Report by the NSW State Coroner

into deaths in

custody/police operations

for the year 2013.

(Coroners Act 2009, Section 23)

NSW Office of the State Coroner
NSW Department of Attorney General and Justice
ISSN No: 1323-6423

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

15th March 2014

Dear Attorney,

Pursuant to Section 37(1) of the *Coroners Act 2009* ('the Act'), I respectfully submit to you a summary of all deaths reported and inquests held by the State Coroner or a Deputy State Coroner during the year 2013 as provided by section 23 of the Act ('section 23 deaths').

Section 23 provides:

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

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

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

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

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

In 2013 there were forty three Section 23 matters reported to the Coroner.

Thirty six matters were completed by way of inquest.

Sixty six Section 23 deaths currently await inquest and many of these matters are in the investigative stage or set down for inquest in 2014.

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

I submit for your consideration the State Coroner's Report, 2013.

Yours faithfully,

Magistrate Michael Barnes

(NSW State Coroner)

STATUTORY APPOINTMENTS

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

NSW State and Deputy Coroners 2013

Her Honour Magistrate MARY JERRAM (retired November 1st 2013)

New South Wales State Coroner

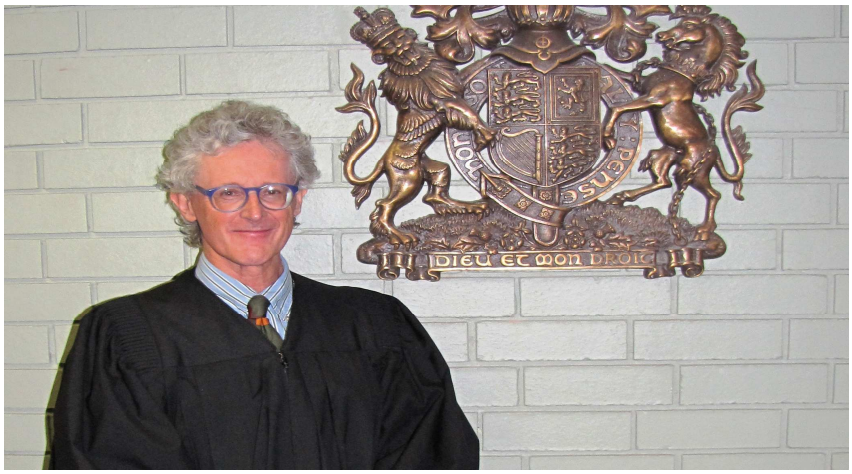
1983	Admitted as a Solicitor of the Supreme Court of NSW.
1983	Industrial Legal Officer Independent Teachers Union.
1987	Solicitor and Solicitor Advocate for Legal Aid Commission.
1994	Appointed as a Magistrate for the State of NSW.
1995	Children's Court Magistrate.
1996-8	Magistrate Goulburn.
2000	Appointed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

His Honour Magistrate PAUL MACMAHON

Deputy State Coroner

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

His Honour Magistrate HUGH DILLON



Deputy State Coroner

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

Her Honour Magistrate CARMEL FORBES

Deputy State Coroner

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

Her Honour Magistrate SHARON FREUND

Deputy State Coroner

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

CONTENTS

Introduction by the New South Wales State Coroner

What is a death in custody?

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

- the death, wherever occurring, of a person who is in prison custody, police custody, detention as a juvenile or detention pursuant to the Migration *Act 1958* (Cth);

- the death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper *care* whilst in such custody or detention;

- the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and

- the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

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

- while temporarily absent from a detention centre, a prison or a lock-up; and

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

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

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

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

Intensive Correction Orders

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

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

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

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

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

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

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

After more than twenty years of operation, most of the scenarios have been the subject of inquests.

The Senior Coroners have tended to interpret the subsection broadly. This is so that the adequacy and appropriateness of police response and police behaviour generally will be investigated where we believe this to be necessary.

It is critical that all aspects of police conduct be reviewed notwithstanding the fact that for a particular case it is unlikely that there will be grounds for criticism of police.

It is important that the relatives of the deceased, the New South Wales Police Force and the public generally have the opportunity to be made aware, as far as possible, of the circumstances surrounding the death.

In most cases where a death has occurred as a result of or in the course of a police operation, the behaviour and conduct of police is found not to warrant criticism by the Coroner's.

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

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

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

> *The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty, and it is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion, and satisfies the community that deaths in such places are properly 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 to notify immediately the State Coroner or a Deputy State Coroner, who are on call twenty-four hours a day, seven days a week.

The Coroner so informed, and with jurisdiction, will assume responsibility for the initial investigation into that death, although another Coroner may ultimately finalise the matter. The Coroner's supervisory role of the investigations is a critical part of any coronial inquiry.

Upon notification by the DOI, the State Coroner or a Deputy State Coroner will give directions for experienced detectives from the Crime Scene Unit (officers of the Physical Evidence Section), other relevant police and a coronial medical officer or a forensic pathologist to attend the scene of the death. The Coroner will check to ensure that arrangements have been made to notify the relatives and, if necessary, the deceased's legal representatives. Where aboriginality is identified, the Aboriginal Legal Service is contacted.

Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit and the Forensic Pathologist. The Coroner, if warranted, should inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during the inquest. If the State Coroner or one of the Deputy State Coroner's is unable to attend a death in custody/police operations occurring in a country area, the State Coroner may request the local Magistrate Coroner to attend the scene.

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

In cases involving the NSW Police

When informed of a death involving the NSW Police, as in the case of a death in police custody or a death in the course of police operations, the State Coroner or the Deputy State Coroner's may request the Crown Solicitor of New South Wales to instruct independent Counsel to assist the Coroner with the investigation into the death. This course of action is considered necessary to ensure that justice is done and seen to be done.

In these situations Counsel (in consultation with the Coroner having jurisdiction) will give attention to the investigation being carried out, oversee the preparation of the brief of evidence, review the conduct of the investigation, confer with relatives of the deceased and witnesses and, in due course, appear at the mandatory inquest as Counsel assisting the Coroner.

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

Prior to the inquest hearing, conferences and direction hearings will often take place between the Coroners, Counsel assisting, legal representatives for any interested party and relatives so as to ensure that all relevant issues have been identified and addressed. In respect of all identified Section 23 deaths, post mortem experienced Forensic Pathologists at Glebe or Newcastle conduct examinations.

Responsibility of the Coroner

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

> **81 Findings of Coroner or jury verdict to be recorded**
>
> (cf *Coroners Act 1980*, s 22)
>
> (1) The coroner holding an inquest concerning the death or suspected death of a person must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so:
>
> (a) the person's identity, and
>
> (b) the date and place of the person's death, and
>
> (c) in the case of an inquest that is being concluded—the manner and cause of the person's death.
>
> (3) Any record made under subsection (1) or (2) must not indicate or in any way suggest that an offence has been committed by any person.

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

> **78 Procedure at inquest or inquiry involving indictable offence**
> (cf *Coroner's Act 1980*, s 19)
>
> (1) This section applies in relation to any of the following inquests:
>
> (a) an inquest or inquiry held by a Coroner to whom it appears (whether before the commencement or during the course of the inquest or inquiry) that:
>
> (i) a person has been charged with an indictable offence, and
>
> (ii) the indictable offence raises the issue of whether the person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.
>
> (b) an inquest or inquiry if, at any time during the course of the inquest or inquiry, the Coroner forms the opinion (having regard to all of the evidence given up to that time) that:

(i) evidence is capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence, and

(ii) there is a reasonable prospect that a jury would convict the known person of the indictable offence, and

(iii) the indictable offence would raise the issue of whether the known person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.

(2) If this section applies to an inquest or inquiry as provided by subsection (1)(a) the Coroner:

(a) may commence the inquest or inquiry, or continue it if it has commenced, but only for the purpose of taking evidence to establish:

(i) in the case of an inquest—the death, the identity of the deceased person and the date and place of death, or

(ii) in the case of an inquiry—the date and place of the fire or explosion, and after taking that evidence (or if that evidence has been taken), must suspend the inquest or inquiry and, if there is a jury, must discharge the jury.

(3) If this section applies to an inquest or inquiry as provided by subsection (1)(b) the Coroner may:

(a) continue the inquest or inquiry and record under section 81(1) or (2) the Coroner ’s findings or, if there is a jury, the verdict of the jury, or

(b) suspend the inquest or inquiry and, if there is a jury, discharge the jury.

(4) The Coroner is required to forward to the Director of Public Prosecutions:

(a) the depositions taken at an inquest or inquiry to which this section applies, and:

(b) in the case of an inquest or inquiry referred to in subsection (1) (b) - a written statement signed by the Coroner that specifies the name of the known person and the particulars of the indictable offence concerned.

Role of the Inquest

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

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

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

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

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

Recommendations

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

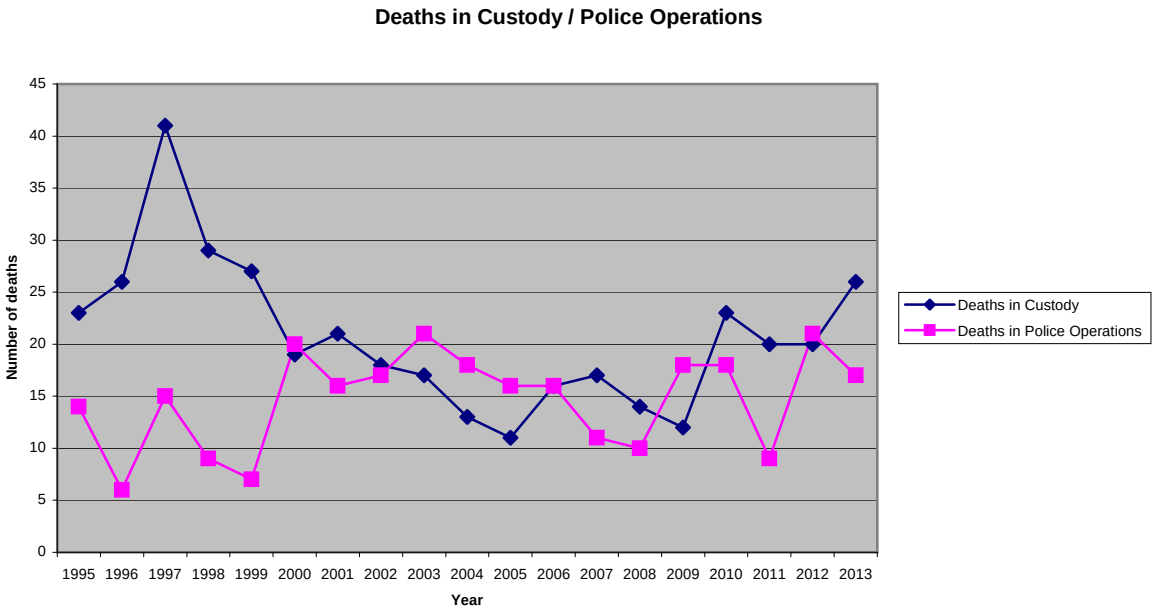
Any statutory recommendations made following an inquest should arise from the facts of the enquiry and be designed to prevent, if possible, a recurrence of the circumstances of the death in question. The Coroner requires, in due course, a reply from the person or body to whom a recommendation is made.

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

AN OVERVIEW OF SECTION 23 DEATHS REPORTED TO THE NSW DURING 2013.

Table 1: Deaths in Custody/Police Operations, for the period to 2013.

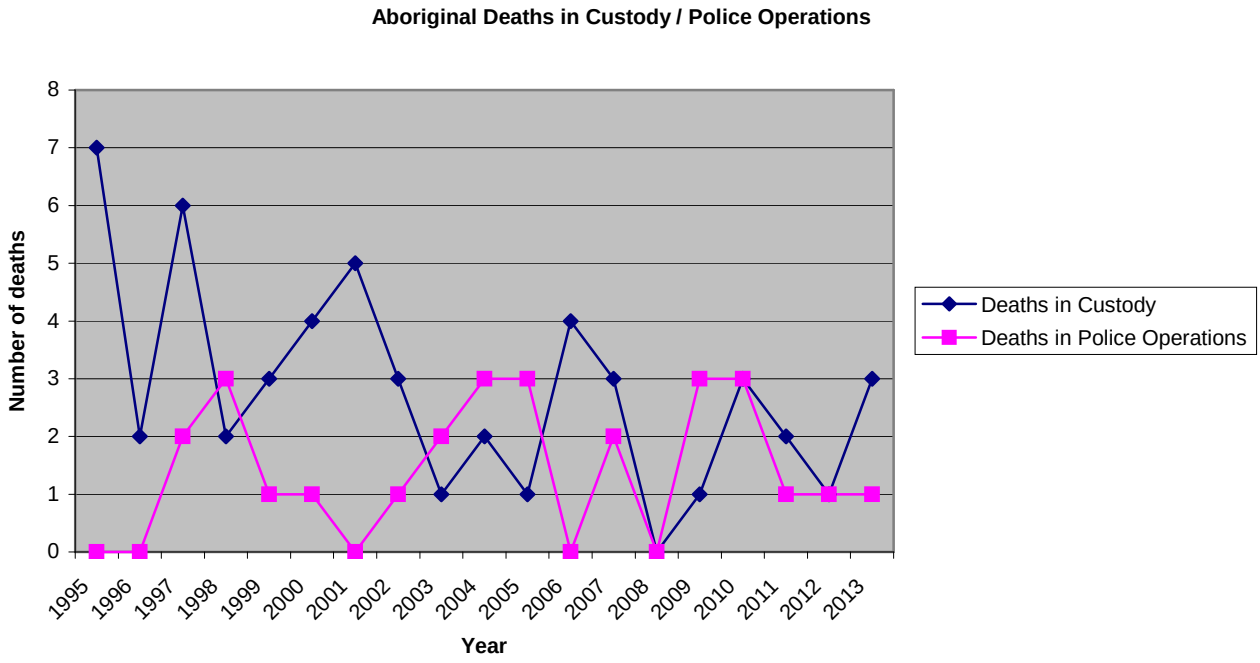
Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	37
1996	26	6	32
1997	41	15	56
1998	29	9	38
1999	27	7	34
2000	19	20	39
2001	21	16	37
2002	18	17	35
2003	17	21	38
2004	13	18	31
2005	11	16	27
2006	16	16	32
2007	17	11	28
2008	14	10	24
2009	12	18	30
2010	23	18	41
2011	20	9	29
2012	20	21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



Aboriginal deaths which occurred in 2013

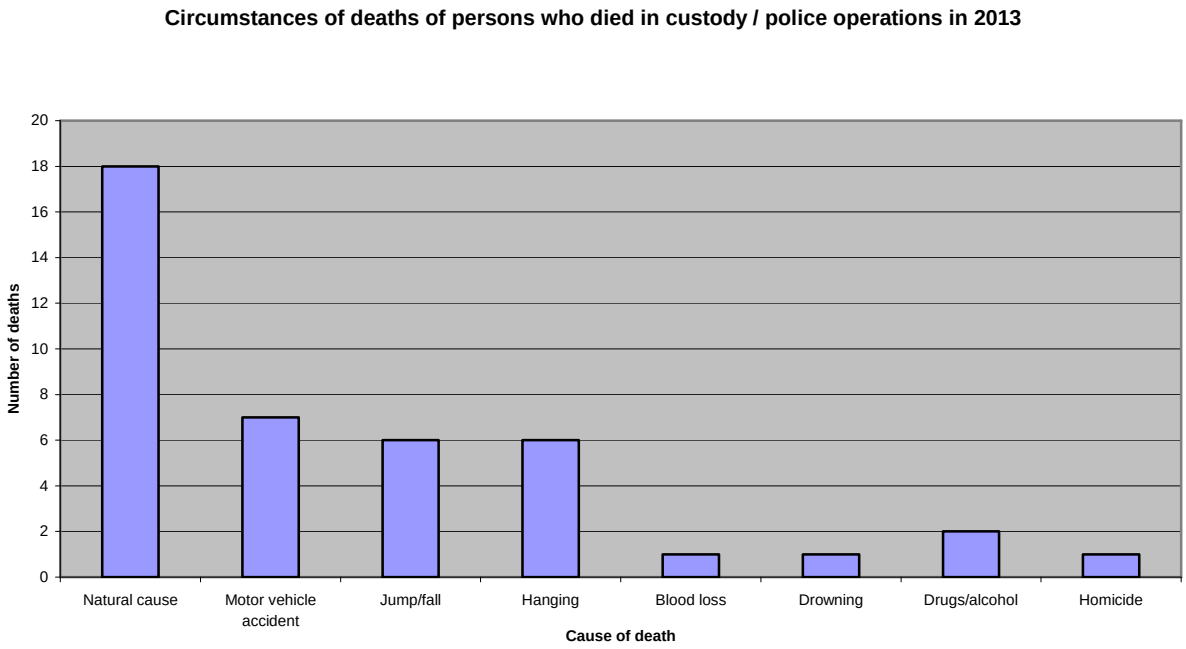
Table 2: Aboriginal deaths in custody/police operations 2013.

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



Circumstances of deaths of persons who died in Custody/Police Operations in 2013:

18x natural causes
7 x motor vehicle accident
7 x hanging
2 x drugs/alcohol
1 x drowning
6 x jump/fall
1 x blood loss
1 x homicide



Unavoidable delays in hearing cases

In 2013 the State Coroner and the Deputy State Coroners completed 36 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 2013

Following are the written findings of each of the cases of deaths in custody/police operations that were heard by the NSW State Coroner or Deputy State Coroner in 2013. 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 XX**.**

SECTION 23 INQUESTS UNDERTAKEN IN 2013

	Case No	Year	Name	Coroner
1	2523	2010	Nigel Davies	DSC Freund
2	2794	2010	Mark Mason	DSC Dillon
3	2860	2010	Ali Antoni El-Hafiane	DSC Dillon
4	2863	2010	John Leonard Cameron	DSC MacMahon
5	43	2011	Christopher Lorenzo	DSC Forbes
6	85	2011	Richard Brown	DSC Freund
7	1029	2011	Anthony Van Rysewyk	DSC Freund
8	1187	2011	Adam Le Marseny	DSC Jerram
9	1388	2011	XX	DSC Forbes
10	1905	2011	XX	DSC Dillon
11	2126	2011	Darrell Jones	DSC Jerram
12	2235	2011	XX	DSC Forbes
13	2573	2011	XX	DSC Jerram
14	2638	2011	XX	DSC Dillon
15	407907	2011	XX	DSC Dillon
16	414027	2011	XX	DSC Forbes
17	414031	2011	XX	DSC Forbes
18	12332	2012	John Francis Leaver	DSC Dillon
19	47897	2012	Carsten Flatow	DSC Truscott
20	49722	2012	XX	DSC Dillon
21	58625	2012	Housam Ismail	DSC Jerram
22	69319	2012	Jane Mary Porter	DSC Forbes
23	71862	2012	XX	DSC Freund
24	86730	2012	Deane Manning	DSC Freund
25	89740	2012	Joseph Gavin	DSC Jerram
26	89735	2012	James Ivimy	DSC Jerram
27	121233	2012	Ryan Pringle	DSC Dillon
28	128835	2012	XX	DSC MacMahon
29	128570	2012	Kenneth Hardy	DSC Freund
30	305904	2012	XX	DSC MacMahon
31	310066	2012	Alan Barnes	DSC Dillon
32	336265	2012	Allen Garner	DSC Jerram
33	371767	2012	XX	DSC Dillon
34	327351	2012	Gregory Howard	DSC McMahon
35	207523	2013	Trevor Coulton	DSC MacMahon
36	39387	2013	XX	DSC Dillon

1. 2523 of 2010

Inquest into the death of Nigel Davies. Inquest conducted by Deputy State Coroner Freund. Finding handed down at Glebe on the 10th December 2013.

Nigel Davies was 50 years old when he passed away from end stage idiopathic pulmonary fibrosis at Prince of Wales Hospital at Randwick.

At the time of his death he was in custody having been sentenced by the District Court at Sydney to a term of imprisonment of five years and six months with a non-parole period of two years and nine months commencing on 25 February 2007 for various offences.

In relation to the illness that ultimately took his life the first sign to authorities that Mr Davies was unwell was on 4 August 2008 when Mr Davies complained of shortness of breath.

It is clear from the documents that form part of the brief that treatment was sought and he was subsequently assessed and transferred to the Prince of Wales Hospital where diagnostic tests were carried out and a diagnosis was made.

Mr Davies ultimately succumbed to his illness on 11 October 2010. A number of issues were identified by his senior next of kin, his younger brother, in relation to his death. The issues that have been identified and I have to note for the record this in fact is a mandatory inquest because Mr Davies was in custody.

Let me summarise as follows:

(1) In relation to the incorrect administration of medication;

(2) The failure of Mr Davies to attend follow up medical appointments;

(3) The question of whether or not he should have been granted early parole;

(4) Whether or not Mr Davies should have been given treatment in a mental health facility rather than being in a prison with the general prison population and finally;

(5) Whether steps should have been taken upon Mr Davies' death to contact the next kin at an earlier opportunity.

In relation to the final three issues regarding Mr Davies early parole, whether or not he should have been within the general prison population as opposed to a mental health facility and contacting Mr Davies' next of kin upon his death, these matters have not been dealt with in detail in terms of the investigation for this inquest.

These are not matters that do not go to the manner and cause of Mr Davies' death and accordingly the officer in charge, who I must say put together an excellent brief of evidence, and Crown Solicitors who assisted in putting together the brief and also did a lot of work in relation to that investigation did not deal with those issues in detail on my instruction.

The two issues that needed to be determined by this inquest and looked at was in relation to the incorrect administration of medication and also the failure of Mr Davies to attend follow up medical appointments. I will deal with each of these issues in turn.

Firstly the incorrect administration of medication. It is uncontroversial that whilst Mr Davies was a patient at the Prince of Wales Hospital he was prescribed the narcotic pain relief of Oxycontin slow release 100 milligrams twice daily. Unfortunately it is clear that at 6pm on 8 October 2010 and at 8am on 9 October 2010 a nurse mistakenly gave Mr Davies a dose of MS Contin 100 milligrams, which was not the slow release form of the narcotic pain relief.

As a result of the administration of the drug the nurse, once realising the mistake had been made, had advised Mr Davies of the error, had advised the treating medical practitioners of the error and had in fact noted it within the patient notes of the error.

Professor David McKenzie, the treating doctor, ensured that Mr Davies was appropriately supervised to ensure no adverse reaction. The Crown solicitors quite appropriately obtained expert opinion in relation to the erroneous medication and it is clear from the expert evidence obtained, namely from Dr Nicholas Murray and Judith Perl, a forensic pharmacologist, that the erroneous medication did not cause or contribute to Mr Davies' death.

In relation to the issue of the failure of Mr Davies to attend follow up medical appointments, I accept the submission of Ms Baker, counsel assisting, in relation to the fact that Mr Davies was not an ordinary patient that could attend medical appointments as and when he wished. He was very much at the mercy of Justice Health and Corrective Services to ensure that he attended those appointments as and when they were made for him. Accordingly, under my direction, queries were made with Justice Health in relation to what steps were then in place to ensure those in Correctives custodies could attend medical appointments with third party practitioners that were not directly related to Justice Health and what steps are now in place to ensure that mix ups and errors do not happen in the future.

Firstly can I say having looked at all the evidence it is clear that the one follow up appointment that Mr Davies did fail to attend and we are not quite sure what the circumstances were in relation to that non-attendance, but it is irrelevant I think for the purpose of this inquest.

The failure to attend that appointment did not cause or contribute to, in my view, Mr Davies' death. Having said that, looking at the steps taken by Justice Health and implementing a new computerised system and a centralised point for all appointments to be made for inmates at various Corrective Services institutions I am satisfied that no recommendations need to be made as steps have been taken to ensure a smoother running system into the future.

Accordingly I now turn to the formal findings I am required to make pursuant to The Coroners Act 2009.

Formal Finding.

I FIND THAT ON 11 OCTOBER 2010 MR NIGEL DAVIES DIED WHILST IN CUSTODY AT THE PRINCE OF WALES HOSPITAL IN RANDWICK IN THE STATE OF NEW SOUTH WALES AS A RESULT OF END STAGE IDIOPATHIC PULMONARY FIBROSIS.

2. 2794 of 2010

Inquest into the death of Mark Mason. Finding handed down by Deputy State Coroner Dillon at Dubbo on the 5th November 2013.

This has been a very painful inquest, not only for the Mason family but I know primarily for you Mr Mason and all of you. But it's also, I know have been a painful experience for the police officers who have been involved. I'm not in any way suggesting that the pain suffered by the family is equivalent with that of the police officers. One thing I am sure we all know as human beings is that nobody can suffer greater pain than a parent who loses a child. Especially if that death comes prematurely and violently.

