.

10. 1330 of 2009

Inquest into the death of Brian Francis Harre at Canberra on the 17th May 2009. Finding handed down by Deputy State Coroner Barry on 19 September 2011.

Inquest into the death of Brian Francis Harre at Canberra on 17 May 2009.This is an inquest into the death of Brian Francis Harre who was born on 23 April 1961. Mr Harre died on 17 May 2009 at Canberra Hospital. His death was reportable under s.23 and 27 of the Coroner's Act and an inquest mandatory because it was a death in custody. At the time of his death, Mr Harre was an inmate at Cooma Correctional Centre.

Ms Williamson was advocate assisting. Mr Walters represented the Department of Corrective Services. Mr Singh represented Justice Health. Formal documents including the report prepared by the Australian Federal Police, the identification certificate and post mortem and toxicology report prepared by Dr M Orde was tendered as exhibit 1.

Mr Harre was born at Grafton NSW. He was the youngest of 9 children. It is reported in a report by his sister Mrs Fowlie that Mr Harre had been diagnosed with epilepsy early in his life. He left school at 15 years and remained living with his mother until 2003, when he resided in a flat in Grafton.

Mrs Fowlie reported that Mr Harre was diagnosed with schizophrenia in his mid twenties. Whilst he remained on medication his illness was managed successfully but his behaviour deteriorated when he stopped taking his medication. NSW Department of Corrective Services inmate profile documents reveal that Mr Harre had a history dating back to 2007 with several notifications of self-harm and other mental health issues. He also had a history of drug and alcohol issues.

At the time of his death, Mr Harre was serving a sentence of 4 years and 6 months with a non-parole period of two years which was due to expire on 23 October 2009. In February 2009, Mrs Fowlie and her husband visited Mr Harre in Cooma Gaol. He looked good but had lost a bit of weight. Mr Harre expressed no complaint about his health other than weight loss.

Dr David Learoyd, Medical practitioner, had been attending Mr Harre on a number of occasions since his admission to Cooma Correctional Centre on 6 September 2008. In December 2008 Dr Learoyd noted Mr Harre had lost 8 KG over two months since October. There was no obvious cause for this weight loss. Dr Learoyd recommended x-rays and blood tests.

In January 2009 he refused blood tests and was advised he might have a potentially serious illness. On March 2009 Mr Harre allowed a blood test to be done. Dr Learoyd reviewed the results. The only abnormality was a mildly elevated C Reactive Protein. Other results were not clinically significant.

Dr Learoyd saw Mr Harre on 6 April 2009 at Cooma Clinic. He had a five-day history of vomiting, constipation, abdominal pain and distension.

He had signs of dehydration. His abdomen was distended and tender. Dr Learoyd made urgent arrangements for Mr Harre to be transferred to Cooma Hospital.

He was subsequently transferred to Canberra Hospital for further management. He was taken for emergency laparotomy where significant faecal peritoneal contamination was observed as a result of perforation in the sigmoid colon. A portion of bowel was removed which showed evidence of natural diverticular disease, with no evidence of injury due to foreign objects. Tests undertaken to investigate shortness of breath revealed what was thought to be thrombus in the aorta. He was commenced on an infusion of blood thinning medication.

On 16 April he deteriorated, with increasing shortness of breath and abdominal distension. He was readmitted to intensive care. Investigations revealed a large pelvic collection with gas locules extending into the left para renal spaces. Drainage was performed and he was returned to the ward on 18 April 2009. On 21 April the abdominal drain started discharging faecal material. He was returned to theatre for an exploratory laparotomy. He was found to have gross faecal contamination of the abdominal cavity with perforation of the terminal ileum. A resection was performed.

On 22 April he was again admitted to the ICU for a further operation and a further ileal resection. Investigation suggested that perforation was likely due to ischaemia. His condition remained critical and on 22 April he returned to ICU and had a tracheostomy and he remained reliant on ventilatory support. He deteriorated further with evolving organ failure. A decision was made to withdraw treatment on 16 May 2009 when palliative measures were implemented until time of death at 04.20 on 17 May 2009.

Dr Nicholas Talley, Specialist Gastroenterologist reviewed MR Harre's medical files. He concluded:

There is nothing suggesting that the three operations were not performed in time, correctly and efficiently, but the ensuing infection with a number of organisms resistant to many antibiotics could not be adequately controlled.

Dr Talley further stated that a number of conditions contributed to Mr Harre's death:

He was emaciated and this could have resulted in some degree of failure of the immune system. He suffered quite severe chronic obstructive pulmonary disease. He was on a methadone programme on a rather large dose, which may have blunted any pain sensation at the time of the development of the sigmoid diverticular perforation.

Dr Talley's conclusion is that the medical care Mr Harre received was as good as ons can expect under the circumstances. Mr Harre was not a very compliant patient and regularly gave misleading and often untruthful history. He further concluded Dr Learoyd managed Mr Harre in a caring and careful way, having seen him on 17 occasions between 8 September 2008 and 6 April 2009. The doctor at Cooma Hospital acted correctly and the surgical team at Canberra Hospital gave dedicated service.

Mrs Fowlie, Mr Harre's sister read a statement to the inquest. In that statement she raised one issue as to why her brother was not been referred to a doctor in the week prior to his admission to hospital. Mr Singh, for Justice Health submitted that Mr Harre was seen regularly by a Justice Health nurse and would have been referred to a doctor if it had been considered necessary at the time. A doctor was available to see Mr Harre on a weekly basis at the clinic within the gaol.

It is noted in Dr Leroy's report that Mr Harre had been transferred to Cooma Hospital Emergency Dept. on 26 March 2009 for assessment of abdominal pain and distension. The doctor who saw him was told that he had the pain for only one day, and it had gone by the time of assessment. At the time, his abdomen was soft and non-tender. Several days later, Mr Harre was again referred out to Cooma Hospital but he chose not to wait to see the doctor because of the long delays.

On 6 April Mr Harre was again seen by Dr Learoyd and transferred to hospital. Det. Sen. Con Hopkins, Officer in Charge, stated that on perusal of the Justice Health files there were no care and treatment issues arising. Mrs Fowlie acknowledged that her brother could be difficult to deal with and certainly his reticence to accept medical advice would not have assisted in his care.

I can find no issue surrounding Mr Harre's treatment.

Mrs Fowlie also wished to acknowledge the care Mr Harre received in hospital and the assistance that she and other members of her family received from officers at the Department of Corrective Services.

FORMAL FINDING

That Brian Francis Harre born on 23 April 1961, died on 17 May 2009 as a result of multiple organ failure, Antecedent causes giving rise to the above cause are listed as: Sepsis, Peritonitis, Sigmoid colonic diverticular perforation and subsequent ileal infarction and perforation due to aortomesentreic thromboembolism.

11. 1868 0f 2009

Inquest into the death of John Helsdingen on the 4th July 2009 at Prince of Wales Hospital, inquest conducted by State Coroner Jerram at Glebe on the 11 February 2011.

The death of this 76-year-old man, an inmate of the Long Bay Correctional Facility was as a result of natural causes. The death was whilst he was serving a full time custodial sentence and as such I am obliged under the Coroner's Act 2009 to hold an inquest into the death. I am satisfied following consideration of the brief of evidence that there are no issues requiring recommendations and the deceased was treated appropriately.

The deceased who was serving a full time sentence was diagnosed with cancer of the colon in December 2008 for which he had previously undergone resection of the tumour and subsequent chemotherapy.

The deceased presented at hospital with symptoms of small bowel obstruction on 3 July 2009. Following admission he was given supportive therapy however his condition continued to deteriorate and he died after a cardiac arrest in the early hours of 4 July 2009.

My formal finding is:

Formal Finding:

John Helsdingen died on July 4 2009 at Prince of Wales Hospital of natural causes, being Metastatic Colonic Adenocarcinoma.

12. 2204 of 2009

Inquest into the death of Shannon O'Dwyer on 31 July 2009 at Katoomba, finding handed down by Deputy State Coroner Dillon at Katoomba Local Court on the 21st February 2011.

Shannon O'Dwyer was a young man of 25 who died while being followed by police in the grounds of the Carrington Hotel at Katoomba on 31 July 2009.

At about 10pm, Mr O'Dwyer and a friend were throwing snowballs at one another at the ice rink in set up in front of the hotel. Some of those snowballs may have gone across the street.

Police officers in a van were conducting a routine patrol of Katoomba Street. They drove past the ice rink and noticed the two figures, next to the rink. One of the police officers saw a verbal exchange between one of the men and a staff member of a café across the street. The Constables drove to the end of the Katoomba Street, did a U-turn and came back.

As the police vehicle approached, the two men tried to duck behind the hedge, before starting to run.

Mr O'Dwyer ran through the hedges in the gardens and his friend in the opposite direction. One officer got out of the car and chased what he thought was two people through the Carrington Hotel gardens. The other drove the car around the driveway of the Carrington Hotel. The officer on foot briefly lost sight of the person running and then saw a person run up the driveway on the northern side of the Carrington Hotel.

The driveway leads to the car-park of the Carrington Hotel. That car-park can be closed off with a roller door, but the door was open on that night. On the northern side of the driveway is a brick wall, which is 1.9m high from the driveway to the top of the wall at that end.

Mr O'Dwyer ran up the driveway along side the wall. By this time the officer on foot had reached the bottom of the driveway, next to the wall and was about six metres behind Mr O'Dwyer.

The officer saw a person climb over the wall and jump down to the other side. The second officer joined the officer on foot within a few seconds, and also saw a man running up the wall and over the fences. Both police officers heard a bang. They ran to the wall and levered themselves to the top and looked over into darkness. Both officers pulled back. Constable Sewell shone his torch over the wall and could see Mr O'Dwyer lying face up in the car-park on the other side. There is a sheer drop into the car-park that has been measured at 7.7m. Mr O'Dwyer had landed on the concrete walkway at the bottom of the wall.

The officers could immediately see that Shannon was lying still, and that blood was pooling around his head. They called for an ambulance, and for backup and assistance, as well as for a duty officer to attend the scene.

One of the constables took a torch and scaled down to a narrow ledge on the eastern side of the car park. From there he has dropped on to the roof of a lean–to and then down on to the ground. He tried to wake Mr O'Dwyer and checked for a pulse. He could not find one to climb to the bottom at night, and holding a torch, took great skill and was a commendable act of bravery.

The ambulance was directed to the car-park where, with some difficulty, access was gained through a roller-door. Unfortunately, however, Mr O'Dwyer's injuries were fatal and ambulance officers pronounced him dead at the scene at 22.09. Laboratory testing later showed that he had a blood alcohol reading of 0.195g/100mL. Shannon was formally pronounced life extinct at 4.25 am on 1 August 2009. The autopsy report concluded that Mr O'Dwyer had died as a result of blunt force injury to his head resulting in multiple fractures to his skull.

Deputy State Coroner Dillon at Katoomba conducted an inquest on 21 February 2011. One of the issues raised by the family at the inquest was the question Mr O'Dwyer had been hit by police before falling.

They were also concerned about whether the chase had been improper and why Mr O'Dwyer had jumped over the wall knowing that there was a considerable fall on the other side.

An issue was raised concerning the timeliness and adequacy of the ambulance response. Finally, the family was concerned about the safety of the wall.

DSC Dillon made findings that Mr O'Dwyer had died by misadventure of the effects of blunt force head injuries suffered after falling from the wall at the Carrington Hotel into the car park.

He found no evidence of any impropriety by police in the chase itself or in the response to Mr O'Dwyer's fall. Mr O'Dwyer had been affected by alcohol and, it appears, had lost balance while attempting to descend the sheer wall of the car-park and fallen during his attempt to escape from the police. He found no evidence that Mr O'Dwyer had been touched, let alone hit, by police before his fall.

He also found that the ambulance response had been timely but delay had been caused by the difficulty in getting access to the car-park. The delay, however, appears to have made no difference to the outcome of this case because of the severity of Mr O'Dwyer's injuries.

He made a recommendation that the Carrington Hotel investigate modifying its northern boundary wall, subject to any heritage restrictions, to minimise the risk of the wall being climbed in future and that it implement such a scheme.

Formal Finding:

I find that on 31 July 2009, at Katoomba, NSW, Shannon O'Dwyer died by misadventure of the effects of a blunt force head injury suffered after falling from a wall at the Carrington Hotel.

Recommendation:

I recommend that the Carrington Hotel investigate modifying its Northern Boundary Wall, subject to any heritage restrictions, to minimise the risk of that wall being climbed in future, and implement such a scheme.

13. 2648 0f 2009

Inquest into the death of AA on the 9th September 2009 at Bathurst. Finding handed down by State Coroner Jerram.

This has been an inquest into the death of AA, who died at Bathurst Correctional Complex (BCC) at some time between 11pm on 10 Sept 09 and 8.20am on the following morning. Family has asked that we refer to him as AA.

At his death, he was only 42. He leaves behind a loving family, his Mother, father and brothers and sisters. My primary function is provided by s. 81 of the Coroner's Act. 2009. It is to make findings as to:

- The identity of the deceased,
- The date and place of the person's death,
- The manner and cause of the person's death.

There is no controversy in this case as to identity or place of death. The medical cause of AA's death, according to the pathologist, Dr Samarasinghe, was hanging, and there was a ligature mark around the neck.

The evidence leaves no doubt that the hanging was self-inflicted and that AA took his own life. There were: no signs of physical struggle on body, no physical indicators in cell, he was on good terms with his cell mate, Michael Pollard, who was separated and interviewed immediately after AA was discovered, and who appeared genuinely shocked. Mr Pollard had no injuries.

The real question in this inquest concerns the manner of death - in other words, what were the circumstances that led up to AA taking his own life. A secondary, but equally important, function is created by s. 82 of the Act. This section enables a Coroner to make recommendations that are considered necessary or desirable in relation to any matter connected with the death.

Public health and prison reform have been the subject of recommendations both by myself and Coronial colleagues in New South Wales in and around Australia. In particular, I will refer to recommendations, which I made in 2010 to the Minister for Corrective Services and the Minister for Health following a death by hanging at Goulburn Correctional Centre and the response to those Recommendations.

CIRCUMSTANCES

AA was brought into custody on 8 March 2009, and after spending several nights in Surry Hills watch house, he was taken to Parklea jail on 11 March. AA had been in custody in a number of jails in NSW at various time of his life, so this was not a strange experience for him.

In April, AA was sentenced in the Local Court for 2 counts of Assault Occasioning Actual Bodily Harm and breaching a Domestic Violence Order. The sentence was for 18 mths, with 12 months Non-Parole Period, which was due to expire on 7 March 2010.

However he was also on remand for a charge of robbery in company, allegedly committed with his co-offender, XX, who had been his defacto (and was the victim of the domestic dispute). On 11 March, an Intake screening form completed by Corrective Services staff noted a previous admission at Gladesville Psychiatric Hospital. It was also noted that AA was prescribed Avanza for depression but denied he had any current self-harm/suicidal thoughts. He was cleared for normal cell placement.

Justice Health staff completed appropriate screening documents. This included a Kessler 10 self-assessment form, designed to assess the risk of self-harm or suicide. On 11 March 2009, AA reported that he did not have thoughts of self-harm or suicide and there was nothing to alert Justice Health to a problem. When he came into custody he was on a dose of Avanza (anti-depressant) and methadone, and those drugs were continued.

However, there were a number of early indicators whilst AA was in custody at Parklea that he was not well. On 23 March AA was assessed by Dr Chew, a Psychiatrist was fearful of being killed and hearing voices. Added 10mg of Olanzapine (Zyprexa), an anti-psychotic. On 30 March AA was assessed by Dr McClure, psychiatrist. He was hearing voices and reported being in danger. On 30 April Dr McClure assessed him again. Olanzapine reduced to 5 mg at night: to be stopped altogether on 15 May.

On 16th July, he was taken to Bankstown Hospital suffering chest pains. An ECG and other tests were done. They returned negative results and he was returned to his cell the same day.

On 17 July, AA was seen in the clinic at Parklea Jail for a pre-court flu screening because he was due to appear in court for the robbery offence. On arrival, he asked when he was going to see the Psychiatrist, and stated, “I have already sent in two referral forms. I need to see the psych urgently otherwise I will kill myself”.

An hour later, he was asked about the seriousness of those threats and whether he needed to be in the clinic for his own protection. At that stage, Primary Health Notes record that he said that he was “ok” but that he really needs to see the psychiatrist because the voices are coming back. He was noted to be presenting as calmer and more accepting at that stage.

A mandatory Notification for Offenders at Risk of suicide or self-harm was completed and an RIT (Risk Intervention Team) was convened. AA was housed in a cell with CCTV and 15 minute observations, nil sharps were allowed, and he was only permitted safety blankets.

AA was assessed again on 18 and 19 July by Justice Health staff. He was noted to be cooperative and talkative, and he denied thoughts of self-harm or suicidal ideation. He told staff that he was just starting to realize what he had lost – a good job, earning plenty of money, his supportive parents and brothers. It was noted that he was to be referred to a psychiatrist.

On 20 July, the Risk Intervention Team (RIT) reviewed AA and it was decided that he could be returned to a normal cell. Just 3 days later, on 23 July, AA presented to the clinic again. He reported to staff that 3 inmates had stood over him for money and he was fearful of them. He was placed on a SMAP order (Special Management and Protection) to commence on that day and expire on 22 January 2010. The effect of the order was that he was not to associate with those 3 inmates. The last time AA was seen by a psychiatrist was on 29 July, when he saw Dr Chew for the second and final time.

Dr Chew recorded that he was:” freaking out”. He had suicidal ideation, but told the doctor that he “hasn’t got the guts”. The notes indicate that AA had a history of methadone use - he believed that the drug had ruined his life and he wanted to reduce his intake. That thought was one that reoccurred for AA. Dr Chew noted that he was for urgent psychiatric review in one week’s time. He did not place a medical hold on him. In Parklea, AA had developed a friendship with his cellmate. A letter sent by Mr G to AA whilst he was at Bathurst gives us some insight into AA’s state of mind. At the end of a friendly, warm letter to his new friend, Mr Gadsden wrote:

“Take care buddy. I don’t want you to do anything stupid now. Be safe’. When asked to explain why he had written those words, Mr G said that while they shared a cell at Parklea, AA had told him that he wanted to kill himself until Mr G arrived. AA told him that he was depressed because all his brothers were successful and he had wasted his life using drugs.

AA was able to see family in Parklea and he received regular visits from his parents and his brother. According to Stephen Dunningham, AA often said to Stephen that he wanted to see a psychiatrist or a psychologist for something, but he was not sure exactly what for.

On 5 August, AA was transferred to BCC, whilst he awaited movement to Wellington, his jail of classification. Evidence was given that some 1200 movements, or transferring inmates, come through BCC monthly.

One of the frustrations for AA's family with his transfer to Bathurst was that it was too far away for them to visit him. AA was able to make some calls to his family, and received letters from his mother. The last call he made to his family was on 9 September 2009, when he spoke with his mother, father and brother. His brother mentioned to him that his co offender for the robbery charge, previously his girlfriend, would be pleading guilty with the potential of giving evidence against him. AA made a point of apologising to his brother and to his father. He told his mum that he had got himself right with God and expressed his love for her, and he asked for his brother to come back on the phone and then told his brother that he loved him.

It is abundantly clear that AA had a deep love for his family and he felt loved and supported by them. During his incarceration at Bathurst, AA did not see a psychiatrist, welfare worker, education officer or drug and Alcohol worker. However, in the last week of his life, he did see a doctor and several nurses, for the reasons I will set out.

7 September – Dr Rikard-Bell, a visiting GP at the Clinic, saw him for a serious rash on his legs. He provisionally diagnosed the rash as vasculitis, possibly due to an allergic reaction to his medication. The GP stopped the Zyprexa and prescribed Prednisone, a corticosteroid at 50mg, plus anti-biotics. On 8 September, Justice Health staff was called to the yard after AA collapsed. He had hypertension and staff was initially fearful that he might be suffering a heart attack. AA was taken to Bathurst Base Hospital. He was diagnosed as having had a stress or anxiety related attack and returned to custody.

On 9 September, AA did not see the clinic. A notation filled in by Nurse Hurst for that date was a mistake, and in fact related to her seeing him on 10th September. 10. At around 9.30am, Nurse Pauline Hurst saw AA at the clinic after being told by a Corrective Services officer that he wished to speak to a nurse. She noticed that he appeared agitated and tired. It appears that an inmate who alerted them to the fact that AA was "acting weird" and may need some help approached CS staff.

AA himself then saw an officer and agreed to be taken to the clinic. We now know that what AA said to Nurse Hurst is critical to determining his mental state that night.

AA told Nurse Hurst that he was going mad and thought he was condemned to eternal damnation because he had gone against God's word. He asked to see a priest and Nurse Hurst reassured him she would contact the chaplain. She did do so but he wasn't in his office and left a message explaining that AA wanted to see him. We now know that the message wasn't received by the chaplain until after AA had died.

He told several inmates that day that he was ‘going to die tonight’. One of them was concerned sufficiently to break the usual code of silence and tell an officer of his concerns for AA. It may be significant that AA returned to the theme of methadone when talking to Nurse Hurst on 10th September. He told her that he had made a mistake commencing methadone 20 years ago because it had been the easy way out. He also said he was “going mad’ and was ‘condemned to eternal damnation’. The Nurse attempted to reassure him. Dr Sandra was conducting a clinic at that time and, at the suggestion of Nurse Hurst, he saw AA briefly. He noted “allergic welts” and recommended a continuation of prednisone at the dose of 50 mls per day.

No discussion occurred regarding AA’s mental state. AA then spoke again to Nurse Hurst. At 8.30pm: Enrolled and Endorsed Nurse Flynn checked on AA in his cell, after being asked to check on him by a nurse from the morning shift. Nurse Flynn told the court that she asked why and was told by her colleague that she ‘just had a feeling’. AA assured her that he was ok, and did not need any medication, or to talk to anyone. She considered him to be calm, directly looking her in the eye, and not delusional. Dr Nielssen opined that it is not unusual for calm to descend when a person has made the decision to commit suicide.

On the evening of 10 September, AA was sharing his cell with a fellow inmate. Other inmates and CS staff suggest that AA and Michael were both relatively easy going prisoners and they got along well. Both attended the chapel on various occasions.

There was no history of tension between the two. Unfortunately, Mr Pollard, who has been released, has not been able to be found to give evidence at this inquest.

Michael and AA watched TV together that night. Michael recalls a special “Q and A” where the then Prime Minister, Mr Rudd was on, and the TV guide for that date shows that to be the case. He noticed nothing out of the ordinary on that night and the TV went off around 10.30pm.

ACTIVE ALERTS

AA had a number of active alerts placed on him, as follows: 9 and 11 March 09– Med alerts he was on methadone 19 August 09 – Association alerts not to associate with 3 inmates – (Andrew Zhang, Adam Drollet, and Shadi Derbas). 19 August 09 – Medication alert – Mirtazapine/Olanzapine 11 Sept 2009 AA’s body was located on the morning of 11 September at around 8.25am, by Officer Peter Stace. At that time, Officer Stace entered the cell for the routine morning “let go”. The cell mate appeared to be still asleep and AA was suspended from the lower bar of the cell window, by a prison sheet, which was knotted round his neck.

Officer Stace immediately yelled for assistance, and he was quickly joined by Officers Potter and Madden. They helped to cut the bed sheet and the body was brought down. No CPR was attempted by Prison Officers because the body was cold and stiff, and it was clear that he had been dead for some time. It certainly appears that AA had been deceased for at least several hours, so that there was nothing they could have done at that point to save his life.

Within minutes of AA being found, nursing staff arrived to assist. AA was noted to be cold to the touch, and there were no signs of life. All Standard Operating Procedures were complied with. The crime scene was secured, a video recording was made so that relevant evidence could be preserved and the cell was secured to await the arrival of police, who, in accordance with protocol, were notified of the tragedy and attended promptly, arriving at the jail at around 8.45am. They then took over the crime scene preservation and the investigation. I heard evidence from two police officers that attended the jail immediately after they were notified. They were the Officer In Charge Detective Senior Constable Andrew Mclean, and Senior Constable Matthew Cullen from Forensic Services group.

They noted that there were a large number of possible hanging points in the cell, at least 8. Officer Cullen was able to take photos of cell bars in AA's cell, and compare them to the bars in other cells. He noted that there was no mesh on the window of Cell 36 that would prevent a sheet being looped through to allow for a hanging point.

THE VIEW

Following the opening of this inquest, I, my Assisting Counsel and Solicitor, and the legal representatives for Justice Health, Corrective Services, the nurses, and the Dunningham family were shown around the relevant areas of BCC by the General Manager, or Governor, Mr Fittler. We viewed the cell in which AA died in D wing, the Clinic, the accesses, the Acute Crisis Management Unit, and the new facility almost completed for women prisoners, the latter two units being designed to minimize the risks of suicide in their outlay, their furniture, and in the case of the ACMU, the installation of CCTV in all cells.

Those two new units were admirable, and a credit to the management of Bathurst. Unfortunately, the antiquity and crowding, and no doubt the lack of funding, in the main gaol, including D wing, is a far cry from those humane and desirable modern facilities. The huge number of transferring inmates passing through Bathurst makes treatment plans difficult, if not impossible, to implement. The Clinic is placed so that Protection prisoners, such as AA, cannot directly access it as do other prisoners, and special clearances are required for their escort to the Clinic.

There is only one, full time position (shared by two nurses) of Mental Health Nurse. The current incumbents, while now experienced and Registered Nurses do not hold formal qualifications in mental health. Their daily workload allows no more than six patients to be seen daily, and the current waiting list is 90, as compared to 50 two years ago. There are 3 full time psychologists at the gaol, employed by Corrective Services rather than Justice Health. A psychiatrist is available one and a half days per fortnight. It is simply impossible for proper health care, both physical and mental, to be provided to the over 500 inmates of Bathurst by the current number of Justice Health staff.

The commitment and compassion of Mr Fittler and his senior staff was impressive.

However, commitment and compassion need to be supported with better staff resources and greater funding. It is noted with pleasure that, three weeks before this inquest began, funding was received for non-risk meshing to be installed on cell windows instead of the dangerous bars, which were used by AA. Transition (or Buddy) cells are being prepared.

But the majority of the gaol still consists of cells where there are multiple hanging points including in the furniture and inadequate windows, heating and facilities generally. As prisoners are locked down from about 2.30 pm until let-go at 8am, the security and comfort of their cells should be paramount particularly given the high occurrence of existing mental illnesses in the prison population.

THE ISSUES:

- Were there obvious hanging points in the cell shared by AA, and if so, was it appropriate to house AA in that cell, given his medical history?

- Were staff at BCC adequately appraised of any mental health issues suffered by AA?

- Did AA receive adequate care for his mental health issues whilst he was at BCC? What link, if any, does this have to his death?

Expert Evidence

Dr Olav Nielssen, a psychiatrist, gave his expert, independent opinion of care and treatment afforded AA both at Parklea and at Bathurst. Dr Nielssen agreed with the prescribing to AA by Dr's Chew and McClure of the antipsychotic olanzapine and also of the addition of the antidepressant mirtazapine. However, given that the presence in AA of symptoms of psychosis months after reception to prison is consistent with an underlying psychotic illness, rather than a transient state, his view was that olanzapine should have been continued and not ceased on 14 May.

While the various medications prescribed were on the whole appropriate, when Dr Chew recommenced the Olanzapine at a relatively low dose on 29 July, Dr Nielsen's view was that it was less than the normal therapeutic dose for psychotics and probably too low to control properly the symptoms.

He felt that the reason for its cessation on 7 September by Dr Rikard-Bell, i.e. that it may have been the cause of the allergic rash, was 'possible but unlikely'. He was critical of the inadequacy of the level of observation and the frequency of review, given AA's initial diagnosis, treatment and history.

Most specifically, he was highly critical of the transfer to Bathurst without warning on 5 August, the day he was due to have the urgent psychiatric review, and the inaction of the Justice Health staff at Bathurst in arranging an urgent mental health review for AA. "Overall, " he states, " the psychiatric care provided to AA was less than adequate". Dr Nielssen also comments on the inadequacy of the notes or case files, which lack any detail to assist review, and treatment plans.

He notes that ‘from entries in the Justice Health records, it does not seem that AA had any psychological care at Bathurst CC, apart from the continuation of psychotropic medication prescribed while he was at Parklea.

It does not seem that he was placed on a list for urgent psychiatric review…(nor) provided with further treatment for psychosis or referred for further review by a mental health nurse at that time’. The psychiatrist in oral evidence also withdrew any real criticism of the GP’s cessation of the Zyprexa, as it was, he said, possible but unlikely that Zyprexa caused the rash, and he thought it probable that AA was already in a psychosis. The prednisone, a steroid, however, in such a large dose, does apparently have mood effects. He told the court that it is only a possibility that ceasing anti-psychotic medication contributes to instability.

Under cross examination by Mr de Mars for the family, Dr Nielssen stated that he considered the main reason for the suicide to have been the disruption to his care by the transfer and the failure adequately to treat his known and severe mental illness. AA was a prisoner with complex physical and mental health needs, so that consistency of treatment was vital. He should not have been transferred from Parklea. There should have been a review of his Justice Health notes by staff at Bathurst.

THE FAMILY

AA’s brother, spoke passionately of the family’s views. He himself had once spent time in prison, and also spoke from his personal experience. He considered that there were no proper resources at all for prisoners. There was no choice at all regarding transfers and placements. The Justice Health and mental health care was virtually non-existent. A prisoner was “a second rate citizen if on methadone, and a third rate one if also on protection”. All the signs of risk were there for AA, who was crying out for help, and none was forthcoming.

CONCLUSIONS

Nothing said by Dr Nielssen was contradicted and I accept it as strong evidence from a highly qualified psychiatrist experienced in the prison system. I am sympathetic to the feelings of the family, and do not dismiss the brother’s opinions, having now presided on a number of inquests into prisoner suicides.

I do recognize however that management at Bathurst is making impressive efforts to improve overall care for inmates, and that Corrective Services has taken strong and effective steps in the last year or two particularly to reduce instances of suicide in its institutions.

It has been successful in that reduction, by introducing multi-disciplinary reviews of prisoners at risk, using observation cells and CCTV, and the ‘buddy ‘ system of two in a cell, and reducing, in many instances, hanging points in cells. But one suicide is one too many in a system with a duty of care. As Dr Nielsen’s report stated, “ there are a huge number of transfers between gaols in New South Wales, which for security reasons are usually done without notification or consultation, and often result in the disruption of continuity of care.

Moreover, the level of psychiatric care available outside the Long Bay and Silverwater gaols is generally below that required to treat all patients with mental illness".

I take judicial notice of the fact that in the civilian community, provision of mental health care has been sparse and inadequate, and that only recently has government recognized that funding for community care needs to be vastly increased. Given the incidence of mental illness in the prison population, that need is proportionately even greater.

It was, as learned Counsel Assisting submitted, a serious lapse that AA was not seen by a psychiatrist (or even a mental health nurse) at Bathurst despite missing Dr Chew's one-week review. Nurse Homan was not able to explain the oddities of files concerning that omission even though she had put him on her list as urgently needing an appointment. It seems it will not be explained why or even whether he actually was 'dropped from the waiting list'. No health professional at Bathurst read his files.

This is unforgivable in view of his known history. Without necessarily blaming any individual staff member, here was a serious systemic failure to ensure the continuity of intensive psychiatric care both at Parklea to some extent, and fully at Bathurst.

Are we serious about the prison system's goal being "correctional facilities", or rehabilitation" when a prisoner voluntarily coming off methadone, and with a history of psychosis, drug-induced though it may be, is not backed up with all the needed psychiatric assistance that is needed.

In 2010 I made a number of recommendations following an inquest in to the death of a prisoner at Goulburn Correctional Centre. I commend the Department of Corrective Services for acting upon those recommendations relevant to it, and in establishing a special Management of Deaths in Custody Committee. A Coronial representative is an invitee on that Committee, as is the CEO of Justice Health. I regret having to comment that one of the Recommendations was to the Minister for Health and Justice Health. It read 'that there should be compulsory mental health training for all nursing staff in Justice Health'. Unlike the response of the Department of Corrective Services, that Recommendation, according to the evidence in this inquest, has apparently fallen on barren ground. I will repeat it, and deplore the inaction of Justice Health.

FORMAL FINDING:

That AA died at Bathurst Correctional Complex sometime between the evening hours of September 10 and the early morning of September 11, 2009, by hanging, which was self-inflicted while suffering from a serious mental illness.