And of course such deaths have ripple effects and we've observed how sad members of the Mason family have been here today when the slide show was shown and the song was played. And when some of the members of the family spoke.

So there's deaths not only cause immeasurable grief to parents and I cannot help but observe with what extraordinary dignity you've sat there Mr Mason thinking about your son. But to many others, especially those close to him in the family. A case like this is always a sad end. A difficult duty for a Coroner to consider to sum up, because it concerns a very tragic death of one of the Coroner's fellow human beings.

I should say for me it's also a humbling privilege to sit in this Court room which is full of quiet, dignified, grieving people who not only have a long, a very long history in this land, but who have a very strong sense and memory of their own history in this country and that history is very different from mine, it's very different from the history most non Indigenous Australians can imagine, perhaps even those who have lived all their lives in western New South Wales and Australia, even the most enlightened and thoughtful.

Aboriginal history is different. Mr Mason's death in a police operation is a tragedy for his family and friends, for the extended Mason family, for the Aboriginal people of this area, for police officers in this region. It has also become whether it should or should not have been, but it has become part of the troubled history of our country, which can only be contemplated with a heavy heart.

It's also in a very different way, a much lesser way it must be said, a real misfortune for Senior Constable Bobako, the New South Wales police and the wider community.

I think it's important to say right out the outset although I've averted to, I've touched on history to say I do not believe at all that Senior Constable Bobako shot Mr Mason because he was Aboriginal or because Senior Constable Bobako holds prejudiced views towards Aboriginal people.

But, it is inevitably the case because of our history, when an Aboriginal person dies in police custody or in a police operation, there will be questions asked about this.

But I think it's very, very important for us who have been participating in this inquest in different ways to understand that Mark Mason, Mr Mason was not a, is not a symbol, he was a living human being, he is being remembered and grieved for as a living human being with considerable strengths, many virtues and also of course weaknesses.

He has been described in various ways and it was a privilege to listen to members of the Mason family describe him. It was also a privilege to listen to Janet Manuel's description of Mr Mason, perhaps at his very best some years ago when he was a liaison officer with the Western Aboriginal Legal Service. The last time I was up in Dubbo, I can't remember, but a police officer said to me outside Court as I walked into the area, "It's such a shame, he was a good bloke." And I think that is very, very true.

I wish I had met him, because he does sound like he was a good bloke, a very good bloke, a good man who loved his family, loved his children and who won the respect of those with whom he worked. Great respect. So it's a mystery to me and none of us can explain it very well what went so terribly wrong on this particular day when he died.

But clearly, the Mark Mason who was known and loved to so many people was not the person who the police met in Shortey Peter's house that particular night. That was not the real Mark Mason at all. No single description of Mr Mason sums him up, words can only go so far, but to me two things really stand out. Perhaps on that day like people who feel that life has treated them very badly, subconsciously or consciously he acted in a way that may have been self destructive or harmful to himself. I'll come back to that.

But much more importantly and despite all that, he was much loved and is very sadly missed and respected. I need to before I go on, it's important to acknowledge that we're all considering a very human story here, but there is also a process that we're all part of. As Ms Dwyer said in her opening statement, an inquest is not a criminal trial, but an inquiry. And it's an inquiry into the circumstances surrounding Mr Mason's death. Most of us are used to sitting in Courtrooms and seeing them as places of trial and punishment. But a Coroner's Court is different. It's a place where we search for the truth and attempt to learn from whatever truth we can discover in the evidence.

An inquest is one of the ways our society publicly acknowledges the significance of human life and the lives of every individual who is a member of this society and the importance of ways of finding ways of preventing unnecessary deaths. There can also be and sometimes are a way in which unfounded rumours or suspicions are put to rest.

But whether or not they do that, Coroners, I know, all hope to enable those who are grieving to learn the truth about the deaths of those who are dear to them, so that they can deal with that truth in whatever way the grieving family finds best. I have certain legal obligations.

It’s my job to make findings concerning the identity of a person who has died, the date, the place, the cause, manner or circumstances of death. In this case of course the only controversial questions relate to the circumstances surrounding Mr Mason’s death.

In July Ms Dwyer set out issues for inquiry and they were, these issues were refined in her closing address this morning. She raised a number of questions and first of all, she touched on the question of whether Stacey Adams’ allegations against Mark that he had threatened her with a knife, threatened others with a knife, had any substance or were reliable. It has to be said that there are probably some question marks over the reliability of the account that Ms Adams gave to the police that ultimately triggered this whole series of events or circumstances.

The second question, but I should say and I agree with what Ms Dwyer said and others said, that it is unnecessary for me to really explore that issue. This is not a question about what she said to the police, whether it was right or wrong or exaggerated or otherwise. What we do know is that that set the police on a path to searching for Mr Mason and we all know the chain of events, well the result of that end of the chain of events at the end of that chain of events.

The second question is this. Were the police justified in searching for Mr Mason. I’ll come back to that. Was it reasonable for Senior Constable Cornwall to join in the search was the planning appropriate or sufficient in all the circumstances, I would add another issue here? Was the initial decision by an officer to use the taser in the house of Shortey Peters unreasonable or excessive? I’ll deal with that. Were Senior Constable Bobako’s actions unreasonable or excessive? I’ll come back to that. And finally of course, is there anything to be learned from this terrible tragedy.

And I’ll touch on the recommendations or the suggested recommendations that Ms Yehia has offered in her written submissions. Although everyone here is very familiar by now, with the outline of facts, it's necessary for me at this point simply to briefly summarise them. As I've already touched on, on this particular day Stacey Adams who had had, it seems, a somewhat rocky relationship with Mr Mason, but who continued to socialise with him, alleged to police that she had been threatened with a knife and that Mr Mason had threatened to kill her. That allegation was supported by some others, but, as I said, rightly or wrongly, whether those allegations were correct or incorrect, whether they were exaggerated or otherwise, they were made to police and the police had no option but to act on them.

Senior Constables Cornwall and Kane then acted on a radio message, attended the Collarenebri Police Station, took a statement from two of the witnesses who had made the allegation and then proceeded in their police car to try to locate Mr Mason at his home on Church Street in Collarenebri. They didn’t find him, about a quarter of an hour later they saw him reversing out of his driveway in his car. The police were driving a four-wheel drive Nissan.

He was driving a Commodore. They activated lights and sirens, they followed him, they tried to get him to stop, and they pursued him. They were about to call off the pursuit when Mr Mason’s car turned around and headed back towards them.

I don’t think there can be any real dispute that he for whatever reasons, deliberately drove his car towards them, trying to drive them off the road and then deliberately collided with the police car. It is very, very difficult to understand precisely what was in his mind at that time. One could speculate about whether he was angry with the police, who know. Angry with himself.

But in any event, it was an extraordinarily reckless action on his part and a very, very dangerous action and possibly a miracle that he got out alive as did the two police and not only got out alive, but all three people who had been involved in the collision survived without serious injury.

The two police were injured, other police of course came to the site, there was a discussion about what to do and so forth. A number of officers attended from Lightning Ridge, questions were asked and a very simple plan was formulated on the basis that the police believed that Mr Mason had or at least had received an allegation that Mr Mason had threatened to stab Stacey Adams, but knew for certain that the two police in the Nissan had been driven off the road and that there had been extremely dangerous conduct on the part of Mr Mason. So the five police decided to go off and try to find him, arrest him and take whatever action then would follow.

In my opinion that was completely justified. There really isn't any question about that. It is self evident that if a person is accused of holding a knife to somebody else and threatening to kill them, has taken action which could have killed a couple of police officers, apparently deliberately and has not been apprehended, found at the scene.

The police really have very little option but to go and look for that person and if possible to arrest him or her. The next issue raised by Ms Dwyer, was whether it was reasonable for Senior Constable Cornwall to join the search. It has been submitted by Mr Nicholson today and Ms Yehia who appeared for the family that this was inappropriate and unreasonable and the implication being or the inference I am invited to draw is that Senior Constable Cornwall was not only injured which might have made it inappropriate because he needed attention, but that he was not in a fit state of mind to go off looking for the person who had caused his injuries. In an ideal world, in an ideal set of circumstances, I think that is perfectly correct. He ought not to have gone if there had been any available alternatives.

The difficulty of course is that Collarenebri is a long way from almost everywhere else and at that particular time in those particular circumstances, there was no-one else available who could recognise Mr Mason easily, there were no photographs, it's not entirely clear to me how useful photographs would have been in such circumstances anyway, but, there were no photographs.

Moreover, Senior Constable Cornwall knew or had local knowledge which other police officers involved in the search did not have. He was at that point in time, invaluable to them and in fact indispensable in my opinion.

The suggestion is that, well the implication is that in his state of mind, he may have been seeking revenge, he may have been inciting the other police to do something, untoward, but, illegal, dangerous to Mr Mason.

There is no evidence that he did so, had he been the shooter in the house, I think that would have made matters extremely complicated and much more suspicious, but I don't think that there can be any reasonable criticism of Constable Cornwall himself, going along at the request of Inspector Splight or the other police who needed his local knowledge and his ability to recognise Mr Mason.

Just one aspect about this that I need to touch on. The police were of course justified in searching for Mr Mason. One of the explanations given and I've forgotten by whom it may have been Inspector Splight, was that the primary concern, well at least, it was suggested that one of the main concerns was to find Mr Mason because he may have been seriously injured in the car crash.

Well true it is, he may have been seriously injured in the car crash, but I find it difficult to believe that that was a particularly strongly motivating factor in the police search. Much more important to the police officers I would think was the fact that he had crashed into a police car, caused injury to two police officers and he was also allegedly carrying a knife which he had or had been carrying a knife with which he had threatened to stab his ex-girlfriend.

The police had every reason to search for a man they believed was dangerous. I don't think the search was carried out for particularly or mainly benevolent reasons, but, it would be obvious as well though, that given that he might have serious injuries and particularly when he was arrested he would have to be checked out for them, that this would be a subsidiary or a secondary factor in undertaking the search.

As we know, after a number of houses were searched or looked at by the police, information was received that Mr Mason may be at Shortey Peters' house at 10 Barwon Street. There have been some criticisms of the planning of this particular search. The police drove to 10 Barwon Street.

In a previous inquest in which I looked at the shooting of a young man who was undertaking an armed robbery at the time. I was critical of police planning and made recommendations concerning training, planning and so forth. This was a case of **El Hafiane**, but in this particular case it seemed to me and I said this to Mr Nicholson earlier in the day or one of the other counsel, but it may have been Mr Nicholson.

I think, that this appears to me to have been but for the fact that of course Mr Mason was dead at the end of it, a relatively common occurrence.

Police arrest people frequently, daily, many people throughout New South Wales on a daily basis. In some of those arrests, non-lethal weapons are used, such as OC spray or tasers. The reason they are used is because the police are hopeful that their non lethal weapons will subdue a person who is resisting arrest and is threatening It is only when violence is being threatened or is actually being used by the person whom the police are trying to take into custody that they are permitted to use these kinds of weapons. But it is a relatively common occurrence. It is a very rare occurrence that someone dies after these things happen, where these kinds of weapons are deployed.

So, in order to understand the events and really to make sense of what was reasonable in the circumstances as they unfolded in front of the police officers we have to divorce, or I have to divorce myself from the knowledge of how it ended. One has to try to perceive the circumstances as they unfolded in front of the police officers.

Could the planning have been done better, possibly, although Sergeant Irwin, the tactical instructor said he did not think so. With the benefit of hindsight, I think I could probably pick fault in some of the things done. It has been a matter of considerable thought for me about whether or not the police could or should have done more to plan what they did. But it seems to me that once they did not have an answer to their arrival from any of the occupants in the house, it was reasonable for them to enter.

They had received permission from Mr Peters, they had received information that Mr Mason may be inside, they entered, they announced their office or three of them announced their office, other police followed in the front door, this is standard operating procedures, shouting “police, police, police” and so forth. It is intended to overwhelm or intimidate or reduce people who may be contemplating action against the police to surrender. It didn’t do that.

Sergeant Norton arrived at the door he spotted Mr Mason, there are different interpretations probably of available as to what Mr Mason actually did when he saw Sergeant Norton, but what we do know is however one interprets his actions, Sergeant Norton perceived Mr Mason as arming himself with some sort of iron bar as it turned out to be, a tyre lever.

He saw Mr Mason switch hands, that is, put the tyre lever from his left hand into his right hand and that certainly could have been interpreted as a man preparing for a fight. One of the things that Ms Yehia says in her submissions is that Mr Mason had been target by police who had intelligence that he was involving in drug dealing. Whether he was involved in drug dealing or not, that was the police intelligence and they certainly acted on it. They stopped him a number of times. He may well have felt that despite his good relationship with police some years before when he was working with the ALS, that the police were now following him, searching him, persecuting him.

He may have felt particular officers were disrespectful towards him and he certainly had some disrespectful feelings I suspect towards some of the police. It may be and I think it would have been highly likely that having had the crash with the police car earlier on and no doubt anticipating that the police would come after him, that he would be afraid of what might happen to him when the police caught up with him. It may well be that he had armed himself anticipating that the police would harm him. Whatever. Sergeant Norton saw an armed man in front of him, a man who had, acted very dangerously earlier on in the day and who clearly was not minded to surrender to police at that very time. Nor did he drop his tyre lever.

Sergeant Norton stepped back. The first observation I’d make about that is that Sergeant Norton wasn’t there to kill Mr Mason. Had he been there for that purpose I don’t doubt that he just could have shot Mr Mason there and then, staged some sort of fight or something or other, told lies about it later.

But that's not what happened and we know a bit more about what happened immediately afterwards because virtually at that point, Senior Constable Bobako entered the scene with a taser and as far as I can tell from looking at the two taser videos which I reviewed at lunch time, things happen very, very quickly and indeed were very violent and very chaotic for the short space of time that the whole incident then lasted.

The moments of decision it seems to me occurred at that very time. As Sergeant Norton stepped back, Senior Constable Bobako could have also stepped back and threatened Mr Mason with the taser. That was the submission by Mr Nicholson. I agreed that was an available course of action.

But the real question here I think is, was the decision made by Senior Constable Bobako to deploy the taser unreasonable, just because there was an alternative, doesn't mean that the action he took was unreasonable. It was ultimately necessary to arrest Mr Mason. There can't be any argument about that.

The question really is, how it was going to be done and when it was going to be done. There were five police officers there, the tactical state protection group and the tactical operations groups were a long way away. It would be hours before they could get there. There were no negotiators immediately to hand and not only that, but Mr Mason had given the police reasonable cause to believe that he was unlikely to be co-operative.

He had given them grounds for that belief earlier on during the pursuit, during the crash and in Shortey Peters' house. He did not drop his weapon, he did not surrender, and that was the obvious thing to do for him. If he was willing to surrender. As I've said, maybe he was afraid of the police. I don't know, none of us know. He may have had reasonable suspicions that they would not treat him kindly. I don't know whether he had grounds for that but that may have been in his mind. In any event, he didn't disarm himself and surrender.

So it seems to me that at that point, the two police officers, that is Norton and Bobako right at that stage and Cornwall who was right behind them, had to make up their minds very quickly about what they would do. It does not seem to me in all the circumstances, it was not unreasonable to use the taser.

The expectation would have been and was that the taser would disable Mr Mason, he would drop, he would be, and then overwhelmed, he would be arrested, taken into custody and presumably taken to hospital for examination and treatment if he needed it. As we know the taser didn't work and the videos that I've again watch at lunch time, then show a truly horrifying scenario unfolding extremely rapidly.

Mr Mason was in enormous pain and was shrieking in pain. He was driven wild by the pain, literally wild. He did not drop the iron bar, he then began to lash out really at anyone who was near him. This was almost an animal instinct to try to stop the pain I suspect, but, he was not a dwarf like creature, he was a big man, he was a powerful man, one can see him swinging the iron bar, the tyre lever with enormous force. He was extremely frightening, he would have been extremely frightening to the police.

Not only that, he managed to, as in that short space of time, that seconds or so, that it all took, he was like something of, he was a whirling dervish almost, trying to beat off his attackers to relieve himself of the terrible pain that he was suffering.

His pain would have been exacerbated no doubt by the OC spray that was used as well. He would have been hurting a very great deal. This is one of the tragic aspects of it, but these weapons, which are meant to disable people and to stop their pain, didn't work in those circumstances. That was not something that the police anticipated, in fact they anticipated quite the opposite. In any event, at a point that it's a bit difficult to determine, Senior Constable Bobako tried to get in there to disable them again with a drive stun, he did that, the drive stun again didn't work, why that didn't work is difficult to understand, but it didn't. So all of these attempts had been made in a short space of time with these very powerful weapons to subdue Mr Mason without success.

In fact they just made Mr Mason even more wild than he had been right at the start. He began to beat Senior Constable Bobako around the shoulders and head, he hit Senior Constable Bobako three times at least, but probably three times. Certainly he got in three effective blows.

Anyone of those blows could have killed Senior Constable Bobako probably almost instantly had he collected him in the right place on the head or the neck or somewhere else. Senior Constable Bobako managed to get his gun out, he managed to get rid of his taser or change hands with his taser, get his gun out and then we hear two shots in very swift succession. He deliberately shot Mr Mason, he did so in self-defence, he believed that he would be killed if he didn't so and in my view that was a reasonable belief that he held. Had one more blow struck Senior Constable Bobako, he well might have been killed. It is of course tragic that Mr Mason was killed and nothing can diminish that tragedy, but, in my opinion and the submission has been put to me, the second shot was reasonable, the submission - I'm sorry, the second shot was put to me that, sorry the submission was put to me that the second shot was unreasonable.

In my opinion it was reasonable. He was a person literally fighting for his life whose only available weapon was not talking, not tactical retreat, not a baton, no OC spray, not a taser, but a gun.

And this was not a position in which I would counsel anybody being attacked in the same way as Senior Constable Bobako was to shoot once, stop, reassess, think again, have a look around the room, check out what was happening and then perhaps fire a second shot.

In that reassessment time it well might have been that Mr Mason could have got in a second and fatal blow. As it happens, it appears that it was the second shot that killed Mr Mason.

It's a bit hard to tell exactly because they came off, the two shots were fired almost simultaneously, well they were fired in very short succession, so, I would not be confident in saying which one actually killed Mr Mason, but one of them did, of course.

But the other one didn’t and couldn’t have and if it was the first one then and an assessment had been called for and followed through on, then Senior Constable Bobako might have died. That, it seems to me to follow that with Mr Mason, almost on top of Senior Constable Bobako, that he acted correctly and justifiably. It was put to me by counsel for the Mason family that I should reject the police evidence about Senior Constable Bobako being trapped in a corner and being attacked by Mr Mason. As I've said, I've reviewed the videos, I can't make out where exactly Mr Mason was nor where Constable Bobako was at the time the shots were fired.

I don’t know whether Mr Mason was shot and just fell on to the bed or whether he shot and staggered towards the bed or if he did stagger, how many steps he took. I'm simply not in a position to make any findings about that. I suspect that given, if Mr Mason was in motion, as I believe he probably was, when he was shot, it may have been that even if he received the fatal shot while he was over in the corner it might still have been possible for him to stagger towards the bed and collapse. In any event, that's what happened.

I think I've said that the force not, it was not excessive and was reasonable in the circumstances. Once the police had made the decision to deploy non lethal weapons, they had crossed the rubicon. Once the situation escalated, there was really no going back and that was not anticipated by the police I must say. I do not think that they intended to escalate this and I certainly don’t think that they intended the very tragic outcome that resulted 20 seconds after they confronted Mr Mason in Shortey Peters’ house in that room. Ms Dwyer then raised the question of whether there is anything we can learn from all of this. I have considered the recommendations of Ms Yehia. I think they're intelligent and I think they're powerful. If I deal with the first one, She suggested that the New South Wales Police Force give consideration to how the tactical options of tactical disengagement containment and negotiation can be deployed in the scenario such as that presented here. The present case could be used as a case study.

It seems to me that that's a good suggestion. I wonder whether though and I don’t know, I wonder whether though this is a scenario that is already very familiar to police and whether it would be helpful to look at it again.

I think possibly what is more helpful is for the police force, not so much to look at the particular scenario that unfolded in the house, but to think about the last point that Ms Yehia makes, which is to do with understanding of culture and I’ll come to that in a moment.

The second point that she suggested was concerning the use of drive stuns and so forth, that has been dealt with in another inquest by my colleague, the senior State Coroner and the New South Wales Police Force have already acted on that recommendation.

The third suggestion she makes is that the New South Wales Police Force reconsider the cultural awareness training provided to police with a view to incorporating aspects of programs and then she outlines the program that is operated by or presented by Dr Tracey Westaman of Indigenous Psychological Services.

It's been put to me that that's unnecessary because these police officers have already undertaken cultural training and so forth. It seems to me that cultural issues are incredibly important, but whether we approach them in Australia in the ideal way or the most effective way, I'm not sure about. We know that kids in schools, every kid in every Australian school I think, probably has some sort of, received some sort of education about Aboriginal history, the history of the people, the history of the colonisation of the country and so forth.

Whether that has enormously changed attitudes, I don't know. What really strikes me that it's a question of quality not quantity, it's how people approach, how non indigenous people approach the question of how we relate with Aboriginal people that is the key.

And I was thinking about this case the other day. I came across and re-read Paul Keating's very famous 1992 speech at Redfern Park and I'm not going to read it all but there are a couple of things that really struck me again. They're about imagination. He said, he was speaking about the year of the world's indigenous people and he said: "It comes at a time when we have committed ourselves to succeeding in the test which we have so far failed."

Well that was 21 years ago and we still haven't passed the test. He said: "There is no more basic test of how seriously we mean these things, it's a rest of our self knowledge."

And I think he's talking there to the non indigenous people of our country, he's talking about how we relate with Aboriginal people as being the test of Australian culture. And he goes on to say this and this is what really struck me.

We non Aboriginal people should perhaps remind ourselves that Australia once reached out to us and it occurred to me that Australia has been a very good country to a lot of us, but perhaps not so good to the people who originally occupied the country, who are the original owners of the country.

And Keating went on to say: "The starting point for rebuilding the relationship or reconciliation is to recognise that the problem starts with us non Aboriginal Australians. It begins I think with that act of recognition. Recognition that it was we who did the dispossessing." And then he describes the various things that non indigenous colonisation of this country has done to the indigenous people.

And he says: "It's our failure to imagine these things being done to us." And that I think is the key. We need to imagine and I think and I was really struck by something that Ms Dwyer was talking about up in Darwin when I went to a recent conference. She talked about a case in which a young Aboriginal man died in police custody. He shouldn't have died, he was badly treated, but at the end of it, some of the police went out and apologised to the family. One of the police officers sat down with the family and humbled himself before them. He tried his best to reach out to them.

I don’t know there that means anything to the Mason family or any sort of reconciliation is possible. But it has been possible in other cases and I refer to this case of Komanji Briscoe(?). In the Darwin Supreme Court there's a set of poles which were placed there by the Aboriginal descendents of a man who was unjustly convicted of murdering a police officer. He was later murdered by police. But the family came back 70 years later and had a ceremony together.

The thing is that in Australia we are Siamese twins, we’re joined at the hip. The white people can't go and the Aboriginal people aren’t going. We can live in resentment and anger and hatred and corrode ourselves or we can try to overcome the bitterness that separates people. I can't say to anybody here the police officers or the Mason family or others, what to do, but I suggest that all of us if we simply live in that intensely corrosive mindset are hurting ourselves more than we hurt those whom we hate.

So when I think about the suggestion of cultural understanding, it seems to me that the key thing is for non indigenous Australians, not just to learn about certain facts that we think we have historically recorded, but to try to make the effort to understand what it might be like to be one of the original occupants of this country and to understand that. Whether that's possible I don’t know, but I think it's something we all need to try to do, those of us who are non indigenous.

I'm not going to make formal recommendations, it seems to me that as I say, it's a question of quality not quantity. But I'm sure that those who think about these things, understand that.

Formal Finding:

I FIND THAT MR MARK MASON DIED ON 11 NOVEMBER 2011 AT BARWON STREET, COLLARENEBRI NEW SOUTH WALES DUE TO GUNSHOT WOUNDS INFLICTED BY A NEW SOUTH WALES POLICE OFFICER, THEN ACTING IN THE COURSE OF HIS DUTY AND IN SELF-DEFENCE.

3. 2860 of 2010

Inquest into the death of Ali Antoni El-Hafiane. Finding handed down by Deputy State Coroner Dillon at Glebe on the 29th April 2013.

Ali Antoni El-Hafiane was a young man aged nineteen years of age when he died at about 8.31pm on the 22 November 2010 in the forecourt of the High Flyer Inn on Birch Street in Condell Park, New South Wales. He had been shot by a police officer as he ran out of the hotel with another man with whom he had just carried out an armed holdup in the hotel.

The other man, Hassan Musleh, was shot twice but not killed. Mr El-Hafiane was not armed at the time but Mr Musleh had been armed with a machete.

The incident in which Mr El Hafiane died occurred in the course of an operation being conducted jointly by officers of the Robbery and Serious Crimes Squad and surveillance officers attached to the State Surveillance Branch of the NSW Police Force.

Under the **Coroners Act** an inquest is mandatory when a death occurs as a result of or in the course of a police operation. In a society in which the rule of law prevails a police force is not a law until itself, it is accountable to the society it serves to protect.

It has been observed that the purposes of a s 23 inquest are to fully examine the circumstances of any death in which police have been involved in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed including the quality of the post death investigation.

If appropriate and warranted in a particular case a State or Deputy State Coroner will make recommendations pursuant to s 82.

This inquest is not a quasi-criminal trial of the armed robbers. I emphasise that no one condones or defends armed robbery. Nor is this inquest intended to exonerate either Mr El-Hafiane or Mr Musleh from their crime but NSW Police Force policies, procedures and training are designed to minimise the risk of deadly force being applied even in dangerous circumstances. Use of firearms should be a last resort. These proceedings therefore are an inquiry into the manner in which the fatal police operation was conducted.

For reasons I will come to I do not believe that the police officers involved in this incident acted with any malice. The ultimate question is whether this operation could or should have been differently and better managed so as to avoid these shootings.

Again, for reasons that I will develop I have concluded that it is likely that had there been better planning and had standard police procedures for dealing with high risk incidents been followed Mr El-Hafiane's death and Mr Musleh's serious wounding could have been avoided.

I will turn to the summary. On page 5 of the summary I will take up in short form the significant findings I have made. During 2010 a series of armed robberies of hotels and TAB outlets in south western Sydney led to the Robbery and Serious Crime Squad setting up a strike force to investigate. It was during that ongoing operation that Mr El-Hafiane was killed by police.

I will go to paragraph 4. NSW Police detectives were taken by surprise when Mr El-Hafiane and another man robbed the High Flyer Inn in Condell Park on 22 November 2010. Although they acted with great courage in confronting an armed robbery at the hotel they did not employ the tactics recommendation by NSW Police guidelines of containment and negotiation. Had they done so it is likely that the death of Mr El-Hafiane and the severe wounding of his co-offender by police gunshots would have been avoided.

Although police did not know this at the time of the shooting Mr El-Hafiane did not have a weapon and Mr Musleh was not armed with a gun. Police assumed that both men were armed with pistols or shotguns or both.

The planning and execution of the police operation to investigate a gang of armed robbers in southwest Sydney was flawed in a number of ways. The Robbery and Serious Crime Squad made assumptions based on past experience about the modus operandi of the gang that a robbery would not attempted before closing time at the hotel or the TAB.

They did not anticipate a change in the modus operandi by the robbers who in fact raided the High Flyer Inn at about 8.30pm that evening. The Robbery Squad prepared itself only to conduct surveillance and other evidence gathering activities. Its officers were unprepared to arrest the robbers in the course of an armed holdup attempt. Some officers went on the operation unarmed. The members of the strike force were in plainclothes and were not easily identifiable as police officers even when confronting the robbers at the Inn.

Communications between officers in the field and with other units involved were complex, and to some extent unreliable, due to the use of multiple radio channels and mobile telephones, this complicated command and control unnecessarily. Undercover officers were unable to identify strike force officers and vice versa during the operation.

At the hotel this led to significant confusion, less on the part of the surveillance branch.

The Tactical Operations Unit, which specialises in dealing with high risk and dangerous situations, especially those involving armed offenders or suspects, were on standby but were not called out in sufficient time to deal with the situation at the High Flyer Inn.

Planning for the operation did not include consideration of using the undercover police to support the strike force in an overt role. Contingency plans were not developed before the operation began for dealing with armed robbers if the strike force or undercover police detected them committing an armed robbery before the TOU could be deployed to challenge them.

The commanders of the operation in the field and back at the command post at police headquarters were unable to exercise complete or efficient command and control due to the incomplete information they were getting from police in the field. This in turn was caused in large degree by the use of multiple channels of communication. Some decisions were made by individual officers or small groups of them in the field without notification to or consultation with commanders of the operation. This created potentially dangerous situations for police officers, civilian bystanders, and the armed robbers themselves.

Two notable examples of this were the decisions of three detectives, two of whom were unarmed, to check out the High Flyer Inn. They did so coincidentally only minutes before the arrival of the armed robbers.

They did not notify their commanders nor have a backup plan if the unarmed police were confronted with an armed robbery in progress. One of the unarmed detectives was surprised inside the hotel as he tried to lock the robbers out. He was lucky to get away in the confusion that then arose.

A second example is that another detective, armed, entered the hotel alone and without support and without knowing what was going on inside the hotel during the armed robbery. This was very brave but very foolhardy and against police guidelines in training. It unnecessarily created a potentially very dangerous situation for him, the civilians inside the hotel, bar staff and, of course, the robbers.

The two senior officers in the field, Detective Senior Sergeant Dukes and Detective Sergeant Chalker, did not order that a perimeter to contain the robbers be set up but entered the premises themselves. Again, this was not the procedure laid down in police guidelines for such situations. The two senior detectives were suddenly confronted by the two robbers, only one of whom was armed, running straight at them out of the hotel doors only metres away.

They assumed that the robbers were armed and that they were desperate to get away and may use their weapons to do so.

Mr El-Hafiane and Mr Musleh were at that time being pursued by Detective Tarren inside the hotel and did not know that the police were outside.

They probably did not hear Detective Dukes, Chalker or Tarren calling on them to stop, they probably did not see Dukes or Chalker clearly outside, they did not stop and the detectives outside fired on them killing Mr El-Hafiane and wounding Mr Musleh. The fatal shot was almost certainly fired by Detective Senior Sergeant Dukes. The detectives perceived Mr El-Hafiane and Mr Musleh as threats to their lives and safety and responded very quickly. In the circumstances as they perceived them to be the response was reasonable.

They did not act with any malice and did not enter the hotel intending to kill or wound anyone. Nevertheless if standard police procedure of containment and negotiation had been followed the police would probably have captured Mr El-Hafiane and Mr Musleh without harm to them or risk to the police officers or civilians at the High Flyer Inn. Despite their experience the detectives were insufficiently well prepared to deal with the situation that arose. In my opinion their training failed them.

As a result of the incident the NSW Police have undertaken a review of procedures and practices of the Robbery and Serious Crime Squad. Operational planning is now significantly more thorough and the squad is better equipped, extra training has been undertaken.

I just want to turn to the conclusion now of the full judgment, and I will read that in full on the record. Mr Bromwich, FC, on behalf of the Commissioner of Police offered his condolences to the El-Hafiane family.

He observed that Detective Inspector Lehman, who was the officer-in-charge of the investigation, had told him that they are close, good decent people and he noted that they had sat through the inquest which must have been a very painful experience for them with quiet dignity. This was exemplified by the apology offered by Mr El-Hafiane's older brother, Marty, to the bar staff and the patrons of the High Flyer Inn.

Marty El-Hafiane described Ali as, "A beautiful boy with a big heart who was easily misled". Armed robbery is, of course, a very serious and alarming crime. In this case it is important, however, to observe that this offence was the act of a very foolish, immature young man still a teenager who was probably carried away by his attachments to older mates and by the outlaw thrills he experienced with them.

This was not the life his family wanted for him.

That he did not live to reflect maturely on his offence and rehabilitate himself is one of the most tragic aspects of this case, and one that caused his family enormous pain. The piercing mark of his death has been left not only on his family but also on his friends, especially Mr Musleh, on the staff and patrons of the High Flyer Inn and of course, on the police officers involved in the operation. It was especially observable in Detective Senior Sergeant Dukes.

As I have stated earlier Mr El-Hafiane's death was probably avoidable and very probably would have been avoided if the policy of containment and negotiation had been implemented. Nevertheless there is little to be gained by scapegoating any individual officer, the failures were collective and cumulative and systemic, not due to any egregious individual's misconduct. While it will be, I know, of very little comfort to the El-Hafiane family at least this means that improvements can be made in the way that the Robbery and Serious Crimes Squad operates. This may in turn reduce the mortal risk toward the young men being investigated by the squad and to the public and the police officers themselves.

I would simply add to that what I have stated in the summary, that Ali had obviously been heavily influenced by older men with corrupt values. He came from a family whom the police acknowledge are good people with good values.

Had he lived there is reason to believe that as he matured his family's influence would have reasserted itself over him for good. So it is a very great tragedy that his life ended so young.

I now turn to my formal findings and I will have a few remarks shortly before I outline the recommendations.

Formal Finding:

I FIND THAT ALI ANTONI EL-HAFIANE DIED ON 22 NOVEMBER 2010 IN THE FORECOURT OF THE HIGH FLYER INN, CONDELL PARK, NSW, AS A RESULT OF A GUNSHOT WOUND INFLICTED BY A POLICE OFFICER WHILE MR EL HAFIANE WAS ENGAGED IN AN ARMED HOLDUP AT THE HOTEL.

These are made to the Commissioner of Police.

(1) THAT CONSIDERATION SHOULD BE GIVEN TO REQUIRING THAT THE CHAIN OF COMMAND BE CLEARLY STATED WITH MEANS OF COMMUNICATION AND OFFICERS IDENTIFIED IN ALL ROBBERY AND SERIOUS CRIME SQUAD OPERATIONAL ORDERS.

(2) THAT AS FAR AS POSSIBLE WHEN DIFFERENT UNITS ARE COMBINED OR WORK TOGETHER FOR THE PURPOSES OF A HIGH RISK OPERATION OR AN OPERATION WITH A POTENTIAL TO BECOME HIGH RISK THE OPERATIONAL PLANNING SHOULD INVOLVE SENIOR MEMBERS OF EACH OF THE UNITS AND MEMBERS OF ALL TEAMS SHOULD PRESENT A JOINT BRIEFING BEFORE THE COMMENCEMENT OF THE OPERATION.

(3) THAT CONSIDERATION SHOULD BE GIVEN TO AMENDING THE ROBBERY AND SERIOUS CRIME SQUAD STANDARD OPERATING PROCEDURES TO INCLUDE A REQUIREMENT THAT OPERATIONAL ORDERS IN RESPECT OF AN OPERATION THAT MAY LEAD TO THE ARREST OF A PERSON OF INTEREST INCLUDE OPERATIONAL ORDERS

(a) SETTING OUT CONTINGENCY PLANNING;

(b) REQUIRING AN ASSESSMENT OF RESOURCES AND CONSIDERATION OF WHAT ADDITIONAL RESOURCES MAY BE REQUIRED AND/OR ACCESSED SHOULD THE OPERATION MOVE TO AN ARREST PHASE;

(c) SETTING OUT CERTAIN PREDETERMINED ACTIONS THAT MAY BE APPROPRIATE SHOULD THE OPERATION MOVE TO AN ARREST PHASE;

(d) SETTING OUT GUIDING PRINCIPLES, TO BE DEPARTED FROM ONLY IF NECESSARY IN THE PARTICULAR CIRCUMSTANCES:

(i) THAT IF PHYSICAL OR ELECTRONIC SURVEILLANCE LEADS TO A REASONABLE BELIEF THAT AN OFFENCE INVOLVING VIOLENCE IS IMMINENT, THE FIELD COMMANDER WILL TAKE ALL REASONABLE STEPS TO PREVENT THAT OFFENCE OCCURRING AND, IF POSSIBLE, ARREST THE TARGET AND SECURE ANY WEAPONS;

(ii) THAT IF THE THREAT OF IMMINENT VIOLENCE OR AN OFFENCE INVOLVING VIOLENCE CANNOT BE NEUTRALISED BY THE APPREHENSION OF THE TARGET(S) THE FIELD COMMANDER WILL TAKE ALL REASONABLE STEPS TO PREVENT THE COMMISSION OF THE OFFENCE BY USING COVERT STRATEGIES SUCH AS SECURING THE TARGET LOCATION AND/OR CAUSING HIGH VISIBILITY POLICING IN THE VICINITY OF THE TARGET LOCATION IF KNOWN. IF THE TARGET LOCATION IS UNKNOWN THE FIELD COMMANDER WILL CAUSE THE DESCRIPTION OF THE WILL CAUSE THE DESCRIPTION OF THE TARGET(S), ANY VEHICLE INVOLVED AND RELEVANT WARNINGS TO BE BROADCAST VIA VKG FOR INFORMATION OF POLICE GENERALLY;

(iii) THAT IF ARMED TARGETS ENTER PREMISES WITH AN APPARENT INTENTION TO COMMIT A SERIOUS OFFENCE, AND IT IS NOT POSSIBLE TO PREVENT THAT OFFENCE BEING ATTEMPTED OR COMMITTED, PRIORITY SHOULD BE GIVEN TO CONTAINMENT, NEGOTIATION AND THE DEPLOYMENT OF THE TACTICAL OPERATIONS UNIT IF POSSIBLE;

(iv) THAT IF ARMED TARGETS ENTER PREMISES IN WHICH MEMBERS OF THE PUBLIC ARE PRESENT AND COMMIT AN OFFENCE OF VIOLENCE PRIOR TO INTERCEPTION, THEY OUGHT NOT BE APPROACHED WHILST IN THE PREMISES OR IN THE PROCESS OF COMMITTING AN ARMED ROBBERY UNLESS THIS IS THE ONLY REASONABLE WAY TO PREVENT FURTHER HARM OR RISK OF HARM TO MEMBERS OF THE PUBLIC WITHIN THE PREMISES;

(v) THAT WHERE REASONABLY POSSIBLE, AN ARREST WILL ONLY BE EFFECTED ONCE ALL TARGETS HAVE LEFT PREMISES OR THERE IS NO IMMEDIATE DANGER TO POTENTIAL VICTIMS INCLUDING OTHER POLICE OFFICERS;

(vi) THAT ARMED OFFENDERS WHO ARE CONTAINED OUGHT BE GIVEN A REASONABLE OPPORTUNITY TO COMPREHEND THIS AND TO SURRENDER BEFORE POLICE RESORT TO THE USE OF
FORCE, ESPECIALLY DEADLY FORCE.

The fourth main recommendation is:

(4) TO SIMPLIFY PLANNING FOR POTENTIALLY HIGH RISK POLICE OPERATIONS IN EXIGENT CIRCUMSTANCES, THAT THE ROBBERY AND SERIOUS CRIME SQUAD DEVELOP AND APPEND TO ITS STANDARD OPERATING PROCEDURES A SIMPLE CHECKLIST FOR DEVELOPING AN APPRECIATION OF THE SITUATION AND A SECOND SIMPLE CHECKLIST

FOR OPERATIONAL ORDERS.

(5) THAT CONSIDERATION SHOULD BE GIVEN TO AMENDING THESTANDARD OPERATING PROCEDURES TO EMPHASISE THAT DURING THE CONDUCT OF OPERATIONS THE FOLLOWING GENERAL PRINCIPLES SHOULD BE ADHERED TO BY MEMBERS OF THE ROBBERY AND SERIOUS CRIME SQUAD, AND THAT THESE SHOULD BE INSERTED INTO ANY WRITTEN OPERATIONAL ORDERS INSTRUCTIONS: 45 (a) THAT IF A HIGH RISK POLICE OPERATIONS

MAY BE REQUIRED THE TACTICAL OPERATIONS UNIT SHOULD BE REQUESTED TO ASSIST AT A POINT IN TIME WHEN THEY ARE LIKELY TO BE ABLE TO DEPLOY IN THE FIELD BEFORE THE POINT AT WHICH IT IS ENVISAGED THAT A HIGH RISK POLICE OPERATION MAY BE REQUIRED;

(b) THAT IF THE TACTICAL OPERATIONS UNIT RESPONDS BY INDICATING THAT IT DOES NOT INTEND TO DEPLOY IMMEDIATELY, ANY SIGNIFICANT ADDITIONAL INFORMATION POTENTIALLY AFFECTING THAT DECISION SHOULD BE

COMMUNICATED TO THE TACTICAL 5 OPERATIONS UNIT;

(c) THAT INTEROPERABILITY OF COMMUNICATIONS AND SHARING OF COMMUNICATIONS IS A PRIORITY DURING HIGH RISK POLICE OPERATIONS;

(d) THAT EFFECTIVE COMMUNICATIONS SHOULD BE ESTABLISHED AS A PRIORITY, WITH AN OFFICER BEING RESPONSIBLE FOR COMMUNICATION FOR ANY HIGH RISK POLICE OPERATION;

(e) THAT THE PRIORITY SHOULD GENERALLY BE PREVENTION OF OFFENCES OF VIOLENCE EVEN AT THE EXPENSE OF ARREST OF THE TARGETS AND/OR SECURING ANY WEAPONS;

(f) THAT OTHER THAN IN EXCEPTIONAL CIRCUMSTANCES, HIGH RISK ARRESTS SHOULD NOT BE ATTEMPTED EXCEPT ON AN IMMEDIATE ORDER FROM THE FIELD COMMANDER OR IN ACCORDANCE WITH OPERATIONAL ORDERS;

(g) THAT THE PREFERRED OPTION FOR CONTROLLING ANY HIGH RISK SITUATION IS CONTAINMENT AND NEGOTIATION, AND NON VIOLENT MEANS SHALL BE USED AS FAR AS IS REASONABLE BEFORE RESORTING TO THE USE OF FORCE;

(h) THAT IN A HIGH RISK OPERATION POLICE SHOULD FIRST CONSIDER THEIR OPTIONS TO CONTAIN AND NEGOTIATE. CONTAINMENT AND NEGOTIATION SHOULD BE THE PRIMARY OPTION CONSIDERED;

(i) THAT AFTER A HIGH RISK INCIDENT HAS BEEN CONFIRMED, WHERE POSSIBLE CONTROL SHOULD BE GAINED BY CONTAINING THE THREAT WITHIN AN INNER PERIMETER, WITHOUT COMPROMISING THE POINT OF EXIT FOR OFFENDERS, AND ISOLATING THE THREAT BY ESTABLISHING AN OUTER PERIMETER; AND

(j) THAT OFFICERS SHOULD IF POSSIBLE AVOID ANY ACTION WHICH WOULD PLACE HOSTAGES, UNINVOLVED CIVILIANS, OTHER EMERGENCY PERSONNEL OR POLICE OFFICERS IN ANY FURTHER DANGER.

(6) THAT, IN ADDITION TO AND FOLLOWING THE THOROUGH INVESTIGATION INTO THE CONDUCT OF INVOLVED POLICE OFFICERS THAT FOLLOWS A CRITICAL INCIDENT, THE NSW POLICE FORCE CONDUCT A POLICY AND PROCEDURE ANALYSIS, SIMILAR TO NEW SOUTH WALES HEALTH'S "ROOT CAUSE ANALYSIS" PROCESS, TO DETERMINE WHETHER OR NOT LATENT SYSTEMS DEFECTS HAVE BEEN REVEALED BY THE INCIDENT AND, IF SO, WHAT MEASURES OUGHT BE TAKEN TO RECTIFY THEM.

I add the note that these recommendations are not intended to suggest that NSW Police Force adopt inflexible rules or fetter the appropriate application of a police officer's discretion as a constable. I should also note that for legal reasons the name of one person has been redacted from the published reasons for my decision.

4. 2863 of 2010

Inquest into the death of John Leonard Cameron. Finding handed down by Deputy State Coroner MacMahon at Parramatta on the 9th April 2013.

This has been an inquest into the death of John Leonard Cameron being file number 2010/437513, previously 2863 of 2010. Mr Cameron was born on 14 May 1954. He resided from time to time at 360 Bourke Street, Surry Hills. In 2010 he was in Western Australia. He was charged with possession of prohibited drug with intent to sell or supply. The drug was ethylamphetamine. He was released on bail in respect of that offence. A condition of his bail was that he was not to leave Western Australia.

On 3 October 2010 he was stopped on the Sturt Highway near Dareton in western New South Wales. He was searched. He was subsequently charged with two counts of criminal offences, being two counts of dealing with property suspected of being the proceeds of crime and the proceeds' particulars were the motor vehicle in which he was travelling and a cash amount of some $27,000. He was refused bail. He was taken to the Broken Hill Correctional Centre. He was then brought to the Metropolitan Remand and Reception Centre in Sydney. On a number of occasions he was interviewed by officers of the New South Wales Crime Commission.

On 18 November 2010 he was transferred to Parramatta Correctional Centre and he was to have a bail application dealt with by the Supreme Court on 22 November 2010. Whilst at Parramatta he was in a cell with a Mr Russell. Mr Russell was interviewed by the investigating officer and as far as Mr Russell was concerned it appeared to him that Mr Cameron believed he had good prospects of obtaining bail when his bail application was dealt with on 22 November.

On 22 November 2010, as planned, his bail application was dealt with by Davies J in the Supreme Court. The bail application was refused and Mr Cameron was returned to his cell. At 11.57pm Mr Russell found Mr Cameron hanging from the window of his cell near the ligature. He was hanging from a cord or rope constructed from some torn sheeting. Mr Russell sought assistance by pressing the emergency button within the cell. Corrective Services officers attended rapidly, as did other assistance, including ambulance staff. Mr Cameron was, however, found to be deceased.

It is important to understand and outline what the role and function of a coroner is. The actions of a coroner are governed now by the **Coroners Act** 2009 which commenced on 1 January 2010. The function is to, among other things, investigate certain kind of deaths, and that is to be found in s 3. The deaths that are the subject of investigation are reportable deaths. All reportable deaths are required by s 35 to be reported to the coroner. Reportable death is defined by s 6. Section 6(1)(a) includes, as part of a death which is reportable, one which is violent or unnatural. Mr Cameron's death met that requirement. The coroner has jurisdiction to hold an inquest into reportable deaths as provided by s 21.

Certain reportable deaths and the inquests to be conducted in respect of those are the exclusive jurisdiction of certain corners, specifically the State Coroner or the Deputy State Coroner, and that is to be found in s 22. One of the types of deaths, which are within the exclusive jurisdiction of the State Coroner or Deputy State Coroner, is a death in custody. That is s 23. The inquest into a death in custody is mandatory, as provided by s 27(1)(b).

Therefore, Mr Cameron being a person who at the time of his death was in custody, it is mandatory that an inquest occurs into his death and such inquest must be undertaken by a State Coroner or a Deputy State Coroner. The Coroners Act provides that at the end of an inquest the coroner is to make findings, should sufficient evidence be available, as to the identity of the deceased person, the date and place of their death and the cause and manner thereof. That is to be found in s 81(1). The coroner also has the jurisdiction and discretion, should they consider it appropriate, to make recommendations as to any matter which arises out of the investigation of the death the subject of the inquest. That is to be found in s 82.

Section 75 is also relevant to these proceedings in that that section provides that a report of an inquest may not be published where the finding is that the death arises out of intentional self harm of a deceased. That prohibition can, however, be lifted if the coroner undertaking the inquest considers that it is desirable in the public interest for a report of the inquest to be published.

In this case, dealing with the matters that s 81(1) requires me to make findings concerning, most of which are non-controversial, Mr Cameron was identified to the officer in charge by Scott William Westlake, a senior correctional officer. Mr Cameron was also identified by his fingerprints on the evidence of Detective Sergeant Tony Bush, a fingerprint expert. I am satisfied that the deceased person found on 22 November 2010 at Parramatta Correctional Centre was in fact John Leonard Cameron.

Mr Cameron was certified deceased at 6.01am at the Royal Prince Alfred Hospital by Dr Paul Ryan, a registered medical officer. As I have already indicated, he was found hanging by Mr Russell, his cellmate, and Mr Russell sought help shortly before 11.57pm on 22 November 2010. The evidence that is available to me establishes to my satisfaction that from the time Mr Russell found him to the time he was certified as being deceased by Dr Ryan there was no change in his life capacity. I am satisfied that it is more likely than not that when found by Mr Russell at 11.57pm or thereabouts Mr Cameron was already deceased. I am therefore satisfied that he died on 22 November 2010.

The place of Mr Cameron's death was the Parramatta Correctional Centre, Parramatta. An autopsy was undertaken by Dr Brouwer.

She found that the appropriate recommended cause of death was hanging and I accept her recommendation.

Manner of death is the circumstances in which the person dies. I am satisfied that Mr Cameron acted with the intention of ending his life. His manner of death was therefore suicide. I am satisfied that this is a case for a number of reasons.