RECOMMENDATIONS

To the Minister for Health and Justice Health:

- That there be compulsory mental health training for all nursing staff employed by Justice Health, according to the recommendation made after the death of an inmate at Goulburn Correctional Centre.

- That Justice Health implement an urgent review of all aspects of the care and treatment of AA from his reception into the prison system in March 2009, until his death on 10 September 2009, to be provided to both the CEO and the Chairperson of the Board of Justice Health by the last day of September, 2011.

- That there be an urgent review of staffing levels at Parklea Prison and in particular Bathurst Correctional Centre(s) to address the growing waiting lists for inmates requiring the services of Mental Health Nurses and/or Psychiatrists, taking into account the forthcoming opening of a new Clinic at Bathurst and the large number of transferee inmates. At least one further full time mental health nurse position to be considered for appointment to each Centre.

- To the Minister for Corrective Services, and the Minister for Justice Health:

- That consideration be given to ways of improving access to Health Care for inmates on protection or in the SMAP programme.

- That consideration be given to amending Clause 297 of The Crimes Administration of Sentences Regulation 2008 to allow for details of the special needs of inmates with mental health issues to be given to Corrective Services staff responsible for the transfer of prisoner in order that they be taken into account.

- That consideration be given by the Department of Corrective Services to the allocation of a Case Officer to an inmate immediately after a Case Plan is developed, regardless of whether the inmate has reached the gaol of classification.

Since completing the Finding above, the State Coroner is pleased to have been advised by representatives of Justice Health that Recommendation A1, made for the second time, has been accepted by Justice Health, and is in the process of being implemented. **Note:** An order under section 75(5) has been made permitting publication of a report of these proceedings.

14. 3333 of 2009

Inquest into the death of Adam Salter on the 18th November 2009 at Campsie. Finding handed down by Deputy State Coroner Mitchell at Glebe on the 14th October 2011.

Note: Certain evidence given during this inquest is subject to a non-publication order pursuant to section 74 (1)(b) of the Coroner 's Act 2009

Objections to the Coronial Brief

There were two matters raised regarding the Coronial Brief to which I should make special reference. The first was raised by Mr Nicholls and related to the *Record of Interview* of Sgt. Bissett and her *walkthrough* conducted on 30 November 2009. These were both *directed* but the view I took is that, leaving aside circumstances where material may be the subject of a valid claim of public interest immunity or legal professional privilege, there is no basis in law for the necessary exclusion of directed interviews from coronial briefs prepared by an officer of *NSW Police* on behalf of the Coroner except where the material was gathered for the purposes of the investigation of a complaint under part 8A of the *Police Act 1990*. There is no evidence of any relevant *complaint* in this case and I do not understand an inquest or the gathering of evidence for the purpose of an inquest to be the kind of *investigation* contemplated by Part 8A of the *Police Act 1990.* No such complaint was investigated here.

Rather, it seems to me that the material was gathered by police to assist the Coroner in the conduct of a mandatory inquest into Mr Salter's death which, more likely than not, was it's dominant purpose. Further, I think the material is not inadmissible merely because it was *directed*. It was gathered by police officers who were subject the Coroner 's power under section 51 of the *Coroner's Act 2009* to give directions in order to assist the Coroner in the conduct of an mandatory inquest. If, as I think was the case, the dominant purpose for which the material was obtained was to assist the Coroner in his/her function and so long as it was not obtained for the purposes of investigating a complaint under Part 8A of the *Police Act 1990*, then it could be admitted as evidence in the inquest subject to the ordinary rules applicable to the Coronial jurisdiction, namely that the evidence be relevant and that procedural fairness be accorded all concerned.

As to the matter raised by Mr Hood, it was that *non-publication orders* be made regarding material contained in Tabs 42, 43, 44, 99, 100(b), 102, 102A and 102B of the Coronial Brief. Given that one of the legitimate purposes of an inquest is to enable the community to be informed of the cause and manner of the death of a fellow member of the community and given the importance of *open justice*, a *non publication order* should be made only where a proper basis is clearly established and it should be directed with precision. At the time of Mr Hood's application, much of the material the subject of the application had been available for only about ten minutes.

I asked Mr Hood to prepare a *Minute* pointing to the precise passages, which he said warranted a *non-publication order* and, in the event, later in the proceedings, I was asked to and did make such an order restraining publication of the material contained in Tab 102 of the Coronial Brief and in paragraphs 7 and 9 of the statement of Sgt. Warren Brown to be found at Tab 100(b), page 1166(D) of the brief. I indicated that at the conclusion of the proceedings, I would remake those orders, which are designed to maintain confidentiality with regard to certain police operating procedures.

The *autopsy*

The autopsy report prepared by Dr Rebecca Irvine of the *Department of Forensic Medicine*, Glebe on 19 November, 2009 records the cause of death as a *"gunshot wound of chest."* Dr Irving mentioned the stab wounds, which Adam Salter inflicted on himself, which she described as *"relatively superficial"* and *"not likely lo have caused death."*

Adam Quddus Salter

Adam Salter was the eldest child of Adrian and Lynn Salter and he had two siblings, a brother Noah born on 19 October 1976 and a sister Zarin born on 15 March 1982. On 26 November 2001 at the Baha'i temple in Apia, Samoa, Adam Salter married Dorothy Taaed whom he had first met in about 1995. She was a Dutch national apparently without an Australian visa and was required to leave Australia in about April 2005. Initially, she went to the Netherlands but in January 2008, her parents reported that she was living *"outside the Netherlands"* and that they had *"no communication access to her."* Adam Salter initiated a separation and ceased sending her money in early 2006 and subsequently commenced divorce proceedings. Difficulties were encountered because Dorothy Taaed's whereabouts could not be established and, in the event, a *decree nisi* for dissolution of the marriage was pronounced in the *Federal Magistrates' Court* on 21 July, 2008. That decree became absolute on 22 August 2008.

Adam Salter was a web designer by occupation. At the time of his death, he had been employed by a website design company, *Creagency*, in Rose Bay where he was engaged in developing a music streaming website *"Kazaa."* Adam's father, Adrian Salter, provided the inquest with a good deal of personal information regarding his son who, professionally,*" was entering the most productive period of his life"* and who, he said, was respected by his peers *"world wide."*

Adam Salter was a *"champion"* of *open source software* and had contributed to *Github, which* is a world repository of software intended to be available on a cost-free basis.

He was expert in his field and, on one occasion, was featured by *Apple* as *"designer of the month."* His employer at *Creagency* told Adrian Salter that there are people who have joined that business just so they would have the opportunity of working with Adam. On a personal level, Mr Salter said that his son had been liked by everybody who met him. He made friends easily and was personable, gentle and kind. Adam Salter was fluent in Japanese, an enthusiastic rock climber and a keen if, in his father's view, not particularly accomplished student of the guitar.
He was known for his laughter, his ready wit and his cheerful nature and he was, to quote his sister, Zarin, *"a genuinely great guy… …loving, gentle and kind."*

Mr Salter told the inquest that there were a number of stresses in Adam's life but *"we could have got him professional help and he would have lived had it not been for the lethal gunshot."* Mr Adrian Salter gave very extensive evidence to the inquest and was very closely questioned and it seemed to me that he was a most impressive witness, truthful and candid.

My impression of him was of a most responsible and dignified man seeking no vengeance but, instead, seeking to ensure that the story of his son's death be faithfully recounted. He seemed to me to be content to acknowledge any uncertainty or mistaken impression, which he might have harboured. I feel sure everybody involved in this inquest would join me in extending to him and to his family our heartfelt sympathy on Adam's loss and I am very confident to accept him as a truthful and clear-sighted witness.

In particular, I am grateful to him for the picture of his son, which he painted for the inquest.

Mental Health

From time to time, Adam Salter consulted Dr Quoc Khanh An, a general practitioner of Campsie. Some of those consultations related to physical conditions such as a skin complaint and, on another occasion, abdominal pain but some related to mental health issues. On 20 August 2006, Adam Salter reported a history of lethargy for which Dr An ordered various tests and prescribed *Efexor XR 75mg daily*. Then, on 18 July, 2008, Dr An received word that Adam Salter had been admitted to the *Repatriation General Hospital, Concord "in relation to a psychiatric condition."*

It appears that Adam Salter had been a voluntary and, later, an involuntary patient and, on 18 July 2008, Magistrate M. Price adjourned a hearing under section 34 of the *Mental Health Act 2007* to I August 2008. Adam Salter was discharged from Concord on 30 July 2008.

The *Discharge Summary* subsequently received by Dr An discloses that Adam Salter had originally presented to the *Canterbury Mental Health Team*. Evidently he had been beaten after trying to remove *P-plates* from motor vehicles in the mistaken belief that he was a prophet of God.

The document records that *"he appeared seriously thought disordered and had religious delusions"* and that he had complained of *"multiple stressors over the last several months"* including his divorce, conflicts between his parents and pressures at work. Mr Salter had reported poor sleep, low mood, negative thoughts and depressed appetite. His parents joined in to report that they were very concerned for their son's safety, particularly when he was standing in the middle of the road and attempting to stop cars *"to deliver God's messages to others."* According to the *Discharge Summary,* it was when Adam Salter had become irritable and anxious in the ward, believing *"that he should go back home because he had duties from God,"*

that he was made an involuntary patient and was started on *Risperidone 1 mg mane/2 mg nocte.* His diagnosis was *"psychotic episode"* and his follow up plan was recorded as *"MHT and GP."*

On 7 August 2008, Adam Salter presented at Dr An's surgery and was prescribed further *Risperidone 3mg nocte, which* had been administered during his admission at *RGH Concord*.

On 27 August, 2008, Adam Salter provided Dr An with a medical certificate from Dr Luisa Ngedm of *RGH Concord* relating to the period 10 July, 2008 to 10 September, 2008 in which Dr Ngedm noted psychotic symptoms, disordered thought and disorganised behaviour.

The follow up plan devised at *RGH Concord* proved to be of limited utility because Adam Salter seems to have taken little notice of it. After 27 August 2008, his next consultation with Dr An was on 16 November 2009.

Nor was there any contact with the local mental health team until Zarin Salter prompted *Canterbury Community Health Team* to contact her brother, which they did on 15 December 2008. On that occasion, Adam Salter assured the team that he remained compliant with medication and had not experienced any symptoms of relapse. An appointment was made for him to see Dr Rosa Geladas, psychiatrist.

He was assessed as suffering from a schizophrenic disorder with depression but he declined to commence a regime of the antidepressant *Cipramil*. Dr Gilandras scheduled a further appointment for 9 January 2009 and noted that follow up should be undertaken every second day by *Acute Care Services* to assess risk of self-harm. On 19 December, the follow up plan was changed to weekly calls and on 9 January 2009, when Adam Salter saw Dr Gilandras, he told her *"I'm not depressed. I'm not suicidal. I do not have intentions of harming others. I'm working full time. I eat well. I think of my ex-wife occasionally because I am puzzled as to why she left me. I also don't understand why I became psychotic. My only problem now is that I don't sleep at the same time. Sometimes I only sleep after midnight and wake up late during the day."*

On 11 March, 2009, Adam Salter failed to attend Dr Gilandras by way of follow up but, when spoken to by the *Canterbury Community Health Team*, explained that he had forgotten his appointment because he was so busy at work and he reported that he was still well and had no symptoms. He failed to keep his next appointment scheduled for 20 March and there was no contact between the team and Adam Salter until 21 August 2009 when he requested a certificate to the effect that he was no longer medicated or in counselling and, instead, was fit to be a counsellor of fellow Baha'i worshippers. This certificate was not forthcoming and Adam Salter was advised that he should consult Dr Gilandras, which, in the event, he did not do.

There was no further contact between him and either the team or Dr Gilandras. Then, on 16 November 2009, Adam Salter presented at Dr An's surgery and provided a history of anxiety over the past week. According to his father, Adam had seemed stressed during most of that week. Evidently, he had spoken to his father about feeling a tightness in the stomach and feeling the need to ease his stress and he complained that a project he had taken on at work had escalated. At one point during that week, Adrian Salter said to his son *"Adam, you know, I think we should go to the hospital and I would like you to come with me to Canterbury Hospital, just to see. They might be able to help and just keep you over night"* but Adam Salter refused and said that he would prefer just to go to bed in his own room.

Dr An's recollection is that, when he saw him on 16 November, 2009, Adam spoke calmly and politely and was not agitated but, due to the symptoms of anxiety which he said he was experiencing, Dr An prescribed *Efexor XR 75my daily* which, he noted, had previously been used to good effect. At the same time, Dr An advised Adam Salter that he be reviewed by the psychiatrists he had seen at *RGH Concord* and keep in touch with the *Canterbury Mental Health Team* and he provided him with a brochure explaining the mental health services in the Canterbury area.

Early in the investigation some questions were raised regarding the efficacy of *Efexor* and whether it might have played any role in Adam Salter's ultimate affect and behaviour. Professor Starmer's evidence to the inquest is that it is not possible to express a firm opinion on this aspect of the matter and there I think it must rest.

17 November 2009

It seems that Adam Salter's mental state deteriorated quickly after his visit to Dr An. On 17 November, a colleague drove him home from work and there was a text message on his phone from a friend, Elton, to the effect that he was unwell, When he got home, he was acting strangely and he advised his father that he had left his tablets, presumably his *Efexor XR,* at Rose Bay. Adrian Salter was sufficiently concerned to drive from Lakemba to Rose Bay to retrieve them. He watched his son take an *Efexor XR* tablet that night.

18 November 2009

Next morning, 18 November 2009, Adam Salter and his father met at breakfast at about 7am. His father thought he was much improved after the *Efexor* tablet and a good night's sleep. Gone was the trancelike affect Adrian Salter had noticed in his son during the previous day when Adam seemed to stand and stare and not respond when spoken to. There was some discussion between father and son about disassembling a bed and, when Adrian Salter went into his home office at the front of the house to attend to correspondence, he thought all was well.

Shortly after, though, he came out of his office and met his son who was speaking very slowly and appeared dazed and Adam agreed with his father's suggestion that he see his specialist that day.

Adrian Salter went back into his office to check the phone number of the specialist and he heard a strange noise, described as *"a cough, gargle or a gurgling type cough"* coming from the kitchen. When he went to investigate, he found his son standing by the sink with blood coming from the centre of his chest. Adam was holding a heavy kitchen knife with a wide, six-inch long blade in his right hand and he had apparently stabbed himself. Adrian Salter said *"Adam, don't do this. Don't do it. Please stop"* and Adam answered, *"I have to."* When his father tried to take the knife from him, Adam Salter resisted and tried to stab or cut himself as they wrestled. Finally, Adrian told his son that he was hurting him and Adam relaxed and allowed his father to take the knife, which was placed, in the sink.

Adam was now bleeding profusely from a wound slightly to the left of the centre of his chest and when he took a breath, a flap of skin came out suggesting that the lung may have been injured. Adrian Salter helped Adam onto the floor against a cupboard, sitting him up straight, hoping to prevent bleeding into the lungs. And then he dialled *000* and spoke to the Ambulance Service.

On advice, Adrian Salter applied pressure to his son's wound, using a tea towel. Adam Salter was talking but not making sense except on one occasion when he asked how long the ambulance would be. Adam was hugging his father who maintained pressure on the wound. At some point, Adrian Salter got off the floor and darted over to the front door to open it so that ambulance officers could gain entry to the house once they arrived and, when he returned to the kitchen, Adam Salter was standing up and moving towards the sink where the knife was lying. Adrian Salter stopped him by putting his arms around him and said *"Adam, come on. Don't do this. You know, just wait for the ambulance. Come on, just sit down again."* It took a few moments to get Adam to the ground and, at one point, Adrian Salter rushed into the sitting room to retrieve a cushion so as to make his son more comfortable. They sat on the floor with Adrian Salter's arm around him and Adam hugging his father and that is the position they were in when the ambulance arrived.

Response Times

Records indicate that Adrian Salter's *000* call was received at *Newcastle Control* at 8.39.24am. Paramedic Karl Johnstone acknowledged the call at 8.44am and he and Paramedic Clements arrived at 33 Wangee Rd., Lakemba at 8.51am, a little less than 12 minutes after the call was first received. Police assistance was sought at 8.49am and the call went out on *VKG* at 8.50am. *Campsie 35* consisting of Snr Constable Leah Wilson and Constable Aaron Abela and *Campsie 14* with Sgt. Sherree Bissett and Leading Snr Constable Emily Metcalfe responded. Officers Bissett, Wilson and Meredith were experienced police officers and Mr Abela was newly out of the *Police College* with about six months experience. *Campsie 35* arrived at the Salter residence at 8.55.31am and *Campsie 14* arrived at 8.57.17am.

At 9.00am a second ambulance containing Paramedics Cheryl Lutz and Meagan Coolahan arrived at the premises. It seems to me that one could not be critical of the response times of either the Ambulance Service or Police.

The ambulance

Two paramedics, Karl Johnstone and Belinda Clements, walked straight into the kitchen as soon as the ambulance arrived.

One cut off Adam Salter's shirt and the other, Mr Johnstone, went to the sink, inspected the knife, put it back in the sink and announced to his colleague *"it's a wide blade.*" They asked a few questions and Adrian Salter confirmed that Adam's wound was self-inflicted. Adam Salter was lying on his back and the paramedics placed a pad on his wound and a bandage around his chest. They gave him oxygen and were still treating him when police officers Wilson and Abela entered the kitchen some two to five minutes later.

At 9.00am Paramedics Coolahan and Lutz arrived and, as an intensive care paramedic, Ms Coolahan assumed the major role in Adam's care.

The Police

On the morning of 18 November 2009, Sgt Sherree Bissett was the shift supervisor at Campsie police station with responsibility for the running of the outside car crews. Ms. Bissett subsequently told her superiors that the call to 33 Wangee Road, Lakemba *"came over as a priority 2"* and was announced as *"something along the lines of male committing self harm, I think with a knife… Trying to kill himself."* A car crew consisting of Senior Constable Leah Wilson and Constable Aaron Abela acknowledged the call and Ms. Bissett and Leading Senior Constable Emily Metcalf went *"to back them up."*

Ms. Bissett was equipped with her gun, baton, and handcuffs, *OC* spray, spare magazine, torch, baton and, once she determined to respond to the job, her *taser* which was hung on her appointments belt in a holster. There are two *tasers* at Campsie police station, kept in the gunroom in a separate safe, available to officers of Ms. Bissett's rank and function. Ms Bissett drove *Campsie 14* with Ms Metcalf as her passenger and, when they arrived at 33 Wangee Road, Lakemba, the other police car had already arrived and Leading Senior Constable Wilson was waiting outside the house. She told Ms. Bissett that Adam Salter had stabbed himself with a knife which was now in the sink and that he and another male (whom we now know to have been Adrian Salter) were inside with the paramedics and that *"the ambos are working on him."*

Ms Bissett ran straight through the front door and into the kitchen, accompanied by Metcalf and Wilson. Constable Abela was already in the kitchen. Adam Salter was supine on the floor and a paramedic (who, I think, was Ms. Coolahan) was kneeling down beside him treating him. According to Sgt Bissett, Adam Salter *"was covered with blood"* and there were pools of blood on the floor and blood on the door and walls. In her record of interview of 18 November, 2009 Ms. Bissett says that, on arrival, she had a look at the knife in the sink but, evidently, she did not seek to remove it or confiscate it. Ms. Wilson spoke to Adrian Salter in an adjoining room. Ms Bissett sent Ms Metcalfe and Mr Abela upstairs and then out the back *"to clear the house."*

Adrian Salter, then in the kitchen, recalls hearing a police officer ask, *"Is it secure?"* and another say, *"Yes, it's clear out the back."* Then, for reasons, which are not clear, police led Adrian Salter out of the kitchen and into his adjoining home office. Perhaps there were good reasons for that but it seems likely to me that Adrian Salter's presence was probably a comforting and reassuring one for his son and it might have been better not to separate them.

Once that was done and after she had established that the paramedics did not need a hand and having observed that Adam Salter *"was not responding, wasn't moving didn't seem as a threat at all,"* Sgt Bissett, accompanied by Metcalfe and Wilson, went outside, *"out of earshot,"* leaving Probationary Constable Abela standing somewhere near the refrigerator and the door of the kitchen on the right hand side of the room looking towards the sink, to remain where he was so as *"to keep an eye on"* Adam Salter.

At the same time, Ms Bissett reminded Abela that the knife was still in the sink. The three female police stood on the front porch discussing the situation.

They saw another paramedic returning to the kitchen with a stretcher. While Adrian Salter was out of the room and perhaps because he was out of the room, Adam Salter unexpectedly sat up, was gently restrained by paramedics, lay back down and then suddenly sprung up off the floor and headed for the sink. Adrian Salter rushed back into the kitchen and said *"no Adam. No, don't. Don't do this. It's hurting me. Don't."* He put his arm around his son but, when Adam pushed him, the older man slipped and fell over backwards and lost his grip of his son as he fell to the floor. Ms Coolahan's impression is that Adrian Salter may have tripped over some of the medical equipment as his son brushed past him.

The *Patient Health Care Record* completed later that morning by Paramedic Coolahan records Adam Salter suddenly becoming *"aggressive +++"* but, according to Ms. Coolahan, that aggression seems to have been limited to *"fighting everyone and lunging forward to get to the sink. Like, I'm going to get there no matter what."* According to Paramedic Johnstone who countersigned the *Patient Health Care Record* and, in that sense, endorsed the description of Adam as *"aggressive +++,"* the aggression consisted of Adam getting up off the floor quickly and unexpectedly, brushing people aside when they sought to restrain him and pulling off leads and cables as he sought hurriedly to disentangle himself from the medical equipment, leads and cables and make his way to the sink. Mr Johnstone was able to say that, although Adam Salter was moving his arms around, there was no punching and he added that, when Adam pushed his father out of the way, it was not really a push or a shove but he merely brushed him aside.

In recalling the scene, Paramedic Karl Johnstone described Adam Salter as *"suddenly becoming aggressive plus, plus, plus, that means very aggressive…"* but, as in Ms. Coolahan's recollection, he recalls the *aggression* as limited to the speed, agility and unexpectedness with which Adam Salter jumped up, his *"lunging at the kitchen sink…"* in order to get to the knife, his pushing his father to the floor when he tried to stop him and his self harm.

Despite the description *"plus, plus, plus,"* there seems not to have been any general aggression and there is no suggestion of Adam Salter turning his attention to police or paramedics. Instead, in Mr Johnstone's recollection, he seems to have been intent on harming himself. Mr Johnstone told Police that when Adam Salter sprung to his feet, *"his arms were flailing around, however, I, I, I don't think he was specifically trying to punch me or push me away or anything like that, however his arms were flailing around… …*

When he initially grabbed the knife out of the sink um, yes, I was in fear of my safety, that's why I've backed away, backed off him straight away. I didn't um, as soon as he grabbed the knife, I just backed off."

When she was asked to assess the degree of danger presented by Adam Salter, Paramedic Coolahan, described *"a highly charged situation*" but she told the inquest that Mr Salter was not threatening anybody and that, even when the words *"taser, taser, taser"* were called by Sgt Bissett,

all that was happening was that Adam Salter was intent on stabbing himself and was in no physical contact with anybody and Ms Coolahan thought that he posed a danger only in the sense that, if he changed his mind and turned his attentions on anybody else, they might have then found themselves in a vulnerable situation. According to his father, *"Adam was perhaps flailing his arms in order to get to the sink but he was not punching anybody."* As he made his way towards the sink, Paramedic Johnstone and Paramedic Coolahan sought to restrain him, Johnstone by standing in front of him with his palms on Adam Salter's chest and Coolahan by standing behind him with hand on shoulder but they too were brushed aside as he lunged for the sink.

According to Ms. Coolahan, with whom Paramedics Johnstone and Lutz agree, *"police were requested to come back into the room urgently."* In fact, Ms. Coolahan told the inquest, she made three separate requests for police assistance as she worked on Adam Salter. The first request was directed to Probationary Constable Abela as he stood near the refrigerator and the door, trying to pull on his glove. Adam Salter was still on the floor having unexpectedly sat up and Coolahan was beside him. She says Abela was facing them but did not move from his position and did not respond to her request. According to Paramedic Coolahan, her second request for police assistance which, she says, she made as Adam was *"in the process of getting up,"* was her loud call "*Can we get a hand here?"* Her evidence is that this was directed, not just to Probationary Constable Abela who, she says, made no answer, continued putting on his glove and otherwise did not move, but also to police officers outside the kitchen.

Ms. Coolahan's third call for police assistance was uttered as Adam Salter neared the sink and regained possession of the knife and, on that occasion, she yelled *"Can we get the f******* cops in here."* Then, according to Sgt Bissett, "*the ambo is screaming we need help in here."* I think the *ambo* in question was Paramedic Coolahan who, Ms Lutz recalls, *"very vocally"* and *"using a few choice words,"* called for *"some more f****** police in here right now."*. Police ran up the short hall way and into the kitchen in single file - officers Bissett, Wilson and Metcalfe. Sgt Bissett was the first police officer into the kitchen in response to that call with Wilson and Metcalfe following her in that order.

By that stage, Adam Salter was standing at the sink, either facing directly into the sink or turned towards the right at an angle of up to 45 degrees and he was stabbing himself in the neck. According to Sgt. Bissett in her recorded interview of 18 November, 2009, *"…I saw as I was running in, I saw the male was standing up and moving towards the sink. Abela was on his left side and there was an ambo on his right,*

and then I went and stood in the kitchen." In her *walkthrough* on 30 November 2009, Ms Bissett said that, on entering the kitchen, she saw Adam Salter at the sink *"and he's got the knife in his right hand … …and Aaron is wrestling him."*. No civilian witness has given evidence of Adam Salter and Probationary Constable Abela wrestling and neither is there any reference to it in the *P79A* Report. But, in the *walkthrough* in which she participated on 30 November, 2009, Sgt Bissett said that, as she entered the kitchen in response to Paramedic Coolahan's call, she saw that Probationary Constable Abela had hold of Adam Salter *"on his left side."*

Confronted, as she alleges, with Adam Salter, knife in hand, struggling with Mr Abela, she says *"I thought 'I'll jump in'"* but then hesitated, deciding that it was too dangerous.

But, she says, Adam Salter and Abela were still struggling, moving around, getting closer to her. She says "*at that stage, (the knife) just swung around towards him* (Abela) *so I thought he was going to stab him and kill him… …so I've just drawn my gun, gone 'taser, taser, taser' … …and so I shot him…"* The evidence of Paramedic Coolahan is that, far from entering the kitchen, assessing the situation and then making a decision to use her firearm rather than her *taser*, Sgt. Bissett had already drawn her firearm before she entered the kitchen and that, when she entered the kitchen, she was holding out her firearm in front of her, arms extended and in both hands, shoulder high.

Sgt Bissett's explanation for calling *"taser, taser, taser"* was that *"…prior to going to the job, I was thinking that I might need to use it" … …just from the initial information that he was a schedule and he was armed and he was doing self harm."* She made it clear in her statements to police that, in fact, there was no mistake involved and that she did not intend to draw the *taser* and she explained *"I didn't use the taser because I thought the guy was going to stab Abela and I didn't think that the taser would work. I used the gun because I thought that he was going to stab Abela, I thought he was going to kill him."* When asked why she didn't think the *taser* would work, Ms Bissett replied *"Because of the space, the confined space, because Abela was on him. I've already tasered someone and it didn't work. I don't think that the taser is so accurate. For the taser to work both prongs have to go in and, if one prong misses, it's not effective. Plus, if both prongs have gone in, depending on the movement, the wires are so thin that they can break anyway. If they break, it doesn't work so he could still stab him and they were still moving. The guy and Abela weren't standing still. I drew my firearm and I shot the guy on the right side. I shot him on the right side because Abela was to his left and I didn't want to hit Abela."*

Asked to amplify the interaction of Adam Salter and Probationary Constable Abela, Ms Bissett said, *"I saw that Abela was struggling with the male. The bloke is at the sink, facing it, and Abela was to his left and standing side on to him. I don't remember where Abela's left arm was but I saw that he was using his right hand to hold on to the male's upper left arm. I think he was trying to pull him away from the sink. I saw the knife in the bloke's right hand. The guy was moving like he was struggling with Abela.*

The male picked up the knife with his right hand. He was holding the knife by the handle and he has moved towards Abela. His right side was coming around with the knife…(the blade) was pointing in the direction of Abela …and I was thinking) that Abela was about to be stabbed."

In the recorded *walkthrough* in which she participated with Detective Inspector Oxford and others, Ms Bissett demonstrated Abela as standing behind and to left side of Adam Salter, locked in a close embrace – Mr Rushton called it a *"bear hug,"* as they struggled. In her police notebook, Leading Senior Constable Wilson recorded that, as Adam Salter approached the sink, *"Cst Abela moved towards the POI"* and as Adam picked up the knife from the sink,

"Cst. Abela tried to restrain the POI's (L) shoulder…" and she told the inquest that she saw Adam Salter brandishing the knife towards Abela and Abela *"struggling with his upper left side."*. It is Ms. Wilson's evidence that Adam Salter, holding the knife in his right fist, was twisting his body towards the left so that his right arm moved around and the knife was pointed at Mr Abela and then back towards the right in a downwards motion. She understood this, she told the inquest, to be an attempt by Adam Salter to stab Probationary Constable Abela.

When she first entered the room, Leading Senior Constable Metcalfe says, she saw Abela standing near the sink, holding Adam Salter by the left shoulder. She did not see the knife in Adam Salter's hand and neither did she see any indication that he was stabbing himself or trying to stab Mr Abela. Instead, her recollection is that, rather than turning to Mr Abela on his left, he seemed to be turning to his right. Mr Abela's version of the event is that, as Adam Salter suddenly got up, he, Abela, walked quietly towards him. He says that, as Adam Salter moved to the sink, he also moved towards the sink and tried to stop Adam Salter by stretching out his right arm. Mr Salter *"got through"* him so Mr Abela, standing behind him, took hold of his left arm and pulled, trying unsuccessfully to pull Mr Salter away from the sink. Here there was no suggestion of a close embrace or a bear hug – the physical contact described was Abela's hand or hands on Mr Salter's arm. It was then, he says, that he saw Adam Salter's hand lift the knife from the sink so he let go of the arm, stepped back and, turning right, saw Sgt Bissett in the room, pointing her gun.

According to Paramedic Johnstone, when Adam Salter sprung to his feet to grab the knife, there was at least one and possibly two police officers in the room and *"there was a lot of yelling… …not necessarily yelling but raised voices."* . Mr Johnstone's recollection mirrors that of his colleague when it comes to *"one police officer yelling 'taser, taser, taser' but shooting the patient in the back at close range."* Like Ms. Coolahan, Mr Johnstone is unaware of any words spoken to Adam Salter other than *"taser, taser, taser."* No paramedic heard a warning, *"Drop it"* being uttered.

Paramedic Cheryl Lutz accompanied Ms Coolahan to the premises at 33 Wangee Road and was present when Adam Salter sprung up from the floor. She too describes him as *"quite agitated and aggressive"* and *"lunging around the room"* and going *"ballistic"* or, as she later said, *"nuts."* She offered as an explanation that *"sometimes people when they've lost blood, are obviously not thinking rationally."* Her recollection is that *"He just sat up and I think they sort of said, you know, 'you need to lie down, lie down.' And he just got up and started swinging his arms around and um, was slipping over on the floor and was grabbing at things, and just pushing people away, and just sort of, um, pretty much out of control. Whether he knew what he was doing or not, I don't really know."*

Ms Lutz recalls that, when Adam Salter grabbed the knife out of the sink, *"he started stabbing himself in the throat probably three or four times."* She recalls police officers – she can't recall how many - then re-entering the room *"…and to my right I heard someone yell 'taser' in a loud voice. And then, shortly after that, there was a loud bang… …and then the guy dropping to the ground."*

Like her colleagues, Ms Lutz recalls no words other than a female voice yelling *"taser"* but, unlike paramedic Coolahan, she does not recall seeing the gun. Ms Lutz emphasised the speed with which everything happened.