Firstly, the evidence shows that Mr Cameron actually left a suicide note addressed to his friend Colin Milne. He also left other material, which indicated his intention to end his life. Subsequent investigation undertaken by the officer in charge has in fact identified that Mr Cameron in fact told his friend Mr Milne and another friend, Mr Jonathon Cameron, that if he did not get bail on 22 November 2010 he actually intended to end his life. This threat was made to both Mr Milne and Mr Jonathon Cameron separately when they visited him in prison. Each of them discussed the threat at a later time because they were acquaintances. However, they dismissed the threats as being part of the melodramatic response to Mr Cameron's circumstances and therefore they did not take the threat seriously. Unfortunately, Mr Cameron was in fact serious as to his intention.

The matter of Mr Cameron's death was thoroughly investigated by the officer in charge and there is nothing to suggest that from that investigation, and the examination of the Corrective Services files relating to Mr Cameron and the examination of the Justice Health files related to him, that any Corrective Service officer or Justice Health officer was aware or ought reasonably to have been aware of Mr Cameron's threat of intentional self harm.

As I said, Justice Health and the Corrective Services files are before me as exhibits. I have examined them and I have not found any evidence contained therein to suggest that the appropriate assessments, which are undertaken on prisoners entering into custody, were not undertaken in an appropriate and proper fashion. There is nothing in that material which would suggest that Mr Cameron intended to end his life or was at risk of doing so.

As I said, Mr Milne and Mr Jonathon Cameron were persons to whom Mr Cameron did indicate an intention to end his life if he was refused bail on 22 November 2010. As I have already indicated, Mr Cameron had made out to his cellmate, Mr Russell that he expected to obtain bail.

He had been to the Crime Commission and it would seem from the material that I have available to me, it would seem that on that material he expected to get assistance in obtaining bail from the Crime Commission because he supposedly could have been assisting them. He expected to be able to show for his bail application that the motor vehicle which was thought to be one of the proceeds of crime was in fact his, he could establish his purchase of that vehicle, and the large amount of cash which he had he was also anticipating being able to establish that that was not the subject of the proceeds of crime. Therefore, the charges against him were weak.

An examination of Davies J's judgment as to his bail shows that that is not an issue which appears to have weighed heavily on Davies J's decision-making and it was more the fact that Davies J didn't believe Mr Cameron when he said that police had told him that not withstanding the bail condition that he was the subject of, that being he not approach within 100 metres of an exit point from Western Australia, that the police had told him he could return to New South Wales. Davies J was also concerned by the fact that there was a warrant for Mr Cameron's arrest in Queensland as well.

It is not for me to canvass those issues, other than to note that that was the case that Mr Cameron believed that he had good prospects of obtaining bail but he did not do so.

As I have indicated, Mr Cameron mentioned to both Mr Milne and his friend Jonathon Cameron that if he did not get bail he would "top himself" or words to that effect. Each of the gentlemen concerned gave evidence before me. Each of them did so in what I consider to be a frank and candid fashion. They had known Mr Cameron for in excess of a decade and they considered him to be a good friend. Each of them indicated that he was at times prone to theatrics when he did not get his own way but he would calm down shortly after. Neither of them, and they did so after discussion amongst themselves, believed that he was capable or likely to intentionally harm himself in the way that he had threatened and as a result of that they did not report what he had said to the relevant authorities. In regard to their evidence, I am satisfied that their action was not inappropriate.

One of the reasons why an inquest into the death of a person in custody is mandatory is, as the former State Coroner Magistrate Kevin Waller has said:

> "Society having effected the arrest and incarceration of a person who has seriously breached its laws has a duty to those persons of ensuring that their punishment is restricted to the loss of liberty is not exacerbated by ill treatment or privation while waiting for trial or sentence."

That is to be found in **Waller's,** 4th Ed, and page 106. It is therefore essential to ensure that a person who is in custody who is likely to self-harm is identified and such risks need to be mitigated where possible.

In this case that I am satisfied, as I have already indicated, the appropriate action was taken to identify the possibility of such risk. However, Mr Cameron did not display that risk or hid it from the relevant authorities. As I have already dealt with, the risk was mentioned to his friends, Mr Milne and Mr Jonathon Cameron.

Unfortunately, that was not transmitted to Justice Health or Corrective Services authorities.

I have mentioned s 82 recommendations. The officer in charge has made a recommendation relating to the hanging point used by Mr Cameron with a view to preventing its further use for such purposes. I am informed that Parramatta Correctional Centre has been decommissioned since Mr Cameron's death and as a result that hanging point is no longer available.

Evidence before me on the general subject of hanging points and what Corrective Services has undertaken with a view to preventing such a problem, which has been highlighted by previous coronial recommendations, the evidence suggests that the Corrective Services has taken appropriate action and is continuing to take appropriate action where available to ensure that such hanging points are not readily available to persons who are at risk of self harm.

Because of the closure of the centre in which this event occurred and because of the general evidence available to me as to the general action taken by Corrective Services to remove hanging points, I do not consider it necessary or appropriate in this case to make any recommendations under s 82 of the **Coroners Act**.

I have already mentioned that s 75 prohibits a publication of the report of the proceedings where a finding that a death as a result of intentional self harms is made. This is to meet the public policy and public interest of protecting the privacy of the deceased person and his or her family in such circumstances. In this case, of course, there are two competing public interests. The first one is the one that I have just mentioned of protecting the privacy of the deceased and his or her family. The second, of course, is that in this case, which is a mandatory inquest, the public interest is in ensuring that the investigation of the death of a deceased person in custody is thorough and that all appropriate action was taken to ensure that the risks of self-harm were sought to be identified and were identified and ameliorated.

These two competing public interests, of course, meet in this case where a person has died as a result of their own actions in circumstances where the public has an interest in ensuring that they are properly protected whilst in custody. In this case I am satisfied that public interest of publication is greater than that of the privacy of the deceased and his family. In those cases I propose to make an order in accordance with s 75 allowing the publication of the report of this matter and the findings in this case. That order will, of course, have the exception that I propose to continue, the non-publication order in respect of the photographs that are contained within exhibit 3 in the proceedings. IN ACCORDANCE WITH S 81(1) I THEREFORE MAKE THE FOLLOWING FINDING:

Formal finding:

I FIND THAT JOHN LEONARD CAMERON, WHO WAS BORN ON 14 MAY 1954, DIED ON MONDAY 22 NOVEMBER 2010 AT THE PARRAMATTA CORRECTIONAL CENTRE, PARRAMATTA, IN THE STATE OF NEW SOUTH WALES.

THE CAUSE OF MR CAMERON'S DEATH WAS HANGING, WHICH OCCURRED AS A RESULT OF ACTIONS TAKEN BY HIM WITH THE INTENTION OF ENDING HIS LIFE.

I CONFIRM AND CONTINUE THE NON-PUBLICATION ORDER I MADE IN ACCORDANCE WITH S 74 IN RESPECT OF THE PHOTOGRAPHS THAT CONTAINED IN EXHIBIT 3 AND I MAKE AN ORDER IN ACCORDANCE WITH S 75(5) AUTHORISING THE PUBLICATION OF THE REPORT OF THESE FINDINGS AND REASONS.

5. 43 of 2011

Inquest into the death of Christopher Lorenzo. Finding handed down by Deputy State Coroner Forbes at Glebe.

This is an inquest into the death of Christopher Lorenzo. Christopher Lorenzo was born on 2 July 1975. At the time of his death he was serving a fulltime sentence, custodial sentence. His sentence details were a fixed sentence of 22 years six months to date from 5/10/1996 and expire on 4/4/1019. He had a non-parole period of 17 years on 5/10/1996 and expired on 4/10/2013.

Christopher was pronounced life extinct by Joseph Wilbers at 6pm on 9 January 2011. As way of background, on 30 November 2010 Christopher was examined by Doctor at the Lithgow Correctional Centre. As a consequence he was transferred to Prince of Wales as Lithgow did not have the capability to treat him. He was treated at Prince of Wales until he died. There was no autopsy conducted and the cause of death on the death certificate is acute myeloid leukaemia. In relation to this matter I note the contents of the brief and I note that Mr Lorenzo passed away whilst in custody as he was suffering from leukaemia and that he was treated and in hospital at the time that he passed away. I make the following formal findings.

Formal Finding

CHRISTOPHER ANTHONY LORENZO DIED ON 9 JANUARY 2011 AT PRINCE OF WALES HOSPITAL NEW SOUTH WALES AS A RESULT OF LEUKAEMIA AND THE MANNER BEING NATURAL CAUSES.

6. 85 of 2011

Inquest into the death of Richard Brown. Finding handed down by Deputy State Coroner Freund at Glebe on the 7th June 2013.

Richard Brown was fifty one years old when he passed away on 15 January 2011 from multiple blunt force injuries after being hit by a police car on the Great Western Highway at Minchinbury.

Upon his arrival at Westmead Hospital sadly Mr Brown was declared deceased. Mr Brown leaves behind a large loving family including his wife Brenda, daughter Shirley, son Kevin and friends who clearly cherished him and missed his deeply.

A coroner's function is to seek to answer five questions, namely who died, when they died, where they died and the manner and cause of their death.

The cause of death refers to the direct physical cause where the manner of death relates to the surrounding circumstances. As this is a death arising out of a police operation pursuant to s23 of the **Coroners Act** 2009 this is a mandatory inquest and it becomes a central issue for this inquest to determine whether the police who were directly or indirectly involved with Mr Brown at the time of his death could have taken steps to prevent the ultimate tragic outcome.

As stated at the start of this inquest there is no controversy in relation to the identity of Mr Brown or where, when and how he died. The primary issue to be considered by this inquest is what were the surrounding circumstances that led to the fateful outcome for Mr Brown.

In particular,

1) the manner of driving of a vehicle driven by police that collided with Mr Brown.

2) the existence and adequacy of any avoidable manoeuvres prior to the collision and

3) any contributing factors including atmospheric conditions and lighting. Due to the nature of the incident involving Mr Brown, the New South Wales Police Critical Incident Protocols came into play almost immediately.

The involved officers, namely Constable Terry Rann, Constable Sean Clark, Probationary Constable Chloe Hall, Constable Scott Hanson and Constable Jarin Baigent were separated and kept separate until their individual versions of events were taken in the early hours of the morning.

Detective Senior Constable Alex Veira from a separating neighbourhood command in accordance with New South Wales Police Critical Incident guidelines was appointed the officer in- charge and attended to gathering the evidence.

The brief complied by Detective Senior Constable Veira was thorough and detailed, much effort went into trying to determine why Mr Brown was on his own on the Great Western Highway in the early hours of 15 January 2011. What was established by way of background can be summarised as follows.

On 12 January 2011 Mr Brown was released from Kempsey Gaol. His wife Brenda reports that he caught a train and arrived home in Sydney at about 6.30pm. That was the first time that Brenda had seen him for approximately two years. Brenda had maintained phone contact with him while he was incarcerated and reported that he looked good, healthy and in good condition upon his return. Mr Brown was sober and looked happy. Brenda further reported that she and her husband spent the whole of Thursday 13 January 2011 at home together and catching up with family who came to see them.

They had a late night that night.

The last time Brenda saw Mr Brown was approximately 10am on Friday 14 January 2011. Mr Brown had told her that he was going to see his brothers and sisters at Ernest Brown's house. Ernest is Mr Brown's nephew. That house was at Gardner Street, Rooty Hill.

Della Schipp who also provided a statement to police. Della was at the time in a de facto relationship with Ernest Brown, the nephew of Mr Brown. Della's evidence can be summarised as follows.

1. That Mr Brown arrived at the house in Gardner Street, Rooty Hill at about 11.30 on 14 January 2011. Ernest was still at work and would not finish until 1 o'clock. Mr Brown told Della that he had gotten out of gaol on Wednesday and that he was out for good and he did not want to go back in.

2. Whilst waiting for Ernest to arrive Richard smoked a cone of marihuana, watched a movie on television and shortly after started falling asleep.

3. During the course of the rest of the afternoon a number of family members came to the house. Alcohol and further marihuana was consumed by Mr Brown. It was late in the evening that a group including Mr Brown set off to look for Uncle Lionel who had left the Gardiner Street property some time earlier.

4. The group left the Gardner Street property before midnight as they were aware that they had to get to the Lone Pine Tavern before midnight to obtain further alcohol.

5. The group arrived at the park across the road from the Lone Pine Tavern. Shortly after arriving Uncle Lionel walked from the Lone Pine Tavern through the park and came and sat on the seat with Mr Brown.

6. Della could not recall specifically how long they were in the park for but it would not have been for more than an hour. It is likely they were there not much past 1am, if that.

7. Whilst sitting in the park there was a disturbance involving two other males, which apparently attracted the intention of nearby police. Accordingly the group that Della was with including Mr Brown did not want to be around so they all started to walk down the footpath along the central park.

8. Della records that Uncle Lionel was walking in front of the group and that Mr Brown was about six metres from Uncle Lionel on his own.

9. An argument broke out amongst some members of the group and Della recollects that Uncle Lionel kept on walking towards home along the path and that Mr Brown stopped for a while and looked at the group. She then recollected that Mr Brown began to walk once again towards home along the concrete path. At some point Uncle Lionel and Mr Brown became separated from the large group which eventually lost sight of Uncle Lionel and Mr Brown, and finally;

10. Della recorded that the assumption of the remaining group was that Mr Brown had caught up with Uncle Lionel and the two of them were ahead of the others. The group continued to walk home and when they got back to the house they found only Uncle Lionel. They asked Uncle Lionel where Mr Brown was. He said, “He didn’t walk with me.”

About approximately 1.30am on 15 January Mr Brown, for reasons unknown, was at the Great Western Highway near the intersection of Minchinbury Drive.

The police, despite extensive efforts, were unable to track Mr Brown’s movement in the period between him being separated from Uncle Lionel and arriving at the section of the Great Western Highway.

In particular the police have been unable to determine what occurred in the half an hour prior to the collision or answer why Mr Brown was where he was at that fateful time. No doubt this causes much distress to his family but some questions just cannot be answered. For whatever reason Mr Brown separated from his friends and family some time after 1am or shortly thereafter on 15 January 2011 and his movements are unknown until the collision which occurred at about 1.35am.

That same evening a crew of police were travelling west on the Great Western Highway at Minchinbury in a fully marked police Volkswagen Transporter van registration number BE-47-GP with call sign SM17 herein after referred to as SM17. Constable Sean Clark and Probationary Constable Chloe Hall were passengers. The van was driven by Constable Terry Rann.

All officers were attached to the St Marys Local Area Command. That evening there was a second police vehicle operating in the area. That vehicle being a fully marked Hyundai Iload van registration BHP-23-U was being driven by Constable Scott Hanson of the Mt Druitt Local Area Command. That vehicle had the call sign MD17, herein after referred to as MD17.

Constable Jarin Baigent was the passenger in that vehicle. The vehicle was travelling slightly behind and in the adjacent lane to SM17 at the time of the collision.

All the involved officers, namely Constable Rann, Constable Clark, Probationary Constable Hall, Constable Hanson and Constable Baigent provided statements by way of electronically recorded interview during the early hours of 15 January 2011.

They also all provided oral evidence to this inquest. There were some minor differences with respect to the evidence of each officer. In particular in relation to when the occupants of each vehicle spotted the other vehicle. For example, Probation Constable Hall in her evidence said that SM17 passed MD17, which had slowed, on the left hand side of the road. She had waved at MD17 and she had commented on MD17 to the other occupants in her vehicle. Constable Clark and Constable Rann can recall passing MD17 but cannot recall Probationary Constable Hall either waving at MD17 or commenting on it.

In contrast neither occupants of MD17 can recall being passed by SM17. According to the accounts of Constables Hanson and Baigent, they simply came up behind SM17 in the flow of traffic and continued to travel behind SM17 in lane 2 of 2 until they changed to lane 1 of 2 just before the collision.

I found all the officers who provided evidence during the course of these proceedings honest and forthright and willing to assist this inquiry in whatever why they could.

The fact that their versions of these events leading up the collision differ is not in my view significant. Memories are imbedded in people after a stressful event in various ways.

The fact that the versions expressed differ in certain somewhat peripheral details supports an interpretation that no collusion took place between the officers.

That these two police vehicles were at the same location at basically the same time was an unfortunate coincidence on this evening and nothing more can be read into it. With respect to the collision itself, it was the evidence of all the involved police officers and in particular Constable Rann who was the driver of SM17 that all of a sudden Mr Brown appeared in the middle of lane just in front of SM17 and SM17 swerved and that brakes were applied to miss Mr Brown but unfortunately SM17 did not miss him.

The two officers who actually glimpsed Mr Brown prior to the collision, namely Probationary Constable Hill and Constable Rann both indicated that they saw only the back of his head prior to the collision.

The post mortem report indicated that and I'm quoting here, "of the high parietal scalp situated some 163 centimetres above the heel and centred about 43 millimetres left of the midline and 130 millimetres above the level of the external ear canal.

There is an irregular partially discontinuous gaping laceration extending over 80 by 47 millimetres with underlaying skull bone exposed at the base. This indicates that the upper left back of Mr Brown's skull impacted with the windscreen, which corroborates the evidence of Constable Rann and Probationary Constable Hall that Mr Brown was facing away from SM17 prior to impact.

SM17 was not being driven in an erratic manner, it was not speeding. It was the evidence of Constable Rann that when he last looked at the speedometer he was travelling at about 80 kilometres per hour or just under. The speed limit on that section of road was 80 kilometres per hour. He was not using his mobile phone and he had his eyes on the road.

The experts' reports engaged for the purpose of this inquest contain conclusions consistent with this account. Despite a detailed report being prepared by Acting Sergeant Sophie Stone, a New South Wales Police crash investigator with over twenty years experience, to ensure complete transparency the Crown Solicitor commissioned an independent report from Michael Griffiths, a biomedical and mechanical engineer and expert in crash investigations and road safety.
His evidence can be summarised as follows:

1. That the impact with Mr Brown was inevitable.

2. That Constable Rann was able to commence the crash avoidance action of swerving and braking but there was insufficient time to complete either of these successfully.

3. That given the poor lighting conditions and Mr Brown's poor dressed in dark coloured clothing, Constable Rann did the best he could in the time available to him.

The death of Mr Brown was a terrible tragedy for all that knew and loved him and also for the police involved that night who found themselves in a situation that they never anticipated or wished for.

Lives will be changed forever. We will never know what caused Mr Brown to be on that particular stretch of road at that time of night. It was an unfortunate turn of events with tragic outcome which is unavoidable given the confluence of conditions at the time. No-one can be criticised or blamed, it was simply a tragic accident. Accordingly I now turn to the findings I am required to make pursuant to s 81 of the Coroners Act.

Formal Finding

I FIND THAT RICHARD BROWN DIED ON 15 JANUARY 2011 AT WESTMEAD HOSPITAL AS A RESULT OF MULTIPLE BLUNT FORCE INJURIES SUSTAINED AFTER BEING HIT BY A POLICE MOTOR VEHICLE WHILST HE ATTEMPTED TO CROSS THE GREAT WESTERN HIGHWAY AT MINCHINBURY IN THE EARLY HOURS OF 15 JANUARY 2011.

7. 1029 of 2011

Inquest into the death of Anthony Van Rysewyk on the 8th May 2011. Finding handed down by Deputy State Coroner Freund at Junee.

These are my findings in relation to the death of Anthony Van Rysewick. Anthony Van Rysewick was 28 years old when he died from heroin toxicity. At the time of his death Anthony was a inmate at Junee Correction Centre. More specifically C unit, C1 pod cell 3. The Junee Correctional Centre is privately owned and operated by the GEO Group Australia Pty Limited. As Anthony was in custody at the time of his death is a mandatory inquest pursuant to s 23 of the Coroner's Act 2009.

Anthony is survived by his mum Sharon, brother Jai and Reece and sister Shania. Ms Van Rysewick took the time on the final day of the inquest to tell me about Anthony the man and boy and left me with no doubt that he is must missed and very much loved despite difficult final years.

That saw him fall into the wrong crowd, make some wrong choices and wind up in and out of custody. Anthony was due for parole in October 2012 and indicated the will and hunger and to see this as his final stint in custody and was looking forward to a life reunited with his family. Quite simply his mum was looking forward to getting to know her son but never got the chance.

The uncontroversial facts surrounding Anthony's death can be summarised as follows. Anthony was born on 13 April 1983. At the time of his death was 28 years old and serving a sentence of nine years and ten months for robbery commencing on 11 July 2007 with a non parole period of six years and three months. He was classified as minimum security and had been housed at Junee Correctional Centre from June 2009. He participated in a methadone program and as a result had taken methadone on a daily basis between November 2008 and January 2010. However, at the time of his death was no longer on the methadone program.

Records and evidence indicate that Anthony was locked into his cell with his cell mate at approximately 5.45pm on 7 May 2011 by Correctional Service Officers Domski, Evers and Jenkins. At the time of his death he was sharing his cell with John Young who was the last person to see Anthony prior to his death. The post mortem report indicates that a puncture mark was present within the right antecubital fossa. That the post mortem blood samples detected morphine well within the range of concentrations reported for a fatal overdose of heroin.

Anthony was discovered unresponsive in his cell at approximately 6.35am during the head count led by officers Evers and Domski. The emergency response that was initiated was quick and every effort was made to provide medical assistance to Anthony which was unfortunately unsuccessful as he had already passed away. The matter was recognise as a death in custody and all necessary steps in relation to investigating Anthony's death were put in place.

The role of the Coroner is to seek to answer five questions, namely, who died, when they died, where they died and the manner and cause of their death. In the case of Anthony the date, time, place and specific cause of death are uncontroversial. The only real issue for this inquest to determine is in relation to the manner of Anthony's death and its surrounding circumstances.

Namely,

- How was Anthony able to obtain the drugs and the paraphernalia on 7 May 2011.

- How was Anthony able to be locked in his cell clearly under the influence of an illicit substance, in particular, what procedures are in place to assist the well being of inmates prior to lock in. I will deal with each of these issues in turn.

This inquest heard evidence from a number of persons who were inmates of Junee Correction Centre at the time of Anthony's death. In particular Glen Dunstall, Mitch Newman, Robbie O'Reilly and Dean Robertson.

Their evidence as whole was compelling and frighteningly frank. Namely that illicit drugs, including heroin, AKA gear (?), marihuana and illegally obtained prescription medication buprenorphine, AKA, "but" or "bup", was easily accessible to inmates.

Heroin became available after the weekend visits. Buprenorphine was sourced from the Correctional Centre pharmacy from inmates regurgitating their prescribed doses for use and consumption by others. Inmates would be stoned every weekend or every day or Sunday to Tuesday from drugs that were available weekly. Which included heroin, marihuana, speed and "but" was available every day. Moreover an emotional testimony Mr Dean Robertson consider in his three years at Junee he had taken heroin numerous times. Approximately once every three weeks.

The evidence establishes that Anthony had two separate shots of heroin between approximately 4 pm and lock in at 5.45pm on 7 May 2011. In relation to Anthony's fatal doses all inmates who were with Anthony prior to lock in conceded readily that he was stoned and clearly exhibiting the effects of heroin use. In that he was slurring his words, was unsteady on his feet and had pin eyes. Despite this the Corrective Service officers who attended to lock in the afternoon prior to Anthony's death notice nothing out the ordinary.

The officers Mr Kim Jenkins, Mr Joseph Domski, Mr Ken Evers, who I note had all exchanged statements prior to submitting their reports on the incident had concurred that there was nothing out of the ordinary that occurred during the lock in on 7 May 2011. That if an inmate exhibited signs of being intoxicated and was unsteady on their feet they would be taken immediately to medical for reanalysis. However I note all indicated during cross-examination by counsel assisting Mr Caseldon that none of them recognised the obvious signs of heroin intoxication, namely pin eyes. Had received little education in relation to detecting the signs of illicit drug use.

Interestingly despite concessions by Mr Domski that syringes were found at Junee, though he could not recall any numbers and rumours that heroin was coming into the correctional centre he did not recognise inmates under the influence of the drug and did not see it as a problem within the centre. Counsel for Corrective Services Mr Spartalis submitted that the accounts of the inmates not be preferred over that of the correctional officers.

That illicit substances were not an issue with Junee Correctional Centre particularly as there was a lack of drug related death at the correctional centre. The submission was, in my view, baseless. The evidence of all the inmates who gave evidence in relation to illicit drug use at Junee Correctional Centre at the time of Anthony's death was forthright, frank and honest. They simply had no conceivable reason to lie. For many of them it was against their self interest.

In contrast the evidence of the correctional officers was vague and lacking in detail. Furthermore their evidence had been exchanged between them at a point prior to this inquest. Accordingly I am satisfied that at the time of Anthony's death and the years proceeding it illicit substance, in particular heroin, were finding their way into Junee Correctional Centre on a regular basis. Possibly as often as weekly for use by inmates.

The preponderance of the evidence was that heroin and other illicit drugs was being smuggled into Junee Correctional Centre at the time of Anthony's death during the weekend visits at the visitor's centre. The evidence of Glen Dunstall was in my view particularly compelling in relation to what he observed to have occurred at the visitor centre on 7 May 2011.

He stated. "On Saturday 7 May 2011 I received a visit from my wife and kids in the C unit visits area. Whilst I was in the visit area I saw another male, a Lebanese bloke who was also having a visit with a woman. I don't know the inmates name but I do know that he lives in C1 area. She was wearing a singlet top and black tights. The top was quite revealing and the missus and I both spoke about how she had been able to get into the centre wearing such a top. She had black shoulder length hair and she had an ethnic appearance. During the visit I saw the woman remove a parcel about the size of a golf ball, maybe a bit bigger from her crotch and passed the item to the inmate. The inmate then put the parcel near his bum. At the time the inmate and his visitor were lying on the grass on the front gate side of the footpath. Just as the inmate had his hands in his pants Correction Officer Domski went over to him and told him and his missus to get off the grass. At the time I was sitting right next to the barbecue on the grassed area.

The inmate and his missus then sat at the table opposite us. I saw him sit on the edge of the seat and he kept fondling his crotch area. It look to me like he was positioning the parcel to push it up his bum." The evidence of Dunstall was, in my view, corroborated firstly by Officer Domski who was supervising the visits on 7 May 2011 who conceded recalling an inmate and a visitor lying down on the grass and being asked to get up and move over to the seats. Also by David Moore an inmate who also was in the visitor's centre that day who reluctantly gave evidence that he saw a Lebanese inmate and a woman near the barbecue area cuddling and kissing.

The procedure in relation to weekend visits at the time of Anthony's death can be summarised as follows. Visitors had to register their weekend visit by Wednesday prior to their attendance. Visitors were screened at the front officer where they had to put bags into a locker and were subject to a dress code. Upon entering into the correctional centre they may or may not have been screened by a drug dog depending on handler availability. They were then escorted by correctional officer through a fenced walkway to the visitors centre where they met with the inmate they were visiting.

The inmates, before entering the visitors centre to meet a visitor were strip searched, not cavity searched, by two correctional officers. Upon completion of the visit the inmates were again strip searched, not cavity searched, by two prison officers.

Two correctional officers supervised the visitors centre. One usually in the inside area, the other the outside area. The visitors centre comprises a large building or hall and an outdoor area. It was the same officers that conducted the strip search at the end of the visit that supervised the visitors centre. Accordingly at times when an inmate wanted to return to his pod the visitor centre would remain unsupervised for periods of up to five minutes.

Inmates wore usual uniform, namely tracksuit pants and tops during visits and this was the policy in minimum security. At the time of Anthony's death and this has since been rectified inmates had access to visitors centre again after their final strip search before being allowed back into their pod. There was not CCTV camera in and around the visitors centre. The dog squad did not patrol the visitors centre during or after the visiting period.

Mr J Bishop who investigated Anthony's death on behalf of Corrective Services made only two recommendations regarding visits protocol in his report dated 4 May 2013. Namely and I quote. "Whilst visit are being conducted within the correctional centre any inmate who attends the visiting area whether engaging in a visit or attending the area to supply lunch is search after leaving the visits area." The GEO management reinforced to staff to be vigilant whilst visits are being conducted."

However, he conceded during his evidence on May 2013 (1) that two correction officers supervising 30 to 40 visitors in the visitors centre was inadequate and that the area during visits period should be supervised by between ten and 15 officers. (2) the drug dogs, if available, would assist in the detection of drugs being smuggled into the centre. That an inmate should be subject to a cavity search if a drug dogs indicates that it is necessary prior to that inmate returning to their pod. (3) that at the time of Anthony's death there were not CCTV cameras installed in the visitor's centre and that cameras should be installed. Finally, that he had no idea whether or not recommendations 73 and 74 made in his report had be implemented by the GEO Group.

Mr Russell McAuliffe the intelligence manager at Junee Correctional Center gave evidence on the final day of the inquest. In essence Mr McAuliffe was and is the person responsible for the daily management of Junee Correctional Centre on behalf of the GEO Group.

His evidence was that at the time of Anthony's death (1) visits were supervised by two correctional officers so that when inmates were searched prior to returning to the pod there were times that the visitors centre was unsupervised. (2) there was no CCTV monitoring the visitors centre.

That if there was a dog handler rostered on a visits day, namely the weekend or Monday of a long weekend then the visitors would be screened by a drug dog after they entered the main gate and were x-rayed. (3) the drug dogs were not regularly deployed in the C unit visitors centre. (4) drug dogs were not used to search inmates prior to their returning from visits to their pods. Mr McAuliffe acknowledge during cross-examination that it was likely that the drugs responsible for Anthony's death entered Junee Correctional Centre from the visitor's centre on 7 May 2011. However, despite this, the only increase to security was the increase in the number of correctional officers in supervising visits from two to three.

No steps had been taken to install CCTV cameras or to regularly have the area searched randomly by the Dog Squad.

In relation to the syringe used by Anthony or paraphernalia used by inmates to administer heroin the evidence is less clear. The post mortem report revealed a puncture mark on Anthony's right antecubital fossa within the bend of his right elbow.

Furthermore it was evidence of Dean Roberson that the syringe used on 7 May 2011 to administer the heroin to Anthony, which he had also used, was a medical syringe that he had borrowed from another inmate whose name he could no longer recall. It was returned to that inmate once they had finished using it. The inquest heard other evidence that syringes were also constructed by inmates from various items including the hose of a spray bottle, diabetic tip and cotton ear buds as a plunger. Corrective Officer Domski had it in his evidence that syringes were found from time to time. As I am satisfied that heroin is finding its way into Junee Correctional Centre at the time of Anthony's death on a regular basis which follows that the means to inject the heroin was also available to inmates.

These were shared as inmates required. How was Anthony able to be locked into his cell clearly under the influence of illicit substances. The most mortem toxicology report together with the evidence of inmates who observed Anthony prior to lock in on 7 May 2011 make it abundantly clear the Anthony was well affected by heroin at lock in on 7 May 2011. That he was slurring his words, unsteady on his feet and had pin eyes. Despite this the corrective officer who attended the lock in, namely officer Domski, Evers and Jenkins all deny that they observed anything out of the ordinary when performing this task. None of the officer observed Anthony to be unsteady, slurring his word or having pin eyes.

Lock in occurred in C unit at about 5.45 each day. It was attended to by usually two or three officers. One officer would attend to calling out roll, identifying that correct inmate was going into the correct cell. The other officer would attend to locking inmates in their respective cells. They would start at one end of the pod and do each cell in order. Inmates were required to remove any items that obscured their faces, such as hats and sunglasses.

Somewhat surprisingly was the evidence of all these correction officers that they were unaware that pin eyes was a system or heroin use. They had receive no education about the signs or symptoms of drug use. This could explain how Anthony's drug use on after on 7 May 2011 remained undetected. However, I can't help that wonder that the cursory identification check undertaken by corrective officers at lock in to ensure identity and obvious sings of injury not whether or not an inmate is under the influence of stultifying substance.

The evidence in this inquest overwhelming leads me to the conclusion that inmates at Junee Correctional Centre are readily able to access illegal drugs. Many of those substances are entering the correctional centre through visits. The security in relation to the C unit visitor's centre at the time of Anthony's death was clearly inadequate. Unfortunately any improvements made to date have been nominal and the recommendations I have made have been designed to address this.

Formal Finding:

ACCORDINGLY I NOW TURN TO THE FINDINGS I AM REQUIRED TO MAKE PURSUANT TO S 81 OF THE CORONERS ACT. I FIND THAT ANTHONY VAN RYSEWYK DIED ON THE 8 MAY 2011 AT JUNEE CORRECTIONAL CENTRE AS A RESULT OF HEROIN TOXICITY.

For the reasons set out in these findings I make the following recommendations pursuant to s 82 of the Coroners Act 2009 to the GEO Group Australian Corrective Services New South Wales.

(1) They are to review and audit the current training received by correction officers for identifying the signs and symptom of intoxication of inmates, including intoxication caused by inmates engaging in illicit drug use.

(2) To consider increasing the number of drug detection dog units at Junee Correctional Centre to enable a more proactive approach to the screen of visitors attending the Junee Correctional Centre. To ensure that inmates leaving the C unit visits area are receiving a visit are screened and to enable regular patrols by the Drug Dog Detection Unit of the C unit visits area during and following visiting hours.

(3) To review the number and placement of CCTV cameras in the C unit visits area with the view to deterring the introduction of contraband into the centre and to decrease the detection of contraband passing between visitors and inmates.

8. 1187 of 2011

Inquest into the Death of Adam Le Marseny. Finding handed down by State Coroner Jerram at Glebe on the 14th February 2013.

This has been an inquest into the death of Adam Le Marseny, sometimes known as Adam Morrison, who was sadly aged only thirty-three at the time of his death. Adam had a long history of drug abuse and associated criminality. He was arrested by Detective Healy of Newtown Police in a Newtown street on 27 May 2011, about 1.50pm and taken to the Newtown Police Station where he was interviewed, an interview which we have all been able to watch with some horror on the CCTV which is taken mandatorily of any ERISP.

In that interview, which we all viewed, he was obviously affected by something. He said so himself and he was ultimately charged with fraud matters to do with credit card use after a considerable length of time.

After more time he was bail refused and finally when the entire process had been completed he was transferred to the Surry Hills Court cell Complex arriving there at about 11.20pm.

After being strip searched, apparently, as is the norm, he was placed into cell 1 for the night and within the next hour or two, two other prisoners were put in with him. He was known to be still alive after midnight when one of the Corrective Service officers had to move him in placing another prisoner into the cell with him. In the morning at 7.20am he was found deceased in his cell. That is the morning of 28 May.

A post-mortem was conducted here at Glebe by a very senior and experienced pathologist and the cause of death was undetermined.

There were no injuries found which could have contributed to his death and no medical signs of a cause such as an aneurism or a myocardial infarction. His toxicology, however, showed that he had a .6 amount of methadone in his system and varying amounts of various benzodiazepines including Alprazolam, Nordiazepam, Oxazepam, Temazapam and Diazepam.

The pathologist made it clear that because one never knows the entire history of a patient, or in this case of Adam, it is impossible to say what is necessarily a lethal as opposed to a toxic level, and what combination of which drugs may have led to his death. It was on that basis that Dr Szentamariay, who gave evidence to us here, felt it was better left undetermined.

On the other hand he made it fairly clear that the most likely, and he did not put it any higher than that, was a combination of the drugs, which he had taken. There was no alcohol in Adam's system and no Epilim, both of which are interesting, because he had informed both police officers and Corrective Service officers that he had been taking Epilim and that he had a considerable number of beers before his arrest.

The issues basically were these. Should he have been assessed medically by request of firstly the police officers at Newton, and secondly, and/or secondly, the Corrective Services officers at Surry Hills. What is the most likely cause of Adam's death and were there failures systemic or otherwise, which may have contributed to his dying.

Mr Boland for the family of Adam raised the question of whether Adam's detention was unlawful. Without pursuing the entire LEPRA legislation, with respect I have to say I do not believe that is the issue here, nor is the issue whether Adam was fit for interview. From our viewing of the television footage I personally would think that he was not. However, as s 81 requires me to go to the cause and manner of his death, in my view that is not the jurisdiction of this Court, nor in fact could that interview per se have led to his death.

The only thing further I would say about it is that I believe had Adam not died and had that interview been used in evidence against him in a criminal court, it almost certainly would not have been accepted.

Senior Constables McLean and Toovey were seriatim the custody managers at Newtown at the time that Adam was held at Newtown Police Centre. Senior Constable McLean was the custody manager on the first shift and handed over to Senior Constable or now Sergeant Toovey at approximately 6.30pm.

Those officers and others, I might say, did show concern for Adam. They certainly noticed that he was - as is metaphorically known - on the nod from time to time. In fact they asked him if he wanted help and he denied it. Senior Constable McLean told us that that is not uncommon with people who come into the police station while affected by drugs because if medical help is sought or an ambulance help, often they are given Narcan which counteracts the effect of the drug and they do not want it, or for many other reasons they do not want to be seen by a doctor or taken to a hospital.

I also heard from all the police officers, including Detective Healy who arrested Adam and interviewed him that it is not uncommon, sadly, for many in custody to show the signs, which we all saw in Adam. The custody assistant, Constable Williams, also showed concern for Adam and raised with him the question of whether he wanted an ambulance. He was in Newtown for a lengthy time. I accept that that was due to pressure of work but it was more time than is desirable, although again I cannot say that that contributed to how he came to die.

At the time at Newtown Adam showed two quite different conditions. At considerable times, and we saw it on the video, but also hear it from police, he was slurring or nodding off, almost going to sleep and then rousing himself, but at others, and I accept Constable McLean's evidence on that, he seemed to have improved and he ate a meal. In fact he ate again at the Sydney Police Centre. So he ate twice, but still at the police station, he ate a meal. He rolled a cigarette. He was walking around, as seen on the closed circuit TV, and he was talking at times quite clearly.

The Corrective Services officers who received him from the police could have sent him back if he had appeared to be intoxicated, and indeed I have to give them the benefit of that in that they may well have done had he been clearly affected at the time of reception. They all other than Corrective Services Officer Funaki to begin with at least, asserted that at reception at Surry Hills Adam was fine.

Unfortunately, the CCTV footage in cell 22, the strip search cell, by the time it was sought by investigating police had been over-recorded. It was unavailable, in other words. In the light of other similar episodes in other prison cells, that is of concern. I cannot just dismiss it as coincidence. In any case common sense should have prevailed in my view with senior Correctional Services officers, for example, Michelle Kentwell, that such footage would be important and should have been seized. I intend to say something about that in recommendations.

I mean of course that it should have been seized without waiting for it to be requisitioned by the investigating police. I do accept from Mr Damaso that he never received the email that was sent to him by one of those police because the address and name on it were incorrect. However, the evidence remains only that that footage in the strip search cell is not available.

The reason that it matters, apart from the fact that there have been other similar episodes in prison cells, is that it may have removed any question of lack of care on the part of Corrective Services officers which has inevitably arisen. I cannot quite accept that all the others other than Funaki considered him to have been well and fine in light of some of the observations of the police officers.

The question then is were his signs both at the police station and in the cells at Surry Hills of sufficient concern that either police at Newtown or the Surry Hills Correctional officers should have called for medical attention despite his denying the need. We heard from an expert medical specialist Dr Starke of the - she is an employee of police and director of the Medical Clinical Forensic Unit of New South Wales Police.

Her view was that Adam may have died, although she could not be certain, from withdrawals from alcohol. I find that difficult to accept given that there was absolutely no alcohol in his system and that no officer of either service reported his smelling of alcohol. He did tell the police and the Corrective Service officers that he had had a number of longneck beers, but as Dr Starke and other officers said, information from prisoners affected by substances of any kind should never be thoroughly relied on for obvious reasons, and I note, for example, his saying that he was on Epilim, but no Epilim showed in the toxicology post-mortem.

Dr Starke, and a very important useful report from Professor Olive Drummer, both agree on one thing, that death is known to occur sometimes during sleep in people who are on methadone. Today counsel assisting me provided a United Kingdom report on just that topic. It is of considerable interest to us all and highly pertinent. It does not suggest that such deaths are common, but it does give us evidence that it is a known phenomenon to experts and at the very least a possibility, which needs to be looked for.

The police officers did not know that and nor did Corrective Service officers, and I cannot blame them, because frankly I do not know that any of us did, nor did the police officers know that Dr Starke's unit is apparently available twenty-four hours a day for at least phone advice for medical and nursing type issues.

The question of desensitising of police, perhaps it applies to Corrective Services officers too, although I do not think it was put to them - was raised. I think that is a possibility and I do not say that as a criticism of officers at all. I think it is a sad comment on how much police and prison work involved is involved with the problems of drug abuse and persons in our society who have used drugs.

So that, for example, what the police at Newtown saw of Adam was not at all sadly unusual for them. The officer in charge, Detective Lister, was initially, although I do not think that was pursued, criticised by Adam's family. I have to say that I found no fault whatsoever in his actions, evidence and his hard work. I did not see the slightest evidence of any over familiarity between police and Corrective Services officers at Surry Hills, or in particular Detective Lister. I than them very much for doing a very good and difficult job. I know it is always difficult, detective, and in this case I think you did extremely well.

The police officers in my view were decent, hard working, concerned people, but they were not highly trained and they agreed with that themselves. I think Senior Constable McLean had had one day of training for custody management and Sergeant Toovey five days, possibly five days plus one, and even then no medical information as part of either of those courses. They had no information, as we now have, about the possible or the risks of death with people on methadone.

The length of the time it took to process Adam and get him to the police centre is of concern, but I just stress again I do not believe it had any effect on Adam's ultimate fate. The question of the equipment at the Surry Hills cells, again, that is probably not connected with Adam's death, but the logging of knock up calls, the retention of CCTV footage, appropriate requirements re apparent faults in the system, such as more watchmen and the placing of responsibility for all these matters, are missing in Corrective Services protocols in my view, and had they existed they may have removed the shadows of doubt which arose re some of the evidence of officers Barbisan, Villaruz and Puibello. I do not say the same of Officer Damaso, I found him to be a credible witness.

I do not suggest that any authority caused Adam any harm. The question really is whether there could have been done for him more and the answer without blame is yes. At least medical advice should have been sought, although I understand why it was not, it should have been, following his obviously affected initially condition.

The fact that the forensic unit is there needs to be promoted loudly and clearly. More training of those responsible for custody management in police stations is needed. We cannot say that if seen by a health professional or even if the officers had sought medical advice what may have been done differently for Adam. Even in a hospital he may not have been checked more constantly than he was or to the extent that his death was prevented, but it is a possibility.

In any case, it is possible he would not have been admitted to hospital. Nevertheless now that the possibility of death during sleep for those on methadone is known. All police officers need to have that knowledge and instructions as how to be more vigilant.

Formal Finding.

THAT ADAM LE MARSENY DIED AT THE SURRY HILLS CORRECTIVE COURT CELL COMPLEX AT THE SYDNEY POLICE CENTRE BETWEEN 1.00 AND 7.20AM ON 28 MAY 2011 IN HIS SLEEP, WHILE AFFECTED BY METHADONE AND MULTIPLE BENZODIAZOPINES, BEING ALPRAZOLAM, NORDIAZEPAM, OXAZEPAM, TEMAZEPAM AND DIAZEPAM.

Recommendations

THAT CORRECTIVE SERVICES CONSIDER REQUESTING JUSTICE HEALTH TO BEGIN A SIX MONTH TRIAL OF A FULL-TIME NURSING PRESENCE AT THE SURRY HILLS CELLS.

9. 1388 of 2011 s 75 NON PUBLICATION ORDER

Inquest into the death of XX. Finding handed down by Deputy State Coroner Forbes at Glebe on the 14th May 2013.

XX died at the Metropolitan Remand and Reception Centre, Silverwater, in New South Wales between 20 and 21 June 2011.

The Coroner's Act 2009 confers jurisdiction on Coroners to conduct inquests into deaths of prisoners who die in custody and those inquests are mandatory.

XX was born on 29 July 1970. He was the father of two children. He was on a Community Treatment Order with the Campbelltown Mental Health Team before going into custody. He went into custody on 7 November 2010 when he was refused bail for stealing offences and an indecent assault offence. He was held on remand at the MRRC Mental Health Unit in the Hamden Wing. His Community Treatment Order continued and he received anti psychotic medication from Justice Health in that wing.

On 5 May 2011 he was sentenced for both of the matters he had been refused bail and his earliest release date was 8 June 2011 about one month after the sentence date.

He had been classified by Corrective Services as suitable for transfer to a minimum security however Justice Health did not give a clearance for the transfer as his Community Treatment Order was still in place and he needed to be given the medication.

On 8 June when he was eligible for parole his parole was not granted because there was no suitable accommodation available for him. His uncle gave evidence in this inquest that he had spoken to XX about the accommodation problem and that XX was not particularly concerned about not making his parole on the first occasion.

On 20 June, XX requested that the Correctional Officer Boura to move him from the cell that he was in, as he was not getting on with the other inmate. Correctional Officer Boura had known XX for many years and gave evidence that this was the first time he had had a request like this from XX and he organised the change of cell. XX was moved into cell 508. On 20 June, later that day at 5.45, XX was handed his anti psychotic medication by Registered Nurse Regao. The cell was then locked for the evening.

At 6am the next morning when the cell was opened, XX was found hanging from a sprinkler attached to the ceiling of his cell 508. The window in the cell door had been covered from the inside and there was paper placed over the cell call system.

The investigation that ensued included viewing the CCTV footage and it was determined that no other persons were involved or present.

The review of Justice Health Records and the evidence from XX's uncle indicated that XX was doing well.

The response by Corrective Services has not been an issue in this inquest.

The response upon the finding of his body.

The wing where XX was being held is a step down mental health wing. M Block at the MRRC is the mental health screening block. It has 50 beds.

This was built subsequent to the Hamden wing and it has no sprinkler heads. This is the block where XX was initially held and I there have been no suicides in that block.

H Block is the step down for the mental health unit. It has 120 beds and it forms part of the original MRRC. It has a sprinkler fire rose in each cell. The Superintendent of the Custodial Corrections Division gave a statement in this inquest that the Corrective Services New South Wales has established a management of deaths in custody committee and that this committee is responsible for centralising the consideration, management and reporting of inmate death in custody for Corrective Services.

He informed the Court that the committee is currently undertaking a major multi staged project towards the removal of obvious hanging points in step down cells in Correctional centres. He said that the MRRC is one of the four locations identified as a priority for capital works. He says that the feasibility study for removal of fire rose sprinklers had indicated that it was not feasible. Subsequent to him giving his evidence I have received a document which has now become Exhibit 5 and that document sets out the Correctional Services multi stage project program and that document indicates that there are 148 cells in the four Hamden pods in the MRRC and the estimate of undertaking work of removal of the sprinklers would be in the vicinity of $317,143.

I am told why there could be some economies of scale, the work required would involve taking four Hamden pods back to a local alarm post and linking each pod back to the main gate fire panel.

I am told that Corrective Services has initiated a fully scoped project estimate as to the steps that would be involved and the cost of removing protruding sprinkler heads in the Hamden block and that the process is currently in the investigation phase.

I am further told that Corrective Services continue to manage the risk of self harm by inmates by putting in place across the State an appropriate risk management system to ensure that inmates at more acute risk of suicide are managed in environments where hanging points have been eliminated. In relation to the other Correctional Centres, I note that Exhibit 5 sets out a table where the sprinklers are and I note that that table is slightly lacking in detail in a sense that the middle column where it says "location cells with sprinklers," that was when the building was built and as you can read when one looks at the asterisk in relation to the inclusions in that middle column it explains what the current situation is.

I accept that Corrective Services are attempting to eliminate hanging points from cells, particularly in cells where inmates maybe more vulnerable in terms of their mental health.

I note that over the years there have been many recommendations made by Coroners and by the Royal Commission that relate to the elimination of hanging points and I note that the combination at this point of the works that are taking place and due to take place in eliminating the hanging points together with the policy of managing the risk of self harm, that the ideal situation will eventually be reached where there will be no persons who have mental health issues who are being held in cells with these sprinklers.

In the meantime I do not propose to make any recommendations because I note the works that are taking place and I accept those submissions that have been put before me and mark that document Exhibit 5.

Formal Finding

THAT XX DIED BETWEEN 20 AND 21 JUNE 2011 AT THE METROPOLITAN REMAND AND RECEPTION CENTRE, SILVERWATER. THE CAUSE OF HIS DEATH WAS HANGING AND THE MANNER OF HIS DEATH WAS SUICIDE.

10. 1905 of 2011 s 75 Non Publication Order

Inquest in to the death of XX on the 16th May 2013. Finding handed down by Deputy State Coroner Dillon at Wagga Wagga.

XX died after shooting himself in the back of a police truck at the Wagga Wagga Police Station with a gun he had managed to conceal on his person shortly before he was arrested. He had not been searched before being placed in the rear of the van.

Under the *Coroner's Act 2009*, an inquest is mandatory when a death occurs as a result of, or in the course of, a police operation.