Her recollection is that, at the moment he was shot, Adam Salter was still intent on self-harm. He was *"sort of still in the process… …I mean he might have been waving the knife around a bit but he was, it was almost like he was still stabbing himself… …It was the shot, whatever it was, that actually stopped him. So, I don't think, there was, if he stopped before he was shot, it wasn't a very long time. Like it wasn't like he sort of lunged at anybody or did anything like that. It was almost like he was stabbing, stabbing, bang and then down."*

Questions which spring to mind regarding those few minutes – some witnesses described them in terms of seconds – in the kitchen at 33 Wangee Road, Lakemba include these. Was there a struggle between Adam Salter and Probationary Constable Abela and were they in physical contact? What, if any, danger did Adam Salter pose to anybody but himself? Did Ms Bissett really assess the situation while in the kitchen and then decide to use her *Glock* or had she already decided to do so before she entered the room?

Why, in the circumstances, did she use her *Glock* rather than her *taser*? And given that she used her Glock, why did she call *"taser, taser, taser?"* These matter are important because it is largely her claim that she perceived Mr Abela as being in danger of being stabbed that Ms Bissett cites as justifying her decision to shoot Mr Salter.

Difficulties with the police version of events

There are several difficulties with the police evidence regarding these matters. In the first place, the three female officers would place Abela much closer to Mr Salter than would Probationary Constable Abela himself who described himself as pulling Mr Salter's arm and more or less at arms length from him. By contrast, Ms Bissett has them in a close embrace, a *bear hug,* as she demonstrated in her *walkthrough*.

It seems to me that the state of Mr Abela's clothing worn at the time, which is **EXHIBIT 11,** is more significant for what it fails to show than for what it does show and I think it lends no support to the version of officers Bissett, Wilson and Metcalfe.

His uniform *cargo pants* show what apparently is some blood droplets which may have been acquired when Adam Salter was shot or when Mr Abela assisted paramedics in lifting and carrying him outside to a waiting stretcher or at some other time. It is not possible to say. More significantly, the front of his shirt is free of any bloodstains and there are some blood spots on the back of the shirt at the top left and the left sleeve. I cannot say how those bloodstains came to be on the shirt but it seems to me that, had Mr Abela been in as close a physical embrace with Adam Salter as Ms Bissett says he was, the blood staining on the shirt might have been heavier and more extensive.

The photographs of Adam Salter, admittedly taken after he had been shot, show that he was covered in a great deal of blood and evidence of almost everybody present is that, even before he was shot, there was a great deal of blood from his earlier wound. Indeed, Probationary Constable Abela himself, writing in his official police notebook **EXHIBIT 7**, recorded that Adam Salter was *"covered in blood on arrival"* and Sgt. Bissett described him in the same terms when speaking to Inspector Oxford.

Much of the police evidence regarding the physical exchange between Probationary Constable Abela and Adam Salter directly contradicts the evidence of other witnesses present at the scene, notably Adrian Salter and Paramedic Coolahan. According to Adrian Salter, Adam Salter was standing at the sink when he recovered the knife and was stabbing himself. Two or perhaps three paramedics were present in the room as was Probationary Constable Abela who, he says, was standing near the refrigerator while Adrian Salter himself got up from the floor where he had fallen as his son had brushed past him. Mr Salter says that he was focused on his son who, he says, was not being held by anybody. *"I don't think he was being held…"* he told the inquest *"…I'm sure he wasn't a source of surprise was why he wasn't being held. Alone in a room full of trained people, I was the only person holding him."* Mr Salter told the inquest that *"when police first arrived I thought that Adam is in good hands but when he got up and went to the sink, nobody tried to intervene."* None of the paramedics agrees with the police evidence of Probationary Constable Abela holding let alone struggling with Adam Salter.

Mr Johnstone recalled no physical contact between them and he told the inquest that, while Adam Salter was at the sink, Constable Abela maintained his stance near the refrigerator. Asked about Adam Salter stabbing or trying to stab Abela, Paramedic Lutz told the inquest that there was no such threat and that nobody was near Mr Salter as he stabbed himself and, in particular, that Mr Abela was well away from him.

Paramedic Clements was not in the room at this time but Paramedic Meagan Coolahan certainly was and she told the inquest that at no stage up to the point when the shot was fired did she see Adam Salter and Probationary Constable Abela engage in any physical contact and that at no time was her sight of Adam Salter obscured. She told the inquest that, while he was at the sink stabbing himself, perhaps four times, Adam Salter rotated his body clockwise but, even then, Mr Abela remained in his position about a metre away.

Her evidence is that, while he was at the sink, Adam Salter was not threatening anybody but himself. There are other aspects of the police officers' recollections of what went on in the kitchen at the time of the shooting where they are plainly wrong. One of these involves the presence in the kitchen of Mr Adrian Salter at the time of the shooting. On his version, which I accept, Adrian Salter ran into the kitchen as soon as his son stirred and got up from the floor and was in the kitchen and remained there after he himself fell to the floor and was present in the kitchen when his son was shot. The paramedics support that evidence. On the other hand, Mr Abela told the inquest that he cannot recall Adrian Salter intervening to stop his son get to the sink and indeed cannot recall Adrian Salter's presence in the kitchen at the time of his son's shooting.

It seems to me that, if Mr Abela were paying attention and participating in restraining Adam Salter, he could hardly have missed seeing Adrian Salter.

Probationary Constable Abela made notes of the events of 18 November 2009 in his official police notebook, which is **EXHIBIT 7**. His evidence is that he made these notes after he had returned to Campsie Police Station that morning. He says he made the notes before discussing those events with anybody else. Curiously, he wrote the words *“Critical Incident”* in the margin of each page although, initially, he told the inquest that he did not know what those words meant – something which may suggest that somebody who did understand what those words meant had a word with him at some stage in the process.

At a later stage of his evidence, he told the inquest that he had understood the meaning of the words *“Critical Incident”* having heard them used previously in relation to another police shooting. Initially Mr Abela was unable to explain to the inquest why he wrote those words in his notebook which, he said, he entered after the notes were written and after he was interviewed by his superiors on 18 November, 2009 but, ultimately, he said that the purpose of the entry, in the absence of a *COPS* event number, was to mark the notes for ease of reference. He told Mr Rushton of Senior Counsel that he had been aware of the importance of his notes in any investigation into Adam Salter’s death.

Probationary Constable Abela’s notebook entry records some of the events of 18 November 2009 although, apparently, without any attempt to list things chronologically. One matter that is not mentioned in the notebook is any attempt by Adam Salter to stab or otherwise attack him and neither is there any reference to Mr Abela wrestling or struggling with Adam Salter or being in particularly close physical contact with him or being threatened by him. The closest Mr Abela’s notes come to corroborating Ms Bissett’s evidence regarding his physical interaction with Adam Salter is the entry reading *“as male was rising went to assist ambos.”*

I am unable to see Leading Senior Constable Wilson as a reliable witness regarding the events in the kitchen when Adam Salter was shot. I note that Ms Wilson has Adrian Salter absent from the kitchen and, instead, in the home office at the time of the shooting and I note further that she has Sgt Bissett, before calling *“taser, taser, taser”* and shooting Adam Salter, providing a warning to him and inviting him to avoid trouble by calling *“drop it drop it”* – something that nobody else heard and not even Ms. Bassett herself alleges.

Ms. Bissett has not given sworn evidence in these proceedings but Ms Wilson’s evidence relating to the alleged warning “drop it drop it*”* is contrary to what the sergeant said in her recorded statement and during the *walkthrough* there Ms Bissett stated *“he* (Adam Salter) *made it to the sink. He grabbed the knife with his right hand and Abela was holding on to his left arm, he was on his left side. I shouted ‘taser, taser, taser’ but Abela was too close to him and I’ve drawn my gun and he’s turned with his knife towards Abela. And so I shot him there in his right rear shoulder blade area.”* During the *walkthrough*, she was asked *“But you’ve said ‘taser, taser, taser’ and then was there a pause or simply, just, you, you fired straight away?”* to which Sgt Bissett replied *“No, I fired straight away.”*

I am not aware that Sgt Bissett made any notes regarding the incident in her police notebook and Ms Metcalfe told the inquest that she made no notes herself. It is Paramedic Coolahan's evidence that, when officers Bissett, Wilson and Metcalfe entered the kitchen, Sgt Bissett already had her firearm in both hands, arms extended at shoulder height. Ms Coolahan says she saw a female police officer, clearly Ms Bissett, enter the room, her arms extended in front of her, holding what looked like a black gun in both hands.

She heard that officer yell "… *'Taser, taser, taser' … …but shooting the patient in the back at close range."* When asked by police, Ms Coolahan suggested a range of probably one but possibly up to two metres. This uncontradicted evidence would strongly suggest that Ms Bissett made a tragic mistake, intending to use her *taser* but, instead, firing her *Glock.* If, to the contrary, Sgt Bissett really did intend to use her *Glock* as she says had long been her intention, then the fact that, on Ms Coolahan's evidence, she drew that weapon before entering the kitchen suggests to me that she gave herself very little opportunity to assess the situation and decide whether lethal force really was necessary.

At pages 21 to 25 inclusive of her *walkthrough*, Ms Bissett explained why she did not choose and could not safely have chosen her *taser* rather than her gun when dealing with Adam Salter. She was trained in the use of the *taser* in November 2009. That training consisted of *"lectures, an exam and then simulation training where you have a scenario and you use the taser."* The *taser* works by firing at least two cables, each tipped by a little barb or a number of little barbs, which have to enter the body of the person to be subdued in order to complete an electric circuit.

If only one barb-tipped cable finds its mark so that the circuit is not completed, the *taser* will be ineffective unless the operator is able to *"Drive stun"* the person to be subdued.

Drive stunning takes place where the *taser* is placed against the skin of the target person so that an electric circuit is almost guaranteed, and then fired but this requires the person operating the *taser* to get into very close range of the person to be subdued.

Sometimes, although not often where the *Drive stun* technique is employed, the person operating the *taser* may miss the target and sometimes the barbs will fail to enter the body of the target person and instead get caught up in his or her clothes. This is called *"a clothing disconnect."* Given that, on Sgt Bissett's evidence, Mr Salter was being held by Mr Abela and had his back to Ms Bissett so that she could get in at very close range and given that he was wearing only shorts so that the barbs were unlikely to be caught up in his clothing, one would have thought that Adam Salter presented a very favourable target for a *taser*.

It seems likely that at the critical time Ms Bissett intended to use her *taser* and, in the event, made a mistake but, if that be not the case and she always intended to go for her gun, it is difficult to see that she gave the use of a less deadly alternative any real consideration.

I think it is clear that the only *conversation* between Ms Bissett and Adam Salter were the words *"taser, taser, taser."* Why Sgt Bissett used those words is a mystery.

One might have thought that they were intended as a warning to Adam Salter but, to the contrary, Sgt Bissett explained at *Q 213* of her *walkthrough* that those words *"are to let other police know that you're using the taser,"* presumably to warn them to get out of the way and avoid unintended electrocution. Or one might have thought that they indicated a momentary confusion – that Ms. Bissett meant to fire her *taser* but mistakenly fired her gun instead. But her evidence is that such is not the case. I note that the *taser* and the *Glock* could not easily be confused with each other. The *taser* is bigger than the *Glock* and is a bright yellow in colour. Further, it may be significant that a *taser* usually hangs from a police officer's appointments belt on left hand side and a *Glock* on the right. At any event, Sgt Bissett made it plain on both her statements that she had made no mistake and had intended the use of the firearm.

Paramedic Coolahan's evidence is that she did not hear Ms. Bissett or anybody else utter the words *"drop it. drop it."* Nobody other than Ms Wilson - not even Sgt Bissett herself, remembers those words being used and I am satisfied that they were not for those reasons, I think it is more likely than not, firstly, that no warning was given other than the words *"taser, taser, taser"* (if they constitute a warning), secondly, that Sgt Bissett made a mistake, intending to use her *taser* but, instead, firing her *Glock* or, if that be not the case, gave little if any consideration to enhancing Adam Salter's chances of survival by employing her *taser* rather than her *Glock,* thirdly, that Probationary Constable Abela was not in close physical contact with Adam Salter until at least after the latter was shot and, fourthly, that neither Mr Abela nor anybody else was in any particular danger from him. Indeed, I prefer the evidence of Adrian Salter and the evidence of Paramedic Coolahan who told the inquest that, once Adam Salter reached the knife and stabbed himself, she was aware that he posed no threat to anybody other than himself.

Note the evidence of Paramedic Lutz that *"I personally didn't feel to be in danger… …I didn't feel threatened by him… …they're no indication of him seeking to threaten anyone else."*

Even if these assessments of Ms Coolahan and Ms Lutz were overly optimistic, it is more likely than not that Probationary Constable Abela was ever in danger because he was never sufficiently close to Adam Salter to be in danger. Further, although the evidence on the topic comes from only one source, Ms. Coolahan seems very certain that Ms Bisset's firearm was already drawn at the time she entered the kitchen.

The Death of Adam Salter

Adrian Salter told the inquest that he saw his son standing up and stabbing himself and then somebody cried *"taser"* followed by a loud bang. *"The next thing I saw,"* Adrian Salter told police in his *ERISP, "was Adam going over backwards, stabbing at his throat with the knife."* Adrian Salter could see a wound to the throat with blood pouring out of it and Adam was lying on the floor with the knife still at his throat and he was jerking the knife into the left side of his throat,

underneath the jaw and Mr Salter *"…grabbed it. I said 'Adam,' and I grabbed his wrist and tried to stop him and then people grabbed me and pulled me away."*

Ms Coolahan recalled that, on being shot, Adam Salter *"Dropped to the ground and went into cardiac arrest."* On examination he was initially 10 on the *Glasgow Coma Scale*, tachycardic, tachypneaic with decreased breath sounds and, Ms Coolahan thought, a lung was filling with blood. Adrian Salter was removed from the room and he watched as Adam, on a stretcher, was placed into the ambulance and sent off to *Canterbury Hospital*. Adam Salter arrived at the hospital at 9.17am in cardiac arrest and Dr Marta Malkiewicz pronounced life extinct at 9.19am on 18 November, 2009.

Police response - The *P79A*

The original report of this fatality to the Coroner is constituted by the *P79A Report* signed by Constable D Bozakis of Burwood Police. A *P79A* is the document, which ordinarily goes to the State Coroner or her deputy and to the pathologist carrying out a *post mortem* examination of the deceased. At page 2 of her *Autopsy Report*, Dr Irvine mentioned that *"police attempted to convince (Adam Salter) to surrender his weapon but he refused to comply and charged an officer."* This is information, which, I suspect, she gleaned from the *P79A, which* recites, under the heading *"Narrative of Circumstances Under Which Death Took Place",* that *"the deceased was challenged several times by Police to drop the knife, refusing to do so. The deceased lunged the knife at Police."* Those statements were simply not true. In cross-examination, Det Sgt Gorman, the case officer and, effectively, the deputy to the *Officer in Charge,* Detective Inspector Oxford, agreed that neither of those representations is true. Nobody other than Leading Senior Constable Wilson has recalled any conversation between police and Adam Salter or any *"challenge"* to drop the knife but, rather, the *civilian* evidence seems to be that, almost immediately upon entering the room, the fatal shot was fired. Evidently they misled the pathologist and, perhaps as importantly, they had a potential to mislead the Coroner .

Further, apart from those false and misleading allegations, the *P79A* document makes no reference whatsoever to police providing a warning or attempting to deal with Adam Salter by any means less intrusive than shooting him and nor is there any reference to the words *"taser, taser, taser"* being uttered. Perhaps the author of the *P79A* was unaware of the details of this incident but the fact remains that, in this regard, the report is a most unsatisfactory, not to say potentially misleading, document.

Police Response – The *SITREPS*

Four *Situation Reports*, known as *SITREPS* found their way into evidence as **EXHIBIT 15.** The earliest was composed at 12.20pm on 18 November, 2009 and was signed by Inspector Matt Hanlon who, I was told, is on extended sick leave from *NSW Police* and unavailable to give evidence at the inquest. That document recites *"Police assisted the ambulance officers in restraining the POI. However, the POI was able to momentarily break free from their grasp and reach for the kitchen knife that had been secured on the kitchen bench.*

The primary police officer Sgt. Sheree Bissett challenged the POI to Dr op the knife on several occasions.

The POI did not comply and began to counter towards the officers whilst armed with a knife…" This description was almost entirely wrong. Police did not assist ambulance officers in the restraint of Adam Salter as he sought to get up off the floor. They were not *grasping* him so that there was no question of him *breaking free of their grasp.*

The kitchen knife had not been secured but, instead, left in the sink while the one remaining police officer in the kitchen, Probationary Constable Abela was told to stand, not close to the sink thus guarding the knife but, rather, across the room and near the refrigerator. Even on Ms Bissett's evidence, she did not challenge the *POI* to drop the knife on several occasions or at all and, on the evidence, which I prefer, namely that of Adrian Salter and the paramedics, Adam Salter did not *"counter towards the officers."* I have no idea where Mr Hanlon acquired his version of events but it was nonsense.

But, perhaps more significantly, the false version of events originally announced by Mr Hanlon was repeated in *SITREPS* composed by Superintendent P. Lennon at 6.30pm on 18 November and by Detective Inspector Oxford at 10pm and not corrected until 6.30pm on 19 November 2009. Now, as I understand it, these *SITREPS* were designed to keep the Commissioner of Police and his senior officers informed of this very serious incident and, no doubt, informed spokesmen for Police in their representations to the media. Accordingly, for the best part of a day and a half the public, through the media, and probably the Commissioner himself were misinformed as to what had happened and why it had happened.

Detective Inspector Oxford who, as the signatory of one of these *SITREPS,* might well be regarded as an author of this misinformation was or should have been well aware, by the time he signed his document, that there was available evidence to contradict the assertions contained within it.
His excuse for allowing these misrepresentations to go forward is that the *SITREPS* were *"cut and paste"* jobs for which he should not be held responsible. Others in the community and perhaps members of Adam Salter's family might see it as an attempt to manage the news, which evidently is what it did when an Assistant Commissioner of Police gave a media interview. As an exercise in the type of scrupulous impartiality, rigour and balance advocated in the *Critical Incident Guidelines* it fell far below an acceptable standard.

Police Response – Ms Bissett's *walkthrough*

Both Sergeant Sherree Bissett and Probationary Constable Aaron Abela participated with Detective Inspector Oxford in individual *ERISPs* and *walkthroughs* on 30 November 2009. Adrian Salter likewise participated in a *walkthrough* on 19 November, the day after he provided an *ERISP* interview. None of the four paramedics were offered that opportunity and neither was Senior Constable Metcalfe whose evidence differed in several respects from that of her colleagues.

For reasons, which I will outline, Ms Bissett's *walkthrough* seems to me to have been a deeply flawed process. The *walkthrough* was conducted by Detective Inspector Russell Oxford whose task it was *"to lead the investigation into the fatal shooting of Adam Salter."*

The *walkthrough* is uncontroversial to the point, at *Q144*, where Sgt. Bissett describes Adam Salter holding a knife and he and Probationary Constable Abela struggling and *"they're moving a bit over this way… …So I've just drawn my gun, gone 'taser, taser, taser'… …And so I shot him here."* Perhaps concerned lest anybody think that Sgt Bissett acted rashly in firing her gun, Inspector Oxford prompts her at *Q147 "You made a conscious decision now that actually you've got to intervene"* to which she answers *"yep."* No civilian witness suggests that there was any appreciable time between Ms Bissett entering the room and firing the gun and Paramedic Coolahan's evidence that the firearm was already drawn before Sgt. Bissett had entered the kitchen was already known to Police.

These contrary accounts should have been put to Ms Bissett – they were not, and should have prompted Mr Oxford to exercise a degree of caution which evidently they failed to do. Continuing the *walkthrough*, Ms Bissett then tells Mr Oxford that, as soon as she said *"taser, taser, taser,* " she fired her gun without any pause or delay.

If *"taser, taser, taser"* was meant to be a warning that, unless he ceased his unacceptable behaviour, Adam Salter would suffer grave consequences, it could have had no effect given that he was given no time to comply. If it was meant to be a warning to other police officers that an electrical circuit was about to be established and that they should stand clear, it was, on Ms Bissett's version of events, gratuitous as she insists that she had no intention of resorting to her *taser*. And, if it wasn't meant as a warning, it is not clear why *"taser, taser, taser"* was said.

Indeed, if one accepts Ms Bissett's evidence that she always intended to fire her *Glock*, it is not clear why there was any mention of a *taser* at all.

At *Q149* her explanation of *"taser, taser, taser"* is that *"they were the words that just came out of my mouth"* which is really no explanation at all. Mr Oxford tries to help her out at *Q150 to 152* by saying *"well, it's certainly not the case you pull out and go 'gun, gun, gun' do you?"* to which Sgt Bissett answers *"No." "No…"* Mr Oxford agrees, *"…you simply, if you've got to … …produce your weapon, you either pull it out and either say stop police, or, or some police response if you have to…produce your firearm."* Neither Sergeant Bissett nor Inspector Oxford has offered a rational and believable explanation for the words *"taser, taser, taser."* Mr Rushton of Senior Counsel for the family has suggested that the words were uttered in the course of *"blind panic and confusion"* when Ms Bissett made the *"tragic mistake"* of firing the wrong weapon followed, he says, by a deliberate attempt to *cover up* the tragic error. Despite the obvious and clear differences in appearance of a *taser* and a *Glock*, no better explanation for the utterance has been advanced and I think it is more likely than not, although I cannot be sure, that a mistake was made.

The situation has been descried as *chaotic*, the small room was crowded, everyone was yelling, Adam Salter was acting extremely irrationally and Ms Bissett seems to have drawn her weapon on the run and fired without much opportunity to assess what was going on and what should happen next. Returning to the *walkthrough*, in contrast to the evidence of the paramedics and of Adrian Salter, Ms Bissett, in her *walkthrough*, speaks at *Q162* of Adam Salter still struggling with Mr Abela after the shot was fired and, at *Q164,* of Adam Salter, after being released by Abela, turning around and facing her and standing his ground. By the time this *walkthrough* was undertaken, Police were in possession of evidence to the contrary. They had Probationary Constable Abela's statement of 18 November, 2009 that, as soon as he saw that Sgt Bissett had drawn her firearm, he had let go of Adam Salter and taken two steps away from him. And they had evidence from Ms Coolahan and from Adrian Salter describing the victim's behaviour and affect immediately after he was shot where there was no question of him showing any further challenge to Police. Mr Oxford chose to direct no further questions to Sgt Bissett regarding these apparent discrepancies.

Sgt Bissett had 22 years experience as a police officer and nearly seven as a sergeant. I suppose she was under some sort of obligation to explain why she had failed to select a method of subduing Adam Salter less drastic than shooting him dead with her *Glock*. At *Q193 s*he indicates that she *"just did not consider"* using her baton and she explains at *Q194* or, rather, Inspector Oxford explains on her behalf that using her baton instead of shooting Adam Salter dead would not have been an acceptable option because, as Mr Oxford put it, *"you, we have to spring it, it still takes some time to actually get it out."* Unprompted, Sgt Bissett says, *"I just didn't consider it. I didn't think it would be effective."* At *Q199*, Inspector Oxford prompts her that, in the circumstances, *"a baton would have been the least of your options do you think?"*

Nor did Ms Bissett regard her capsicum spray as an alternative to shooting Adam Salter because, as she explains, *"You've got to spray them in the face and because he had a knife and pretty much his, he wasn't facing me, like, he was struggling with Abela, so I'd have to get in close to try to come around and spray him in the face, so I didn't consider OC… …it's such a confined space, everyone would get secondary contamination."* And as Inspector Oxford puts it at *Qs202 to 205, "I suppose even, even today we've got the, the window open, there's a bit of breeze coming through here. Had you sprayed that, you could have effectively sprayed everybody in the room … …you could have sprayed yourself… …and incapacitated yourself. …You could have sprayed yourself… …And incapacitated yourself. …Would that be right?"*

Warming to the inadequacies of capsicum spray, Mr Oxford says at *Q207* and *208"…in a split second, you've got to make a decision in a split second. …That's certainly something that, that would have, may not have of, of stopped the situation, in fact it could have caused more harm to you and you could have been injured by it yourself."*

At *Q208 to Q255* of the *walkthrough*, Ms Bissett or, more accurately, Detective Inspector Oxford, sometimes with the concurrence of Ms Bissett, explains why she did not chose and could not safely have used her *taser* rather than her gun when dealing with Adam Salter.

She had up to date training in the use of a *taser*. The training consisted of *"lectures, an exam and then simulation training where you have a scenario and you use the taser."* At *Q212* Mr Oxford asks Sgt. Bissett *"can you draw the taser on a person and, and warn them that it can be used. Is that an option that you can with the taser? Or simply, if you draw it, you must fire it?"* Perhaps that question was too much, even for Ms Bissett, who replies *"Usually you're taught that if you're going to…you draw to fire it, not, you don't draw it just to cover people with it. If you're going to use it, you use it."* On another tack, Mr Oxford recalls that the *taser* works by firing barbs, some type of spears or little barbs into the body both of which have to enter the body in order to *"connect"* or *"to complete the circle "* as Ms Bissett corrected him. *"…So if you were to fire the barb and one missed…"* Mr Oxford continues *"…and you only got one barb in there, would it be effective?"*

Not surprisingly, Ms Bissett agrees that it would not. In those circumstances, Ms. Bissett says at *Q222 "I'd have to go in and what we call drive stun them where there's another two points on the actual taser. So say, if the barb went in here to make an effective circuit, I'd say go down there."* Given that Adam Salter had his back to Ms Bissett and was naked to the waist, that might have presented little problem for her.

At *Q226* Ms Bissett tells Mr Oxford that, as of 18 November, 2009, she had used a *taser* on only one prior occasion and, as Mr Oxford remarks, *"…on that occasion, It didn't work properly… …it wasn't effective."* As Detective Inspector Oxford explains *"if* (the taser) *hadn't worked then, potentially the officer* (Mr Abela) *could have been harmed… …because, regardless of what options you've got to use…"* At *Q235* Mr Oxford goes on *"…in your mind there was a situation where a man had a knife with* the *police officer struggling with him…*

…regardless of what options you had to use, you saw that there was potentially harm or the other officer being killed." Returning to her use of the words *"taser, taser. taser"* when she was about to use her gun, Sgt Bissett tells Mr Oxford that the only explanation she could think of was that, when the job first came up and she set off for Lakemba, she had thought it would be a job for a *tase*r. Perhaps, like me, Mr Oxford thought this an unsatisfactory explanation so he enhances it at *Q241* by saying *"…Would it be the case that with a self-harm you're looking possibly at some kind of irrational behaviour on the part of the person, that if they're harming themselves they're not, they're acting quite irrationally, would that be something you'd think?"* Ms Bissett agrees *"Yeah, yep."*

Perhaps Mr Oxford felt that the explanation of the use of the words *"taser, taser, taser"* was not entirely clear, so, at *Q242* he *"wrapped this up"* by misrepresenting what Bissett had told him and saying *"…the fact that you said 'taser, taser, taser' is merely a warning to others… …that you're intending to use a taser. As I said, when you produce your firearm, you don't yell 'gun, gun, gun,' do you? So it could be the case that by simply giving some, in the, in the, in the, I suppose in the, the timing of all this, it was very traumatic, a very emotionally charged type of incident, you're trying to give some warning to police officers here that you're about to take some action."* It is hard to imagine that this explanation satisfied Ms Bissett even if, as is unlikely, she understood it. It certainly does not satisfy me.

Finally, perhaps exhausted by the intricacies of reasoning to which she had been exposed throughout the *walkthrough*, Ms Bissett agrees with Mr Oxford's statements that *"it was a conscious decision that you realised you were reaching for your pistol and not your taser… …there is no mistake you were reaching for your pistol and you didn't mistakenly grab the wrong weapon,"* and *"you thought the gun, your pistol, was the best option."* Indeed, as Sgt Bissett says *"my only option."* For reasons, which would be obvious to any fair-minded person reading this *ERISP,* it would be dangerous to place reliance on it.

A particular difficulty with Ms Bissett's explanation of the basis of her decision to use her *Glock* rather than a *taser* is that, in contrast to her evidence that she entered the kitchen, assessed the situation and then drew her revolver, the evidence of Paramedic Coolahan is that at the time that Ms Bissett entered the room, she had already drawn her revolver and was holding it out in front of her in both hands. This allegation, namely that *"she* (Sgt. Bissett) *has come in with a weapon out"* was known to police on 18 November 2009 when Ms Coolahan gave her *ERISP*. Mr Oxford did not put the allegation to Sgt. Bissett. Nor were the versions of Adrian Salter or any of the paramedics as to the absence of any threat to or struggle with Constable Abela, well known to Oxford as at 30 November 2009, put to Ms Bissett.

In my respectful opinion, as an exercise in fact finding and investigation for the purpose of informing the Coroner, the Commissioner of Police or the public of the circumstances of the death of Adam Salter and reassuring the community that the matter has been subjected to close and independent scrutiny, the *walkthrough* with Sgt Bissett was a failure and a disgrace.

Instead of eliciting information from Ms Bissett, Mr Oxford went out of his way to provide much of the evidence himself and to ignore material, which might suggest a view or views contrary to his apparently preconceived version of the circumstances surrounding the death of Adam Salter. I do not accept his explanation that, because Ms Bissett's version of events contained in her *ERISP* was already to hand, the *walkthrough* should be regarded as no more than a dramatisation of the *ERISP* intended not to introduce evidence into the proceedings but merely to aid in a better understanding of the evidence already provided. Mr Rushton of Senior Counsel for the family described it as *"a whitewash"* and *"a cover up."*

Police Response – The Critical Incident Investigation Report

Included in the Coronial Brief is a copy of the *Guidelines For The Management And Investigation Of Critical Incidents*. This is a Police document governing the proper response, *inter alia*, to the death of or injury to a member of the community in circumstances involving a police officer. Here, because the actions of fellow police officers may have to be investigated, the guidelines recognise that there is a public interest in ensuring that investigating police act and are seen to act with particular thoroughness and complete impartiality.

And so, the decision was taken to treat the death of Adam Salter as a *critical incident* and to subject its investigation to the particularly rigorous practices set out in the guidelines.

These include the appointment of a specialist and independent team to undertake the investigation and a review of that investigation by an independent and high-ranking *Review Officer.* The specialist and independent team was that headed by Detective Inspector Russell Oxford as senior critical incident investigator (the *SCII*) and the independent *Review Officer* was Detective Inspector Steve Tedder. According to the Guidelines, the task of the SCII is to ensure that critical incidents are critically and rigorously investigated and the *Review Officer* is required to furnish a report to the *Deputy Commissioner –Field Operations,* certifying the quality, timeliness and probity of the investigation.

A 50 page *Critical Incident Investigation Report* into the fatal shooting of Adam Salter at Lakemba on 18 November 2009 was signed by Mr Oxford on 29 May 2011. A copy of the report is contained in the Coronial Brief. His conclusion is that *"Sergeant Bissett was reasonable in her belief that Constable Abela was in immediate risk of death or serious harm. Her decision to fire her weapon at the deceased was reasonable, necessary and justified."*

In his report, Detective Inspector Oxford devoted three approving pages to Sergeant Bissett's evidence at her *walkthrough,* perhaps not surprising since he was the author of so much of it, and three lines to Adrian Salter's *walkthrough*. In particular, he made no reference to Adrian Salter's evidence that his son made no lunge towards any person in the kitchen. Adrian Salter's response *"No. No…definitely not. In fact there was no one else, I was the closest person…I was the only person sort of within touching distance of him"* was entirely ignored by Mr Oxford. In his *ERISP* on 18 November 2009, Adrian Salter was asked questions about the police response to his son lunging for the sink and picking up the knife. He provided a number of answers including that *"they seemed to be in the same spot… …I ran in front of them to grab Adam… …they didn't seem to do anything except shoot him…"* which seem to have been entirely ignored by Mr Oxford.

At page 46 of the Report, under the heading *Investigation Opinion,* Detective Inspector Oxford describes Adam Salter as *"armed with a knife and swinging it around"* and Probationary Constable Abela as *"boxed into the corner of the small kitchen…"* with *"…no way to repel any stabbing threats."* The only way Mr Oxford could have come to those conclusions was entirely to ignore the contrary evidence of Adrian Salter and the paramedics, particularly Paramedic Coolahan. Indeed, to enable him to find that Abela was *"boxed in"* would have required Mr Oxford to ignore the evidence of Probationary Constable Abela himself.