In a society in which the rule of law prevails, a police force is not a law unto itself. It is accountable to the society it serves to protect. It has been observed that:

> *"The purposes of a s.23 Inquest are to fully examine the circumstances of any death in which Police …… have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."*

This inquest, therefore, is not a quasi-criminal trial of either XX or the involved officers but an inquiry into the manner in which the police operation was conducted. NSW Police Force policies, procedures and training are intended to minimise the risk of harm to arrested persons and police officers, even in dangerous circumstances. The police officers involved in this incident acted with no malice towards XX.

The arrest was a difficult one not only because he attempted to escape from the police and resisted arrest when caught but because he was a large, determined and powerful man.

Nevertheless, the ultimate questions are whether this operation could or should have been differently and better managed and whether XX's death could have been averted. For reasons that I will develop, I have concluded that it is likely that, had he been searched before being placed in the back of the truck, XX's death would probably have been prevented.

Before considering these issues, however, it is important to focus on XX himself. He was a 37-year-old man who was well known in Wagga Wagga as a martial artist, a physical trainer and a rugby league identity.

His death has caused great pain to his mother and his family and friends. It has also affected the police officers, especially those immediately involved in his arrest, and those who saw him put his own gun to his head in the back of the police truck.

XX had a history of mental illness and had been diagnosed with bipolar disorder. He also had an extensive criminal history.

This began in 1993 and included convictions for assaulting and resisting police, driving offences, detaining a person for advantage, possession of a prohibited weapon, stalking and intimidation. In 2004 he was sentenced to two years and seven months in prison. In 2011 he received a 12-month suspended sentence for driving whilst disqualified.

At the time of his arrest, the police computer system ("COPS") held several warnings in relation to him. First, it warned that he may resist police; second, that caution should be taken when dealing with him as he was highly trained in martial arts and had previously stated he would not return to jail; third, that he should be approached with caution because he may be in possession of a sawn-off shotgun, pistol or knives. The last warning also cautioned that he might carry items on his person or have them in his vehicle. Finally, the system contained a warning that he may be in possession of a stun-gun disguised as a mobile phone. The system also held 43 intelligence reports relating to him including reports suggesting that he may have been involved in the supply of prohibited drugs, consorted with criminals and possessed weapons.

He had been treated by a psychiatrist and was prescribed medication for depression and substance abuse. There is some evidence that he suffered from suicidal ideation. Unfortunately, it appears that, at the time of his death, he had also stopped taking his medication.

These facts do not, however, sum him up. Despite his troubled life and his mental condition, he was a colourful character, much loved by his family and friends. Those who knew him best had great affection for him.

This was evidenced at the inquest held at the Wagga Wagga Courthouse by the attendance of many of his relatives and friends.

Summary of facts

XX was involved in an on-and-off relationship with Ms M. She was much younger than he was. The relationship was volatile and, on his part, was at times violent. It has been suggested that the violence may not have been always one way but certainly it appears that he was principally responsible for whatever physical aggression there was in the relationship.

Ms M lived in Sydney. In August 2011 XX was living in Wagga Wagga with his parents. Ms M came down to Wagga Wagga to see him and to attend a "hen's night". They booked into the Townhouse International Motel on 13 August 2011.

During the afternoon they parted in different directions. He met friends at the Victoria Hotel including his cousin and a friend. Ms M stayed at the motel preparing to go out with friends and later that afternoon attended the hen's night for a few hours.

After leaving the hen's night, she became agitated when she rang XX's phone and discovered that he was apparently out drinking with KM. On returning to the motel, she went through XX's possessions. In them Ms M found a USB stick of his that apparently had a number of photographs of women on it. Hidden in a black beanie belonging to XX she also found a small revolver and a number of bullets.

Ms M was outraged by finding the pictures of women. She concluded that XX was being unfaithful to her and sent a number of text messages to him and Mr C. The text messages to Mr C included the following: " Well you better tell him his precious gun went walkabouts" and " You better tell him I just found pics of girls on his USB I know everything and I'm calling cops to hotel to pick up gun" and "Not kidding he's fucked I had enough". She also telephoned Mr C and told him that she had had enough of XX.

Mr C alerted XX to the text messages and the telephone call. XX then stormed out of the hotel and back to the Townhouse Motel. Mr C followed. When XX left, Ms M telephoned DP who came straight down to the Victoria Hotel with XX's stepfather. They then drove to the Townhouse motel.

By this time XX had reached the motel. The receptionist and two guests saw him assault and verbally abuse Ms M. The staff member unsuccessfully attempted to intervene before calling the police.

At 8.11 pm, Senior Constable Parsons and Probationary Constable Swarbrick attended the motel in response to a radio call alleging that a domestic assault had taken place there. At the motel the police began preliminary enquiries including speaking to XX. They then arrested XX.

He attempted to flee from the scene. As he did so he crashed into a glass window, was then chased by police and eventually caught, wrestled to the ground by two officers, handcuffed and placed into the rear of a caged police truck.

XX was a very large man. He was heavily built, weighed approximately 123 kg, and was 189 cm tall. The police officers found him very difficult to restrain and subdue. They were unable to handcuff his hands behind him due to his strength. During the struggle to restrain him both police officers had had contact with various parts of his body. He was wearing a tight grey top and loose jeans. Before putting him on the truck, the officers did not conduct any frisk search. They later gave evidence that, because they had been in close physical contact with him during the struggle and had not felt the gun on his person, they did not think it necessary to further search him at the scene.

During the course of the evidence one of the officers said that they had had such a great deal of difficulty in getting him under control that they had decided simply to put him in the back of the truck and to conduct a proper search back at the police station. It was only about three minutes drive away. XX was left under guard in the truck with another police officer, Probationary Constable Earl.

The police officers did not know, and were not told by anyone at the scene, that on his person XX may have secreted the small pistol that Ms M had seen in the motel room. During the arrest of XX, Ms M was unco-operative with police. She refused to give details of what had happened to cause the "000" call to be made by motel staff.

Shortly afterwards, DP, Mr M, KM and MC turned up at the motel. Ms XX was very upset and demanded to see her son. She told one of the police officers that he had "problems." While the police were there,

Ms M demanded to see and speak with Mrs P. Initially Mrs P was dismissive of Ms M but she ultimately agreed to speak to her away from the presence of the police.

Ms M's evidence was that she had then told Mrs P that XX had a gun somewhere in the motel room. In her evidence Mrs P denied this. It is common ground, however, that NM, Mrs P and KM went back to the motel room together shortly afterwards and that Mrs P and Ms M refused to allow police entry into the room while they were in there.

Mrs Ps evidence is that all she did in the motel room was to pack up her son's belongings. She said that she had intended to do this because she knew that he would be taken to the police station and that she would not be allowed to see him for some little time. She said that this had taken only a few minutes.

Ms M's version is that the three women searched the whole of the motel room including under the toilet seats for the pistol. They were unable to find it or the ammunition.

It is also common ground that none of them gave any warning to the police that XX may be armed with a gun or indeed any other weapon. I will discuss this issue further below.

XX, therefore, was sitting handcuffed in the back of the police truck with a gun somewhere on his person.

He was driven back to the Wagga Wagga police station where the truck drove into the dock. The two officers on board the truck then secured the vehicle and their firearms inside the police station. They returned to open the pod of the police truck and to get XX out. When they opened a side door of the pod, XX refused to get out. An argument ensued and Constable Astrup went to the other pod door and opened it. As this occurred XX then produced the pistol from somewhere in his clothing, placed the barrel of the gun under his jaw and fired a single round into his own head.

The police immediately initiated first aid and called an ambulance. XX was transported urgently to the Wagga Wagga Base Hospital where it was found that he had suffered significant brain damage. He was placed on life support. It became clear at the hospital, however, that the brain damage was fatal and the life support system was turned off.

The Coroner’s statutory role

The Coroners Act requires me, if possible, to identify the person whose death is the subject of the inquest, the date and place of death and the cause of death. None of these matters are controversial. I am also required to determine if possible what the Act describes as “the manner of death”.

The focus of this inquest has been on the circumstances of XX’s death and, in particular, on the actions of police officers who arrested him.

A coroner may also make recommendations relating to a death if it appears necessary or desirable to do so. I propose to make a number of recommendations at the conclusion of these findings.

The issues

As Counsel Assisting explained in his opening address, XX's death raised a number of issues:

- What were the standard or appropriate procedures for arresting and searching XX?
- Were those procedures followed and, if not, why not?
- Was the fact that XX possessed or had access to a gun known to anyone at the time of his arrest?
- Was this information made known to police or did police have independent sources of such information available (eg, previous COPS events, gun registration details, Crimestoppers reports, witness accounts, etc) prior to his arrest?
- Did XX have a history of self-harm?
- If so, was information about this known to police or available to police in the COPS system or were they given this information by other means prior to his arrest?
- Did the arresting police suspect or ought they reasonably to have suspected that XX was at risk of self-harm when he was arrested? If so, what precautions ought they have taken to prevent it?
- As a result of this incident, have any changes been made to police procedures or training in the Local Area Command, the Regional Command or the NSW Police Force?

In a nutshell, the weightiest and most difficult issue explored during the inquest was whether, despite the evident difficulties the police had in controlling XX, they ought to have searched him before placing him in the back of the police truck to ensure that he had no weapons or implements on him that could be used to harm police officers or himself. This raised questions both of law and police policy.

The second cluster of issues can be distilled to the question of whether the police at the scene ought to have done more to familiarise themselves with the warnings concerning XX before driving him the short distance to the police station.

The third question is whether his death may have been averted if the police had been given information by those who knew XX that he may have an illegal gun.

I will deal with the last two issues first as they are relatively quickly resolved.

Should the police have checked the warnings on the COPS system?

In an ideal world, it is arguable that the police should have been able to confirm the identity of XX on arrival at the motel and then to check any warnings the COPS system held in relation to him.

Reality, however, is rarely ideal. In this case, the police officers responded to a direction from the police radio operator to attend what appeared to be a relatively typical, if unpleasant and difficult, domestic violence incident. It must have appeared to these General Duties officers to be the sort of event that constitutes much of their day-to-day work.

Before their arrival, the police did not know XX's true identity. He had used a false name at the motel. It is true that one of the officers who attended the scene recognised him but there was nothing to indicate to the officers that XX was contemplating suicide or was armed with a gun. Nothing that the police officers found at the scene gave rise to such a suspicion. The impetuosity of his actions at the motel in running away, and at the police station in shooting himself, suggests that he was not, in fact, thinking of suicide at the time of his arrest.

If he was contemplating self-harm, even those who knew him best – Ms M and Mrs P certainly saw no signs of this. He gave no hint or sign of suicidal ideation at the motel. It follows that, even if the police had been fully informed about his mental illness and other issues when they arrived at the motel, they had no basis on which to treat him as a person who was at genuine risk of self-harm.

Moreover, given that the police station was only three minutes away, it was reasonable for the officers to think that they could gather any relevant information about him once they had returned to the station and handed him over to the custody manager. One of a custody manager's duties is to explore issues such as a prisoner's potential for self-harm.

It was also reasonable for them to think that any "issues" or "problems" XX had could be better managed at the police station, with reinforcements available if necessary, than in the foyer of the motel.

And, finally, given XX's behaviour, and the emotional reactions of his family and friends at the motel, as well as their lack of co-operation with the police, it was reasonable for the police officers to take urgent action to remove him from the motel to minimise the chances of any further breaches of the peace there.

In my opinion, there is no material causal connection between XX's suicide and any omission by the arresting police officers to make a full check of COPS warnings and other intelligence about him.

XX's Gun

The officers at the scene were at all times unaware that XX had a gun. They received no warning from anyone that he may have one on his person.

At the hotel, Ms M spoke with XX. Ms M insisted that this conversation take place out of earshot of the police. Following that conversation, Ms M, Mrs P and Ms M immediately went to the room shared by Ms M and XX. When police requested entry, they refused to allow the police in. Ms M's evidence is that the three women searched the room for the gun and ammunition she had earlier seen in the black beanie. Mrs P and Ms M disputed this.

NM knew he had a gun somewhere and, despite their denials, the irresistible inference from their behaviour at the motel is that Mrs P and Ms M were informed by Ms M that he had one in his room. Their conduct was much more consistent with an attempt to find the gun and ammunition and hide it from the police than with versions of events that they gave at the inquest. When questioned about these issues at the inquest, their evidence was, in my opinion, evasive, inconsistent and unreliable.

It is highly likely that Mrs P, Ms M and Ms M were all aware that if XX's gun was found that he would go back to gaol to serve out his suspended sentence and what would probably be a significant additional sentence for firearms offences. They probably did not suspect that XX in fact had the gun hidden on his person. They certainly did not suspect that shortly afterwards he would use it to take his own life. In my opinion, their only concern at that time was to prevent XX from being incarcerated for a lengthy period. Even the outraged Ms M did not wish this on XX.

This does not make the three women responsible for XX's death. They did not know what he had done with the gun and could not have foreseen what he would later do with it at the police station.

Nevertheless, had one of XX's supporters revealed to police that he had a gun hidden somewhere this incident probably would have played out very differently.

He may have been searched by police and had the gun removed. On the other hand, when challenged about the gun, he may have pulled it out and used it on himself or on the police or NM or some other innocent person. He may have been shot by the police. Exactly what course it would have taken is impossible to say. The odds are, however, that he would have been kept safe and disarmed.

Should the police have searched XX at the motel?

When this issue was discussed during final submissions at the inquest, the proposition that the police ought to have searched XX before he was placed into the back of the police truck was strongly opposed by counsel for the Commissioner of Police and the involved officers.

Also during the course of closing addresses, and flowing from the facts of this case, a number of possible recommendations to the Commissioner of Police were canvassed by Counsel Assisting and myself. This led to an exchange of views concerning the law of arrest and search and its application to XX's case.

One suggested amendment to police procedure was to the effect that the NSW Police Force ought consider adopting a policy when persons are taken into police custody that the default procedure is that they be searched pursuant to the discretionary power under s.24 of the LEPR Act. To be clear, it was *not* suggested that the LEPR Act be amended or that police discretion to search be removed.

I heard lengthy oral submissions, which were followed by written submissions, from counsel for the Commissioner of Police. In the course of his oral submissions, Mr Saidi argued, among other things, that the arresting officers had not been lawfully empowered to frisk search XX after they had detained him at the motel. His argument, in essence, was that, in the circumstances that obtained at the motel, any body search by the arresting officers at the motel would have been unlawful.

He also argued that it was not open to police officers other than the arresting officers to conduct a search of XX at the motel.

Section 23(1) of the LEPR Act empowers a police officer who has arrested a person for an offence or under warrant, or an officer present at the arrest, to search that person "if the officer suspects on reasonable grounds that ***it is prudent to do*** so in order ***to ascertain whether*** the person is carrying anything" which, among other things, could be dangerous to any person including him- or herself.

Section 23(2) applies in a situation where a person is arrested for the purpose of taking person into custody. It also provides for a discretionary power, enabling an arresting officer, or another officer present at the arrest, to search the arrested person if the officers have reasonable grounds to suspect that is prudent to do so to ascertain whether the person is carrying anything that could be dangerous to a person (including him - or herself) or could be used to assist in escaping lawful custody.

In each case, the test is objective and relates not to the question whether the officer has reasonable cause to suspect that the arrested person is *carrying* something dangerous but to the *prudence* of the search to ascertain whether or not this is so. The search power is discretionary.

Mr Saidi's argument in oral submissions was that the police had had no information and no reason to suspect that XX may have been armed and that therefore none of the grounds giving rise to a discretion to search under s.23 of the *Law Enforcement (Powers and Responsibilities) Act 2002* were available to the arresting police officers or other police at the motel.

If this was what Mr Saidi intended to submit, the argument overstates the restriction on police and raises the threshold for a search too high. It implies that police officers arresting a large, agitated, violent man in a public place, a man who has caused such a disturbance in a motel that staff had called the police to deal with him, a man who had resisted arrest and attempted to escape, would have been acting unlawfully in searching that person before placing him in a police truck unless they had reasonable cause to suspect he had something dangerous on him.

If that argument is correct, I suspect that police officers all over NSW are, inadvertently and in good faith, daily breaching the LEPR Act. If so, the Act may need urgent amendment or an authoritative statement of statutory interpretation from a superior court. In my view, however, the argument is incorrect. It is true that the arresting police did not have any information or grounds to suspect that XX was armed. But that is not the issue. The question is whether they had reasonable grounds to suspect that it would be prudent to search him.

Before I explain why, in my opinion, Mr Saidi's ultimate submission opposing the suggested recommendation is incorrect, it is important to lay out his argument more fully.

Because of his experience in other jurisdictions where he has appeared for the Commissioner in civil cases concerning claims of unlawful arrest, trespass to the person and false imprisonment.

Mr Saidi was understandably concerned not to accept a proposed recommendation that he thought may expose the Commissioner to future civil proceedings if adopted.

One of the points of discussion was whether, if Mr Saidi's submissions concerning s 23 were correct, s 24 of the LEPRA Act would have applied, enabling the arresting officers or officers at the motel to search XX.

In both his oral and written submissions, Mr Saidi argued that s 24 could not be used to skirt around the restrictions placed on the search powers of arresting officers. He argued that s 24 is a general provision whereas s23 is a specific provision and that therefore, according to standard canons of statutory construction, s 24 cannot override s 23.

While, of course, I accept the maxim that, where there is an apparent inconsistency between two statutory provisions, a general provision gives way to a specific provision, this argument, with respect, is irrelevant: ss 23 and 24 are not inconsistent. Both are specific provisions -- they address different situations.

Furthermore, s 23 (4) specifically provides that nothing in s 23 limits s 24. That is, s 24 is not to be read down to conform to the test in s 23.

The purposes of the two sections are distinct. The first grants a power of search to *arresting officers* provided a test is met.

The second empowers any police officer (including, in my view, officers who have effected an arrest and taken a person into custody but also others, such as custody managers at police stations) to search a person who is (lawfully) in police custody. The two sections are intended and designed to meet different situations although, obviously, arrest may be very shortly followed by the arrested person being taken into custody.

Mr Saidi argues that "the mere act of arrest leads to a person being detained in lawful custody" and then goes onto argue that if s 24 applied, ss 23 and 23A would have no work to do.

This, it seems to me, is where the fundamental flaws in Mr Saidi's argument emerge because he effectively conflates the concepts of arrest and lawful custody; secondly, he appears to me to have interpreted the test in s 23 too narrowly; and, thirdly, he also appears to have read into s24 limits on the application of the powers available to police officers which the statute itself does not impose.

It may be that the NSW Police Force interprets s 24 as having application only once a person is in custody at a police station or some other place with a custody manager. That may even have been what the legislature was intending to achieve. Those, however, are not the terms of the provision itself.

A person is arrested by a police officer when that officer stops and holds him or her with a view to detaining him or her.

Under the common law, it is necessary for the officer to touch or hold the arrested person unless he or she immediately submits. Words, without physical restraint, may, in some circumstances suffice.[4]

In short, arrest is the stopping and apprehension of a person suspected of committing an offence.

Halsbury's Laws of Australia defines "arrest" as follows:

> 'Arrest' has been given a broad definition at common law, and this definition has, in large part, survived in Australian law without substantial statutory modification. Arrest need not require any physical force, provided there is acceptance of the situation by the person arrested. The concept of arrest may cover both the stages leading to action not involving physical restraint, provided there is submission, including in particular interrogation of a suspect, and it covers actual physical restraint, which need not involve physical force. There will not be an arrest if the subject believes he or she must merely accompany the officer. The arrest may lead to detention or custody, in relation to which further rights inhere in the detained person.[5]

A lawfully arrested person is sometimes not taken into custody. It is quite common for arrests to be discontinued.

For example, a person who is lawfully arrested may be released having been cautioned; a suspect may provide the arresting officer with an explanation that extinguishes the officer's reasonable suspicions; or the officer may decide that the matter can be dealt with by way of an on-the-spot fine or the issuing of a Field Court Attendance Notice: see s 105 LEPR Act.

Police custody is a different, though allied, concept. It is "the *keeping*, by police, of a person under lawful restraint *following* arrest and before the person is granted police bail or appears before a court."[6]

A police officer takes someone into custody by exercising physical control and restraint of that person *and maintaining it*. This may mean handcuffing the person, it may mean consigning the person to a cell, it may mean placing him or her in the back of a police van. Provided that the police have lawful grounds to arrest, custody will generally be lawful.

It follows that XX, who had been held, handcuffed and restrained, was *ipso facto* in custody.

---

[4] See, for example, *Lewis v Norman* [1982] 2 NSWLR 649 at 655 per Enderby J.

[5] [80-1020] online edition http://www.lexisnexis.com/au/legal/auth/checkbrowser.do?rand=0.7716673357359612&cookieState=0&ipcounter=1#80-1020.2 visited 03 April 2013.

[6] *Encyclopaedic Australian Legal Dictionary* online edition: http://www.lexisnexis.com/au/legal/results/enhdocview.do?docLinkInd=true&ersKey=23_T17066850297&format=GNBFULL&startDocNo=0&resultsUrlKey=0_T17066853013&backKey=20_T17066853014&csi=267785&docNo=5&scrollToPosition=200 visited 03 April 2013.

Mr Saidi agreed that once a person was arrested and handcuffed he or she was "in custody" but nevertheless maintained the view that the test in s 23 applied at the motel and that s 24 had no application there.

If a person is taken into lawful custody, a police officer may search him or her: s 24 LEPR Act. Once an arrested person is taken into custody – and this may happen within a very short time – s 24 does not require that a police officer have reasonable grounds to suspect that it may be prudent to search the person. A search may be conducted without reference to such a test. Any such search, however, must comply with the requirements of Division 4 of Part 4, and Part 15 of the Act (which deal with the type of search, the manner of the search, the places searches may take place, safeguards for privacy during searches, identification of the reasons for the search and of the officer who is to conduct it, and other such matters).

And, of course, the *purposes* of any such search must be lawful: see s 30(1). Although the Act does not define all the lawful purposes of a proper search, the test in s 23 provides some guidance. Lawful purposes include searching for items that may harm a person; that may aid escape from lawful custody; or that may have been used in or be evidence of the commission of an offence or intention to commit an offence or be ill-gotten gains resulting from the commission of an offence.

In the course of submissions, I have been referred to a decision of Toner DCJ in which, in a judgment delivered, I assume, ex tempore in the middle of a busy list, His Honour considered s 24.[7] This was a judgment in an appeal from the Local Court.

Relying on the decision of the Full Court of the Supreme Court of NSW in *Clarke v Bailey*[8], he stated that, in his view, it was necessary at common law for a police officer holding a person in custody to justify a search.

He went on to say, without further reference to authority, "It seems to me… there remains a requirement that police have to have at least a reasonable suspicion before they are entitled to exercise that power. It is not and cannot be unfettered." (at [94]).

His Honour (at [99]) went on to pose the question, "Can such a common law restriction be placed upon the statutory capacity of police to search vested pursuant to s 24 of the [LEPR] Act?" and to decide that it could. He did so by relying on a decision of the Court of Appeal relating to powers of arrest without warrant under s 352 and 353A of the Crimes Act 1900.[9] He did not refer to principles of statutory interpretation.

I am not bound by decisions of District Court judges and, in any event, with the greatest of respect to His Honour, I do not regard this judgment as pertinent to the issues at hand. Even if it was relevant, I am not persuaded by His Honour's reasoning that common law interpolations ought be read into the construction of s 24, or that he has correctly interpreted *Clarke v Bailey.*

[7] *R v Janel Anne Boekeman* [2011] NSWDC 126.
[8] [1933] 33 SR (NSW) 303 at 310.
[9] *Clarke v Bailey*[1933] SR Vol 33 303

His Honour is correct in stating the power under s 24 is not unfettered. As I have stated above, the purposes of a search conducted under s 24 must be lawful. Conducting a search for an unlawful purpose, for example, to humiliate a person or to indecently or sexually assault him or her would never be authorised by s 24. It does not follow from this, however, that the Parliament intended to place further limitations on police powers under s 24. It is here that I part ways with His Honour.

The LEPR Act is a code. In his Second Reading Speech introducing the LEPR Bill, the Attorney-General, the Hon Bob Debus, stated[10]:

> This bill constitutes significant law reform. It radically simplifies the law in relation to law enforcement powers, setting out in one document the most commonly used criminal law enforcement powers and their safeguards. Previously complex and diverse law enforcement powers and responsibilities once buried in numerous statutes and casebooks have been consolidated into the bill so that the law is now easily accessible to all members of the community.
>
> Matters included in the bill represent a *codification of the common law*, a consolidation of existing statute law, a clarification of police powers, or a combination of these. (Emphasis added).

By enacting a code, the legislature seeks to consolidate and clarify the law on a given topic so as to make it a complete and unambiguous statement of the law. Orthodox canons of statutory interpretation require that the code be construed in its own terms, not by reference to previous law.[11] As Professors Pearce and Geddes have put it, "… an ambiguity in the code will justify resort to the common law…

[b]ut the ambiguity must appear from the provisions of the code; it is not permissible to resort to antecedent common law in order to create an ambiguity: *Mellifont v Attorney-General (Qld)* (1991) 173 CLR 289 at 309."[12]

Section 24 of the LEPR Act does not appear to be ambiguous in its terms. If there is no ambiguity, it is impermissible, under standard rules of statutory interpretation, to read a common law gloss of the type referred to by Toner DCJ into it.

In the absence of clear expression or necessary implication, legislation will be presumed not to abrogate fundamental common law rights. Section 9 of the Act emphasises this point and also that the common law functions, obligations and liabilities of constables are not abrogated or restricted except by clear expression or necessary implication. Section 24 neither abrogates common law rights nor derogates from the functions, obligations and liabilities of police officers as constables. Indeed, new protections for citizens are provided for in Division 4 of Part 4, ss 29-34 and Part 15 of the Act.

---

[10] Hansard, NSW Legislative Assembly 17 September 2002 p.4846

[11] See Pearce & Geddes *Statutory Interpretation in Australia 6th ed*Sydney, 2006 pp 272ff; *Brennan v The King* (1936) 55 CLR 253 per Dixon and Evatt JJ.

[12] *Statutory Interpretation* (2006) p.275.

In my opinion, the officers who were present at the arrest of XX had reasonable grounds to suspect that it would have been prudent to search him. The reports of a serious disturbance at the motel involving violence or potential violence towards Ms M gave rise to reasonable grounds to suspect that he had committed an offence against her or some other person in the motel. I have no doubt that his arrest was lawful.

The same reports and behaviours could reasonably have suggested to an arresting officer that XX may have something on his person that he could use to harm himself or others, or which related to the suspected offence(s) and that it would therefore be prudent to search him. His behaviour in the presence of the police, especially his agitation, his lack of co-operation with police, his resistance of arrest, his violence during the struggle to restrain him as well as his attempted escape, together constituted more than sufficient grounds for one of the arresting officers to form the view that a search would be prudent.

Once he was caught, restrained and handcuffed, XX, in my view, was in lawful custody. To reiterate, a person does not have to be taken to a *place* of custody, such as a police station, to be held in custody – the criterion is whether the person is physically controlled, restrained and that restraint is maintained, the person thereby being lawfully deprived of his or her liberty. Whenever and wherever that occurs, s 24 of the Act would seem to empower a police officer to search the person in custody.

If my interpretation of s 24 is incorrect, the foregoing discussion may have revealed a latent ambiguity in the interpretation of s 24 and how it is intended to work with s 23. Does a reading of other provisions in the LEPR Act imply that "lawful custody" under s 24 should be read down as reference to a police station or any other *place of custody?*

(See, for example, s 23(2), which talks of an arrest for the purpose of taking a person into lawful custody, but which is itself constrained by the reasonable grounds test; and provisions relating to a custody manager's powers: s122; or medical examination of persons in custody: s 138.)

If so, in my view, the Act should be amended to define explicitly the meaning of "lawful custody" as it is intended to apply under its provisions.

Search at the motel? Conclusions

I understand that it is usual NSW police practice for arrested persons taken into custody to be searched before they are placed in a police vehicle. XX's case makes it obvious why this is both usual practice and best practice.

In June 2008, I conducted another inquest into a similar death in custody. A mentally ill man was arrested and placed in the back of a caged police truck. He was not searched. In the back of the truck, he mortally wounded himself with a knife he had concealed on his person.[13]

[13] *Inquest into the death of Steven Caton* 19 June 2008.

In both these cases, the officers took the view that it was best to get the arrested man away from the scene of the disturbance to the police station where they expected it would be easier to deal with him and where they would have more assistance if they needed it. That point of view is understandable but does not address the problem that this case exposes.

Both cases, however, could have resulted in the deaths of police officers as well as of the man who took his own life. In my view, expediency or convenience should never trump the safety of prisoners to whom the police owe a duty of care or of the safety of police officers whose duties are already sufficiently risky.

Of course, deaths of these types are rare events. If persons were not routinely searched on being taken into custody, however, the far more common risk is that those carrying drugs on them would consume those drugs while in the back of a police vehicle on the way to a police station. Such conduct is inherently risky but also destroys evidence.

In summary, with the benefit of hindsight, it can be clearly seen that it would have been prudent to search XX. Given that there were several officers available to restrain him if necessary for the purpose, and there were rooms or places in the motel where a search could have taken place with appropriate dignity, in my view, he should have been searched.

Latent systems defects

It is not my purpose to browbeat or scapegoat individual police officers. I fully understand that policing is almost always difficult, often dirty and occasionally dangerous work. Decisions have to be made quickly and very often by young and relatively inexperienced police officers dealing with people behaving badly. Much more important is that organisational issues be addressed internally by the NSW Police Force.

The British expert on human error and systems failure, Professor James Reason, has written:

> The basic premise in the system approach is that humans are fallible and errors are to be expected, even in the best organisations. Errors are seen as consequences rather than causes, having their origins not so much in the perversity of human nature as in "upstream" systemic factors. These include **recurrent error traps** in the workplace and the organisational processes that give rise to them. Countermeasures are based on the assumption that though we cannot change the human condition, we can change the conditions under which humans work. A central idea is that of system defences. …When an adverse event occurs, the important issue is not who blundered, but how and why the defences failed.[14]

[14] "Human error: models and management" *British Medical Journal* (2000) March 18; 320(7237): 768–770 at 768.

Reason's "Swiss Cheese" model of accident causation is 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, each slice representing a defence against the consequences of human error. It was originally propounded by him 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.

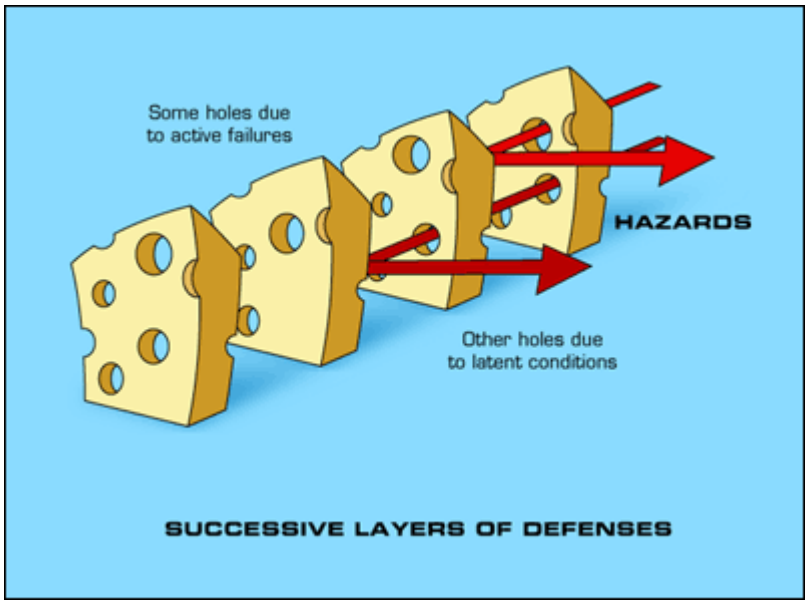


Fig 1. The defence layers work: holes do not line up

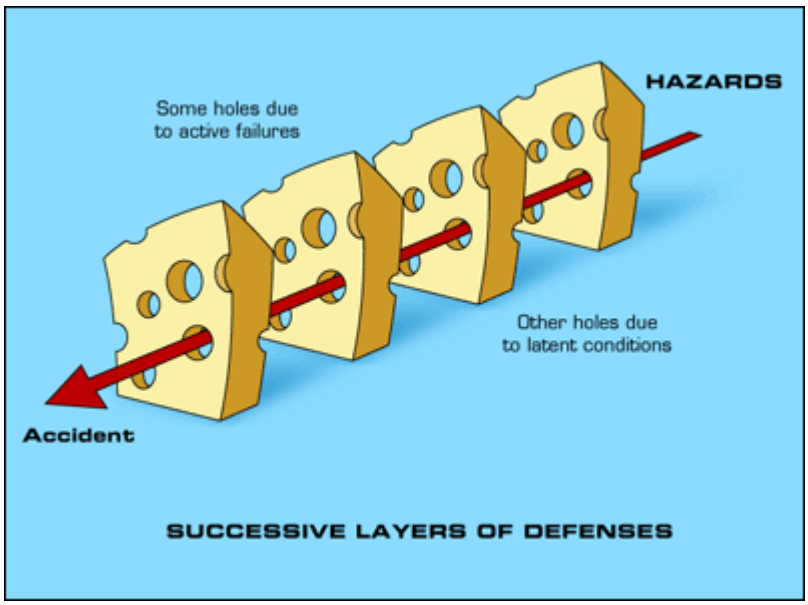


Fig 2. Accident trajectory – defence layers are penetrated [15]

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.

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

The holes may be *latent* defects: that is, they may not be obvious until something goes wrong. 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 above.) One of the layers of defence that was penetrated in this case was that the usual police practice of searching arrested persons before they are placed in the back of a vehicle was not followed on this occasion. The reasons for that omission are immaterial in analysing the *systems* defect in that approach.

Having identified a latent defect in the system, the next and most obvious step is to rectify the problem. In arguing that police policy ought not be based on rare occurrences, counsel for the Commissioner of Police overlooks a serious but latent *systems* problem. This is not a forum in which liability or vicarious liability *in tort* is an issue. The issues with which *this* court are concerned are the circumstances of XX's death and whether recommendations that are necessary, appropriate or desirable to reduce risk for police officers and persons in custody should be made.

In any event, the evidence speaks for itself, as it did in the X case. With the benefit of hindsight, it can be clearly seen that XX could and should have been searched after being handcuffed and before being placed in the police truck. Although the officers who had struggled with him may have had trouble doing so by themselves, sufficient reinforcements had arrived by the time he was placed in the truck to do so. Had the police done so, it is more likely than not that the gun would have been found and his death averted.

Should recommendations be made?

It is evident that organisation-wide lessons have not been learned from either the XX incident or this incident. Mr Saidi's submissions suggest that this case has not prompted any intensive internal review of police practice.

That is unfortunate. I have no doubt that if XX had shot a police officer rather than, or in addition to, himself, a very thorough review would have taken place. It would be preferable that such a review takes place internally before an armed prisoner in the back of a police vehicle does kill or injure a police officer.

In my view, as a result of XX's death and the findings of this inquest, the NSW Police Force ought consider changing its practice and procedures in a number of respects.

First, (assuming my interpretation of s 24 is correct), I propose that the Police Force should consider adopting a policy pursuant to their power under s 24 of the LEPR Act, that unless there are sound reasons *not* to do so, police officers should search all persons taken into police custody before placing those persons in police vehicles or transporting them to a place of custody.

Prisoners in the back of police trucks are contained but the police have a barrier between them and prisoners. If they are not searched before being put in the truck's pod, this allows prisoners time to self-harm or take drugs or attempt to divest themselves of incriminating small items.

If police subsequently become aware of something untoward happening in the back of a truck, because of the confined space in the truck, it is very much more difficult to manage the prisoner and conduct a search than if it had been done beforehand.

Second, I propose that the Police Force should consider adopting a policy that if, pursuant to s 23 of the LEPR Act, arresting police officers have reasonable grounds to suspect that it would be prudent to search arrested persons, they should do so unless there are sound reasons do otherwise.

It seems to be common sense that if reasonable grounds exist to suspect that it would be prudent to search an arrested person, it is imprudent not to do so. The question then becomes one of when, where and how. This raises the question whether it is practicable in the prevailing circumstances to conduct a search. It is raises those considerations, such as the dignity of the person, governed by the provisions of the LEPR Act.

Third, I propose that the Police Commissioner review the policy or practice of police officers securing their firearms before unloading persons in custody from police vehicles at police stations. In particular, I recommend that consideration be given to situations in which police transport persons who have not been searched to police stations or other places of custody. In such cases, I recommend that the Commissioner consider issuing a guideline that one or more officers should, at a safe distance from the vehicle, retain their firearms to provide protection while unsearched prisoners are unloaded.

This recommendation is a fallback position from that proposed in the first recommendation.

XX could have shot unarmed police officers at Wagga Wagga Police Station. Not only had they unwittingly allowed him to remain armed but also they had disarmed themselves.

Fourth, I suggest that the NSW Police Education and Training Command consider using this case and the *Caton* incident as case studies for training officers in appropriate search procedures, including the desirability of ascertaining an arrested person's identity and considering COPS warnings if reasonably practicable.

Fifth, I also suggest that the NSW Police Force review its training curriculum in the light of these incidents.

Sixth, the NSW Police Force has a program of installing CCTV cameras in its caged vehicles. I propose that it be expedited as fast as resources, funding and competing priorities allow.

Seventh, in addition to and following the thorough investigation that follows a Critical Incident, I propose that the NSW Police Force conduct a policy and procedure analysis, similar to NSW Health's "Root Cause Analysis" process, to determine whether or not latent systems defects have been revealed by the incident and, if so, what measures ought be taken to rectify them. This may not be a matter for detectives conducting Critical Incidents but for those involved in police management, training and policy development.

I make this proposal in the light of Professor Reason's identification of the characteristics of "high reliability organisations". Such organisations make a habit of learning from their errors:

> High reliability organisations—systems operating in hazardous conditions that have **fewer than their fair share of adverse events**—offer important models for what constitutes a resilient system. Such a system has intrinsic "safety health"; it is able to withstand its operational dangers and yet still achieve its objectives.
>
> High reliability organisations are the prime examples of the system approach. **They anticipate the worst and equip themselves to deal with it at all levels of the organisation.** It is hard, even unnatural, for individuals to remain chronically uneasy, so their organisational culture takes on a profound significance. Individuals may forget to be afraid, but the culture of a high reliability organisation provides them with both the reminders and the tools to help them remember. **For these organisations, the pursuit of safety is not so much about preventing isolated failures, either human or technical, as about making the system as robust as is practicable in the face of its human and operational hazards.** High reliability organisations are not immune to adverse events, but they have learnt the knack of converting these occasional setbacks into enhanced resilience of the system. (Emphasis added).[16]

The best organisations have a powerful culture of brutal honesty with themselves. They face up to their mistakes and failures and learn from those experiences. They conduct reviews and "autopsies" into their failures to learn what went wrong and how to fix the problems. [17] They are their own most meticulous critics.

Formal Finding:

I find that XX died on 14 August 2011 at Wagga Wagga Base Hospital as a result of a single gunshot wound deliberately self-inflicted while in police custody.

Recommendations s 82 Coroners Act 2009

To the Commissioner of Police:

- I recommend that the NSW Police Force should consider adopting a policy that, pursuant to their power under s 24 of the *Law Enforcement (Powers and Responsibilities) Act 2002* police officers should search all persons taken into police custody before placing those persons in police vehicles or transporting them to a place of custody, unless there are sound reasons not to do so.

[16] "Human error: models and management" *British Medical Journal* (2000) p. 770.
[17] See generally Jim Collins *Good to Great: Why Some Companies Make the Leap… and Others Don't* William Collins, NY (2001).

- I recommend that the Police Force should consider adopting a policy that if, pursuant to s 23 of the *Law Enforcement (Powers and Responsibilities) Act 2002*, arresting police officers have reasonable grounds to suspect that it would be prudent to search arrested persons, they should do so unless there are sound reasons not to do so.

- I recommend that the Police Commissioner review the policy or practice of police officers securing their firearms before unloading persons in custody from police vehicles at police stations. In particular, I recommend that consideration be given to situations in which police transport persons who have not been searched to police stations or other places of custody. In such cases, I recommend that the Commissioner consider issuing a guideline that one or more officers should, at a safe distance from the vehicle, retain their firearms to provide protection while unsearched prisoners are unloaded.

- I recommend that the NSW Police Education and Training Command consider using this case and the *Caton* incident as case studies for training officers in appropriate search procedures including the desirability of ascertaining an arrested person's identity and considering COPS warnings if reasonably practicable.

- I recommend that the NSW Police Education and Training Command review its training curriculum in the light of these incidents.

- I recommend that the rollout of CCTV cameras in NSW Police Force caged vehicles be expedited as fast as resources, funding and competing priorities allow.

- I recommend that in addition to and following the thorough investigation that follows a Critical Incident, I propose that the NSW Police Force conduct a policy and procedure analysis, similar to NSW Health's "Root Cause Analysis" process, to determine whether or not latent systems defects have been revealed

To the Attorney-General and Minister for Police:

- **I recommend that the Law Enforcement (Powers and Responsibilities) Act 2002 be amended so as to define with precision the meaning to be given to the phrase "lawful custody" in s 24 of the Act.**

11. 2126 of 2011

Inquest into the death of DARRELL JONES. Finding handed down by State Coroner Jerram at Glebe on the 9th August 2013.

Maxwell Jones was receptive to the initial investigation, provided a statement in relation to his brother's background. Veronica, his de facto, he'd been - Mr Jones had been arrested by Dubbo Local Police in relation to some offences up there. Veronica was not receptive to those police.

The brother Maxwell has no offences, has never been in trouble with police, and was quite receptive. We had contact with him all the way along. He had no issues to raise in relation to his brother. He was informed of the transport issue and effectively in regards to today's proceedings Maxwell initially indicated he wished to be part of it, to have a family interest more so than to ask any questions, was my understanding. Well, to show they care, and I assume they identify as Aboriginal.

Sergeant Roberts that there remained an intention for Darrell John Jones to be moved to 24 hour nursing care, but that as we all know, the mills grind slowly, especially in the country, and the recommendations have been made only two and one day before. It was complicated by the fact that he himself had asked not to be moved, but he was in fact in a two-out cell and it was in fact his cellmate who noticed that he was not breathing or snoring as normal and raised the alarm. Unfortunately it was too late, but it is quite clear that what he died of was natural causes, and no doubt that is why Justice Health had recommended that he be moved.

I make the finding. I assume that the family would prefer really that it said at Wellington Hospital.

Formal Finding

THAT DARRELL JOHN JONES DIED ON 3 SEPTEMBER 2011 AT WELLINGTON CORRECTIONAL CENTRE, NEW SOUTH WALES, HYPERTENSIVE AND VALVULAR HEART DISEASE, CONTRIBUTED TO BY DIABETES MELITIS AND MORBID OBESITY (NATURAL CAUSES).

12. 2235 of 2011 s 75 NON PUBLICATION ORDER

Inquest into the Death of XX. Finding handed down by Deputy State Forbes at Glebe on the 22nd March 2013.

This is an Inquest into the sad death of XX who died on 18 September 2011, aged 40. After suffering many years with mental illness, she took her own life by jumping off a cliff at the Lighthouse Reserve in Vaucluse. She is survived and missed by her mother and daughter.

This inquest is mandatory pursuant to s 27 of the Coroners Act because XX died in the course of a police operation. The police were called and attended the scene just prior to her jumping to her death.

An inquest is intended to be an independent examination of the available evidence relating to the circumstances of a persons death. The Coroners Act requires me to identify the person whose death is being investigated, the date and place of the death and the cause and circumstances of the death. In this inquest, there is no issue with the police operation and the inquest has been an examination of the care and treatment XX received as a mental health patient.

XX's mother, resides in the United Kingdom. She is unable to be here in person for this inquest. However, Ms J has been in regular contact with Counsel Assisting. Ms J feels that the mental health system let XX down and that more could have been done by clinicians to prevent XX's death. She has requested that XX's treating doctors be required to give statements and appear at this inquest to be examined about their care and treatment of XX. In the course of this inquest being prepared for hearing, medical records concerning XX's mental health treatment were obtained.

I also requested that an independent expert Psychiatrist, Dr Nielssen, review all of XX's medical records including her treating Doctors medical notes together with written statements made by particular witnesses, including police, mental health case workers and other persons. On the basis of his opinions and for the reasons set out below I decided that I neither required statements from the treating doctors nor their appearance for examination at the inquest. In coming to that conclusion I have carefully read all of Ms J correspondence and have considered all of the matters she has raised.

It should always be born in mind that inquests are not criminal investigations, nor are they civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. Rather, the focus is how and why a person died and whether there are things that can be done in the future to prevent a similar death.

Furthermore, that the advantage of hindsight was not available to those whose decisions, made in real time, are the subject of some examination.

XX was born in London 1971, and her family moved to Australia. Her parents separated whilst she was very young and her mother raised her.

It appears that XX had limited contact with her father during childhood, and he passed away when she was aged about 15 years.

XX attended school in Rose Bay. She was passionate about ballet and aspired to be a professional ballet dancer. XX completed year 10 and then attended a ballet academy for a period of time.

In 1990 her mother moved to London. This was intended to be a one-year stay, but Ms J stayed on living and working there. XX and her mother remained in regular phone contact and visited each other.

In 1992, XX had a daughter with BG. Their relationship ended shortly after the birth. Notwithstanding her love XX appeared to be struggling to cope with caring for the child by the end of 1993 and Mr G and his family assumed the childs day-to-day care.

At some stage in her early adult life, XX was diagnosed as suffering schizophrenia. This resulted in her having frequent contact with mental health in NSW and elsewhere, including London in 2000. She had two known suicide attempts in 2001 and 2004. A lengthy chronology outlining many of XX's admissions in NSW since 1996 forms part of the brief of evidence tendered in these proceedings.

In about 2004, XX met MM. He was from the United States and she moved there with him to commence a new life.

It appears that her condition deteriorated and she was repatriated to Australia and admitted to RPA, Missenden Unit. She then moved into a flat in Moore Park.

In 2008 Cherie Jenkins became her Community Mental Health caseworker. XX resided in accommodation in Darlinghurst, which was provided by the *Inner City Housing Project* ("ICHP"). It is a joint project between St Vincent's Hospital and NEAMI. NEAMI is a non-government organisation that provides rehabilitation and recovery support to people with serious mental illnesses.

Medication

Ms Jenkins provided support and follow up with XX to ensure she was receiving proper treatment. Ms Jenkins stated that XX's chronic schizophrenia was considered treatment resistant. She was receiving Clozapine; being a medication that is used after all other options are exhausted. Dr Nielssen, the independent Psychiatrist expert, explained to this Court that Clozapine is reserved for resistant schizophrenia. He gave evidence that it must be reliably taken for it to be useful and is only available in tablet form.

In 2009, XX was admitted involuntarily to the Caritas Unit, St Vincent's Mental Health Hospital, twice. The first on 8 March 2009 for two months and then on 24 July 2009 for 5 days. She had not been taking her medication correctly. After being discharged on 29 July 2009 she was monitored on a weekly basis with regards to her medication. It appears that XX did not like the side effects of this drug, particularly the weight gain associated with its use. She was discharged on a community treatment order (CTO).

Ms Jenkins saw XX on a regular basis. XX also received treatment from Dr Atherton, Consultant Psychiatrist, St Vincent's Mental Health.

In about October or November 2010 XX was again admitted into the psychiatric emergency care centre at St Vincent's Hospital. Clozapine was ceased.

She was prescribed a long acting injection of Zuclopenthixol (also known as Clopixol) an anti-psychotic medication, fortnightly pursuant to a CTO. This change was at XX's request, she wasn't taking the Clozapine prescribed, she was concerned with her weight gain and she considered that Clozapine did nothing to curb her auditory hallucinations. XX was also prescribed, in tablet form, Seroquel (300mg BD), a weaker form of anti-psychotic medication compared to Clopixol. She was also prescribed Cipramil, an anti-depressant medication.

Dr Nielssen gave evidence that the change in her medication was appropriate. He gave evidence that it is not possible to administer Clozapine reliably, which is in tablet form, without a patient's co-operation and compliance. He said that in the circumstances of XX not taking the Clozapine as prescribed that the change to an administration of the fortnightly long acting injection was appropriate. I accept his evidence in this regard.

Monitoring of XX by her psychiatric team and by NEAMI in 2011

In 2011, XX was living in accommodation provided by NEAMI at 62 Taylor Street, Darlinghurst. This was a terrace house with 3 rooms and a shared kitchen and other utilities. XX also frequented the Paddington Uniting Church for breakfast and lunch.

Ms Jenkins observed early signs of a relapse with XX's mental health in early 2011 and referred her to the attention of the Acute Care Team (ACT). It was made clear to XX that an application was being made to the Mental Health Review Tribunal to have her CTO extended. Soon after, XX made a request for a new caseworker to be assigned to her. The exact reason for this request is not clear, but it may have been because XX disagreed both with the involvement of the ACT, the extension of the CTO.