Still at page 46 of the *Critical Incident Investigation Report*, Inspector Oxford explained Ms Bissett's use of the words *"taser, taser, taser"* as *"a sign or warning that she intended to fire."* That was not her evidence. The response she made to police indicates to me that she could give no convincing explanation for using the words which were merely *"the words that came out of my mouth"* until Mr Oxford provided an incomprehensible explanation which I doubt even she understood. Dealing further with Ms Bissett's cry of "*taser, taser, taser,"* Mr Oxford reported that *"her choice of words which may give the impression that she has mistakenly drew (sic) the wrong weapon, has in my opinion no bearing on the ultimately fatal outcome."*

At page 47 of the *Critical Incident Investigation Report,* Detective Inspector Oxford stated, *"the Police when interviewed gave consistent evidence. This is supported by Mr* (Adrian) *Salter and the ambulance officers who were present."* In my opinion, that statement gravely misrepresents the truth. They're are discrepancies in the evidence of the various police officers themselves and very major discrepancies between police on the one hand and Adrian Salter and the paramedics on the other. These go to whether Probationary Constable Abela played any useful part in the proceedings, whether he was ever in close physical contact with Adam Salter, whether he was ever in danger from Adam Salter, whether Adam Salter posed a danger to anybody else and, if so, when, whether Bissett had her firearm drawn when she entered the kitchen, whether it was necessary to go so far as to shoot Adam Salter and various other matters.

Mr Oxford's report refers to the evidence of Paramedic Cheryl Lutz but significantly omits any reference to her description of Adam Salter's behaviour once he recovered the knife from the sink and immediately before he was shot. Ms. Lutz told Police as early as April 2010 that, although Mr Salter was flailing around, he was not approaching anyone and she added *"I didn't feel it, I, like it was a threatening dangerous situation… …I think he was just intent on hurting himself… …I don't think he was trying to hurt anyone else there. Like, I didn't want to get anywhere near the guy… …with a knife like that. But I think he was just more intent on getting that knife and just sinking it into himself, rather than actually hurting anyone… I wouldn't have liked to test it."*

Elsewhere in her statement to Police, Ms Lutz said, *"I mean he might have been waving the knife around a bit, a little bit maybe, but he was, it was almost like he was still stabbing himself.*

It was almost like the, it was the shot whatever it was, that actually stopped him. So I don't think there was, if he stopped before he was shot, it wasn't a very long time. Like he wasn't, like he sort of lunged at anyone or did anything like that. It was almost like he was stabbing, stabbing, bang and then down…" This is evidence which clearly bears on the degree, if any, to which Adam Salter posed a threat to Probationary Constable Abela and others, something which is vital to Mr Oxford's stated opinion that *"Sergeant Bissett was reasonable in her belief that Constable Abela was at immediate risk of death or serious harm"* – a matter on which his ultimate conclusion that Ms. Bissett was justified in shooting Adam Salter turns. That Mr Oxford should have virtually ignored this evidence is a significant defect in the integrity of his Report.

Police Response – Ignoring the Paramedics

A remarkable aspect of the investigation, it seems to me, is the failure of police to arrange a *walkthrough* with any one of the paramedics who was present in the kitchen at the time Ms Bissett shot Adam Salter. There are several marked differences in the versions of events provided by Sgt Bissett and Probationary Constable Abela on the one hand and the paramedics on the other. One would have thought that, in an attempt to clarify at least some of those differences, a *walkthrough* with at least one of the paramedics – a witness who might have been thought to have had less invested in the outcome of the investigation than did police, would have been helpful and important for the investigation.

A *walkthrough* by at least one of the paramedics might have been helpful in providing an independent view for the community, which, after all, has an interest in knowing exactly how Adam Salter died. But Det Sgt Gorman told the inquest that she and Detective Inspector Oxford had decided that such participation of paramedics would not be necessary and that police evidence as to what had happened would be sufficient.

She said this notwithstanding that she and Mr Oxford were aware of the divergence between the recollections of police officers and those of the paramedics. Ms Gorman was unable or unwilling to explain the basis of that decision but, in light of my view that a good deal of police evidence regarding very significant issues is, at best, doubtful, I would have thought that the clarification which the paramedics' evidence might have offered should have been welcomed. Instead, it was largely ignored.

Police Response – The Review

At any event, Inspector Tedder, the *Review Officer*, told the inquest that he could see no difficulty with regard to that decision. He explained that it is the behaviour of police officers rather than the behaviour of paramedics or anybody else, which is to be investigated in the course of a *Critical Incident Investigation*. I am not sure if Mr Tedder was being disingenuous in giving that opinion. The point, of course, in having the benefit of a *walkthrough* by the paramedics is not that their behaviour could have been more closely monitored but, rather, that the behaviour of the police officers could have been independently observed.

At any event, Mr Tedder gave his colleague's report a clean bill of health. According to Mr Tedder, "the voluminous Critical Incident Report (50 pages) plus attachments details an outstanding and thorough investigation. Detective Inspector Oxford and his team have demonstrated a high degree of professionalism and diligence in conducting this investigation." For the reasons I have outlined, my opinion in contrast is that the investigation was seriously flawed, provided the Commissioner with a very unreliable view of the circumstances of Adam Salter's death and will have failed to persuade the community that the circumstances surrounding Adam Salter's death were investigated scrupulously and fairly.

Detective Inspector Tedder went on in his review to express the opinion that "all involved officers performed their professional duties in a highly commendable fashion both at the time of the incident and over the following days." In what, Mr Rushton SC told the inquest is seen by the Salter family as "abhorrent" and "an unforgivable insult," Mr Tedder went so far as to recommend that "at the appropriate time/juncture all four involved officers receive formal recognition for their actions in the performance of their duties." This recommendation was made as recently as June 2011.

In my respectful view, the Commissioner should most definitely not accept this recommendation which he might well see as likely to contribute to community unease regarding Adam Salter's fate and to the family's suspicion of what Mr Rushton described as *"a cover up and a whitewash."*

Summary

In fact, there is very strong evidence that Probationary Constable Abela played little effective part in this matter and very compelling evidence, casting doubt on his version of events, that he was never in close physical contact with let alone in any significant danger from Adam Salter.

So far as Sgt. Bissett is concerned, there is very strong evidence that her description of the risk posed by Adam Salter is exaggerated, real doubt as to whether she gave any consideration to an appropriate means of dealing with Adam Salter, real doubt as to whether shooting him was justified and whether a less drastic means of appropriately dealing with him was not available.

Most importantly there is a very strong flavour of confusion and mistake and, given her cry *"taser, taser. taser,"* I think it is more likely than not that Sgt, Bissett mistakenly chose her *Glock* having intended to employ her *taser* . As to the police intervention generally, a mentally ill man who, in the opinion of his father and those professionals who were taking care of him, may have been manic but posed a significant threat only to himself, lost his life at the hands of police who had intervened presumably in order to help him. At best, the police intervention was an utter failure. Police killed the person they were supposed to be helping. They forgot to remove or secure the knife from the sink.

They removed from the kitchen the very person, his father, most likely to be able to contain him. They left Adam Salter in the care of a young and inexperienced and, on the evidence of Adrian Salter and the paramedics, ineffective and unresponsive officer. When called in from the front porch, *"nattering"* as Mr Rushton would have it or briefing Sgt Bissett as they say was the case, they blundered into the kitchen, Ms. Bissett probably with gun drawn. There was a high degree of chaos in the room and perhaps police perceived that Adam Salter posed some sort of threat although it is more likely than not that he posed a threat only to himself.

It is most unlikely that he posed a threat to Probationary Constable Abela or that Mr Abela was anywhere near him. And then, without any proper warning or even challenge, Sgt Bissett fired the fatal shot, either mistakenly as I think is most likely the case, or deliberately and apparently without taking time for any thoughtful consideration of the alternatives on offer. At least two police officers failed to take notes and, on his own evidence, another took most inadequate notes. To talk about *"formal recognition of their actions in the performance of their duties"* is ridiculous. And all this was followed by an inadequate and apparently prejudiced *Critical Incident Investigation* chiefly directed, as far as I can tell, to avoid embarrassment to Police.

Police Integrity Commission

I was asked by Mr Rushton of Senior Counsel for the family to refer to certain police officers caught up in this matter and in the investigation of this matter to the *Police Integrity Commission*. On close consideration, I have decided not to do that.

My reasons have less to do with an assessment of whether or not there are matters here which might justify examination by the Commission than with the view that, in cases such as this, such Coronial referrals should be made only in circumstances where no recourse is otherwise available to those who feel aggrieved. In this case, the family will have my findings and reasons - public documents, to use as they wish and they may be advised to approach the Commission armed with those. I think they will lose nothing by reason of bringing their own concerns to the Commission rather than relying on mine.

Formal Finding:

My findings are that Adam Quddus Salter who was born on 18 June, 1973 died on 18 November, 2009 at Canterbury Hospital, Campsie, NSW of a gunshot wound having that day been shot in the back by Police while at his home at 33 Wangee Road, Campsie, NSW.

15. 807of 2010

Inquest into the death of AA on the 9th April 2010 at Concord. Finding handed down by Deputy State Coroner Barry at Glebe.

This is an inquest into the death of AA who was born on 16 July 1956 and died on 9 April 2010 as a result of complications of self –immolation.

S. 81(1) of the Coroner's Act 2009 stipulates that I must find, if sufficient evidence is available, the fact that a person has died, the identity of that person, the date and place of death and the cause and manner of death.

Because AA died as a result of severe burns I must also find the date and place of the fire and the circumstances of the fire pursuant to S81 (2).

In addition, AA's death occurred in the course of a police operation and accordingly an inquest is mandatory pursuant to s23©and s27 (1)(b) of the act.

Facts

AA was at the time of her death a 53-year-old woman. She had a partner with whom she had been in a relationship for 18 years. She also had a daughter and a grandson who was about 2 years old. Her daughter and partner provided statements to the inquest in which they described AA and the devastating effect of her death upon each of them.

The daughter described her mum as kind, gracious and loving. She described her as a caring person who always put the needs of others before her own. In her words her mum was" amazing". She is greatly missed.

Her partner described how his partner was a loving and caring mother and grandmother. She was his 'mate'. AA adored her grandson and there are numerous references to her love for her grandson contained in the brief of evidence as well as in other statements.

Throughout her late teens and adult life, AA struggled with mental health issues. She had been diagnosed with bi-polar disorder, post traumatic stress disorder and anxiety and depression. She also had a history of anorexia nervosa. At the time of her death Dr Pennington, psychiatrist at the Bankstown Mental Health Unit, was treating her.

There is a well-documented history of at least six occasions when AA had self-harmed with the intention of taking her own life. On Saturday 3 April 2010, AA was visited in her home at 45A Chaseling St, Greenacre by her daughter, grandson and her partner. The purpose of the visit was to celebrate Easter. The daughter reports that her mother appeared in good spirits. She consumed one glass of wine.

During the course of the afternoon and evening the daughter had a number of telephone conversations with her mother. The last call was about 10pm when the daughter asked her mother if she was all right. AA assured her she was and reiterated how much she loved the grandchild. That is the last time the daughter spoke with her mother. The daughter did not detect anything in that conversation that indicated to her that her mother had been drinking or affected by medication.

At 10.11pm AA called '000' and spoke with a police operator. There followed about 10 minutes of conversation with the operator in which AA revealed that she was 'pissed' and had covered herself in petrol and was planning to light it. A transcript of that conversation is in evidence. It reveals the efforts made by the communicator to keep AA engaged whilst at the same time alerting the emergency services to the situation.

AA at one stage told the operator she had "poured all the house with petrol". Later she informs the operator that she has poured petrol "at the front steps, all over the lounge room, kitchen, in the bedroom, all over the bed, all of the bathroom”. That information was disseminated to the police via CIDS.

AA later says*,” I don't want some help, I just want to say goodbye to the police because they have been really good to me*". AA later says” *I can hear the sirens already, so I'm telling you now I'm going to light it*".

A number of police vehicles responded to the call and were at the scene prior to the commencement of the fire. Shortly after their arrival, a fire alarm was activated from within the premises. Police became aware of the rapidly unfolding events inside the house at the sound of the alarm and the observation of flames. A number of police had positioned themselves at locations around the outside of the house. Some of these police took independent action and attempted to gain access to the house but were prevented by the thick smoke.

Fire officers arrived soon after the police and were able to evacuate AA from the premises. She was attended by ambulance officers at the scene and transported to hospital. At the scene she spoke with ambulance officer Dominic Carr. Ms Carr records the following conversation with AA whilst in the back of the ambulance:

Ms Carr: “ Did you do this to yourself? Did you set yourself alight?”

AA “yes”

Ms Carr “ Why?”

AA “ I wanted to kill myself”

Unfortunately, AA sustained burns to about 65% of her body and succumbed to her injuries on 9 April 2010.

THE ISSUES

Should the NSW Police Critical Incident Guidelines have been applied to this incident?

What was the efficacy of the treatment AA received by Dr Pennington and the Health Service?

What is the mechanism for sharing information between emergency services?

Critical Incident Guidelines

NSW Police has developed guidelines for the management and investigation of critical incidents. Those guidelines are in evidence. Essentially a critical incident is one, which requires an independent investigation and review. The guidelines describe a number of matters that are held to be critical incidents, including: *Death or Serious injury to a person arising from a police operation.*

The responsibility for declaring an incident as critical rests with the Region Commander. The Region Commander at the time was Det. Supt McErlaine. He has provided a statement and given oral evidence.

My understanding of Det Supt McErlaine’s evidence is that it was his belief that the incident was not a police operation. His evidence was that the incident was “ *a response to attend from a radio message”.* He further stated: *“It was an initial response resulting from a radio broadcast and it had not formed an operation at this stage*” and later “*an operation had not commenced”.* The definition of 'police operation' has been broadly interpreted and includes situations where police officers have been called to a scene and prior to their arrival the deceased causes his or her own death, whether or not he was or could have been aware of the potential involvement of police. (Waller p.106)

<u>NSW Police Guidelines for the Management and Investigation of Critical Incidents</u> includes the following (p.39):

<u>Police not at the scene</u>

This may include incidents where police are in contact via telephone/computer from a remote/distant location, or other circumstances where there is a clear and recognised absence of police presence about the site if the death or serious injury.

In the event that a death or serious injury is occasioned to any person as a result of any interaction with the police who were not at the scene, the same principles of investigation will apply. In this matter, AA contacted '000' and spoke with a police operator for an extended period of time. The operator created a number of CIDS messages during the course of that conversation which resulted in police, the fire service and the ambulance service being dispatched to her premises.

Police were at her premises before the fire, which resulted in AA's death, took hold. The police were involved from the initial '000' call to their attendance at the scene and their valiant attempts to evacuate AA. There is no question that this incident was a police operation within the meaning of the NSW Police guidelines:

Firstly: the police were on the telephone to AA and were interacting with her for over 10 mins. They assisted the Fire Service in evacuating AA. They then, quite correctly provided an escort to the ambulance transporting the seriously injured AA to hospital. This is clearly within the guidelines.

Secondly: police were at the scene. Although there is no evidence that AA knew of their presence prior to igniting the fire, such a situation has been held to be a police operation.

The appendix to the guidelines classifies that "*an operation to contain or restrain persons*" (p4 appendix) is to be considered a police operation. AA was speaking to the operator threatening to ignite herself. Det Supt McErlaine's oral evidence was that if the fire had not started then he would have expected police to interact and contain the situation.

The police were there before the fire ignited. They were there to hopefully contain the situation. Even on a narrow interpretation of the guidelines and annexure, this situation was a police operation.

Det. Supt. McErlaine stated in his written statement that in assessing whether or not to declare the incident critical he took into account the following information. AA was not aware that the police were outside her premises and therefore there is no evidence to suggest that the attending police may have precipitated her actions. Initially, the Duty Officer advised him that the injuries were non life-threatening. The duty officer had received this information from the attending ambulance officer. Some hours later he received information that AA was in a critical and unstable condition.

As a result of that information he decided to "ramp up" the investigation to almost critical incident protocols and directed the Bankstown Crime Manager to immediately attend the scene. In making an assessment of whether to declare the incident critical, Det Supt McErlaine also took into account that AA's injuries were self inflicted and not attributable to police activity.

In addition, he had no information that he believed would warrant the making of a declaration, such as community expectation or adverse comment concerning the behaviour of attending police. In his oral evidence, Det. Supt McErlaine conceded the following in relation to what criteria to apply in declaring an incident a critical incident:

There is no need for a geographical connection to the person who is injured. There does not need to be evidence that AA knew of the police presence. There does not need to be any evidence of wrongdoing on behalf of police before an incident is declared a critical incident. The fact that AA's injuries were initially considered non-life threatening is not a test. Indeed Det Supt McErlaine stated

"*I take for granted that in these matters it is a serious injury*"

Given the accepted serious nature of AA injuries and the fact that this was a police operation, the question of a declaration that the incident is critical is crucial one. The purpose of an incident being declared a critical incident is to ensure that the incident is subject to <u>independent investigation</u> and review. In this case there is no suggestion of police wrongdoing.

However, Det Supt McErlaine, at the time, had no knowledge of the information being disseminated to the other emergency services from the '000' call, especially in relation to the use of sirens, which is an issue in this inquest and a matter for review.

This becomes important in light of Sgt Miller's evidence. Sgt Miller was the station manager at Bankstown Station on the night of the incident. He received a message concerning the incident from the police radio. He also received information that the occupant of the house had threatened to set herself on fire if the house was approached. It was his evidence that he immediately requested VKG to have the Fire Brigade attend and he instructed VKG "to advise all cars and the fire brigade attending the scene, to make a silent approach".

In his oral evidence, Sgt Miller acknowledged that the transcript of the VKG messages does not reflect that instruction. Sgt Miller reiterated that it was "my recollection that I did give a silent approach. I believed I gave it to all cars and the Fire Brigade at the time."

The evidence adduced does not make it clear what siren AA heard. She certainly referred to hearing a siren when speaking with the '000' operator. It is clear from evidence that the Fire Service did not initially receive the instruction and when they did, the message was not disseminated to all fire services attending.

The fire Service has provided statements detailing how this came about and the steps now taken to rectify the situation. The evidence is clear that the Ambulance Service did not receive the instruction and the radio operator at the Sydney Communication Group VKG has explained this.

The evidence also suggests that the ambulance did not arrive until after AA had been evacuated. Fire Pumper 62 did not receive the direction concerning the silent approach until it was about 1km from the premises. By that time Fire Pumper 64 had already arrived at the scene and was attending the fire.

Fire Pumper 64, which was driven by John Bolwell did not receive a direction to attend without sirens.

However, he knew from experience that it was good practice to turn off the siren in approaching a suicide situation. He exercised his discretion and turned off the siren about one kilometre from the address.

It is not clear whether it was the sirens of these 2 services that were in fact heard by AA. Given that the fire had already been ignited before the second Fire Service arrived and well before the Ambulance service arrived, it is questionable whether it was the siren from one of these services that was heard by AA, or a simply a random siren relating to an unrelated incident.

In any event it would have been appropriate for the issue of the instruction by police, to the emergency services to have been independently investigated. Det Supt McErlaine's evidence that he "ramped up " the investigation to almost critical incident protocols' is puzzling, given his evidence that the incident was not a police operation but only a police response.

There is no category of 'almost critical incident protocols' that appears in the NSW police guidelines. If the incident was not a police operation, as claimed by the witness, why then claim that the incident "*was serious enough* to warrant having *a professional and thorough investigation from the word* go" and why apply some of the guideline protocols?.

When asked what is was that ultimately determined in his mind that it was not a critical incident, Det. Supt. stated

"*It was a combination of all factors*"

He again referred to*" lack of information regarding police misconduct*' and to the fact that there was" *nothing to suggest that any action on behalf of police officers contributed to AA's actions."*. He had already conceded that these were not, of themselves, relevant matters in assessing whether to declare a critical incident.

Mr Spartalis submitted that the correct test to apply concerning Det Supt McErlaine's decision is the test in *George v Rockett* (1990) 170 CLR 104. In that decision at p.112, the High Court held that:

When a statute prescribes that there must be "reasonable grounds" for a state of mind – including suspicion and belief – it requires the existence of facts, which are sufficient to induce that state of mind in a reasonable person.

That decision is not applicable in this case. The decision to be made in this particular matter did not involve the exercise of a power conferred upon a decision maker under statute. In any event there is authority that discretionary power to do something means that the power must be exercised "reasonably" and not in an "arbitrary" or "vague" way. (*Sharp v Wakefield* (1891) AC 173 at 179).

When scrutinized, Det Supt McErlaine's decision to not declare a critical incident is "unreasonable" because it took into account irrelevant and irregular considerations.

That the Region Commander failed to properly identify this incident as warranting a declaration as a critical incident should not reflect on the behaviour of the police at the scene who behaved in an exemplary manner. Comment needs to be made, however to ensure that senior police in the role of Region Commanders have a clear understanding of their responsibilities in relation to the guidelines.

The efficacy of Medical Treatment

The brief of evidence contains a number of files relating to the treatment AA received for her mental illness. Bankstown Hospital Medical Records contain documents relating to a number of suicide attempts made by AA and the follow up she received through the Bankstown Mental Health Team. Records reveal that AA presented in 1988 with an 18-month history of panic attacks and avoidance behaviour. A history was given of alcohol abuse and anorexia.

Over the next number of years there is documented history revealing her panic attacks, depression and anorexia as well as agoraphobia and personality disorder. From 2008 to 2010 there are 6 documented accounts of AA attempts at self-harm which in some cases resulted in her being admitted under the Mental Health Act . On a number of these occasions police had been involved in having her admitted to hospital.

The documents reveal a very troubled woman with a multitude of mental health issues. In the 12 months prior to her death, AA was being seen by Dr Honour Pennington, psychiatrist. She had been AA treating doctor since February 2009. She records her involvement in her statement and in her oral evidence. It is apparent that the medical approach to AA case was comprehensive and caring.

Dr Pennington's conclusion about AA diagnosis was that she probably had a borderline personality disorder, rather than bi-polar disorder. She stated in her report that AA had a "fragile chronically dysfunctional mood. There were many attempts to counteract this with mood stabilisers throughout her life but it had not been effective."

Dr Pennington last saw AA on 26 March 2010. This was a self-presentation. Dr Pennington described AA mood as being a little down compared to her visit on 23 March. She stated in oral evidence that there was no particular significance that attached to AA self-presenting. From her knowledge of AA Dr Pennington said it was not unusual for AA to have difficulty maintaining regular appointments and sometimes she would just turn up.

Because of her presentation on 26 March, Dr Pennington planned for AA to be included in the intensive stream for the weekend. That included having someone from the staff at the unit make telephone contact with AA over the weekend.'

At that time there were only enough resources available for telephone contact to be made after 6pm. There was no capacity for home visits. The records reveal that staff attempted to contact AA by telephone on Saturday and again on Sunday. Messages were left for her. In addition contact had been made with AA about an appointment with Dr Pennington on 6 April. This contact had been made prior to the weekend and confirmation of the contact had been noted in the file.

Dr Pennington stated that AA presentation on 26 March did not raise any particular concerns. There were no thoughts of suicide and although there was some increased risk of self-harm Dr Pennington believed that her mood would have settled by the next day. She stated that this reflected the historical mood changes experienced by AA.

In addition, the fact that telephone contact had not been successful over the weekend was, on a longitudinal view, not of particular concern. She was satisfied with the recommendations that she had made concerning contact over the weekend. Dr Pennington presented as a caring and thoughtful practitioner who clearly had a warm and therapeutic relationship with AA. I also note that the Root Cause Analysis conducted by NSW Health found no root cause or contributory factors were identified relating to the death of AA. Given the chronic lack of mental health services available, I am satisfied that all was done that could be done for AA at the time.

Communication between emergency services

The Police Service

I had before me a statement from Jaime Croucher- communications officer with the Sydney Communication Group VKG – NSW Police.

Ms Croucher advised that her job entailed responding to police requests for help over the radio, receiving and broadcasting jobs to police cars. It also included notifying other emergency services such as the ambulance service or the Fire Brigade.

She states that about 10.12pm on 3 April 2010, she received a priority job from ‘000’. This message was received by the Computer Aided Dispatch (CAD) system.

This was a message about a female threatening to set herself alight. Her co – worker, the dispatcher, dispatched the job to Bankstown cars over the air. He ‘double beeped’ the job meaning it was to be given priority for police attendance. A short time later the Fire brigade was notified through ICEMS. This is an electronic dissemination of information to the Fire Brigade and the RTA. The Ambulance service is not currently on this system.

Because of that, Ms Croucher notified the Ambulance Service of the job by telephone.

It would appear that almost simultaneously her co-worker dispatched a message to the police (BK13) to have the Fire Brigade attend without sirens. Ms Croucher concedes that it is possible that she missed this message and the ambulance service was not notified of this direction. Inspector Stafford, State Co- ordinator Communications Centre gave oral evidence. He explained that the CAD messages are changing all the time and they can move out of sight on the screen. He started that the practice is to notify all emergency services of any direction and the failure to notify the Ambulance Service on this occasion was an oversight.

The Ambulance Service

Mr Jamie Vernon, Director of Controls Division for the Ambulance Service provided a report stating that ANSW have been moving towards the integration of ICEMS. Certain steps have been taken to implement that system including implementing the CADIUP (Computer Aided Dispatch Infrastructure Upgrade), which has resulted in all four ASNSW control, centres sharing a common database.

A review is currently being undertaken to enable ICEMS to progress.

The Fire Service

Director Specialised Operations, Fire and Rescue NSW, Mark Whybro, provided a report. He stated that Inter Cad messaging ICEMS received the incident call at the Sydney Communication Centre. The 000 call, which was received by police was transferred by ICEMS to FRNSW and received at 22.13 on 3 April 2010. At 22.14.19. 64 Station Lakemba's Pumper was mobilised. At 22.25 a second ICEMS message was received from NSW police stating:

"Get FB to attend without sirens"

Sydney Communication Centre did not pass on this request to 64 Station Lakemba.

As a result, Mr Whybro stated that FRNSW has reviewed its handling of incident – related safety information. He outlined the corrective actions that have now been put on place: An Operational Communications Bulletin has been developed for issue to all communication Centre Staff reminding them of the need to properly manage incident – related information received through ICEMS. This incident has been developed into a case study to be used by communication Centre Instructors in skills maintenance and acquisition training. The review has determined that the request to attend without sirens was not passed on because the IUM (incident update message) was not received by the communication centre until after 64 Lakemba had already arrived on scene. The reason the message was not promptly reviewed was that the system had been reconfigured so that the IUM was not accompanied by an audible warning alert. This had been switched off due to the receipt of unnecessary material.

As a result FRNSW gas reactivated the audible alerts for all IUMs. FRNSW will continue to work with the multi-agency ICEMS Governance Committee to ensure the best possible operational use of this capability. The dissemination of information to Emergency Services is a matter of importance.

Clearly ,when human interaction is involved in the 000 room there is the possibility for crucial matters being overlooked even though those operators have been well trained. The lapse in this matter in not notifying the ambulance service of the direction is understandable given the operational tempo at the time. The police recognise this. In addition, the ambulance service is moving towards an automated system which, whilst not perfect will certainly assist in the receiving of urgent updates to their service.

Conclusion

The identity of AA and the date, time, place and cause of death are not in dispute. In order for me to be satisfied that a finding of suicide can be made, the Briginshaw Standard needs to be established (**Briginshaw v Briginshaw** (1938) 60 CLR 336)

Counsel assisting submitted that there is sufficient evidence available to me for me to be satisfied that AA intended to take her own life. I agree.

When I take into account the statements made to the 000 operator, together with her having obtained the petrol and poured it onto the bed and her statement to Ambulance Officer Carr that she wanted to kill herself, I am satisfied that AA intended to take her own life.

The investigation of Inspector Faunce, Fire and Rescue NSW concludes that the fire was deliberate and the origin of the fire was the mattress and bedding in the main bedroom where AA was located. Finally comment must be made of the actions of various police officers and fire officers who behaved in a professional and gallant way in attempting to rescue AA. The police officers that attempted to enter the premises but were beaten back by thick smoke should be commended.

They are:

Constable Southall

Senior Constable Moore

Constable Gava

Constable Crews

Constable Anthony Doyle. Those officers were assisted by

Sen. Con Gebrael

Con Fahlstrom

Con Stewart Doyle.

The actions of the fire officers who entered the premises and evacuated should also be commended. They are:

Fire-fighter Bolwell

Fire-fighter Wright.

In addition I acknowledge the professional way in which the 000 operator engaged with AA during this extremely traumatic and stressful incident. That person should also be commended.

Formal Finding:

I find that AA (DOB 16 July 1956) died at 6.40 pm on 9 April 2010 at Concord Hospital, NSW from injuries sustained following self – immolation which occurred at approximately 10.21pm on 3 April 2010 at Greenacre, NSW caused with the intention of ending her own life.

Fire

I find that the fire at the premises located at 45A Chaseling Street on 3 April 2010 was caused by the deliberate ignition of petrol poured throughout those premises. I find that the fire had its origin in the mattress and bedding in the main bedroom.

16. 835 of 2009

Inquest into the death of John Hollingworth at Malabar on the 13th April 2010. Finding handed down by State Coroner Jerram at Glebe on the 11th February 2011.

The deceased was a 69-year-old man serving a full time sentence. The deceased was also on remand for other matters. The deceased, John Hollingworth suffered various medical conditions, such as emphysema and back pain, he was also a smoker. Mr Hollingworth was diagnosed on the 9th March 2010 with lung cancer that had unfortunately spread to his vertebrae and pelvis. He was deemed unsuitable for treatment due to his extremely compromised health and a decision was made to treat him as a palliative care patient.

As such the deceased was transferred to Long Bay Gaol to their hospital section. His condition continued to deteriorate and on the morning of the 13th April a decision was made to cease all medical intervention. At 10.10am the deceased died in his cell in company with Dr Stewart. This man died of natural causes, as the death was in custody it is mandatory that I hold an inquest into the death in accordance with the *Coroner's Act 2009*. I am satisfied that Mr Hollingworth was provided with appropriate care and treatment following the diagnosis.

Having reviewed the evidence and hearing the officer in charge of the investigation I am satisfied that there are no issues that require my attention and accordingly I am left with the formal finding, there is no requirement for recommendations.

Formal Finding:

That John Hollingworth died on the 13th April 2010 at Long Bay Gaol Hospital of natural causes, metastasis Adenocarcinoma of the lung with acute bronchopneumonia.

17. 914 of 2010

Inquest into the death of Richard Grenfell at Malabar on the 21st April 2010. Finding handed down by State Coroner Jerram at Glebe on the 15th June 2011.

This mandatory inquest relates to the death of a 77-year-old inmate who at the time of his death was serving a four-year full time custodial sentence for Commonwealth fraud offences. He was due for parole in October 2010.

Richard Grenfell had a history of hypertension and deep vein thrombosis as well as coronary ischaemic syndromes, he was legally blind. On 21 April he was seen by the Nurse in the medical clinic and stated he was feeling dizzy and had a pain in his throat, it was organised for him to see doctor on the 23rd April. The deceased returned to his cell for the remainder of the day.

At 7.30pm the same day he was given a dose of warfarin and returned to his bed.

Not long after his cellmate reported hearing gurgling sounds and he activated the knock up button to which corrective service staff responded and commenced CPR on Mr Grenfell. Despite their efforts he passed away.

The post mortem has determined the cause of death to be hypertensive heart disease a natural cause. There are no issues that would warrant the making of recommendations and accordingly my finding is the following.

Formal Finding:

That Richard Grenfell died at Long Bay Correctional Facility on April 21 2010 the causes of his death being aortic dissection and hypertensive heart disease and, natural.

18. 959 of 2010

Inquest into the death of Robson Pham at Silverwater on the 23rd April 2010. Inquest suspended by State Coroner Jerram on the 15th November 2011.

After being advised by police that a person has been charged with an indictable offence in connection with this death, the State Coroner in accordance with the *Coroner's Act 2009* suspended the inquest on the 15th November 2011.

19. 1155 0f 2010

Inquest into the death of Stephen Moore at Randwick on the 15th May 2010. Finding handed down by State Coroner Jerram at Glebe on the 11 February 2011.

The deceased a 44-year-old man was serving a four-year full time custodial sentence. In April 2010 he was taken to the Prince of Wales Hospital suffering liver failure, Mr Moore's condition was so poor he was placed on the liver transplant list.

On the 15th May 2010 he suffered a massive intra abdominal bleed, which has further compromised his pre-existing liver condition. He was conveyed to theatre and placed on life support. A decision was made some hours later to remove Mr Moore from life support due to the unlikely possibility that he would recover taking into account the seriousness of his illness. A short time later he passed away.

The cause of death is natural causes there are no identifiable issues that require further investigations he was serving a full time custodial sentence I am required to hold an inquest into his death. There are no issues that require the consideration of recommendations to be made.

Formal Finding:

Stephen Moore died at Prince of Wales; Randwick on 15 May 2010 of natural causes being that of Liver Cirrhosis, Ischaemic Heart Disease, and Chronic Obstructive Pulmonary Disease.

20. 1305 of 2010

Inquest into the death of Lance Johnson on the 1st June 2010 at Coonamble. Finding handed down by Deputy State Coroner Barry on the 1st November 2011.

Non-publication order

The contents of the NSW Police Policies and Procedures located in Volume 3 of the brief of evidence. The contents of the Safe Driving Policy and Critical Incident Protocol and Guidelines. Any evidence given by XX, which identifies, or may identify him. This is an inquest into the death of Lance Johnson who was born on 12 January 1992 and died on 1 June 2010 as a result of a severe head trauma suffered in a motor vehicle accident on 29 May 2010 at Coonamble. S.81 (1) of the Coroner's Act 2009 stipulates that I must find, if sufficient evidence is available, the fact that a person has died, the identity of that person, the date and place of death and the cause and manner of death. In addition, Lance Johnson's death occurred in the course of a police operation and accordingly an inquest is mandatory pursuant to S. 23(c) of the Act.

INTRODUCTION

At the time of his death, Lance Johnson was only 18 years old. He lived in Coonamble with is father and his brothers. He had a wide circle of friends and worked casually as a fencer. His Aunt, Hazel McMillan, spoke warmly of her nephew. She described him as a 'gentle giant' with a famous smile. He enjoyed horse riding, pigging, riding a motorbike and Jet Ski. She stated he walked 'the tight rope of life.' He was a "ray of sunshine, playful, dependable, reliable, honest and faithful." His death has had an immeasurable impact on the family and life has become a struggle. Hearts are shattered. Lance was greatly loved and adored.

FACTS

On 29 May 2010, Lance was the driver of a white Toyota Landcruiser PBG 568. He was the owner of this vehicle. He and XX who was the passenger, were driving around Coonamble. He stopped the vehicle near a Caltex service station on Quambone Road and took a jerry can to the bowser to obtain petrol. There he was observed by S/con Smith and S/con Dalkeith who were driving a fully marked Nissan Police vehicle (Coonamble 28).

The Toyota had no windscreen. Coonamble 28 attempted to stop the Toyota but it failed to stop. The police vehicle 'Coonamble 28' commenced a pursuit of the Toyota, approximately 300 metres before a right hand bend in a stock route and continued for a total distance of approximately 1.7km before being terminated. A short time later another police vehicle (Castlereagh 202) attempted to stop the Toyota on Carinda Road. The Toyota again failed to stop and a pursuit was initiated by Castlereagh 202. That pursuit commenced approximately 800 metres east of the intersection of the stock route and was self terminated at the intersection of the Castlereagh Highway; a distance of approximately 1.1km.

The Toyota continued straight across the Castlereagh Highway. Both police vehicles turned right onto the Castlereagh Highway. The Toyota continued along Conimbia Road and approximately 40 metres west of Yuma Street, and approximately 1.35kms from where the second pursuit was terminated, it entered a section of roadway, which had 2 large wheel ruts running parallel with the roadway. The Toyota was unable to negotiate the wheel ruts and as a result, the vehicle commenced to rotate in a clockwise direction before tipping and rolling. The collision caused extensive damage to the Toyota. Lance Johnson and XX were ejected from the vehicle.

Police in Coonamble 28 had been searching for the Toyota after the pursuit by Castlereagh 202 had been terminated. Approximately four minutes later those police officers discovered the accident. Both young men received serious injuries. Lance Johnson died as a result of the injuries he received.

ISSUES

- The identity of driver and manner of driving
- Circumstances of the accident
- Presence of a third person in the car
- The Role of police, first pursuit by Coonamble 28
- The Role of police, second pursuit by Castlereagh 202
- The investigation by police of the accident.

IDENTITY OF DRIVER AND MANNER OF DRIVING

The weight of evidence supports a finding that Lance Johnson was the driver of the Toyota Landcruiser. XX gave evidence that Lance was the driver, and whilst it is clear that some of XX's evidence was self-serving, he remains consistent on this point. At the scene of the accident, S/con Pryce spoke to XX and was told by him that Lance was driving. In his first interview with police on 31 May 2010 he stated that Lance was driving. In his second statement to police on 16 June 2010 he confirmed that Lance was the driver.

S/Con Dalkeith describes the driver of the Toyota as being taller then the passenger. Lance was nearly 2 metres tall. S/Con Dalkeith and S/con Smith refer to the driver wearing a blue shirt or blue jumper.

S/Con Noffke describes the driver of the Toyota as it passed him to be a Caucasian male with a blue shirt. Both Lance and XX are Aboriginal but Lance had lighter skin. Ambulance officer Charles Morrison, who attended to Lance at the scene of the accident, cut away Lance's jumper. He described it as a light grey hoody jumper. He believed Lance to be wearing a light blue coloured t-shirt underneath the grey hoody.

There is no credible evidence to support a conclusion other than that Lance Johnson was the driver and on balance of probabilities, I am satisfied that he was the driver of the Toyota Land cruiser on 29 May 2010. There is no dispute that Lance held only a learner driver’s license and was not accompanied by a licensed driver. XX did not have a driver’s license.

Dr Perl gave evidence concerning the issue of cannabis in Lance's blood. Cannabis was detected in a sample of Lance's blood that had been taken after he left the Coonamble Hospital. Dr Perl concluded:

“ The blood concentration of THC and THC acid found in the deceased does not suggest heavy use of cannabis but such concentration would normally be expected with recent usage of a moderate dose of cannabis, expected use most likely within 12 hours of the blood sample”

and further

…" some impairment cannot be excluded"

CIRCUMSTANCES OF THE ACCIDENT

S/Con Clout from Oxley Crash Investigation Unit gave evidence concerning the roadworthiness of the car and the condition of the road where the collision occurred.

He described the road where the collision occurred to be compounded dirt in poor condition:

"There are two large wheel nuts. The road is well travelled and subject to a 50km/hr speed limit…The wheel ruts run parallel with the roadway."

S/Con Clout stated in his report:

> **"The Toyota was unable to negotiate the wheel nuts and as a result the vehicle lost lateral stability and commenced to rotate in a clockwise direction before tripping and rolling. The collision caused extensive damage to the Toyota."**

In relation to the speed calculation of the vehicle S/Con Clout established that the Toyota would have been travelling at a speed ranging between 63-85 km/hour on the section of roadway to trip and roll the distance, being approximately 44 metres from start to where it came to rest. He further identified that the vehicle registration was cancelled and had expired on 13 May 2009.

He concluded:
"there was no mechanical defect of failure with the vehicle that may have been a contributing factor to the collision."

He described in his oral evidence that the Toyota was a short wheel base vehicle, it is less stable than other motor vehicles because of this and its height off the ground. S/Con Clout was unable to enter into the vehicle to test the seatbelts, because of the extensive damage. XX's evidence was that he had removed his own seatbelt during the course of the drive and was not sure if Lance had his on for the whole time. Noting the position of Lance's body which was lying on the ground alongside the fence line and the location of XX outside the vehicle, the irresistible implication is that neither XX, nor Lance was wearing a seatbelt and that both Lance and XX were ejected from the vehicle after it left the roadway and commenced to roll.

PRESENCE OF A THIRD PARTY IN THE CAR AT THE TIME

Considerable confusion arose over the question of a third person within the vehicle. The evidence disclosed that there had been rumours circulating around Coonamble to the effect that a third person was in the Toyota. S/Con Dalkeith stated that when he arrived at the scene of the accident he observed Lance lying on the ground and he could hear yelling coming from the vicinity of the overturned vehicle.

At that point he contacted VKG calling for urgent assistance and noted the possibility of a trapped person within the vehicle. He did not know at that point that XX was in fact outside the vehicle. After locating XX, he organised for a line search of the area to discount the possibility that a third person might have been ejected and was lying injured. He stated that this was a normal procedure that he adopted in these incidents. His evidence was that he asked Lance how many people were in the car and Lance replied with a single word "two”. He has since had misgivings about whether he heard Lance answer because medical professionals at the hospital believe it could not have been the case.

However, there is no medical evidence on this issue and S/Con Dalkeith’s evidence should not be discounted. Certainly the ambulance officers who first arrived at the scene heard Lance moaning. S/Con Smith, S/Con Dalkeith and S/Con Noffke were all consistent in identifying only 2 persons in the car during the time of the police pursuits. XX has always maintained this to be the case.

Again there is no credible evidence to suggest otherwise and I am satisfied there were only 2 people in the vehicle during the course of the driving and at the time of the collision.

Role Of Police and Pursuit by Coonamble 28

S/Con Dalkeith gave a directed interview as well as a response to a directive memorandum. He also gave oral evidence. On 29 May 2010 S/Con Dalkeith was performing general duties with S/Con Smith. He was the driver of a fully marked police vehicle, a Nissan Patrol 4 wheel drive. S/Con Smith was the passenger.

They were patrolling the stock routes around Coonamble. On Quambone Rd, heading towards Aberford Street he heard S/Con Smith say words to the effect: “did you see that car?” He heard S/Con Smith make reference to the fact that the vehicle had no windscreen or windows. He observed a white 4 wheel drive stationary near a Caltex Service Station.

He looked across at the service station and observed a young male filling up a jerry can at one of the bowsers. The male was wearing a blue jumper and a baseball cap. S/Con Dalkeith continued across Aberford St and conducted a u-turn. He was looking for the young male who had been at the service station. He saw the small 4-wheel drive vehicle travelling southwest on Quambone Rd. He accelerated behind the vehicle in order to obtain the registration number. His evidence is that the state of the vehicle required further investigation. The vehicle was defective and his intention was to check the bona fides of the vehicle.

His primary purpose was to check everything on the vehicle and the “flag of a defect” had been raised. Had he been able to stop the vehicle he would have gone through routine checks including a Random Breath Test. He saw the Toyota pull off onto a stock route and he followed in the police vehicle. He flashed his high beam two or three times to get the other driver to slow down and stop. He also depressed the ‘yelp’ button 2 or 3 times. When the vehicle failed to stop, he activated lights and sirens and asked S/Con Smith to “call it” for the purpose of a pursuit. The time was 16.02.55. Both vehicles travelled along the stock route. S/Con Smith advised VKG that Coonamble 28 was a category 4 vehicle.

The VKG operator terminated the pursuit at 16.03.40. Based on measurements provided by S/Con Dalkeith during a drive through of the route taken, Det.Sen/Con Falkiner estimates the total distance of this pursuit was 1.7km. S/Con Dalkeith stated that the order to terminate the pursuit came at a point before a large ditch, which appears in the stock route before the Carinda Rd exit.

He put the vehicle into neutral and slowed down but kept travelling in the same direction because he could not turn around and he did not want to get bogged. He had been bogged on that route twice before. He observed the Toyota continue through the large ditch and turn right onto Carinda Rd. S/Con Dalkeith travelled in the same direction down Carinda Rd at about 50–60km/hr and saw a highway patrol car heading towards them. He observed the highway patrol vehicle activate his lights and perform a u-turn and pursue the Toyota.

XX corroborates the point at which Coonamble 28 terminated the pursuit. He marked on a map the point at which he observed the distance between the Toyota and the police vehicle increase. This point is close to the point of termination noted by S/Con Dalkeith. XX also stated that he was keeping a lookout for the police and was telling Lance what was happening. When the distance between the Toyota and the police vehicle increased he made up his mind that they had “gotten away from police” and he told Lance.

S/Con Smith did not give oral evidence to the court. Her written evidence corroborates the evidence of S/Con Dalkeith. Mr Graeme Proctor resides in a property on the corner of Carinda Rd and the stock route laneway.

At about 4pm on 29 May 2010 he was outside his house when he heard a vehicle travelling along the stock route. He saw the Toyota travelling quite quickly for the conditions and estimated its speed at about 60 – 70km/hr.

He stated in his oral evidence:

”I have never seen anyone travel that fast out of the gully”

He saw the Toyota bounce out of the gully and all 4 wheels left the ground. Five to ten seconds later, he heard the police vehicle. It also was travelling quite quickly but had no flashing lights. He observed the first vehicle slide around the corner onto Carinda Rd and in so doing it moved onto 2 wheels. It came to a stop for a second and it then took off again.

He observed the police vehicle to continue “casually” down Carinda Rd.

Part 5 of the **NSW Police Safe Driving Policy** categorises all police vehicles for their suitability in pursuits. A category 1 vehicle is the most suitable vehicle for pursuits. It is a fully marked ‘police pack’ vehicle fitted with electronic siren and light bar.

Generally a category 4 vehicles is not to engage in pursuits. Some category 4 vehicles such as Nissan Patrol, as was the case with Coonamble 28, may be used in pursuit in remote circumstances where no other vehicle is readily available.

'Remote' is defined in the policy as meaning:

"Remote from any other assistance that might be available within a reasonable time and distance, taking into consideration the circumstances that are present at the time"

At the time of calling the pursuit, Coonamble 28 was not aware of the location of Castlereagh 202, which was a category 1 vehicle. Sgt Russell gave evidence that Castlereagh 202 is based at Walgett, a distance of 1–1 1/2 hours away from Coonamble.

The area covered by Castlereagh 202 stretches from Gulargambone to the Queensland border, a distance of about 300km and to the east for a distance of about 90km. When he heard Coonamble 28 call pursuit at about 4pm, he had no knowledge where Castlereagh 202 was. In these circumstances, he considered there was nothing wrong with Coonamble 28 initiating a pursuit.

Taking into account S/Con Dalkeith's evidence that he was unable to ascertain the registration of the vehicle, the unusual circumstances surrounding the young male obtaining petrol in a jerry can, the obvious defect in the vehicle, the vehicle's failure to stop when first commanded by police and the early termination, I am satisfied that the pursuit initiated by Coonamble 28 did not breach the Safe Driving Policy.

ROLE OF POLICE Pursuit By Castlereagh 202

S/Con Noffke from Coonamble Police station was driving a fully marked highway patrol vehicle - Castlereagh 202. He heard Castlereagh 28 call "urgent" in pursuit. He heard the location as adjacent to Quambone Road. He headed south on Aberford Street and turned right into Quambone Road. He was aware that Coonamble 28 was a category 4 vehicle and not suitable for pursuits. He heard Coonamble 28 inform VKG that the offending vehicle would enter Carinda Road.

S/Con Noffke completed a U-turn on Quambone Road and turned left on Aberford Street, heading toward Carinda Road. He travelled west on Carinda Road and observed a white four-wheel Drive vehicle heading east. He believed this to be the offending vehicle because of the description given by police vehicle 28 and because of the speed of the vehicle, which he estimated to be 80-100 kph. He observed the vehicle to have a windscreen missing and it looked unroadworthy. He also observed two young males in the vehicle. One in the driver's seat and one in the passenger's seat. In his statement, he described the driver as wearing a blue shirt and as being Caucasian but in his oral evidence he stated he had no independent memory of the description.

At the time the vehicle passed him, he estimated the speed to be 80 - to no more than 90km/hr. He activated his siren and lights a completed a U-turn and commenced a pursuit.

He notified VKG that he was in pursuit of the Toyota. He stated in is oral evidence, the purpose of the pursuit was to stop the vehicle.

He was aware from radio calls that the vehicle had failed to stop for the police vehicle Coonamble 28. In deciding to pursue the vehicle, S/con Noffke took into account the fact that the initial pursuit had been on a stock route and the vehicle was now on a roadway and therefore, as a category 1 vehicle, his vehicle was the appropriate vehicle to engage in a pursuit. In addition, there were no pedestrians about, there was clear visibility and not much traffic. He stated that he needed to obtain some identification of the vehicle and the only way to achieve this was to pursue the vehicle.

The **NSW Police Safe Driving Policy** states the following:

Re-initiation:

A pursuit is not to be re-initiated by any other vehicle unless approval is first granted by a D0I, VKG supervisor, DO or supervisor in the field. S/Con Noffke stated he believed he was commencing a fresh pursuit but in his oral evidence, he stated: "in hindsight I guess it was a re-engagement."

In relation to his responsibility to notify the D0I, he stated that he believed that notifying VKG of his intention was sufficient to comply with the policy in the circumstances. There was a potential for trauma and the vehicle had failed to stop.

The pursuit was called at 16.06 and terminated at 16.06.40. S/Con Noffke self terminated the pursuit before the intersection of Carinda Road and Castlereagh Highway. S/Con Noffke terminated the pursuit because he saw the driver approaching the stop sign at that intersection.

He observed the driver turn his head to the left and to the right. When he saw this, he knew that the driver did not intend to stop. It was unsafe to follow. The Toyota proceeded through the stop sign across the highway. The S/Con completed a U-turn and about 30-45 seconds later he saw Coonamble 28 on Carinda Road. He heard Officer Dalkeith yell something out about heading toward the river.

S/Con Noffke then followed Coonamble 28 onto Castlereagh Hwy, and lost sight of the Toyota. The in car video (ICV) played to the court corroborates this version given by S/Con Noffke, and Coonamble 28 is seen on that video traveling down the Castlereagh Hwy in front of S/Con Noffke. Sgt Russell, who had heard the radio broadcast, immediately resolved to terminate the pursuit. However, by the time he reached the radio the VKG operator had already ordered Coonamble 28 to terminate the pursuit. When he heard Castlereagh 202 call a further pursuit he left his office again with the intention to also terminate that pursuit.

In his oral evidence, Sgt Russell stated that in his mind, this pursuit was a re-initiation of the first pursuit. Sgt Russell agreed that he always takes a cautious approach to pursuits and in this case he took a cautious approach because Castlereagh 202 was involved in a pursuit with the same offending vehicle. At the time, he had not heard Castlereagh 202 seek permission to pursue the Toyota. He intended to terminate the pursuit but 202 quickly self terminated before he could give that order.

Counsel for the police submitted that the pursuit by Castlereagh 202 was not a re-initiation but a second pursuit. He submitted that S/con Noffke attempted a traffic stop. He had observed the vehicle with no windscreen and was therefore entitled to perform a traffic stop and when the offending vehicle failed to stop, S/Con Noffke acted appropriately in initiating a fresh pursuit.

Whether or not this incident is characterised as a second pursuit or a re-initiation of a pursuit, I am satisfied that S/Con Noffke's reason for pursuing the vehicle were genuine and should not be criticised.

Notwithstanding S/con Noffke's failure to first obtain permission to pursue the offending vehicle, I am satisfied that his actions in terminating were correct and in compliance with the Policy as was Sgt Russell's stated intention to terminate.

ROLE OF POLICE - INVESTIGATION OF THE ACCIDENT

The incident of 29 May 2010 in which Lance Johnson was seriously injured, and later died, was appropriately investigated as a 'critical incident' within the meaning of the meaning of the **NSW Police Critical Incidence Guidelines**.

The senior investigator was Inspector Spinks from Mudgee Local Area Command.

Inspector Morley from Orana Local Area Command conducted a review of the Critical Incident Investigation. There are a number of factual inaccuracies in his report provided to the court and the report proved to be of no assistance to the court. Sgt Russell, the duty officer Castlereagh Local Area Command, stated that in his mind, on hearing of the accident, he believed it to be a critical incident. He was aware of the guidelines relating to the duties of a duty officer.

For the most part, he complied with those guidelines. Criticism has been raised by counsel for the Johnson family that Sgt Russell failed to comply with the following guideline:

"Keep involved officers and other witnesses separated and ensure the evidence of these people is not cross contaminated. It is important that involved officers are informed of the reasons of the separation. Ensure that the officers have sufficient welfare support." S/Con Smith and S/Con were in a personal relationship. Sgt Russell sent them home together but asked them not to speak about the incident. He states in evidence that he put his trust in the officers.

Sgt Russell gave evidence that a consideration in sending the officers home together was to ensure they each had welfare support. This was especially important because of the state of distress exhibited by S/Con Smith. Although this action is in breach of the guidelines, given the relative remote location of the officers, S/Con Smith's distress and the lack of evidence of collusion between the two officers, I find that no criticism is warranted, nor do I intend to make any recommendation in relation to this issue.

One issue that warrants comment, however, is the issue of notification of family members following the accident.

It is not clear how Lance's family came to know of his accident and transportation to hospital, but it was not through the action of police. Sgt Russell was not aware that he was the first police officer to speak with Lance's father and that was at the hospital, about 1 –1 1/2 hours after the accident.

Inspector Spinks maintained that the family would not have been notified until identification of the injured person was certain. He maintained S/Con Smith merely "believed" that the injured young man at the scene was Lance Johnson. This is simply not true and is not supported by S/Con Smith's own evidence. In her directed interview conducted by Inspector Spinks she stated that upon coming upon the scene of the accident she jumped out of the police vehicle and saw a young male lying on the ground along the fence line. She further states:

"*I immediately recognized him to be Lance Johnson*"

Sgt Russell attended Coonamble Hospital just after 17.44pm. The accident was discovered at about 16.11pm. Sgt Russell spoke with Lance's father. This was the first interaction between the police and Lance's family following the accident. For the first contact to occur nearly 1-1/2 hours later in a small community such as Coonamble smacks of lack of compassion and lack of concern for the welfare of Lance's family.

Police practice in these matters need to be improved.

CONCLUSION

There is no doubt that the actions of the police in the two police vehicles involved in the pursuit of Lance Johnson's vehicle form an integral part of the circumstances surrounding Lance's death.

However, the Toyota lost control and rolled approximately 1.35kms from where the pursuit was terminated by Castlereagh202. The evidence is clear that the Toyota was not being pursued at the time of the accident and indeed the police vehicles were traveling in a different direction and were out of sight.

The cause of this accident was a combination of factors:

Lance was an inexperienced driver. The lack of a front windscreen would have made visibility difficult, the condition of the road was poor and excessive speed for the conditions all contributed to this tragic accident.

FORMAL FINDING

Lance Johnson (born 12 January 1992) died on 1 June 2010 as a result of severe head trauma following a single vehicle motor accident.

21. 1322 of 2010

Inquest into the death of Royce Williams on the 2nd June 2010 at Ivanhoe. Finding handed down by Deputy State Coroner Forbes on the 6th October 2010.

Mr Royce Williams was a thirty-five year old Aboriginal man and he was an inmate at the Ivanhoe Correction Centre when he died in his cell on 2 June 2010. He had been in custody since 29 February 2008. He was serving a seven-year sentence with a four-year non-parole period for maliciously inflict grievous bodily harm with an intent to do so. Because he passed away whilst he was in custody s 23 and 27 of the **Coroner's Act** require an inquest to be held.

The purpose of the inquest is to review the circumstances of his death. The autopsy report that was prepared by the pathologist who did a post mortem found that the direct cause of the death was a coronary thrombosis with coronary artery atheroma and hypertensive and ischemic heart disease as the antecedent causes of death. Royce Williams had been complaining of chest pain to his cellmate. He thought perhaps he might have pulled a muscle perhaps working out at the gym.

On the afternoon of his death he had played football and then he rested for several hours. He took some Panadol and some Nurofen. He felt sick and at about 8pm his cellmate, Mr Burson raised an alarm because he started to have what appeared to be a seizure. The correctional officers attended and the ambulance attended and CPR was administered and he was pronounced dead at 8.45pm in his cell. Royce Williams had a strong history of coronary artery disease.

His father is known to have a heart condition and his mother had died from a myocardial infarct and his twin brother had died from a myocardial infarct a few months prior.

In all of those circumstances the persons investigating this matter determined that it was appropriate that a specialist cardiologist who works here in Sydney overview the medical records and treatment that Royce Williams obtained while he was in the correctional centre and at the time of his death and that was most appropriate. The consultant cardiologist who looked at this matter is Dr Hellestrand. Dr Hellestrand was given access to all the medical records and he has carefully read all of the documents in relation to this matter and he has written a lengthy report about Royce's history and Royce's treatment.

He has also given evidence in court today about some further details in relation to Royce's condition. He said that with the strong genetic component to Royce's risk of premature coronary artery disease together with chest pain that specific investigation such as a stress test could have been undertaken and it would have been, if that was done it was highly probable that his, Royce's coronary artery disease could have been identified and treated.

However, he said that in view of the fact that Royce was only thirty-six, that in the normal course of events that that investigation, the stress test would not have taken place without some sort of event, some signal event to indicate there was an issue. In this case he says there was no such event. He notes that there is research that has clearly shown that twins - if one twin dies of a heart attack then there is an increased risk for the other twin above and beyond the rest of the community and that if this knowledge, the doctor had this knowledge that they may go on and make those investigations.

However, in light of any other symptoms it would not be an urgent investigation and he said that had he been Royce's treating doctor and Royce had come and seen him in his surgery in Sydney that he would not have done anything different; he would have managed Royce's medical treatment in the same way as it was and he said to me that in this case he is of the view that there has been no lack of care or negligence on behalf of anybody who was involved in Royce's treatment and care and that he would have done the same.

Pursuant to s 81 of the **Coroner's Act** I must make findings as to the identity of the deceased, the date, the place, the cause and the manner of the death of the deceased. In this inquest there is no doubt as to the identity, Mr Royce Williams and there is no doubt as to the date of his death being 2 June 2010. The place of his death was the Ivanhoe Correction Centre.

The cause of his death is as set out in the post mortem report and that was coronary thrombosis with an antecedent cause of coronary artery atheroma and the significant condition contributing to the death of hypertensive and ischemic heart disease and the manner of Royce's death was a natural cause.

Another function of any inquest is to consider whether there are any recommendations, which are necessary or desirable in relation to any matter connected with the death.

I note that the officers who responded to the alarm; there's no criticism to be made of them. I note that the CPR and the defibrillation were given and then the ambulance arrived; there's no criticism of the ambulance officers.

I note that his cellmate was involved in helping administer the CPR and there's no criticism of him.

I also note that the police who attended the scene and subsequently investigated the matter have given evidence that there was nothing unusual or suspicious in relation to the circumstances surrounding Royce's death. I also of course the bear in mind the independent cardiologist's evidence that the treatment and medical attention given to Royce was the same as he would have given Royce if Royce had come and seen him in the community and in all of those circumstances I am satisfied that there are no recommendations that need to be made in this case.

I do note that when the Comprehensive Health Assessment Plan form was completed I'm pleased to see that the front page of that form includes and prioritises the family history because as the doctor has already given evidence this is an important tool in screening and diagnosing heart conditions and I note that the family history is set out and I note that the family history that was given on 19 March has changed or there's more detail that could be added. The first point that is there is "Dad is diabetic and on dialysis." Now, as I understand it from the statement given he's not on dialysis. You're not having dialysis.

Then the second point is the twin "MI" as we know unfortunately Gregory passed away from that MI and it would be very important that that were included in the note there. Furthermore it says, "Mum MI"; once again she passed away from that MI It would be very important that that were included in the note so I think the comment can be made that that further detail should be included when the form is being completed so that any medical officer can accord the appropriate weight in relation to that family history and I have been assured by Mr Rooney who represents Justice Health that that feedback and these comments will be given to the person who will do the screening and that it's important that those details are provided and certainly whilst it didn't make a difference on this occasion it may be important for somebody else in the future that that is there.

In all of those circumstances the formal findings that I make are the ones that I have already read out.

Formal Finding:

Royce Williams died on 2 June 2010 at Ivanhoe Correction Centre, NSW. Caused of Death: Coronary Thrombosis with an antecedent cause of Coronary Artery Atheroma and the significant condition contributing to the death of Hypertensive and Ischaemic heart disease

22. 1369 of 2010

Inquest into the death of Colin Dixon at Randwick on the 8th June 2010. Finding handed down by State Coroner Jerram on the 15th June 2011 at Glebe.

The deceased a 63 year old aboriginal man was serving a 16 month sentence and was due to expire in December 2010.

The deceased on the 10th April was treated at the Bathurst Base Hospital on the 10th and 30th April and it was decided that he would be transferred to the Prince of Wales Hospital at Randwick to undergo Aortic valve repairs.

However his condition deteriorated and it was deemed by the Doctors that his condition was such that he would not survive any surgery. The deceased was then treated palliatively and all heart medications were withdrawn. He died on the 8th June 2010 in the presence of his family.

This is a mandatory inquest however the manner of death is natural causes there are no issues.

Formal Finding:

Colin Dixon died at Prince of Wales Hospital Randwick on 8 June 2011 of Congestive Heart Failure and Ischaemic and Valvular Heart Disease, the manner of his death being natural.

23. 1374 of 2010

Inquest into the death of AA on the 9th June 2010. Finding handed down by Deputy State Coroner Forbes on the 16th June 2011 at Glebe.

At 2.28pm on 9 June 2010 AA jumped to his death from the fifth floor of the Westfield Shopping Centre, Bondi Junction. Before AA jumped the police had become involved in trying to stop him. Accordingly, his death is considered to have occurred during the course of a police operation and s. 23 and s. 27 of the Coroner's Act 2009 requires that an inquest be held.

MR AA HAD LEFT A "SUICIDE NOTE" IN HIS BEDROOM AT HIS SISTER'S HOUSE, WHICH STATED:

"I feel I'm some place where you walk and walk but you're always in the same spot. You can't find the exit, if there is one. Every step you take is a mistake. I've made lots of mistakes, a life time is [sic] isn't long enough to pay for them all, but believing that someone like me could still have a future was my biggest mistake. That's the reason I should die."

After security guards, police and a police negotiator attended at the scene and spoke with Mr AA he remained on the outside of the railing at Westfield until he released his grip.

AA suffered from chronic depression and other associated problems. He also suffered from chronic suicidal ideation. AA had been attending the Canterbury Community Mental Health Centre for counselling since 2002. AA's illness necessitated him spending two periods of time admitted at the Rozelle Mental Health Unit.

He had engaged in acts of self-harm in the past. In particular, he had not less than five previous suicide attempts (on 7 June 2006, 6 August 2006, 22 June 2007, October 2007 and 16 April 2008), all involving cutting his wrists. His last previous suicide attempt had been on 16 April 2008 and resulted in his admission to Canterbury Hospital.

I am satisfied on the Briginshaw standard that his intention was to end his own life.

Pursuant to section 81 of the Coroner's Act, I must make findings as to identify of the deceased, the date, place and direct cause of death and the manner and circumstances surrounding the death. In this inquest, there is no doubt as to AA's identity.

Furthermore, the date, being 9 June 2010, and the place of his death, being Bondi Junction NSW are not in doubt. There is no doubt that the cause of death was multiple blunt force injuries which were sustained as a direct result of AA jumping from the fifth floor of Westfield at Bondi Junction when he intentionally took his own life.

Another function of any inquest is to consider whether there are recommendations, which are necessary or desirable in relation to any matter connected with this death. On the basis of the evidence from the police who attended the scene, the security guard who first came upon AA and AA's mental health caseworker, Mr Brereton, I am satisfied that they all acted with propriety and professionalism and there is no recommendations to be made in this case.

Formal Finding:

That AA died on the 9th June 2010 at Bondi Junction in the state of New South Wales from multiple Blunt force Injuries he sustained when he jumped from the 5th floor of the Westfield Shopping Centre at Bondi junction with the intention of ending his own life.

24. 1378 of 2010

Inquest into the death of AA on the 9th June 2010 at St Marys. Finding handed down by Deputy State Coroner Mitchell at Glebe on the 29th April 2011.

This is a mandatory inquest into the death of AA who was born on 2 January, 1970 and who died between Monday 7 and Wednesday 9 June, 2010 at South Creek, Kingsway Playing Fields, St. Mary's, NSW when, having administered to himself a dose of prescription medication which may have been stupefying, he entered the waters of South Creek and drowned.

The circumstances in which AA came to take this medication and found himself at Kingsway Playing Fields arose out of his knowledge that police were looking for him and were anxious to speak to him regarding an allegation by his step-daughter, that, in about January or February, 2007 when she was about 14 years of age and while he was caring for her at home in the absence of her mother, he had touched her inappropriately in circumstances which may have amounted to a serious sexual assault of a minor.

The step daughter disclosed AA's alleged misbehaviour to her mother within a few weeks of its occurring. Neither mother nor daughter saw fit to report the matter until, finally, it was reported it to police on 31 May 2010, some three years after the event.

Whether that report was truthful is something I am unable to say.

The partner confronted AA regarding her daughter's allegation on 2 June 2007. According to the partner, he *"denied that anything had happened and appeared outraged about what had been said."* There was a scene and the partner decided to remove her daughter from the house and take her to be cared for by friends while she returned home to deal with AA. When she got home, she found her partner in bed with medication bottles next to him. He appeared drowsy and *"out of it"* and she judged that he had tried to take his own life so she phoned an ambulance to take him to *Mount Druitt Hospital.* She had time to ask him why he had tried to kill himself and, by way of an answer, he is alleged to have said something to the effect that *"I couldn't face that I have done something like that."*

AA recovered on that occasion but his relationship with his partner was fatally damaged and sometime in 2008 or 2009, they ceased living together and he returned to his mother's home. He continued to have intermittent contact with the daughter, supervised by her paternal grandmother, and there were disagreements and stresses between AA and his former partner regarding this contact as late as May 2010. Further, his former partner formed a relationship with one of AA's friends, and this may have been another sauce of stress to AA. By mid 2010, AA was drinking heavily.

On the day after the report to Constable Anthony Blair was made at St. Mary's police station, Mr Blair sought out AA residence but there was nobody at home. Blair returned on 7 June 2010 and spoke to AA'S mother. AA was not at home and Mr Blair left a phone number where he might ring him, which AA did at about 6.15 that evening.

Evidently, AA knew why police were keen to speak to him, informing Mr Blair that a friend had told him *"that XX made a report about me touching XX up."* AA expressed his own views as to why such a report had been made against him, which had to do with what he perceived to be XX's antipathy and punitive attitude towards him. He cried when he told Mr Blair "*the stigma from this will fuck me."* He refused to disclose his whereabouts to police and said, *"It's too late. I've already done it. You won't find me. I told Mum I was going to Pialla (the psych. unit attached to Nepean Hospital). I've left letters for the kids please tell them I'm sorry."* Mr Blair told him *"That's not the way to solve it. What about your mum and kids?"* to be told, *"Don't worry about that. You won't find me… …Do what you have to do."*

Thereafter, police accelerated their attempts to locate AA. His photograph was obtained from his mother, scanned and circulated and his mother and sister were interviewed so that a list could be compiled of persons who might know his whereabouts.

These included XX, a former *de facto* partner and the mother of his two sons, a long time friend and, the *de facto* partner and another friend, were interviewed but, sadly, without any light being thrown on AA's whereabouts.

Triangulation, which put AA in the St. Mary's area, was maintained throughout the search, a car crew was assigned and a *"Keep a Lookout For*" message was created for hourly broadcast. Hospitals and the ambulance service were canvassed.

As the search gathered pace, somewhere between 60 and 100 police officers together with officers of the *State Emergency Service* and volunteers were engaged along with trail bikes, the Dog Squad and the police helicopter.

Friends of AA and local mental health facilities were canvassed and train stations, licensed premises and the St. Mary's *CBD* were searched along with the much more difficult terrain alongside South Creek where AA was ultimately found.

At about 1320 hrs on 9 June, 2010, police located a small black and blue coloured backpack on the ground about one and a half metres from the western bank of South Creek, together with medication packaging bearing AA's name and, several metres to the north along the banks of the creek, they saw marks on the soil suggesting that something or somebody had slid into the water. Police divers were engaged and, at about 1600 hrs. On 9 June 2010, AA's body was found submerged in the waters of South Creek.

The *Autopsy Report* was prepared by Dr Irving here at Glebe and dated 10 September 2010.

The Report identifies drowning as the direct cause of death. Dr Irving mentions the discovery near a skid mark, the apparent scene of AA's entry into the water, of *"an empty bottle of temazepam, a bag of Efexor (vanlafaxine) tablets with 1 remaining (both dispensed in the name of the decedent) and an empty can of bourbon."* Dr Irvine notes that *"Toxicological examination revealed a modest (0.023g/100mL) blood alcohol concentration; the alcohol concentration in vitreous fluid was somewhat higher, even when corrected for different water content, indicating that the decedent was on the downward slope of alcohol metabolism; in other words, his blood alcohol content had been higher one or two hours prior to his death. It cannot be determined how high it may have been in the preceding hours.*

"Toxicological examination also showed a therapeutic range concentration of temazepam (Restoril, a sedative hypnotic) and a modest concentration of its metabolite, oxazepam. There was a 'therapeutic' range concentration of valproic acid (for seizure prophylaxis, although it was presumably prescribed in this case as an adjunct to psychotropic therapy).

There was a very low concentration of venlafaxine (Efexor), an antidepressant. Zolpidem (Stilnoct, a benzodiazepine sedative with a very short half-life) was detected only in urine. Cannabinoids were also detected.

"The pattern of toxicological results, in concert with evolving bronchopneumonia, suggests that the decedent likely took the medications hours earlier; he did not succumb to the combined effects, possibly because of vomiting up a portion, but was stuporous for a period of time. The presence of apparent pill material in the stomach is not at odds with this hypothesis as stomach emptying is extremely variable and may slow significantly during sedation; note that stomach contents were submitted to the toxicology laboratory but not tested.

"The cause of death is Dr owning and a toxicological factor cannot be directly implicated.

The decedent's heart was enlarged to the point, however, where a contributing dysrhythmia occurring while in cold water or during the hypoxic phase of Dr owning cannot be excluded."

According to AA's mother, her son has suffered from emotional or mental health difficulties since he was a boy. She first took him to counselling at 10 years of age when *"he wasn't sleeping and could be rebellious but then would get sorry and be quite tearful."* AA's father was *"hardly ever (at home) and was always drunk when he was."* and AA's mother says *"I later found out that he had been cruel to AA."*

Then, at eighteen years of age, AA cut his wrists in an apparent attempt to kill himself. Nevertheless, Mrs. AA's recollection is that her son did well during his late teen years and, subsequently, throughout his relationship with XX, holding good jobs and *"having no issues"* until that relationship came to an end in about 2002. But in October, 2006, his mother found him hanging by a rope around the neck when he had tried to kill himself and he was admitted to the *Pialla* unit and, later, *Cumberland Hospital* and, after his discharge, *"he was regularly in contact with mental health workers and regularly sought counselling"* as often twice per week.

Police records indicate that, in 2008, AA made two attempts on his own life, once with a knife and another when he cut himself with a can. But, according to his mother, things seemed to be getting better for him in the last twelve months of his life. *"He wasn't taking any medication and he was going well. He was getting his life in order. He was looking forward to getting his licence back. He was excited about it. He had gone to Parramatta and got his birth certificate. He was going to get his truck licence. He was looking forward to getting a car and teaching his eldest son to drive."* But she concedes that the breakdown of his relationship with XX affected him, as did her grudging attitude, as Mrs. AA perceives it, regarding his contact to his daughter.

AA had long been battling chronic depression linked originally with unhappy experiences at the hands of his father and later with various social and other stressors including persistent insomnia, the loss of his drivers licence, conflicts regarding his contacts with his daughter and, ultimately, the accusations which had been made against him regarding his step-daughter. In October 2006, he had been diagnosed at Nepean Hospital as suffering *an adjustment disorder with depressive features* and *a major depressive illness*. It appears that, notwithstanding the loving care of his mother and sister, these continued to plague him to the end.

Mrs. AA statement indicates that, on Monday 7 June 2010, her son got up for work at about 6.30 or 7 o'clock, brought her a cup of tea and said *good bye* as he normally did as he set out for work. By the time he returned home at about 5pm, police had already been to the house and had spoken to Mrs. AA and she told him *"police want to speak to you."* His reply was *"I know what it's about. XX told me."*

A little later, he emerged from his room wearing a dark jacket, black jeans and his work boots and carrying his backpack but it was later discovered,

leaving his wallet and keys behind. He was *"distraught"* and *"in tears,"* and told his mother *"I've had it. I've got no fight in me. I think I have to go back to Pialla."* AA rang him a taxi and he departed, not as it turns out, for *Pialla* as his mother had expected but just to the end of the street where, apparently, he alighted and sent the cab away. Mrs. AA never saw him again.

I think that the circumstances I have recited indicate that Mr AA left home in extreme distress with an intention of taking his own life and, to that end, he ingested a quantity of medication, which, in the event, proved not to be fatal. Whether he maintained his original intention right to the end is something we will never know but, apparently in a state of stupefaction and disorientation prompted by the medication, he appears to have slipped or skidded into the creek where he drowned.

The inquest into the death of AA was heard at Glebe on 28 April 2011. Mr C. McGorry of Counsel instructed by Ms. M. Heris of the Crown Solicitor's Office appeared very ably to assist the Coroner. Mr S. Robertson appeared for the Police.

The *formal documents* comprising the *P79A Report*, the *Identification Statement*, the Hospital *Life Extinct certificate* and the *Autopsy Report*, are **EXHIBIT 1** and the Coronial Brief is **EXHIBIT 2.** Photographs taken at the crime scene are **EXHIBIT 3.** Those appearing at the inquest included Constable Anthony Blair of St. Mary's police and Det. Sen. Const. Daniel, the Officer-in-Charge of the investigation.

It might be argued that, considering his delicate state of mental and emotional health, police might have been more circumspect in first approaching AA and seeking to interview him but I would certainly not criticise Mr Blair for his actions in that regard. He tried to maintain a degree of discretion in deference to AA's right to privacy and, in the event, AA had already been informed by XX of the terms of the accusations, which had been made against him.

He spoke honestly and respectfully to AA and tried to lower the latter's level of distress and, although he was aware that there had been some mental health concerns, he could not have known the extent of the stresses operating on AA. Nevertheless, he immediately alerted his superiors so that a search could be instituted.

As to the police search, the details of which are carefully set forth in the evidence, particularly in the coronial brief **EXHIBIT 2**, it was prompt, extensive and thorough.

I propose making a limited non-publication order regarding identities of AA and members of their respective families. I do so conscious of the general principal that coronial proceedings ought be open and conscious of the provisions of section 74 of the *Coroner's Act, 2009* but it seems to me that, in this particular case, it is in the public interest that confidentiality be maintained, not so much to protect AA's reputation or to protect the feelings of his family as to protect the privacy of his step-daughter who was only fourteen years of age at the time of the events she has alleged and may still be under eighteen years of age.

In most jurisdictions it is generally recognised that her identity should not be disclosed and I think it is no different here. Publication of the evidence in this case, which would identify AA's identity will inevitably open XX, as his only stepdaughter, to the possibility of identification and publicity and it is in the public interest that such not be allowed happen.

Formal Finding:

I find that AA who was born on 2 January, 1970, died between Monday 7 June and Wednesday 9 June, 2010 at South Creek, Kingsway Playing Fields, St. Mary's when, having consumed an excessive dose of prescribed drugs, he became stupefied and slipped into the waters of South Creek where he drowned.

25. 1753 of 2010

Inquest into the death of AA at Berkshire Park betwen the 16th and 17th July 2010. Finding handed down by Deputy State Coroner Mitchell on the 21st October 2011.

The deceased a 23-year-old man was a remand prisoner at the time of his death having been charged with numerous drug related offences. He had an extensive criminal record and had been in custody several times. On the 10th July he was arrested and refused bail. He was taken into the custody of the John Moroney Correctional Centre where he underwent the necessary risk assessments and was then placed two out in a cell.

The cellmate reported nothing untoward indicting that he went to sleep at around 6pm and the deceased was pacing the cell.

The cellmate woke at 8am the following day and found the deceased hanging from a bed sheet attached to the shower rail. No CPR was commenced, as it was apparent Riga mortis had set in.

A number of suicide notes were located which detailed his intention to end his life.

I am satisfied on the evidence before me to the appropriate standard that the deceased took his life intentionally there are no suspicious circumstances.

Formal Finding:

AA died of Hanging on the 16 or 17 July 2010 while a prisoner at John Moroney Correctional Centre at Berkshire Park, NSW.

26. 1834 of 2010

Inquest into the death of AA at Shepparton in the state of Victoria on the 24th July 2010. Finding handed down by Deputy State Coroner MacMahon on the 7th September 2011 at Albury.

Introduction

AA (who in this finding I will refer to as AA) was born on 17 June 1934. In 2010 he lived in Berrigan in the State of New South Wales with his wife XX. They had been married for about thirteen years. AA was in poor health due to a number of medical conditions. He suffered from emphysema that resulted in him needing continuous oxygen. In about 2007 he had undergone surgery for prostate cancer. He also suffered from gallstones and back pain.

Due to his ill-health AA had five admissions to the Berrigan and Finley Hospitals between April 2010 and June 2010. On 21 July 2010 AA discharged himself from the Berrigan Hospital. On 22 July 2010 XX became concerned for AA's wellbeing and consulted her brother and sister-in-law who lived nearby. The assistance of police was sought. Sergeant Paul Jones from Tocumwal and Senior Constable Sophie Germein from Jerilderie responded to the request.

Sergeant Jones was advised that there were concerns that AA was suicidal and that there were firearms in his home that he may have accessed. At 12.17am on 23 July 2010 Sgt Jones spoke to AA by phone. AA was asked to come outside and talk to Sgt Jones. AA agreed to do so. Sgt Jones waited outside for a period of time however but AA did not emerge from his home. Further attempts were made to contact AA however these were unsuccessful. About 2 am Sgt Jones and other police entered the home and found AA on his bed. He was suffering from a gunshot wound to the head. Ambulance officers attended to assist AA. He was taken to Goulburn Valley Hospital at Shepparton in Victoria. The injuries he had suffered were such that life was not sustainable. He was declared deceased at 12.13am on 24 July 2010.

<u>Jurisdiction and function of the Coroner</u>

Section 81(1), Coroner's Act 2009 (the Act) sets out the primary function of the Coroner. 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 that a Coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate 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. It is not the role of the Coroner to attribute blame.

There are a number of other sections of the Act that are relevant to an examination of the circumstances of AA’s death. Sections 23 and 27 of the Act provide that it is mandatory for an inquest to be conducted where a death occurs in circumstances to which Section 23 applies. Section 23 (c) applies to a death that occurs “as a result of, or in the course of, a police operation.” In addition either the State Coroner or a Deputy State Coroner must conduct such inquest.

Section 75 (5) of the Act provides that if a finding is made at an inquest to the effect that the death of a person was self-inflicted a report of the proceedings (or any part of the proceedings) must not be published after the finding unless (and to the extent that) the Coroner holding the inquest makes an order permitting the publication of the report.

Section 81(1) requirements:

AA’s identity, the date and place of his death and the cause and manner thereof were not matters of contention at the inquest.

His son identified AA. Dr Janith deSilva declared him deceased at Goulburn Valley Hospital at Shepparton at 12.13am on 24 July 2010. Dr Michael P Burke conducted an autopsy on 30 July 2010 and found that the cause of AA’s death was a gunshot wound to the head.

Dr Burke also found that AA suffered from Ischaemic Heart Disease, Chronic Obstructive Pulmonary Disease and Prostatic Adenocarcinoma. Having regard to the evidence of the ambulance officers who attended, the findings on admission to Goulburn Valley Hospital and that of Dr Burke I am satisfied that AA died as a result of a gunshot wound to the head.

This brings me to the question of the manner or circumstances of AA’s death. I do not need to recite in at this stage the events of the evening in detail. I accept the evidence of Sgt Jones and Sen Const Germein.

I am satisfied that when they arrived at AA’s home he was alive and that he spoke by phone to Sgt Jones. I am also satisfied that some time before 2am when Sgt Jones and other police officers entered the home AA shot himself.

I am also satisfied that in shooting himself AA acted with the intention of ending his life. In coming to this finding I have had regard to the notes that he left on the coffee table in his home that were found by his wife on 23 July 2010. I also have had regard to the comments that he had made to his wife about his thoughts about self-harm in period prior to his death. I have also had regard to the location AA was found by police, the location of the firearm and the location of the spent cartridge. In my view there is no evidence to suggest that AA’s death was suspicious or that there was any third party involvement in his death.

Examination of Police actions:

AA’s death occurred during a police operation. As set out above police had been called to assist as there were concerns for AA’s welfare.

Sgt Jones and Sen Con Germaine had responded to those concerns. AA shot himself whilst they were seeking to assist him. His death therefore was not caused by a police operation but did occur as a result of injuries that he received during a police operation. The provisions of section 23 are therefore applicable. Deaths in police operations are the subject of mandatory inquests because it is considered by the Parliament that the public has a right to know the circumstances in which such deaths occur. This right is for the benefit of the family of a deceased and also for the police involved.

In many, if not most, cases there will be no grounds for criticism of the officers involved however it is essential that in all cases the actions of the officers must be thoroughly examined. As previously mentioned Mrs AA returned home on the evening of 22 July 2010 and became concerned for AA's welfare. She sought assistance from her brother and sister-in-law who lived nearby. The assistance of the police was sought.

Sgt Jones became aware of the request by police radio at 11.15pm and as a result travelled from Tocumwal to Berrigan. Whilst travelling to Berrigan he arranged for Senior Constable Germein and ambulance officers to meet him there.

He and Sen Con Germein met at about 11.45pm after which they spoke to Mrs AA. Sgt Jones was aware that AA was licensed to hold seven firearms and Mrs AA had told him that she thought he had taken a firearm from the gun safe in his home. He and Sen Con Germein appropriately took the precaution of wearing bullet resistant vests.

At 12.03am Sgt Brown contacted and sought advice from Inspector Tunks, the Duty Officer at Deniliquin. As a result of that discussion it was decided that Sgt Jones would seek to make contact with AA. At 12.07am Sgt Brown phoned AA's landline phone. AA answered. I accept that the following conversation then took place. Sgt Jones "Hello, I'm Sergeant Jones from Tocumwal Police" AA then said something in reply. Sgt Jones: then said "It's Sergeant Jones form Tocumwal Police. I've been speaking to some people who are a little concerned about you.

Are you in possession of firearms? AA replied: "Yes I have got firearms on the premises". Sgt Jones then said: "You are not in any trouble. I've just got some people here who are concerned about you. Could you come out the backyard and walk to the rear gate?" AA then replied: "Yeah, I'll come out and see you." AA then terminated the call.

AA did not come out of the house. Sgt Jones made further calls to AA's landline phone at 12.22am, 12.27am and 12.30am without success. Sen Con Germaine then spoke to Mrs AA, her brother and sister-in-law about what they thought AA would do if confronted by police.

The advice that they were given raised concerns as to how AA might respond. Sgt Jones then sought further advice from Inspector Tunks. It was then decided to seek the assistance of specialist police trained to deal with siege situations (the SPSU).

At about 1am Inspector Tunks advised Sgt Jones that the situation did not meet the criteria for the involvement of the SPSU and that he was travelling from Deniliquin to assist. Inspector Tunks and Sgt Campton arrived in Berrigan at about 1.52am. It was after that the police entered the house and found AA in the situation that I have described.

The actions of the police have been set out in some detail. Sgt Jones and Sen Con Germein were in a difficult situation. They were aware that AA had firearms. They did not know AA personally and did not know how he would react were police to have entered his home. Indeed the evidence is that those who knew AA best were also unsure of what his reaction would be. Sgt Jones at all times sought to involve his senior officer and to act on the information he had available. His actions were most appropriate. He and Sen Con Germein are to be commended for the manner of their response.

The background to AA's Suicide:

The death of an individual at his or her own hands is always a tragedy. It poses the question whether it could have been prevented. That question cannot be answered with any certainty however it is important to examine the circumstances that led up to the death to determine whether or not any lessons can be learned from the tragedy. Such examination may, in appropriate cases, lead to recommendations being made.

I have already mentioned that AA was a man who suffered from multiple medical conditions. Dr Aiad Ziarar Al_esse who provided a report and gave evidence the inquest provided his primary medical care. AA was admitted to the Berrigan Hospital on 26 June 2010 presenting with infective chronic obstructive airways disease and back pain. A CT Scan undertaken on 12 April 2010 had shown that AA suffered from anterior wedge compression fractures involving the T12 an L1 vertebra. He also suffered from mild scoliosis and multilevel disc degeneration throughout the lumbar spine.

Dr Al_esse's evidence was that on admission AA was most unwell however his condition improved over time. AA did not want have the assistance that hostel or nursing home would provide so plans were made for his return to his home.

AA decided that he wanted to be discharged from hospital and did so on 21 July 2010. Dr Al_esse had earlier tried to arrange for a referral to a pain management specialist however an appointment could not be arranged before October 2010 due to the demands on that service.

The records of the Berrigan Hospital were available as evidence in the inquest. Dr Al_esse also gave evidence. I am satisfied that there is no evidence to suggest that the actions of the hospital and Dr Al_esse were other than appropriate. When AA left the hospital his conditions had improved however he was beset by the continuing difficulty of dealing with the very considerable pain he was experiencing with a long wait before he was able to obtain the assistance from a pain management specialist.

It would seem that dealing with that pain was a matter that was very much on his mind on the evening of 22 July 2010. In the note that Mrs AA found the next day he had referred to the pain saying that he: “can’t stand any more.” That was written at a time that Mrs AA was at bingo however it is indicative of the trauma AA was experiencing and perhaps some explanation for his subsequent action.

Publication of Findings:

As already mentioned where a finding is made following an inquest that the cause of a death is self inflicted the publication of a report of the findings is prohibited unless the Coroner makes an order allowing the publication. I have found that AA’s death was self-inflicted. The provisions of Section 75(5) therefore apply.

In cases such as these there are two competing public interests. The first, recognised by the Parliament in enacting the prohibition on the publication, is the need to be sensitive to the pain that a family will experience when a member takes action that results in the ending of his or her life. The second public interest, recognised by the Parliament in requiring all deaths in police operations to be the subject of a mandatory inquest conducted by the State Coroner or a Deputy State Coroner, is the need to ensure that such deaths are not contributed to in any way by the actions of the police involved.

In this case Mrs AA has asked that AA’s name not be published. She has, however, indicated that she recognises the need for the review of the actions of the police involved to be available.

This is no doubt because she recognises, as I have found, that their actions were entirely appropriate. In the circumstances I am satisfied that the competing interests can be accommodated by allowing the publication of a report of the proceedings however prohibiting the publication of AA’s name and any evidence that would identify him. I propose to require that in any such report where it is necessary for him to be mentioned he be referred to by the pseudonym “AA”.

Section 82 Recommendations:

I have already outlined the circumstances in which recommendations would be made in accordance with Section 82 of the Act. In my view the examination of the circumstances of AA’s death do not give rise to such circumstances and as such I do not propose to make any recommendations.

Formal Finding:

AA (born 17 June 1934) died on 24 July 2010 at the Goulburn Valley Hospital, Shepparton in the State of Victoria. The cause of his death was a gunshot wound to the head that was self-inflicted at his home in Berrigan in the State of New South Wales on 23 July 2010 with the intention of ending his life.

27. 1919 of 2010

Inquest into the death of Derek Wales at Prince of Wales Hospital on the 31 July 2010. Finding handed down by Deputy State Coroner Mitchell at Glebe on the 4th October 2010.

This is an inquest into the death of Derek Wales. It is a mandatory inquest because Mr Wales died in custody and parliament has provided that where people are in custody and therefore their ability to defend themselves and speak for themselves is to some extent diminished by reason of that custody but if there is a death the circumstances of that death will be mandatorily examined by the Coroner. It is a way parliament has adopted of ensuring the rights of or at least some of the rights of people who are in custody and also of ensuring in the interests of Correction Services New South Wales that their policies and practices are scrutinised and, where appropriate, are approved.

Ms Williamson, a police advocate is assisting the inquest. Mr Walters appears for Corrective Services New South Wales. Ms Doust appears for RN Georgiou who was one of the nursing sisters employed by Justice Health at the Long Bay Prison attended on Mr Wales when he fell ill. Mr Singh appears for Justice Health. Ms Robertson appears for Registered Nurse Tripolone who is another nursing sister who played the same role as Ms Georgiou. The officer-in-charge of the police investigation is Constable Michael Robinson of Maroubra Police and it was he who gathered the formal documents, prepared the coronial brief and gave evidence today.

The formal documents are exhibit 1 in the proceedings, they constitute the P79A report which is the initial police report to the Coroner of a death, an identification certificate relating to Mr Wales, a certificate of life extinct, the post mortem report and the attached toxicology analysis prepared by the Division of Analytical Laboratories. Those documents jointly called the formal documents are jointly exhibit 1 in the proceedings.

Dr Owen prepared the autopsy report and it provides a view that the death of Mr Wales was caused directly by complications of spontaneous left intracerebral haemorrhage on a background of hypertension and also on a background of diabetes mellitus.

The coronial brief prepared by Mr Robinson is exhibit 2 and that contains, among other things the statement of the officer-in-charge; a statement of Mr Felsch who is the correctional services officer; statements of RN Tripolone and Georgiou; an expert report from Dr Dudley O'Sullivan and a copy of the investigation report prepared by Correction Services New South Wales to the death in custody committee.

Mr Wales sadly was only fifty-five years of age when he died. He was born on 11 May 1955. He was born in Kota Kinabalu in Malaysia and he was by the time of his death an Australian citizen as well as an Australian resident. He had some family in Australia though not a great many. A sister in Western Australia and a partner in Victoria. The family, for their own reasons, have decided not to appear at the inquest today.

I don't know what the reason is but it may be a perfectly - and I assume it is a perfectly legitimate and understandable reason and this Court's sympathy is extended to family members who loved Mr Wales and, no doubt, will miss him.

Mr Wales was sentenced for an offence of fraud on 7 June 2010. His release date was 6 June 2012. He suffered a heart attack on 31 July 2010 at about 6.22am he was taken shortly after 7am that day to the Prince of Wales Hospital and he remained there until he died on 4 August 2010. Mr Wales had a history of coronary artery stent following an anterior myocardial infarction in 2006. He suffered also hypertension and diabetes, which was managed by diet control. In the early morning of 31 July 2010, his cell mate found him dizzy and disoriented and hit the knock up call button at 6.22 in the morning so 6.22 is the time when corrections officers were alerted to the fact that there was something wrong with Mr Wales.

They moved quickly it seems to me and visited his cell and found him indeed dizzy and disoriented and notified the Justice Health nurse on duty who was Registered Nurse Tripolone at about 6.30, perhaps 6.35 that morning. Ms Tripolone then left her position at the special programmes centre, which is part of the Long Bay, complex sometime around 6.30 or 6.35 to make her way to the section of the prison in which Mr Wales was incarcerated which was called MSPC3.

She arrived there and indeed she arrived at Mr Wales' cell at 6.55 and she has given a statement, which explains why it was that it took her that period of time to get to Mr Wales. Essentially what it had to do with was moving from one section of the complex to another.

It involved her in getting past I think five or it might have been six security gates and at many of those gates there are security procedures which have to be undertaken to get through.

It involved her also in walking a distance of 100 or 120 or so metres once she got to the gate of MSPC3 it involved her when she left her position at MSPC1 in handing over her duties in that section of the gaol and indeed her security keys to other staff and it involved her in driving a car two or three minutes because, as she explained in her statement, driving a motor vehicle from MSPC1 to MSPC3 is still the fastest way to get form one point to the other so she arrived at the cell at 6.55.

Fortuitously, RN Georgiou, who was arriving for her rostered duty at the prison at about this time, happened to get to Mr Wales' cell first. She arrived there at about 6.50 - about five minutes before Ms Tripolone got there. In the event neither Ms Tripolone nor Ms Georgiou could have got to Mr Wales early enough to make any difference to his prognosis because, as Dr O'Sullivan indicated, Mr Wales had already suffered a very large intracerebral haemorrhage which was fatal and there was nothing that either registered nurse could have done no matter when they'd arrived on the scene.

Looking at it as calmly as one can, it seems to me that in light of the difficulties in moving from one section of the prison complex to another, difficulties which have to do with necessary security it would be quite wrong for me to be critical of anybody in relation to the period of time it took to get to Mr Wales and, as I say, even if it could have been done quicker, sadly, it would have made no difference.

Formal Finding:

I find that Derek Wales died in the Prince of Wales Hospital at Randwick in the state of New South Wales of complications of spontaneous left intracerebral haemorrhage sustained on 31 July 2010 while he was an inmate with a background of hypertension and diabetes mellitus.

28. 2460 of 2010

Inquest into the death of Ba Thinh Le on the 5th October 2010 at Sefton. Finding handed down by State Coroner Jerram at Glebe.

I do not intend to go over in huge detail exactly what happened leading up to the death of Mr Le. I will do a short outline, but you have heard it in great detail from Mr Ranken in his opening and closing submissions and from everybody else at the bar table. In brief, Ba Thinh Le, having been in Australia only some seven months, had had a relationship, which had become, I think, a sexual one with a young Vietnamese woman with whom he was clearly very entangled.

A few days before his death, according to the statement from her, which was unchallenged, as she was not called, he had begun to display some extremely jealous and strange behaviour forms as she pulled away from that relationship. He had, for example, thrown away her phone or broken her phone and flushed her SIM card because he believed that a text she had received was cause for jealousy.

On the night of 4 October, a Monday night, the beginning of the long weekend, he had a great deal to drink - and there is no doubt about that - at her flat with some other Vietnamese tenants of that flat who had only arrived in the flat that day and who, the poor things, had only been there for - only been in the country for about two days and he became belligerent and threatening and unpleasant. He obviously was very drunk. He could not make up his mind where he wanted to go. One of the friends drove him and he changed his mind, eventually coming back to the flat. According to the statement of his girlfriend, he then sexually assaulted her in a quite violent and unpleasant way. We will never, of course, be able to establish that he now being dead. But her statement was not challenged and nobody required her to attend even though we were told that she has come back to Sydney.

In any case, she managed to evade him and went downstairs to the lower flat where ultimately she was helped by one of those residents to leave the premises and go to the police station, the police already having been called. Meantime, Mr Le was yelling and screaming and making threats and making death threats, I might say, and hammering or banging on the doors of, particularly, the downstairs flat.

At one point, Mr Ninh, who was one of the new arrivals upstairs, came out of his room because of the noise to find Mr Le in the upstairs flat holding two knives. He did, as far as he could, confront Mr Le saying, "If you want to see Yen, why have you got the knives?" in other words, what is that to do with it.

He went - he left the flat and again went downstairs and started banging again and yelling and making threats such as, "You let me in or you will die." and swearing and generally making a great hullabaloo. Police arrived, Sergeants McEvoy and Cuddy, and immediately - simultaneously a car driven - or containing at least - I am not sure who was the driver - Constables Morrison and Turner. Constable Turner - and this is not a criticism - had been in the police for five weeks. He admitted himself he hardly knew what a critical incident was and he certainly had not come upon a situation such as this. The two constables were directed by Sergeant McEvoy to go round to the lane at the back of the house in order to set up a security perimeter. Mr Fam, a resident of the downstairs flat, who walked in front of the police car to show them the way, took them there.

Everybody tells me that it was quite dark. There probably were some streetlights but they do not seem to have been particularly strong. The two police parked the car and walked up the lane led by Mr Ninh and still hearing the yelling and banging coming from the house where they had - which they had originally left and just as they reached the rear exit from that house, which was through a carport, realised that someone was coming towards them. There is some inconsistency about whether he was running or walking. Constable Morrison is very sure that at least at the end he started to run. I think Mr Hood is right in - I think it was Mr Hood; it may have been Mr Haverfield - that the fact that there are some inconsistencies between the two police officers only goes to their credibility because we all understand how in situations of great trauma, nobody is a totally accurate observer.

As he came towards them - and by this time, very close - only about 3 metres or so - Constable Morrison saw in some light which then glinted on the knives that this person - and it was Mr Le as it turns out - was holding knives. Constable Morrison is quite sure that he had one in each hand. He called out "Knife." and a civilian who was watching events through the fence corroborates that and Constable Turner corroborates it, I think, too. Constable Turner wondered whether to use his firearm, but by the time that he had considered that or gone to pull it out, Constable Morrison deployed the Taser, the electronic control device, which he had on his load-bearing vest at chest level.

Mr Le, by this time, was less than 2 - probably about 2 metres from the two police officers who had taken a step back - and he, for a moment, froze - according to both officers - and then fell forward on to the road. His feet, as I understand it, were just outside the outer edge of the carport.

That is what is to be expected, as I understand it, when an electronic control device is properly deployed. I should say at this stage that like most lay persons I do not have any great love of the idea of Tasers or electronically controlled devices and, in fact, they are quite scary sounding.

But I thought I might just give this short quote from one of the pieces of material that was tendered to me by Ms Bashir. It is from a Dr Bozeman at Wake Forest University in Northern Carolina and it is in a - a magazine, I think, called the, "Annals of Emergency Medicine", of November 2009 and he says this:

"From a public health or epidemiologic perspective the use of conducted electrical weapons is similar to that of automobile air bags, which are also known to pose a small risk of serious injury and even death in rare cases, but are clearly responsible for marked overall reductions in injuries and fatalities. While investigations to clarify the risks and optimize the safety of these devices must continue, the overall balance of risks versus benefits in terms of injuries prevented and lives saved weighs heavily in favour of the use of both."

Now, I do not want to be quoted by TASER International as being a proponent, but I think that is a useful and interesting comment. What happened next I will not go over. I am quite satisfied with the very quick arrival of the two sergeants and Leading Senior Constable Wilson of the dog squad that the events, once Mr Le was on the ground, are properly and well set out. And I do not think, really, anybody has challenged those. I think all police officers, at first Mr Le seeming to be all right, acted quite properly and then when it was noticed that his breathing had either become laboured or had stopped, I think every one of them did what they could to assist Mr Le. He made groaning noises. The most unpleasant experience for all of them and particularly for Sergeant Cuddy when, in attempting to give him artificial respiration even with a mask, his stomach regurgitated its contents and that, sadly, hit Sergeant Cuddy and, indeed, because it later turned out that Mr Le was Hepatitis C positive, caused him and, to some extent, the others considerable concern. I am glad to say that concern was not borne out and I deeply regret for all the officers' sake that they had to go through something so unpleasant, but I suppose it will not be the last time.

In any case, concern became intense for Mr Le because he was not responding to compressions or to the artificial respiration by breathing.

The ambulance arrived. They, too, were unable to revive Mr Le and I applaud their efforts as well. They continued those efforts having put Mr Le into the ambulance but both ambulance officers from whom I heard yesterday, were quite clear that they were convinced that Mr Le was dead at the time that they - that the first ambulance arrived. That driven by Officer Davey came a - a moment or two - a minute or two earlier than the second ambulance, but she said that that was her immediate belief as soon as she drew up in the ambulance. He was pronounced dead at the hospital, but I agree with Mr Ranken, my able counsel assisting, that, in fact, on that evidence I am entitled to say that he, in fact, died at Anderson Lane and I - I will make that finding.

Unfortunately, the police dog still young and, I gathered, still in training, was a little over excited and seeing the offender on the ground was unable to be totally restrained and came forward and nipped Mr Le while he was on the ground.

Nobody has suggested that that in itself was a fatal bite or caused any deep injury, although some abrasions probably from it, at least consistent with dog bites, were found on Mr Le's thigh, which is exactly where the officers told me the dog nipped at autopsy. What we have is a whole bundle of what Dr Szentmariay, the pathologist who gave evidence having performed the autopsy, agreed together were a bad combination. Autopsy showed us, one, that Mr Le was Hepatitis C positive; two, that he had drugs in his system not obviously to a fatal level, but some traces of methamphetamine and certainly some traces of morphine or heroin. He also had a high reading of alcohol; .162 which is well over the high range for driving.

There is a possibility, which we cannot confirm but which one of the family here in Australia raised that he had had previous heart cardiac problems. Autopsy did not show any, but as Dr Szentmariay said, it does not always do so. Nevertheless, he did not think that there was a valvular problem, but he made it clear that autopsies do not always show every cardiac problem that can arise.

Then Mr Le had had a shock, an electric shock, and he had fallen and fallen, while not flat on his face, he had certainly fallen quite heavily and fairly prone from the description. He then lay, if not totally face down - because I accept that he was partly on his right shoulder - he lay facing forwards and was cuffed behind his back. I do not suggest anything improper about that, but it is an uncomfortable and awkward position.

And then finally it became obvious from what happened during CPR both for the officers and for the ambulance officers that he had a large amount of food in his gut which aspirated, to some extent, and which may have led to some choking. As I said, Dr Szentmariay agreed that this was a bad combination, that I do not think - although Ms Bashir disagrees with me - that he quite said any one of them could have been a cause of death, although I think that is possible. But - and we will never know the reason because the post-mortem was not able to establish it - he seems to have died within a minute or so after the tasering despite the efforts of all.

I had some extremely good, strong and interesting evidence from Senior Sergeant Davis as to the justification for using a Taser and you all heard him say that in his view it would have been most justified to use the firearm in those circumstances and, in fact, by using the Taser there was a greater risk for the officers. The Taser may not have worked, they might not have been able to fire it in time because he was so close. Luckily, there was no harm done to the officers, although I accept that situations like this cause trauma for all those involved and it has been more than a year that they have had to wait for this to be dealt with.

I am terribly sorry for Mr Le's family. They must have been completely incredulous as to how their son reached this point and died in such a way. Nevertheless, he obviously had had far too much to drink, he may not have been leading a very healthy life at that particular stage and while they must have wondered about the electronic control device, the Taser, from everything that I have heard, I am satisfied that there was completely appropriate behaviour by all police officers involved,

despite - and this is my only despite - concerns that I have expressed for the last two days about the whereabouts of the knives. You would all recall - and I - you may not have all seen the photographs - that when the knives were seen, I think, either during CPR on Mr Le or shortly after by some, Mr Le had gone in the ambulance, they were - two knives were behind the post that is back into the house premises of the carport. The smaller one was sticking into the ground and standing up and the larger knife was lying flat very close to it.

They were odd - they were both in odd positions, given that Mr Le was tasered and fell outside the carport. However, Senior Sergeant Davey said anything can happen as with ballistics.

Two or three hypotheses were put to me, any of which are possible, about how they came to be there. I think it is possible - and I put it absolutely no higher than that - that Mr Le, at the last possible moment, had, in fact, partly obeyed Constable Morrison's orders to put the knife down or to get on the ground and thrown them. It may have happened literally a second or less before the Taser was deployed. I do not put any blame on Constable Morrison even if that were true - and we will never know. Constable Morrison, I hasten to say, says that he was sure that he saw his knife - the knife in his hand at the moment that he deployed the Taser.

As I say, we just will not know. I find it hard to think how the knives could have got there if that was so, but perhaps he had thrown down one and then the other one flew through the air. I do not know. However, again, on Senior Sergeant Davey's evidence, even if that were so and even had Constable Morrison known that he had thrown down the - the knives - and I accept that he did not, if he had - then the tasering was, in Senior Sergeant Davey's view, the most appropriate thing to have done.

Some of you may know that I do not always exonerate the police and sometimes I have been very critical of them. I am not in this situation. I think, in fact, the two young policemen acted very well.

I cannot remember how - what experience Constable Morrison had, but I know that Constable Turner had very little and was not too proud to say so and I am glad to see that they are both still with you and have not left the police force as a result.

I make a - a comment about the critical incident guidelines. You all saw the - Inspector Newton's face when asked by my counsel assisting when he had realised that his directions were not carried out and his answer, only just before he came into the witness box. They are important. Police might forget sometimes that critical incident guidelines are there to protect them as much as to - to - keep the evidence uncontaminated because when police are separated immediately after such an incident with no chance to speak to each other - and human nature suggests most people would want to speak to each other after such an incident - but that if they are separated as immediately as possible with no such chance, then their evidence is given even greater credibility.

And, as I say, it is to protect police as much as it is the evidence that might - or might eventually go to Court. I do ask - and I think rather than make a formal recommendation that I might write to the Commissioner just suggesting and without making any criticisms of any person that there might be some better training. You heard Inspector Newton say that while he was aware of the guidelines, he had never had any training in them and he is obviously a very experienced officer.

I do not know that there is anything very much else I need to say. I just comment that Mr Stanford, the man who looked through the fence, was a very helpful civilian witness. Whilst he could not see a knife, he did not see Mr Le until the second or two when he came out of the carport and before he fell to the ground after the tasering. He did hear an officer call out "Knife." The man on the balcony - whose name I cannot remember - also said that he clearly recognised that these were police in the back lane and that there could not have been much doubt about that. I think it is true that most people, no matter whether they could describe a New South Wales police officer's uniform or not, most people in most countries recognise police.

Some of you may have been in Vietnam - I have - and I - you certainly recognise a Vietnamese police officer when you see one. I know it was dark and, of course, that has had various effects. But I do not think that Mr Le could have been in doubt especially given that the - the police cars at the front of the house had arrived with sirens and lights and the dog was barking pretty consistently. I think Mr Le must have been well aware that police were coming from that side and that is, of course, why he was heading for the rear exit and I do not see how he could have doubted that they were police whom he saw as he came out of the carport.

I am just going to make the formal finding and - I think I can leave it at that. Sorry. I thank you all for your assistance and for your cooperation too. It has obviously been a matter of great concern to police. I recognise that. Detective Agnew and Inspector, thank you very much. I also think we should acknowledge Mr Ho who has had to speak more than anybody non-stop for the last four days, Mr Ho. I did notice. Thank you very much for that.

<u>Formal Finding:</u>

I find that Thinh Ba Le died on the 5th October 2010 at Sefton in the State of New South Wales during the course of a police operation in which an electronic control device was deployed striking him, however the cause of death was subsequently unable to be ascertained.

29. 2490 of 2009

Inquest into the death of AA at Batlow on the 27th August 2009. Finding handed down by Deputy State Coroner MacMahon on the 12th August 2011.

Non-publication order

The publication of any photograph containing an image of AA taken following his death is prohibited. The publication of details of the geographic areas of New South Wales in which Department of Corrective Services officers in inmate transport vehicles do not have radio contact with the Department of Corrective Services is prohibited.

Introduction

AA (who throughout this finding I will refer to as AA) was born on 14 March 1950. He had a personable nature and came from a close and supportive family. Unfortunately he was both a heavy smoker and drinker.

On 7 May 2009 AA was detected driving a motor vehicle in Guyra whilst he was intoxicated. He was charged with the offences of “Drive with High Range Concentration of Alcohol” and “Drive Whilst Disqualified from Holding a Licence”.

On 11 August 2009 AA appeared at the Mt Druitt Local Court and in respect of the two offences he was sentenced to concurrent custodial terms of eight months with non-parole periods of six months. He commenced his sentence that day.

Following him being taken into custody by the Department of Corrective Services (DCS) AA was transferred to the cells at the police centre at Surry Hills and on 13 August 2009 to the DCS Metropolitan Remand and Reception Centre (MRRC) and subsequently the Dawn De Loas Correction Centre (CC) both of which are at Silverwater.

Following his classification AA was to be transferred to the Mannus CC, a low security prison, near Tumbarumba. To get to Mannus CC AA was transferred firstly to the Parramatta CC on 25 August 2009 and then to the Bathurst CC on 26 August 2009. At about 9am on 27 August 2009 he then commenced his journey to the Mannus CC.

The journey from Bathurst CC to Mannus CC was one of approximately five hours duration.

To get to Mannus from Bathurst it is necessary to travel through the New South Wales towns of Cowra, Cootamundra, Batlow, and Tumbarumba. It is a distance of a little under 400 kilometres.

Somewhere in the vicinity of Batlow AA collapsed in the prison van and became unconscious. Other inmates tried to attract the attention of the drivers of the vehicle and laid him on the seat in the section of the van in which he was travelling. The van continued onto the Mannus CC arriving at about 1.40 pm.

On arrival at Mannus CC the noise being made by the inmates attracted the attention of DSC officers who directed that the van be opened.

The inmates were removed and Justice Health staff attended to AA. NSW Ambulance officers were also called and on their arrival they took over from the Justice Health staff. The efforts of the Justice Health staff and ambulance officers were not able to assist AA and he was subsequently pronounced life extinct.

Jurisdiction and function of the Coroner

Section 81(1), Coroner's Act 2009 (the Act) sets out the primary function of the Coroner. 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 that a Coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate 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. It is not the role of the Coroner to attribute blame.

Because AA was serving a prison sentence in the custody of DCS 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 reason why an inquest is mandatory in the case of such deaths has been explained by the former State Coroner Magistrate Kevin Waller in the following terms:

"The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached the laws, owes a duty to those persons of ensuring that their punishment is restricted to this loss of liberty, and is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentence.
The rational 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 satisfied the community that deaths in such places are properly investigated."

Identity and Date of Death

In AA's case his identity the date of his death were not in contention. Senior Constable Erin Hilton identified AA by way of fingerprint comparison. I accept Senior Constable Hilton's evidence in this respect. All the evidence available was to the effect that AA died on 27 August 2009. I am also satisfied that this is the case.

Cause of Death

The cause of AA’s death was also not in contention. On 31 August 2009, a government medical officer Dr Douglas Oxbrow performed post mortem examination on AA's body.

Having undertaken his examination Dr Oxbrow found that AA suffered from significant atherosclerotic cardiovascular disease and considered that the cause of his death was myocardial ischaemia.

The subsequent police investigation found that on 20 August 2009 AA had experienced chest pain and sought medical treatment. An ECG was undertaken at that time and the results, and interpretation thereof, were available to the inquest. I will come back to the events of 20 August 2009 later in this finding however having regard to those events, the ECG findings and the findings of Dr Oxbrow at post mortem I am satisfied that the cause of death recommended by him is appropriate and accept it. The effect of this is that AA died of a natural cause process.

Place of Death

As mentioned above at the time of his death AA was being transported from Bathurst CC to Mannus CC. The evidence of the inmates is that at a point during the course of that journey AA fell forward and became unconscious. The evidence of inmates was also that a short time after AA lost consciousness he became incontinent. I accept the evidence of the inmates on this matter.

Andrew Bond was an inmate who was also being transported from Bathurst CC to Mannus CC on 27 August 2009. He was in the same compartment of the van with. He gave evidence at the inquest. He said that prior to August 2009 he had worked for a number of months picking apples in Batlow and that as they went through the town he recognized it. He said that he was mentioning that fact when AA fell forward and became unconscious. I accept Mr Bond’s evidence on this point and am satisfied that AA lost consciousness in the vicinity of the township of Batlow.

In preparation for the inquest Associate Professor John Raftos was asked to review the circumstances of AA’s death and his previous medical history. He provided a report as to his opinions and conclusions and gave evidence during the course of the inquest. Dr Raftos is the senior specialist in emergency medicine at St Vincent’s Hospital, Darlinghurst and at the Sydney and Sutherland Hospitals.

Dr Raftos concluded that AA suffered from coronary artery disease. It was his view that AA suffered an episode of acute coronary syndrome on 20 August 2009 and that during the journey to Mannus CC on 27 August 2009 he had suffered a further episode of acute coronary syndrome.

Dr Raftos said that the typical cause of death in acute coronary syndrome is the sudden onset of ventricular fibrillation in the heart muscle that is made irritable when its blood supply is cut off by occlusion of atherosclerotic coronary artery.

When giving evidence Dr Raftos explained that following the onset of ventricular fibrillation unless cardiopulmonary resuscitation (CPR) and urgent electrical defibrillation are provided within a period of five to ten minutes death will occur.

Dr Raftos whilst giving evidence said that AA's loss of consciousness and subsequent incontinence in the van was, in the circumstances of AA's medical history, indicative of him suffering an episode of acute coronary syndrome and the onset of ventricular fibrillation. As previously mentioned in such circumstances death will follow unless CPR and electrical defibrillation is provided within a matter of minutes. I accept Dr Raftos's evidence on this matter and am satisfied that that AA's death occurred in the corrective services van shortly after it left the township of Batlow.

Issues examined at Inquest.

As outlined above the reason why the Parliament requires that an inquest be conducted into all deaths that occur whilst the deceased is in custody is to ensure that the punishment that a prisoner receives is the loss of their liberty and is *"not exacerbated by ill-treatment or privation"*. The police investigation of the death therefore examines the circumstances of the death and the history of the incarceration so as to determine whether or not this is the case. In AA's case although it was clear that his death was due to a natural cause process the investigation identified a number of issues that became the subject of close examination at inquest. It was necessary to determine whether or not the issues identified contributed to the occurrence of AA's death when it occurred and whether or not the circumstances gave rise to the need to make recommendations pursuant to section 82 of the Act. Those matters can be summarized as follows:

Whether or not the medical care provided to AA by Justice Health on 20 August 2009 following him seeking their assistance after experiencing chest pains was appropriate.

Whether or not AA was refused medical or pharmaceutical assistance at Bathurst CC on 27 August 2009 prior to him entering the van that was to transport him to Mannus CC, and

Following AA's collapse in the van did the other inmates in the van try to seek the assistance of the van's driver and observer, and if they did were the driver and observer aware of those efforts, and if they were what was the response of the driver and the observer and was it appropriate?

Medical care provided on 20 August 2009.

On 20 August 2009 AA was at the MRRC. He was suffering chest pain and sought medical assistance. He initially consulted Registered Nurse Elaine Pointer in the Goldsmith clinic within the jail. Nurse Pointer provided a statement for the inquest and gave evidence. She said she saw AA at about 10.25am. She recorded that he complained of chest pain described as a cramping feeling in the centre of his chest, cold left hand, pallor of the left fingers and face and was sweating moderately.

Nurse Pointer took a detailed history from AA, provided him with Aspirin and Anginine and arranged for an electrocardiogram (ECG) to be undertaken. She then arranged for him to be examined by Dr Suresh Badami, a staff specialist general practitioner, who was working in the main medical clinic at the jail. She also spoke to Dr Badami.

Dr Badami also provided a statement and gave evidence at the inquest. He agreed that he examined AA on 20 August 2009 after being referred by Nurse Pointer. Dr Badami took a history and arranges for a second ECG to be undertaken. Dr Badami examined each ECG. In respect of the first he recorded *"EGC – initial- no acute change"* and in respect of the second *"Second ECG shows no new change."* Dr Badami recorded his conclusions and plan of treatment as follows: *"Impression. If pain recurs go to hospital. Treat as gastro-esophageal reflux disease. Review next week."* As mentioned above Dr Raftos was asked to review the medical care provided to AA. He concluded that the actions of Nurse Pointer were appropriate however Dr Badami's interpretation of the two ECG's were not correct. In his report he said: *"Dr Badami's interpretation of the first electrocardiogram as showing no acute changes is not correct: the electrocardiogram shows borderline elevation of the ST segments in leads II and V6 indicative of inferolateral acute coronary syndrome. The second electrocardiogram shows clear evidence of ST segment elevation in leads II and V6 indicative of inferolateral myocardial infarction."*

It was Dr Raftos' evidence that an ordinary skilled doctor such as Dr Badami: *"Should have appreciated that AA's electrocardiograms were abnormal and that the ST segment elevation meant that he was in the high risk group of patients for acute coronary syndrome, treatment of whom should include: Urgent hospital admission Medical therapy, and Urgent reopening of the artery with either coronary angiogram, dilatation, and stenting or thromblytic medication."*

Dr Badami's failure to properly interpret the ECG's that were undertaken on 20 August 2009 was catastrophic for AA. Dr Raftos summarized that effect as follows:

"If AA had been transferred to a hospital from the Justice Health centre on 20 August 2009, as should have been the case considering his abnormal electrocardiograms, coronary angiography would have been performed before he was discharged from hospital and would have revealed the blockage in the coronary artery that was causing his acute coronary syndrome. The blockage would have been dilated and stented. He would then, on the balance of probabilities, not have developed fatal ventricular fibrillation on 27 August 2009 and he could reasonably have expected a normal lifespan in respect of his coronary artery atherosclerosis."

In Dr Raftos's view AA's death was thus entirely preventable and that had he been provided with proper medical care on 20 August 2009, which necessitated transfer to a hospital, it was probable that he would have experienced a normal lifespan. I accept Dr Raftos's opinion in this regard.

Dr Badami also made a statement and gave evidence at the inquest. To his credit Dr Badami conceded that on 20 August 2009 he misinterpreted both ECG.

He also conceded that having regard to the history taken and the ECG findings the appropriate treatment for him to have provided AA was to have transferred him to a hospital.

AA was serving a custodial sentence because of the offences that he had committed. The punishment was loss of his liberty. Because he had lost his liberty he had no choice as to the medical care that he received. Had he not been in custody on 20 August 2009 when he suffered chest pain he would no doubt have done what he had previously done and sought medical attention. It could reasonably be expected that he would have received appropriate medical care from his chosen medical practitioner. It could therefore reasonable be expected that he would have remained alive.

AA's death is therefore primarily the result of the failure of Justice Health to provide him with proper care. Once again, to their credit, Justice Health through their representative at the inquest acknowledged this failure and its consequences.

Events of 27 August 2009.

The investigation of the events surrounding the death of AA raised other issues relating to his care by Justice Health and DCS staff on 27 August 2009. Put simply it is alleged that whilst in the holding cell at Bathurst CC a request was made by him, or on his behalf, for medication and that this request was refused. It is also alleged that following AA's collapse during the journey to Mannus CC, efforts the other inmates made to seek help for him from the driver and observer were ignored.

The matters raised involve the actions of Justice Health and DCS staff however it is necessary to deal with the issues together as they involve an assessment of the evidence of the various inmates in the van, that of the Justice Health and DCS staff involved as well as AA's medical history in the period between 20 and 27 August 2009.

Dr Badami examined AA on 20 August 2009. I accept that AA was told that if the chest pain recurred he would have to go to hospital and that Dr Badami intended to review him in a week. The intention to review and the making of arrangements for that review raises another matter to which I will return however AA began his journey to Mannus CC by being transferred from Silverwater CC on 25 August 2009.

Within the CS system certain Justice Health procedures apply on the transfer of an inmate from one CC to another. Put shortly on arrival at an institution the inmate is interviewed and an intake questionnaire completed and signed whilst on leaving an institution a transfer out form is completed without the need to interview the inmate. In August 2009 there was a variation to this procedure in that due to the then current influenza epidemic there was a general screening process that took place on all inmate movements.

Following seeking medical assistance on 20 August 2009 AA underwent this transfer process and on 22 August 2009 on his transfer from the MRRC to the Dawn deLoas CC he indicated that he was not: *"confused or worried, did not require support, did not have any problem and did not need to see the nurse."* On his arrival at Parramatta CC on 25 August 2009 at the intake interview he indicated that: *"he was not on medication and did not require any information or support."* Again on his arrival at Bathurst CC on 26 August 2009 he indicated that: *" he was not confused or worried, did not require support and did not have any problem."*

Dr Raftos in his evidence expressed the view that, having regard to the condition of AA's illness, it was likely that in the period between 20 and 27 August 2009 he would have experienced further chest pain. At this stage we will never know whether or not he did however if he did it would seem that it was not such as to cause him to seek assistance up until and including 26 August 2009.

AA sought medical assistance on 20 August 2009 when he needed it. The treatment he received on that occasion was such as to relieve the symptoms from which he suffered. I am satisfied that in the period 20 August 2009 to 26 August 2009 had AA suffered further symptoms that caused him concern he would more likely that not have sought assistance. The fact that he did not satisfy me that from 20 August 2009 to 26 August 2009 he was effectively symptom free. I am also satisfied that apart from the one off medication provided to him by Nurse Pointer on 20 August 2009 AA was not prescribed or receiving any medication.

This brings us to the events on the morning of 27 August 2009. AA and other inmates who were to be transferred to Mannus CC were firstly taken to a holding cell. They were not provided with any breakfast although they had been given a breakfast ration with their meal the night before.

At about 8am, whilst waiting to be placed on the transport van, Kate Douglas, an endorsed enrolled nurse employed by Justice Health, undertook what was called a: *"Screening Tool for Suspected Influenza – Like Illness Prior to Transport."* The screening tool was seeking to identify persons that might have been affected by what was known as "swine flu."

Nurse Douglas gave evidence at inquest. She had no specific recollection of AA or the morning of 27 August 2009. In July 2011 she had been shown the Screening Tool relating to AA dated 27 August 2009 and had identified her signature on it. She accepted that she had undertaken the screening. She said that she had undertaken the screening on numerous occasions both before and after 27 August 2009. She said that it was her practice to say to the group of inmates in a holding cell awaiting transfer words to the effect of: *"does any one feel unwell or have flu-like symptoms? Does anyone need to see the nurse?"*

Relying on the form that she signed, and her normal practice, she concluded AA had not indicated he was unwell nor had he sought any assistance. She said that if anyone answered her questions in the affirmative she would take the inmate to the clinic where they could be reviewed by a registered nurse. She also denied that AA, or any of the other inmates, had asked for medication.

She said that had that occurred she would have consulted the inmate's medication chart and, if appropriate, arranged for the medication to be provided.

Contrary to Nurse Douglas's evidence it was suggested by inmates that on 27 August 2009 medication was sought by, or on behalf of, AA and another inmate and that they were told that such medication would be provided on arrival at Mannus CC.

Following AA's death police were called to Mannus CC. During the evening of 27 August 2009 all inmates in the transport were interviewed by police as to the events of the day. During those interviews a number of the inmates that were with him alleged that AA had sought medication at Bathurst CC and had been denied such medication.

Sanni Primorac was one of the seven other inmates in the compartment with AA. He gave evidence at inquest. He said that he was on medication for an arm injury and had not received it the night before. He said that both he and AA made an inquiry with the nursing staff and were told that:

"They'd look at our medication when we got off the truck."

During cross-examination he strongly maintained his assertion that both he and AA had asked for medication. Andrew Bond was also an inmate in the compartment in which AA was travelling. He gave evidence at inquest. He also asserted that AA asked for medication. He said: *"The nurse came and asks us if we were right, do we need anything, and he said he wanted his pills. And they said 'you'll get that at the other end."*

And again: *"Then me mate asked for Panadol. They said you'd have to wait to get it at the other end. And AA was asking' for his pills."*

Roland Douglas Marsh was another of the inmates in the compartment with AA. He also gave evidence. His evidence was that AA had asked for medication at Bathurst CC. He said: *"AA had said that he needed medication and the nurse said, well you'll get it at the other end at Mannus"*

Jason Krose and Shane Woodside were also in the compartment with AA. They did not give evidence at inquest however in their interviews with the police on the evening of 27 August 2009 they also asserted that AA had asked for medication and had been told that he would receive it when he arrived at Mannus CC.

As I have already said I am satisfied that on the morning of 27 August 2009 AA was not prescribed any medication. When he had experienced chest pain the previous week the symptoms had been mitigated by the medication he had received from the nurse at Silverwater. On the 27 August 2009 had he been experiencing further symptoms it is likely that he would have asked for similar assistance. Five of the inmates who were travelling with him say that he did and it was refused.

Nurse Douglas on the other hand denies that was the case.

She says that if anyone would have asked for medication or to see the nurse she would have responded to the request. She has no specific memory of the morning but relying on the documents she authored and her practice she asserts that no such request was made.

It is suggested that I would prefer the evidence of Nurse Douglas to that of the inmates on this issue. It was established that the inmates discussed the events of the day amongst themselves after their arrival at Mannus CC. Indeed all inmates were placed in a cell together on their arrival at Mannus CC and having experienced the death of a fellow inmate and the trauma that having had to remain in the compartment for a period of time with a deceased person it would have been natural for them to have discussed the matter amongst themselves. Although some of the evidence of the inmates would no doubt be hearsay I am satisfied that there would be no reason for them to concoct evidence.

At the same time although Nurse Douglas had no specific memory of the events of the morning of 27 August 2009 there would be no reason for her to depart from her normal procedures and if asked for medication to refer the inmate to the registered nurse. It is undoubted that she did not do this and as such she asserts that no request was made.

I have no reason to prefer the evidence of either the inmates or Nurse Douglas on this point. I do not know whether or not AA sought medication on the morning of 29 August 2009 prior to beginning his transfer to Mannus CC. It may be that he did and Nurse Douglas misinterpreted the request. It may also be that when he began to experience difficulties he mentioned to the other inmates that he should have asked for his "pills.' All this is speculation and as such I am unable to make a finding one-way or the other.

I have already said that I am satisfied that at or about Batlow AA collapsed and within a few minutes thereof had died.

I am also satisfied that from about the time of AA's collapse the inmates in the compartment in which he was travelling sought to get the attention of the driver and observer by banking on the floor and walls of the van. Indeed the inmates in the forward compartment also joined in this action.

It was the evidence of all seven inmates in the middle compartment of the van that after AA collapsed he was laid on the seat of the van whilst action was taken by the inmates to attract the attention of the DCS staff. Such action continued from the time of his collapse to their arrival at Mannus CC. I accept that this was the case. This time was estimated to be about forty minutes. Given the distance from Batlow to Mannus CC of about 52 kilometres that estimate would be about right however the exact time does not matter.

Peter Augustine Sheppard and Clive Anthony Bateman were the DCS officers on the van that transported AA from Bathurst CC to Mannus CC. Mr Sheppard was the driver and Mr Bateman the observer until Cootamundra and at that point they reversed the roles. They each prepared an incident report concerning the events of the day were subsequently interviewed by police. They each gave evidence at inquest.

Mr Bateman's evidence, which he confirmed at inquest, was as follows: *"Somewhere between Batlow and Tumbarumba, and I think it was around um, the turn off at Tarcutta and just before you go down the steep hill –I heard banging coming, obviously from the back of the truck."* And: *" Pete's got a monitor on his side of the truck and I asked what was wrong, what's going on and um, he looked at it and couldn't see anything wrong and we just assumed that it's because it's such a long trip --- and we haven't had a break from the trip at all that they were just bored with the trip."*

The evidence was that there was a monitor in the driver's cabin that allowed observations of the various compartments by the observer. The view that was available rotated from compartment to compartment showing each compartment for a number of seconds before moving to the next compartment. Mr Bateman, as the driver, was unable to see the monitor but in evidence he stated that it appeared to him that Mr Sheppard was looking at the monitor.

There was no capacity for inmates to communicate with the DCS staff and because there was no microphone available there was equally no capacity for the DCS staff to communicate with the inmates. In Mr Bateman' report he said: *"Mr Sheppard told me that it (the banging) was from the front cell. He checked all the cells and told me that he couldn't see any problems."*

Mr Sheppard also heard the banging coming from the rear of the van. He said: *"At about 1.20pm we could, ah, hear inmates making a noise and I looked up in the monitor… I could see the three inmates in the front, ah, banging their feet on the floor. I assumed that they were getting irate because it was taking so long 'cause we're nearly at the destination. I checked all the other cameras in the other cells. The fourth cell contained property, so there were no inmates there. The rear cell up the back had two inmates was good, and the middle cell, ah showed no indication of any problems whatsoever.*

I just assumed the front cell which contained the three inmates, they were just getting agitated at the long, ah, at the long, um, transport."

At a later time in his interview on 27 August 2009 Mr Sheppard was again asked about his observations. Concerning the middle compartment he said: *"The, they were all, um just appeared to be just sitting up there normally."* And again later:

"…if you were aware that there was something pretty big going on.
Q 3 Yeah, yeah. But the only commotion you said you saw was in, in the front cell.
A Yeah, in the front cell, yeah.
Q54 and that was…
A Stamping the floor"

Mr Sheppard was also interviewed by the DCS investigator Mark Farrell as part of an internal investigation into AA's death. During that interview he said:

"…the run was routine just regular checks on the monitor and we got close to Tumbarumba and we could hear some noise coming from the back cells,

I checked the monitors, in the front monitor I could see three inmates banging their feet on the , the front of the , on, on, on the floor on the front of the cell, I checked the other monitors and couldn't see any obvious problems, the offsider asked me, you know, what the hell is going on and I … they're just protesting at the fact it took so long… we just assumed that were getting fed up with that slow progress. We decided only probably 15, 20 minutes away from Mannus we'll just keep going, you know, not suspecting anything…just thought might've been the inmates playing up."

Later during the same interview when asked where the noise was coming from:

"Q 38 What exactly did you see on the monitor again?
A I saw the three inmates, we heard the noise and then I saw the three inmates just banging, banging their feet, they were sitting like that…
Q39 and is that where the deceased was housed?
A No, the deceased was housed in the middle cell in, in the eight, in the eight, in the eight-cell section.
Q40 All right you say the banging was definitely from…
A Definitely from the …front cell.
Q41 Yeah.
A Yeah."

Mr Sheppard gave the same evidence at the inquest.

The evidence of Mr Sheppard is in stark contrast to that of the inmates. Those in the front section only began banging after they heard the banging from the middle section. Nick Brough was one of those inmates. He heard the noise and the word *"heart attack"* mentioned. He and his colleagues joined in the action to obtain the attention of the DCS officers.

The evidence of the inmates in the middle compartment was also in stark contrast to that of Mr Sheppard.

Their evidence was that from the time AA collapsed they were banging on the floor and walls of the van, making signs at the camera trying to attract attention and that AA had been laid on the bench seat. The evidence of the inmates in the front compartment supports this assertion in part.

I accept the inmate's evidence as to the efforts that they went to in order to seek help for AA form the DCS officers. Whether those efforts lasted twenty minutes, as the DCS officers said, or forty minutes, as the inmates said, does not matter. According to Mr Sheppard he looked on the monitor and did not see anything of any significance. The evidence at inquest was that the monitor was working effectively on the day. For Mr Sheppard not to have noticed AA laying on the bench and the other inmates acting as they did required him to either not look or just ignore what he saw.

I am comfortably satisfied that having seen the inmates in the front compartment banging on the floor Mr Sheppard assumed that they were getting bored and thereafter simply chose to ignore what was going on. He either did not look to see what was happening in the other compartments or, if he did look,

he was not telling the truth about what he saw. Either way his attitude to his duties as a DCS officer was totally inappropriate. I propose to recommend that the Commissioner for Corrective Services give consideration to commencing disciplinary action in respect of Mr Sheppard's conduct.

I am satisfied that had Mr Sheppard undertaken his duties in a proper fashion he would have been aware, sometime shortly after having left Batlow, that there was a welfare concern in the middle compartment of the van. This raises the question of what, if anything, could he and Mr Bateman have done in the circumstances.

DCS Standard Operating Procedures (SOPS) that govern the functions of DCS officers undertaking escort duties provide as follows:

"Inmates requiring Medical Attention

When the escorting officers become aware, via surveillance monitors, of a medical emergency in the vehicle, they will immediately contact 1Post for advice from the Executive Officer on duty. The Executive Officer will assess the situation and advise the escorting officers of what action is to be taken. In general, where medical treatment is not urgent, the escort will proceed to the nearest secure location to gain assistance. In an extreme medical emergency, escort officers will be directed to open the compartment of the truck immediately and render assistance with due regard to security. 1Post in these instances will arrange for additional security personnel to attend as well as medical assistance

Had Mr Sheppard and Mr Bateman become aware that there was a medical emergency in the middle compartment of the van that they were travelling in they were obliged to make contact with their superior officers and seek advice as to what action was to be taken. AA's circumstances would without doubt be described as an *'extreme medical emergency'* and as such it would be likely that they would have been directed to *'open the compartment of the truck immediately and render assistance'* whilst taking *'due regard to security.'*

They of course did not do this for the reasons that have already been discussed. Equally troubling however is that even if they were performing their duties effectively they were unable to comply with the SOPS as there was no way that they could make contact with the executive officer on duty.

It leaves the officers and inmates totally vulnerable. One would think that this systematic failure would raise significant occupational health and safety issues and it is simply amazing that it has not been identified and dealt with well before now. I propose to make a recommendation in accordance with section 82 of the Act concerning this matter.

The question remains whether or not had the officers identified the medical emergency and acted in accordance with the DCS SOPS could they have made a difference to AA's chances of survival following his collapse. I am satisfied that they could not.

Dr Raftos was asked questions about the treatment to be provided and the chances of survival following onset of ventricular fibrillation due to acute coronary syndrome. His evidence is that survival past a period of five to ten minutes is unlikely without CPR and defibrillation. The evidence of officers Sheppard and Bateman was that they had received training in CPR but did not have a defibrillator on the van. In the circumstances I am satisfied that even if the officers had become aware of AA's collapse shortly after it occurred, had removed him from the van and provided CPR there was little or no likelihood that he would have survived. The failure of Mr Sheppard to undertake his duties appropriately was thus not a contributing factor to AA's death.

Other Matters.

The examination of the circumstances of AA's death raised a number of other matters that now need to be dealt with. Those matters are: The failure of DCS to provide inmates with food and water during the journey from Bathurst CC to Mannus CC, The failure of DCS to plan a toilet stop for inmates during a journey that was to take about five hours, The failure of Dr Badami's request to re-examine AA the following week to be noted in the Justice Health records that accompanied him after he left Silverwater CC, and What, if any, additional recommendations would it be appropriate for me to make in accordance with section 82?

Failure to provide food and water:

The evidence at inquest was that those inmates being transported from Bathurst CC to Mannus CC were provided with an evening meal and a breakfast package on the evening of 26 August 2009 following their arrival from Parramatta CC.

Some may have kept the breakfast package for the morning of 27 August 2009 and others may have consumed it on the 26 August 2009. We do not know what AA did.

Following them being assembled in the holding cell at about 8am the inmates left for Mannus CC about 9am. The journey was expected to take about five hours so the earliest time of arrival would have been about 2pm. There would no doubt have been a period of processing after their arrival so the inmates could have expected a period of six hours without food or water.

The evidence available does not allow me to make a finding that the failure to provide water to AA during the journey was a contributing factor to his death. Dr Raftos was examined on this point at the inquest and although he said that dehydration might contribute to the onset of coronary syndrome because it made the blood "sticky" he agreed that there was no scientific evidence to support such a conclusion.

Notwithstanding the lack of scientific evidence as to the possible relationship of dehydration to the onset of coronary syndrome I can take judicial notice of the strong advice given by doctors and others of the need for all people to maintain their level of hydration.

To require an inmate to go for a period of some six or more hours without water and possibly food in my view comes within the definition of *"privation"* which the former State Coroner, Magistrate Waller, outlined as the reason why an inquest into the death of a person in custody is mandatory.

He reminded us that the inquest is to ensure that: *"Their punishment is restricted to this loss of liberty, and is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentence."*

The evidence of officers Sheppard and Bateman made it clear that there was no consideration given to the provision of food and water to the inmates on the journey from Bathurst CC to Mannus CC on 27 August 2009. I also have considerable doubt that there had ever been any such consideration on previous similar journeys either.

I am pleased that since AA's death I am advised that the situation has changed. Inmates are provided with a breakfast package on the morning of their transportation and are also provided with bottled water. Notwithstanding this I propose to recommend in accordance with section 82 of the Act that such a requirement be mandatory and be included in DCS SOPS.

Failure to provide a convenience stop:

The evidence at the inquest was that in planning the transport of the inmates from Bathurst CC to Mannus CC no consideration was given to planning a toilet stop for the inmates. It appeared that the DCS officers took the opportunity to *"go to the toilet"* when they stopped to refuel at Cootamundra. The evidence at inquest was that during other journeys inmates had *"relieved themselves"* on the floor of the van and that during this journey one inmate had wanted to pass a motion but had decided not to because he did not have any toilet paper. Once again this is, in my view, an unacceptable and indeed unnecessary privation.

The failure to plan for a toilet during a journey of some five or more hours appears to be simply to be for the convenience of the DCS and pays no regard to the human needs of the inmates.

I recognise that to provide a toilet stop requires the location of an appropriately secure area along the journey and the making to the necessary arrangements for the stop. It might even add time to the journey. The failure, or refusal, to make adequate planning for a toilet stop in such circumstances is simply for the convenience of the DCS and fails to recognise the dehumanising effect such situations must have on inmates. I propose to make a recommendation in accordance with section 82 of the Act concerning this matter.

Forward medical examinations:

When Dr Badami saw AA on 20 August 2009 he recommended that he be reviewed "next week." For this to occur it was necessary for the review to be recorded. The recording of forward appointments by Justice Health was undertaken in a computerised system known as the "PAS system."

Once an appointment is entered in the PAS system, nurses at any Justice Health location can see it. Thus even if the inmate is transferred to another corrective services location the review can be arranged at that location.

In AA's case the proposed review was not recorded in the PAS system and as such each time he was transferred the transfer documents did not record that he had an outstanding medical review. The effect of this was that had AA arrived at Mannus CC it was possible that he would not have received a medical review unless he began to experience further symptoms.

Dr Badami was questioned on the circumstances of not recording the forward appointment in the PAS system.

The evidence he gave suggested that there was confusion on the part of Justice Health staff as to the responsibility for updating the PAS system. These circumstances, while not directly contributing to AA's death, show a systematic failure on the part of Justice Health that might, if not rectified, adversely affect other inmates. Whilst acknowledging that since AA's death Justice Health has taken action to rectify this problem I still consider that I should make appropriate recommendations in accordance with section 82 of the Act concerning this matter.

Other Recommendations:

At the conclusion of the inquest various parties submitted that I should make a number of other recommendations in accordance with section 82 of the Act. I now propose to deal with such submissions.

Communication between inmates and DCS staff:

In AA's case it was not possible for the inmates to communicate with the DCS staff and, because the microphone was missing it was not possible for the DCS staff to communicate with the inmates.

This situation is patently unsatisfactory. There needs to be the ability for communication. It is no answer to say that where a facility is available it might be abused. Such abuse needs to be dealt with on its own terms. The facility should be available for times when it is needed.

The evidence is that the DCS is moving to install in all its transport vehicles a two-way communication facility. I was informed that the completion of this work would be completed some years into the future. Whilst the action of DCS is to be commended, and I am not in a position to balance one financial priority against another, I propose to recommend to the Commissioner that the priority given to provision of such facilities be reviewed so as to ensure that two-way communication is available on all transport vehicles at the earliest possible date.

Recording of Observer' observations:

Mr Sheppard's evidence was that he made observations of the prisoners on a regular basis during the course of the journey.

I have found that he either did not do this or ignored what he saw. During the course of the inquest this issue was the subject of submissions. It was suggested that the observer ought record the observations made from time to time on a running sheet so that there was a record of the of the time and place of the observation and what, if anything, was observed.

Another alternative was that the images of the monitor should be recorded and kept for a period of time following each journey. It was submitted that were the images to be recorded there would be no dispute as to what was on the monitor and what could, or ought, to have been seen by the observer. Each of the proposals were said to have practical problems. Making observation notes in a moving vehicle could be difficult and in any event there would be no objective way of determining if what was recorded was accurate. The recording of the images on the monitor would involve additional cost to the DCS and might interfere with its other budget priorities.

I agree that there appears to be little to gain from requiring the observer to make observation notes during the course of a journey. Such notes might not have assisted in resolving the issues in this matter. Having a record of what is on the monitor would, however, have been of considerable assistance. Having such a record is a way of ensuring that there is accountability for their actions by both the inmates and the observer. I propose to recommend that consideration be given to the upgrade of current monitoring capacity so that a record of the monitoring is obtained and kept for a period after each inmate transfer.

Transport Vehicle Maintenance:

Prior to a transport vehicle being used the relevant DCS officers are required to identify any aspect of the vehicle that requires maintenance. In this case it was identified that the microphone to enable the officers to communicate with the inmates was missing. The evidence was also that it had been missing for some time although it was not possible to identify how long this had been the case.

Clearly in a review of a vehicle for use some items requiring maintenance would be of lesser importance and their existence would not prevent the vehicle being used. Other items, however, would go to safety or other concerns and any defect of such a nature would require urgent attention and should result in the vehicle being withdrawn until the repairs were undertaken. It would seem to me that the communication capacity between officers and inmates together with the functionality of observation monitors and air-conditioning equipment would be likely to come within the latter group of maintenance requirements. I propose to recommend that the pre-journey checklist for DCS officers be reviewed so as to identify such matters and ensure that where essential maintenance is required it occurs before the vehicle is used for transporting inmates.

Separation of Witnesses following Death in Custody:

DCS policies and procedures require that where there has been a death in custody relevant witnesses should be separated until investigating police are able to interview such witnesses.

In this case none of the relevant witnesses were separated. The inmates were placed in a cell together and the DCS officers were allowed to remain together.

An inquest into a death in custody is mandatory. The objective of the policy of separation is to ensure, as far as possible, that the best evidence as to the circumstances of the death is available to the Coroner.

In this case the officer in charge of the investigation was of the view that the failure to separate witnesses had not inhibited his investigation. I accept that this may be the case in this investigation however it might not be the case on all circumstances. In this case the impression I gained was that the senior officers at the Mannus CC gave little or no attention to the implementation of this policy. They appeared, quite rightly, to have been focusing on the provision of assistance to AA. There may also have been practical difficulties in implementing the policy however efforts should be made to ensure that it is implemented. I propose to make a recommendation in accordance with section 82 of the Act that the existence of and importance of the policy be brought to the attention of all DCS officers.

Dr Badami:

Counsel for AA's family submitted that I should refer Dr Badami to the relevant disciplinary authority following his failure to properly interpret AA's ECG on 20 August 2009. It is, of course, not my place to deal with disciplinary matters relating to medical practitioners. I am, however, entitled in accordance with section 82(2)(b) of the Act to make a recommendation that:

"A matter be investigated or reviewed by a specified person or body."

The question I must ask myself is whether or not I should exercise my discretion in the case of Dr Badami?

As already indicated Dr Badami acknowledged both before and at the inquest that he had misinterpreted the ECG and that had he had not done so the appropriate medical treatment to be provided to AA on 20 August 2009 was to have sent him to hospital for further investigation. He also gave evidence at the inquest as to his efforts to improve his skills in interpreting ECG's and the arrangements he had put in place to be able to obtain advice in respect of such matters when necessary.

It was my assessment that Dr Badami was genuine in his efforts to ensure that the acknowledged failings that contributed to AA's death would not occur again. In the circumstances I do not think that it is necessary or appropriate for me to take the matter any further and I do not propose to do so.

Pre Transfer Health Check:

Counsel for corrective services officers Bateman and Sheppard submitted that I should recommend that prior to any inmate transfer Justice Health nurses should administer a pre transfer health checklist.

It was submitted that doing so would ensure that all inmates were aware of the opportunity to obtain medical or nursing assistance and there could be an audit of the offer of such assistance if issues were to arise in the future.

The evidence is that on admission to each corrective services centre a health assessment, including a personal interview, is undertaken. On transfer there is what is described as being a “paper” health review undertaken. This exit review does not include a personal interview but involves an examination of the health file of the inmate and seeks to identify any continuing issues. The evidence is also that any inmate can ask to see a Justice Health nurse at any time if they have any health concerns.

The issue that the pre transfer checklist seeks to address is a valid one however I do not consider that the proposal is the best way of dealing with the issue. The issue seeking to be addressed is the availability of access to a Justice Health nurse. I am of the view that this issue can be addressed during the entry assessments and I propose to make a recommendation in accordance with section 82 dealing with this issue.

Provision of Defibrillators on Inmate Transport Vehicles:

Counsel for AA’s family submitted that all inmate transport vehicles be equipped with a defibrillator and that DCS staff involved in the transport of inmates be trained in the operation of the defibrillator. The suggestion has some attraction. In this case on the evidence if the medical emergency had been noticed and AA given CPR and defibrillation his chances of survival would have been greater. Whilst the suggestion is attractive I do not consider that sufficient information as to the benefits or otherwise of such a proposal was provided to me during the course of the inquest for me to confidently make such a recommendation. In the circumstances I do not propose to do so.

Formal Finding:

AA died on 27 August 2009. The cause of his death was myocardial ischaemia due to atherosclerotic cardiovascular disease. His death occurred near Batlow in the State of New South Wales whilst he was being transported between Correctional Centres by the NSW Department of Corrective Services.

Recommendations:

To the Commissioner for Corrective Services:

- That the Standard Operating Procedures and Departmental practices for inmate transfers be reviewed so as to ensure that:

- Adequate drinking water is always available to inmates during transfers,

- If the proposed journey is anticipated to be longer than three hours a toilet stop be included during the course of the journey, and

- If the proposed journey is anticipated to be longer than four hours a meal is to be provided to each inmate prior to the commencement of the journey as well as during the course of the journey.

- That the DCS conduct a review of radio communication facilities available for DCS officers providing inmate transfers so as to ensure that they are always able to obtain advice and assistance from senior officers.

- Whilst the review referred to in 2 above is being undertaken DCS officers working in areas where radio communication facilities are unavailable be provided with satellite phone capacity.

- That the programme for providing two-way communication between inmates and DCS officers in transport vehicles be reviewed with a view to ensuring that such communication capacity is available on all inmate transport vehicles at the earliest possible date.

- That consideration be given to the upgrade of current technology for the monitoring inmates in DCS transport vehicles so that the monitoring images are recorded and kept for a period of at least fourteen days following each inmate transfer journey.

- That the vehicle checklist used by DCS officers prior to transporting inmates be reviewed. All items going to the wellbeing and safety of DCS officers and inmates should be identified as priority matters and where a priority matter is identified as being defective the vehicle should not be used until the defect has been made good by appropriate repair or maintenance.

- That the DCS draw the attention of all officers to the policies and procedures to be followed in the event of a death in custody and emphasise the importance of compliance by officers with such policies and procedures.

- That disciplinary action is considered in respect of the performance of Peter Augustine Sheppard with particular regard to his actions as observer on an inmate transport vehicle between Bathurst Correctional Centre and Mannus Correctional Centre on 27 August 2009.

To: The Director, Justice Health

- That Justice Health take such action as is necessary to ensure that all relevant employees are aware of the functions and importance of the PAS computer system and that there is no confusion as to which employees have responsibility for the updating of such system following a consultation with an inmate.

- That Justice Health take such action as is necessary to ensure that at all times inmates are aware and encouraged to seek the assistance of Justice Health staff in respect of any medical concern and that the availability of such staff is to be emphasised during intake assessment interviews

conducted following transfer of an inmate from one corrective services centre to another.

30. 3169 of 2010

Inquest into the death of Wesley William Johns on 25th April 2008 at Inverall. Finding handed down by Deputy State Coroner MacPherson at Inverall.

Wesley William Johns was born on 3 April 1964 and was 44 years, 3 months and 22 days of age at the time of his death on 25 July 2008 at Inverall Hospital after suffering a cardiac arrest whilst in Police custody at the Inverall Police Station.

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 Wesley Johns who may not always appreciate and understand the role of a Coroner or the Coronial Inquest.

Background

About 8.30pm on Friday 25 July 2008, Shannon Cobley, then a Senior Constable of Police stationed at Inverall, was conducting mobile random breath testing in New England 210 a fully marked Highway Patrol Vehicle.

Senior Constable Cobley, as he then was, stopped and tested three drivers in the area bounded by Urabatta, Brown and Rosslyn Streets Inverell. At about 8.45pm whilst testing a fourth driver, a Mr Corry, his attention was drawn to a Ford Station Wagon registered number STL276 with a trailer attached.

This vehicle, as it turned out, was being driven by Wesley Johns, and it remained in the middle of the road for at least the time it took for Senior Constable Cobley to conduct the breath test. As a result of this suspicious behavior the Senior Constable entered New England 210 performed a U turn and followed the vehicle to an address in Rosslyn Street.

At about 8.47pm the Senior Constable pulled New England 210 behind the Wagon and observed Wesley John's walk from his vehicle to the front door of the premises. He called on him to stop and at that point Wesley John's replied that he could not be breath tested because he was at his place of abode.

Shannon Cobley gave evidence that he observed Wesley John's having difficulty in putting a key into the lock of the front door and could smell intoxicating liquor on his breath. Given the suspicious actions of the vehicle at the intersection earlier coupled with Wesley John's response when directed to stop along with the problems he had using his key to open the front door and the smell of intoxicating liquor the Senior Constable determined that an offence of driving under the influence had been committed and he attempted to arrest Wesley Johns.

At that point a struggle ensued it was clear, even though the Senior Constable told Wesley that he was being arrested for driving under the influence not for the purposes of breath testing, Wesley Johns was clearly of the view that he could not be arrested at his own home.

During the struggle the Senior Constable was elbowed by Wesley Johns, and we heard evidenced that Wesley was a large man and very strong, described by family as a 'gentle giant', the Senior Constable sprayed Wesley with OC spray which did not have the desired affect with Wesley John's entering his premises through a front verandah window.

Senior Constable Cobley then used his mobile phone and called Inverell Police Station for urgent assistance and within minutes Senior Constables Leon Fleming and Peter Foley who had been performing General Duties at Inverell Police Station joined him.

The two Senior Constables arrived in a caged truck and met with Senior Constable Cobley. All three then entered the premises at 26 Rosslyn Street, Inverell to effect and arrest of Wesley Johns for the alleged offences of driving a motor vehicle under the influence of intoxicating liquor, assault police and resisting arrest.

After a struggle inside the premises the Constables were able to handcuff Wesley Johns and once outside the premises any resistance ceased and they were able to place Wesley inside the caged area of Police vehicle Inverell 25 and transport him, in custody, to the Inverell Police Station.

During the struggle inside his premises Wesley John's complained he was having heart problems and needed a pill from the top of his fridge. Senior Constable Fleming obtained a foil pack from the top of the fridge and administered one to Wesley with some water.

An ambulance was called for to decontaminate Wesley Johns of the OC spray however, Ambulance Officer Murray, one of the two Ambulance Officers that attended, decided, after speaking with Wesley Johns who complained of chest pains, to treat Wesley as a heart patient.

A decision was made by Ambulance Officer Murray to transport Wesley Johns to the Hospital for further treatment but he collapsed at 9.21 pm with resuscitation commenced and continued, with a further Ambulance and officers arriving to assist in accordance with Cardiac Arrest protocol, until his death was confirmed at 10pm at Inverell Hospital.

A Death in Custody

Notwithstanding the fact that at the time of his death Wesley Johns was at the Inverell Hospital, he was otherwise lawfully detained and in the custody of the Police. Accordingly his death occurred at a point of time that he was in lawful custody. As such an Inquest into his death was and is mandatory by virtue of section 27(1)(b) of the Coroner's Act 2009.

Independence of the investigation

According to that protocol, an investigator was then called from a separate Local Area Command to those who were involved in the subject arrest of Wesley Johns to create as much transparency as possible.

Detective Inspector Timothy Beattie was leading the critical investigation team from the Barwon Local Area Command which is the neighbouring command to New England Area Command until Detective Chief Inspector Pamela Young from the Homicide Squad State Crime Command assumed leadership of the team on and from the 26 July 2008. And who carried out the investigation and preparation of the extensive brief of evidence.

After Wesley Johns was taken from the charge room in accordance with critical incident protocol the charge room was closed down the Constables involved separated and directed not to speak with each other.

Issues

This Inquest deal with the following issues:

- Were appropriate procedures followed in relation to the arrest of Wesley Johns?

- Did the fact and manner of arrest cause or contribute to the death of Wesley Johns?

- Did the use of capsicum spray cause or contribute to the death of Wesley Johns?

- Did the care provided by the paramedics and the difficulties faced by them in administering treatment cause or contribute to the death of Wesley Johns?

- The underlying state of health of Wesley Johns.

The Issues

The first issue relates to the arrest of Wesley and whether appropriate procedures were followed.

The former Senior Constable had every right to follow and speak with Wesley Johns at what turned out to be his place of residence.

He was operating a Random Breath Testing Operation is a fully marked Highway Patrol Vehicle and fact that would have been obvious to Wesley when he stopped and propped at the intersection before heading home**.**

That much is clear because his first words to the Senior Constable were that he could not be breath tested at this place of residence.

The former Senior Constable then made certain observations that I referred to earlier regarding the smell of intoxicating liquor and the trouble Wesley had using a key to unlock the front door coupled with his response when first spoken to and his behaviour earlier at the intersection.

In those circumstances the former Senior Constable was entitled, under the legislation, to remain on the premises and to affect the arrest of Wesley Johns for the suspected offence of driving a motor vehicle on a public street under the influence of alcohol.

Section 10 of the Law Enforcement (Powers and Responsibilities) Act 2002 states;

A police officer may enter and stay for a reasonable time on premises to arrest a person, or detain a person under an Act, or arrest a person named in a warrant.

However, the police officer may enter a dwelling to arrest or detain a person only if the police officer believes on reasonable grounds that the person to be arrested or detained is in the dwelling.

A police officer that enters premises under this section may search the premises for the person.

This section does not authorise a police officer to enter premises to detain a person under an Act if the police officer has not complied with any requirements imposed on the police officer under that Act for entry to premises for that purpose it is not applicable.

Whilst Wesley Johns was correct in asserting that he could not be breath tested at his residence he had no right to resist the officers or order them from his property as they were present for the purposes of affecting an arrest for the suspected commission of, by that time, a number of offences in accordance with *Section 10 of the Law Enforcement (Powers and Responsibilities) Act 2002*.

I will deal with the Second and Fifth issues together because his general health had a direct bearing on the effect the manner of his arrest had which eventually led to his cardiac arrest at Inverell Police Station.

Wesley Johns had a significant history of coronary disease. Wesleys' father died at the age of 38 from a heart attack. As early as 2002, an exercise stress ECG had to be cancelled due to stress during the test. Wesley Johns proceeded to an angiogram and subsequent stenting in June 2002 with further stents in September 2006.

The medical notes from the intervening period suggest, amongst other things, alcohol consumption, smoking and a diet that was detrimental to the underlying cardiac condition.

As at August 2006, Mr Johns had a cholesterol level of 11. According to Wesley's son, Nathan, his father's health began to deteriorate with breathlessness on exertion and a lack of strength from late 2007. Weight began to accumulate.

The cardiological evidence in this Inquest suggests that as at 25 July 2008, Mr Johns had a life expectancy of days, weeks or months.

The autopsy conducted by Dr Nadesan records the cause of death as coronary artery disease with significant conditions being listed as cardiomegaly and morbid obesity.

Professor O'Rourke, Cardiologist, describes the mechanism of death as *'obstructive coronary disease limiting blood flow to the heart with blood flow totally inadequate when requirement for blood increase during arousal and activity, and with lack of blood and oxygen causing cellular damage, and precipitating the lethal rhythm of ventricular fibrillation (VF) with cardiac arrest resulting'.*

There was some confusion in relation to what witnesses saw at 26 Rosslyn Street Inverell. There was evidence that there was one police vehicle which was a wagon and two police at the front of the premises one with the top part of his body inside a window reaching over towards the door and the other kicking the front door at least three times

I am satisfied that what the witnesses actually saw was a highway patrol vehicle and that the person that was inside the window was Wesley Johns and that the kicking they heard was Wesley kicking a hole in the fibro wall from inside his house. That must be so because there is no evidence of any damage to the front door.

It took some time for the police to be able to handcuff Wesley Johns who resisted the police right up to the time they got him to the front of his house. The police describe the physical effort it took for them to place the handcuffs on Wesley with Wesley anchoring himself in the doorway and putting up stubborn resistance.

There is no evidence of any violence on the part of either the officers or Wesley apart from some minor scratches there was no major trauma found at autopsy on Wesley Johns but his resistance did require a good deal of physical effort and that put pressure on his compromised heart which had to work harder and hence he started experiencing chest pains.

That effort started his downward spiral towards his cardiac arrest at the police station and was hastened, it seems, when after a decision was made to take him to hospital he thought he was going to be handcuffed again which caused anxiety and distress putting further pressure on his damaged heart leading to atrial fibrillation.

Clearly the fact and manner of his arrest contributed to his death.

The Third issue involved the use of the Capsicum Spray and whether that contributed to the death of Wesley Johns. The report from Professor O'Rourke indicates that the role of capsicum spray appears to be a neutral contributory factor as it was part of the overall arrest but also had a calming effect and decreased exertion.

The Fourth and final issues involved the actions of the Ambulance Officers and whether the difficulties they faced in administering treatment caused or contributed to the death of Wesley Johns?

Professor O'Rourke in his report stated that the Ambulance Officers could have done things quicker but that the outcome unfortunately would have been the same no matter what they did.

When one views the CCTV and on listening to the two Ambulance Officers it is clear that they did the best they could in as timely a fashion as the circumstances allowed them given that they were working in a confined area with problems getting the pads from the defibrillator to make contact with the skin of Wesley Johns and no criticism should be made of their efforts in the circumstances.

CONCLUSION

This was a tragic event, which has not only affected the family of Wesley Johns but also the Police, and Ambulance Officers who dealt with Wesley on the night of his death.

The failure of the former Senior Constable to activate the in car audio equipment has been acknowledged by him as was the failure of the other two Constables to log their call out by Cobley with VKG but those failures did not have any bearing on the death of Wesley Johns. In the circumstances there are no issues that required me to make any recommendations.

I acknowledge the work done by the Officer in Charge Detective Chief Inspector Pamela Young in the preparation and compilation of this extensive and detailed brief a fact I will convey to her superiors.

I thank my Counsel Assisting Michael Fordham and his instructing Solicitor Azam Bulbulia for their assistance.

Finally I extend my sympathies to Sean Johns, Wesley's brother and Wesley's family on their sad loss and I thank him for giving this Inquest a glimpse of the sort of person Wesley was.

FORMAL FINDING

I FIND THAT WESLEY WILLIAM JOHNS DIED AT INVERELL HOSPITAL ON FRIDAY 25 JULY 2008 FROM A CARDIAC ARREST DUE TO OBSTRUCTIVE CORONARY DISEASE LEADING TO VENTRICULAR FIBRILLATION BROUGHT ON BY PHYSICAL ACTIVITY, ANXIETY AND EXCITEMENT AS A RESULT OF HIS ARREST AND SUBSEQUENT DETENTION AT INVERELL POLICE STATION.

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 2010.

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	2977/09	28/05/08	Westmead	23	In Custody
2	174/09	18/01/09	Deepwater	21	Police Op
3	1949/09	10/07/09	Parklea	57	In Custody
4	2539/09	1/09/09	Canley Vale	18	Police Op
5	3605/09	14/12/09	Lithgow	56	In Custody
6	3716/09	25/12/09	Lisarow	46	Police Op
7	485/10	25/02/10	Malabar	58	In Custody
8	520/10	28/02/10	Wollongong	39	Police Op
9	778/10	02/04/10	Campbelltown	40	Police Op
10	1107/10	20/03/10	Canberra	23	Police Op
11	1108/10	20/03/10	Canberra	33	Police Op
12	1109/10	20/03/10	Canberra	29	Police Op
13	1110/10	20/03/10	Canberra	3m	Police Op
14	1564/10	30/06/10	Parklea	47	In Custody
15	1576/10	14/06/10	Brisbane	53	In Custody
16	1809/10	23/07/10	Parklea	42	In Custody
17	1889/10	31/07/10	Berkshire Park	22	In Custody
18	2076/10	21/08/10	Malabar	86	In Custody
19	2209/10	06/09/10	Randwick	86	In Custody
20	2222/10	09/09/10	Bankstown	26	Police Op
21	2325/10	20/09/10	Villawood detention	36	In Custody
22	2523/10	11/10/10	Randwick	49	In Custody
23	2794/10	11/11/10	Collarenabri	44	Police Op
24	2804/10	16/11/10	Liverpool	41	In Custody
25	2860/10	22/11/10	Bankstown	19	Police Op
26	2863/10	22/11/10	Parramatta	56	In Custody
27	2877/10	24/11/10	Silverwater	20	In Custody
28	2924/10	01/12/10	Parklea	35	In Custody
29	2980/10	08/12/10	Villawood detention	29	In Custody
30	3036/10	12/12/10	Terrigal	50	Police Op
31	3037/10	11/12/10	Lismore	47	In Custody
32	3159/10	25/12/10	Bathurst	80	Police Op
33	43/11	09/01/11	Randwick	54	In Custody
34	85/11	15/01/11	Westmead	51	Police Op
35	339/11	09/02/11	Armidale	48	Police Op
36	473/11	25/02/11	Liverpool	69	In Custody
37	746/11	04/04/11	Malabar	61	In Custody

No	File No.	Date of Death	Place of Death	Age	Circumstances
39	962/11	29/04/11	Orange	31	In Custody
40	965/11	01/05/11	Junee	44	In Custody
41	1029/11	07/05/11	Junee	28	In Custody
42	1074/11	15/05/11	Berkshire Park	23	In Custody
43	1187/11	28/05/11	Surry Hills	33	In Custody
44	1197/11	28/05/11	Campbelltown	63	Police Op
45	1308/11	14/06/11	Camperdown	67	Police Op
46	1388/11	21/06/11	Silverwater	39	In Custody
47	1567/11	11/07/11	Smithfield	32	In Custody
48	1659/11	19/07/11	Aldavilla	53	In Custody
49	1761/11	28/07/11	Randwick	64	In Custody
50	1905/11	14/08/11	Wagga Wagga	37	Police Op
51	1922/11	16/08/11	AlexanDr ia	54	In Custody
52	2126/11	03/09/11	Wellington	59	In Custody
53	2133/11	05/09/11	Malabar	50	In Custody
54	2161/11	07/09/11	Lansvale	48	Police Op
55	2235/11	18/09/11	Watsons Bay	40	Police Op
56	2305/11	26/09/11	Silverwater	38	In Custody
57	2334/11	29/09/11	Castle Hill	37	Police Op
58	2406/11	03/10/11	Aldavilla	49	In Custody
59	2486/11	15/10/11	Malabar	31	In Custody
60	2573/11	26/10/11	Villawood Immi	27	InCustody (Fed)
61	2638/11	04/11/11	Sydney	47	Police Op
62	407907/11	19/12/11	Parklea	30	In Custody

Report compiled by
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