XX was involuntarily admitted to St Vincent's Hospital on 11 February 2011 for a two-week period. It was noted on admission that she was not coping well at home.

She initially denied suicidal ideation and then stated she would "hurt herself really bad" if she wasn't admitted. It was also noted that her flatmates had recently moved out. It was noted in the progress notes on 18 February 2011 that "…she feels "pushed" to do things with Cherie…". Ms Jenkins submitted documentation in support of the application for an extension of the CTO for a six-month period as did Dr Atherton.

By about this time, XX's contact with her mother had broken down. XX's request for a new caseworker was approved on 21 February 2011 and RN Sara Dos Reis was appointed in that role. She was provided a handover from Ms Jenkins and also had access to St Vincent Hospital's Community Mental Health Records, which are accessible electronically.

The records contained in the brief for this inquest show Ms Dos Reis and other Community Mental Health workers did follow-ups with XX. On 14 March 2011, XX was referred to the attention of the ACT for follow up, which continued up until 24 March 2011. It is also apparent from those records that the workers consulted XX's consultant psychiatrist, Dr Atherton.

During this time, XX also received support from NEAMI caseworkers. It appears that she received visits or contact from those workers on about a weekly or fortnightly basis during 2011. NEAMI caseworkers also had conferences with the Community Mental Health caseworkers to discuss how XX was progressing and other issues, such as accommodation.

XX had stated in late March that she was ready to seek new accommodation. NEAMI were assisting her in that regard, including with an application to the Department of Housing. By way of snapshot, a case review prepared by Ms Dos Reis on 30 May 2011 recorded:

> "…XX attended an appointment with writer on Friday 20/05/11. On this occasion XX's mental state was stable and she presented without acute risks. She stated that she has been compliant with her oral medications…. XX was late with having her injection this week, but attended to the O'Brien Centre early this morning to receive her injection without having to be reminded. This is not unusual for XX who has been attending the centre on the due day without any prompting. On discussion with Alison of NEAMI, she stated that she has no concerns regarding XX's accommodation and is happy to assist her in helping to follow-up her application for DOH."

Ms Dos Reis notes indicate XX introduced her to a new boyfriend SG in July 2011.

Ms Dos Reis performed the role of Mental Health caseworker until August 2011, at which time XX's case file was allocated to Registered Nurse Rebecca Sarkies. Ms Sarkies was given a verbal handover by Ms Dos Reis. She also had access to St Vincent's Hospital mental health records for XX.

Around this time XX was described as 'quite stable over the past few months'. Ms Sarkies saw XX at least every two weeks after that and phone contact once per week Ms Sarkies also sought to assist XX with her housing situation.

According to Ms Sarkies, XX had outstayed her residence in the NEAMI program (3 years instead of 1 year) and that organisation was eager for XX to move. XX appeared to Ms Sarkies to be hesitant to do so. It eventuated that XX had received an acceptance letter from the Department of Housing but that she had not informed anyone of this.

Ms Sarkies saw XX on 7 September 2011, during which she observed XX to be preoccupied and mumbling to herself.

XX reported that she had had a fight with her boyfriend, SG. Ms Sarkies spoke with NEAMI and asked them to monitor XX and notify Ms Sarkies if they believed she was deteriorating.

According to Ms Sarkies, XX's mood and behaviour and overall mental state changed in September 2011 owing to her difficulties with her boyfriend.

On 8 September 2011, XX briefly visited an old family friend, EH, at her home. She also introduced SG as her boyfriend. According to Ms H, XX appeared well, confident and was well dressed.

Dr Nielssen has reviewed all of the records relating to XX's care and treatment throughout 2011 and is of the opinion that the changes in XX's case management were not significant factors in her decision to commit suicide. New caseworkers were provided handover and had access to XX's electronic records. Notwithstanding the changes, XX continued to receive treatment from her regular Consultant Psychiatrist, Dr Atherton, and also support from NEAMI workers. When concerns arose about whether XX was taking her medication, she was referred to the attention of the Acute Care Team to ensure that this was monitored. She was also subject to a CTO.

Discharge from hospital on the 13 September 2011

On 9 September 2011 XX was found at her accommodation and transported to St Vincent's Hospital by ambulance. She appeared to have taken an overdose of Seroquel medication. XX reported to the ambulance officers that she tried to "kill herself".

XX's account about how much she actually consumed varied. She claimed at one point to have taken 168 tablets, but also claimed she had taken 21 tablets (during Mental Health Assessment at Hospital) and 4 tablets (to ED Registrar). It was noted in the admission notes that the overdose had followed a break up with her boyfriend.

It was noted in the progress notes on 11 September 2011 – "XX spoke to nursing staff about her admission to hospital, saying she "took too many tablets because I'm madly in love". Further 'I feel very sleepy now, and I realise I made a mistake, I just need to go home and sleep, there's nothing wrong with me'. It was further noted that XX presented with flat affect, no insight into her illness, and that she was very pressed in speech."

It was noted in progress notes on 12 September 2011 by Registrar Gordon – "…Now denies mood disturbance... Gives a reasonable and logical account of herself and the events surrounding her admin. Denies psychotic phenomena at admin. Positive about the future and no symptoms of mood disturbance or psychosis evident." Further noted "…Currently settled with no evidence of acute psychiatric symptoms at present…"

XX was medically checked and cleared from St Vincent's Hospital but was taken to Caritas. She denied any intention to take her life, citing a reason of fighting with SG for overdosing. She was later transferred from Caritas to the Psychiatric Emergency Care Centre, a lower care facility in which it was noted she was more settled and presenting less acute symptoms compared with that of other patients.

During a team review on the morning of 13 September 2011 it was noted – "denied suicidal ideation" and "has future plan for d/c".

Ms X was discharged later that day, on authority of Consultant Psychiatrist Dr Cullen.

Dr Nielssen stated that based on what was known at the time and on the available recorded observations, he believed XX's discharge was reasonable.

Dr Nielssen testified that, whilst there is a high incidence of suicide amongst people suffering chronic mental illness relative to that in the general community, the percentage of mentally ill persons who commit suicide remains low. Although psychiatrists will endeavour to foresee and prevent a patient from committing self-harm, their capacity to accurately predict if and exactly when this might occur is limited.

In considering discharge, the factors that a psychiatrist must take into account include the person's safety, their wishes, and the viability of him or her receiving appropriate treatment in the community. A treating psychiatrist is bound to ensure that people with a mental illness receive the best possible care and treatment in the "least restrictive environment enabling the care and treatment to be effectively given": *Mental Health Act 2008 s.68(a)*.

Clearly, the circumstances of XX's involuntary admission and her observations during her admission would have been taken into account on considering discharge. In XX's case, the existence of the CTO and the fact that she had a place to live and could be followed up by community mental health workers were relevant factors.

Dr Nielssen pointed to the fact that an experienced psychiatrist assessed her on the day of discharge and her treating psychiatrist assessed her three days afterwards and that neither of them formed the opinion that she required treatment in the restrictive environment of a psychiatric ward. Based on the known information, as documented in the notes, and the recorded observations, he considered the decision to discharge XX 13 September 2011 was reasonable.

Having regard to the evidence, including the medical notes made prior to and during XX's admission to St Vincent's Hospital on 9 September 2011 and the opinion of Dr Nielssen, I am satisfied that decision to discharge XX on 13 September 2011 was reasonable.

Follow up after discharge.

Ms Sarkies saw XX immediately after her discharge on 13 September 2011 and assisted her to get access to her NEAMI accommodation. She informed Dr Atherton of that discharge and then liaised with XX to schedule an appointment for her to see Dr Atherton on 16 September 2011. XX kept that appointment and reported that she was no longer suicidal and was stable.

A NEAMI support worker, Andy Griffiths, attended on XX at her residence on 15 September 2011. It is noted in the NEAMI records that XX stated she was doing really well, going to the soup kitchen every day. She stated that her and her boyfriend had broken up. She claimed that she was now in a different state of mind about the relationship and felt a lot better.

She also expressed some frustration about her housing application and stated that she only wanted to accept living in community housing.

XX called NEAMI on 16 September 2011. She stated that she did not want Department of Housing accommodation. Rather, she wanted community housing "pathways to women". She complained that NEAMI had not been working with her well and that another staff member should work with her.

She also demanded that NEAMI notified the Department of Housing that she did not want that option. It was noted that the person who took the call, Mal Casey, stated he would talk through this with XX at their next scheduled visit.

Day of XX's death

The footage obtained from Edgecliff and Bondi Junction railway and a train ticket found in XX's belongings suggest that XX travelled by train from Bondi Junction to Edgecliff Station between 10:03 and 10:21 am. A Bus leaves from Edgecliff Station that goes to Watsons Bay. In the opinion of the officer-in-charge, XX travelled by bus and got off at one of the stops at Watsons Bay.

At about 11:10 am two witnesses that were between the lighthouses near the cliff top on Old South Head Road, Watsons Bay were approached by two people, who told them that someone was standing on the cliff nearby. One of the witnesses called triple zero on her mobile phone. She also saw XX standing on the other side of the fence. She describes XX as moving around in this location. In particular, she observed XX climbing on top of a rock and then climbing underneath an overhang. She did not hear XX say anything, but saw her to intermittently stand still, click both her fingers and move her arms around. Police COPS records show that job created, in response to the call, at about 11:14 am. COPS records show that Sergeant Michael Kyneur's vehicle was logged as being at the scene by 11:18 am.

Police COPS records show that a VKG radio message/broadcast went out at 11:23 am that "POI has just jumped – 100 m Sth of Weather Stn". Police were only present at the scene for a short period of time prior to XX's death.

The police attended promptly and acted appropriately and their actions could not be said to have contributed to XX's death in any way.

The issue of suicide prevention in this area has been addressed in many previous inquests. The position where XX was located was over a fence. It is observed from the photographs contained in the brief that fencing along that area is above average human height.

This fence was erected as part of the Gap Suicide Minimisation Plan enacted by the Woollahra Council and I am satisfied that measures have been taken to minimise suicides at this location. Sadly it is impossible to prevent all suicides anywhere.

Conclusion

I accept the opinions given by Dr Nielssen and I am satisfied that no one who was directly involved with XX failed her. It cannot be said that she received inadequate treatment, inadequate continuity of care or inadequate response to suicide risk.

Formal Finding

I find that XX died on 18 September 2011 from the effects of multiple injuries she sustained as a result of intentionally taking her own life by jumping from a cliff at Vaucluse, New South Wales.

13. 2573 of 2011 s75 Non Publication Order

Inquest into the death of XX on the 12th April 2013 at Glebe. Finding handed down by State Coroner Jerram.

AT THE VILLAWOOD IMMIGRATION CENTRE ON 26 OCTOBER 2011

The deceased person, hereafter known as X for reasons ordered for the security of his family, was a 27 year old man from Sri Lanka when he died at the Villawood Immigration Detention Centre, Sydney, in the early hours of 26 October 2011.

At the time of his death, this court had very recently completed hearing evidence in to the suicide deaths of three detainees at Villawood, the Findings having been reserved. When Findings were handed down on 19 December 2011, a number of Recommendations were made.

There is some evidence that many of those have now been implemented and improvements made to protocols and practices to ensure the safety and better well-being of those held in detention at Commonwealth Immigration centres. It is acknowledged that those Recommendations had not been made at the time of X's death.

Almost all legal representatives in this inquest appeared also for the same clients in the earlier inquests, with the exception of Mr Peter Morris SC who appeared for International Health and Medical Services. Ms Naomi Sharp appeared again as Counsel Assisting. That duplicated representation helped to expedite these proceedings, armed as all Counsel were with their tragically recent understanding of many details and procedures at Villawood.

A view was held at the centre at which all parties were represented, and the room in which X died was inspected.

THE FACTS

X died in the early morning of 26 October 2011, in the section of Villawood known as Sydney Immigration Residential Housing (SIRH) where he had been placed since mid July 2011.

The autopsy performed by senior Forensic Pathologist, Dr Mathew Orde was able to clarify the cause of death as "ingestion of cyanide", a lethal poison which, when ingested and making contact with gastric juices, produces hydrogen cyanide gas. After his death, a clear plastic bag containing a powder, subsequently analysed as cyanide, was found by a Serco officer hidden behind a poster in X's room.

Hence all requirements of s 81 of the Coroners Act 2009 are met, other than the manner of X's ingestion of the cyanide: how he came to have it, how it was concealed, and whether preventative measures should or could have been taken by either DIAC, IHMS, or Serco and all relevant staff.

It is important to note that although DIAC has contracted out to IHMS and Serco the main functions of providing care for immigration detainees it retains a non-delegable duty of care towards its clients.

As Ms Sharp has submitted, on any view, X was a troubled man. He had been in detention for over two years. He had finally been granted refugee status in August 2011 after a frustrating and lengthy time, but remained in detention because he had not been given a security clearance by ASIO (Detainees were aware that security checks commonly took up to a year to complete).

The particularly lengthy period before decisions were made was partly due to it having taken some months before X had admitted to being a member of the Liberation Tigers of Tamil Eelam (LTTE) in Sri Lanka, albeit forcibly conscripted. He had been a victim of torture and extreme trauma. He held concerns for relatives still in Sri Lanka.

As if that were not enough, in June 2011 he had been diagnosed with Hansen's disease, otherwise known as leprosy, a disease much stigmatised which he feared would isolate him even from his fellow detainees.

Three previous self-harm attempts were documented during his time in detention, and in 2010 he had been part of a roof top protest, a hunger strike and a riot. IHMS and STARTTS records all show him as having a deep sense of injustice, anger and hopelessness, and as being deeply depressed with possible post traumatic stress disorder. He had some friendships in the outside community, including with a Mr Georgiadis and a recent romantic relationship with the woman known as X's partner. X's partner and Mr Georgiadis visited him regularly.

Despite the improvement in his living once he was moved to the SIRH, and the granting of his refugee status, the lack of security clearance and uncertainty generally led to his becoming increasingly depressed. In mid October 2011, X suffered serious disappointment when he was refused leave by DIAC to attend the Diwali festival at his friend Mr Georgiadis' home. X's partner visited him in SIRH on October 24 and said that he was more upset than she had ever seen him. The following day, he was once again refused permission to attend the Diwali festival. Again, X's partner visited him and noted his distress.

Although she denies that they argued that evening, text messages between them suggest otherwise. At 10.56, X phoned her and said "I won't ever be a problem for you" and 'I've taken some poison". X's partner's mother called an ambulance, while X's partner telephoned Serco officers at the SIRH and told them that X was attempting suicide. They found X on his bed, eyes closed and vomiting but still breathing. However, despite all efforts of both officers, and subsequently, ambulance officers, X died a few minutes later.

ISSUES

Given that X's state and mood were known to many DIAC and IHMS officers, were his welfare and mental health needs appropriately or sufficiently managed?

How did X have possession of cyanide, and was that known to others prior to his death?

THE EVIDENCE

Care and treatment

Counsel Assisting submits that DIAC, Serco and IHMS respectively did not appreciate how seriously X was at risk of self-harm, and that had they done so, a greater level of support may have been offered to X to minimise that risk. As examples, she suggests that a more compassionate approach could have been taken to the request to attend the Diwali festival, the refugee status and ASIO security clearance could have been expedited, and X should have received treatment from a psychiatrist rather than a psychologist, with better communications between IHMS and STARTTS. Each of those may have improved life for X.

However, as she herself agrees, it is notoriously difficult to predict the risk of suicide, and easy to be wise in retrospect. As already noted, the length of X's detention was due, to the fact that he had not disclosed his background to officials, for the first sixteen months. He did receive regular treatment both physically and mentally in all his time in detention.

In the weeks immediately before his death, Serco officers detected no issues, and X's friend and partner, though aware of his anxiety, had not seen him as a suicide risk. His DIAC Case Manager, (until mid September 2011), Sunitha Paalare, saw no indication that he was depressed. He had in fact appeared to have improved significantly after his transfer to SIRH. Furthermore he was now being treated for the Hansen's disease. There is no evidence of his having complained to anyone that he feared remaining "in immigration limbo".

Dr Peter Young, a psychiatrist and Director of Mental Health services for IHMS gave evidence, which provides some optimism that there are ongoing improvements to the services provided. It was his view that there was an appropriate continuity of care and obviously good rapport between X and his two clinical psychologists.

The Cyanide

It does seem most likely, though not certain, that X had brought the cyanide in to Australia, perhaps hidden internally, and retained it during his months in detention .I agree with Counsel Assisting that it is difficult to see what Serco, as the entity responsible for security and searching, could have done to detect the poison. Detainees are searched when initially taken in to detention, but not internally.

Thereafter, they are not prisoners, and the right to search them is properly limited.

A fellow detainee, Mr Peralan, gave evidence that he knew X to have cyanide in his possession. Understandably, he did not consider it his duty to report that fact to officials. X's partner strongly denies that she had similar knowledge. However, it is clear that on the night of his death, X told her that he had taken cyanide.

She denies that also, but I prefer the evidence of Heather Rudolph, a Serco officer that she was told by X's partner that X had taken cyanide when X's partner arrived at the gates that night.

CONCLUSIONS

In the judgement I handed down after the inquest in to the three prior suicides at Villawood, in December 2011, I made an observation, which bears repeating as it continues, in my view, to apply, as follows:

"It is surely stating the obvious to observe that persons detained in Immigration Detention Centres must, by the nature of their various situations, be at much greater risk of suicidal ideation than the general community. Loss of families, freedom, status, work and length of time must play their part. The corollary of that is that those responsible for detainees owe a greater than normal duty of care to those persons regarding their health and wellbeing.

That DIAC owes a non-delegable duty of care to immigration detainees is indisputable, and it follows that that is an elevated duty. Serco and IHMS bear their own share of that duty."

I then made a series of Recommendations under s 82 of the Coroners Act of 2009. I am assured, and accept, that implementation of those is in hand, if not already being applied. I do not intend to make further Recommendations arising from this inquest, because, as already stated, X's death occurred before they were made and I do not consider any further recommendations are necessary. I attach a copy of the 2011 Recommendations.

Formal Finding:

That X died on the 26 October 2011, in the section of the Villawood detention Centre known as Sydney Immigration Residential Housing (SIRH) as a result of cyanide ingestion.

RECOMMENDATIONS

I make the following recommendations pursuant to s.82 of the *Coroners Act 2009* (NSW):

To the Honourable Chris Bowen MP, Minister for Immigration and Citizenship:

Use of Force in effecting a Removal

1. DIAC should revise:

(a) The Serco Contract and the Procedures Advice Manual ("**PAM**") 3 (Removals from Australia) to make clear provision as to the procedure to follow and who has authority to abort a removal in a situation where a detainee is resisting his or her removal and is threatening self-harm or suicide; and

(b) Its policies on use of force to provide guidance to DIAC officers as to what matters should be taken into account when they are requested to give a use of force authorisation in order to effect a removal.

(c) The Detention Services Manual should be amended to prohibit notification of negative decisions including removals on a Thursday or Friday. Case Management

2. In relation to case management of detainees, DIAC should:

(a) Direct Case Managers that they are responsible for making referrals for risk assessments to IHMS as soon as risk factors become apparent;

(b) Implement a policy that all referrals for risk assessment be made to IHMS in writing; that there be periodic follow up of the results of risk assessment in writing and that the results of the risk assessment be documented in writing and recorded in Portal;

(c) Direct all staff with responsibilities towards detainees to make contemporaneous notes in Portal regarding their dealings with respect to the detainees, and to specifically record any observations made in relation to risk factors and any information received from DIAC, IHMS or Serco regarding the mental health or well-being of a detainee;

(d) Implement a procedure whereby when information is obtained by DIAC suggesting that a detainee is at risk of self-harm or suicide the DIAC Case Manager is required to seek all information held by DIAC on the detainee and also obtain corroborative/clarifying information to the extent that that is reasonably practicable to do so in the circumstances.

To Serco Australia Pty Ltd:

3. Serco should develop procedures for:

(a) Encouraging Serco officers to proactively seek information on the outcome of risk assessments where Serco is aware that risk factors have been identified with respect to a detainee and/or a detainee has been referred to IHMS for a risk assessment risk;

(b) Documenting in detainee files the presence of risk factors; the referral of risk assessments to IHMS and the outcomes of risk assessments;

(c) Ensuring that where there is a need for additional vigilance with respect to a detainee, that need is effectively communicated to all Serco officers in the compound in which the detainee is accommodated.

(d) That Serco formulate a policy on the basis upon which authority to use force is to be used, including the assessment of risk, appropriate planning to reduce risk and the consideration of de-escalation techniques.

To International Health and Medical Services Pty Ltd:

4. In relation to assessing a detainee's risk of self harm or suicide, IHMS should:

(a) Develop a standard procedure for such an assessment which *inter alia* provides clear guidance as to what topics should be canvassed with the detainee; what instruments/risk assessment tools should be used to guide clinical judgment; stresses the importance of seeking corroborative information where it is available; provides for the documentation of corroborative information obtained; and provides clear guidance as to what must be documented by the clinician;

(b) Periodically train its mental health staff on the above procedure and on the minimum requirements to be satisfied in documenting their consultations with and assessments of clients; and

(c) notify DIAC and Serco on the outcome of its risk assessments in writing **To Serco Australia Pty Ltd and to International Health and Medical Services Pty Ltd:**

Detainee Mental Health – collaboration between DIAC, Serco and IHMS: DIAC, IHMS and Serco should work together to develop policy guidance on what information about a detainee's mental health can be provided by IHMS to DIAC and Serco officers and in what circumstances on the basis of the "need to know", without having to first consult via Detention Health Services.

To the Honourable Chris Bowen MP, Minister for Immigration and Citizenship and to Serco Australia Pty Ltd:

That DIAC and Serco formulate a policy with the NSW Police or the Federal Police to permit the police to provide timely assistance, including trained negotiators, for high risk situations.

To the Honourable Chris Bowen MP, Minister for Immigration and Citizenship and to International Health and Medical Services Pty Ltd:

DIAC and IHMS give consideration to changing the clinical governance structure at VIDC in relation to the provision of mental health services so that they are overseen by a consultant psychiatrist.

14. 2638 of 2011 s75 NON PUBLICATION ORDER

Inquest into the death of XX. Finding handed down by Deputy State Coroner Dillon at Glebe on the 20th May 2013.

XX died on the railway tracks at the Central Railway Station in Sydney on 4 November 2011 after cutting his own throat with a carving knife in front of a number of horrified young police officers.

The police were present because they had responded urgently to a call concerning a man with a knife on platform 8 and 9 of the Central Station and, because they were present when Mr X died and were attempting to prevent him from harming himself, the **Coroners Act** requires that an inquest be held into the death of Mr X and the circumstances surrounding it.

In our society, police are armed and have a near monopoly on the lawful use of force for the protection of the community.

Although individual officers probably do not enjoy the scrutiny of courts when it is imposed on them, it is imposed on them not simply to make them accountable for their action but in the interests of maintaining public confidence in our police force. This is a case in which the involved officers can be proud of their conduct and in which the New South Wales public can be proud of its police force.

As suggested by counsel assisting and Mr Haverfield, I do commend the officers involved in this case and I, indeed, propose to write to the Commissioner to say so. I was particularly impressed, I have to say, by the conduct of Constable Milne, who was a very young man at the time, who struck me as behaving in a very mature and professional and, indeed, humane way confronted with a situation with which he had never been confronted before and in managing it as well as he possibly could. It's very clear that he is still deeply affected by Mr X's death, and I believe he is getting support from the police force, but I hope that, if he is suffering still psychological, he makes a full recovery.

At the heart of this case was a living human being of course, and I may say, just to emphasise the point I have just made about Constable Milne, that it is to the credit of the police who were present at his death that Mr X's death, the death of a man who they did not know, has so upset Constable Milne and the other officers; they were clearly affected. I think Leading Senior Constable Krummins, who is much more experienced than some of the others, remains affected as well.

Mr X was an immigrant to this country. He was born in Morocco.

He had been married a couple of times and he had three children. He is survived by brothers and sisters, including a couple who live in Sydney and who have met with counsel assisting and Mr Mykkeltvedt.

Just before his death he was living in Lakemba with his brother, M, but, despite the support he was getting from his brothers in Australia, it seems that his ties with his wider extended family had, to some extent, failed or disintegrated.

He had worked at BHP back in the nineties. In 1991 his brother was shot and killed in Wollongong and that appears to have had a profound effect on him. Before that it seems that he had been well and mentally healthy but, after that, he became mentally ill and was diagnosed with schizophrenia.

Some time in the early nineties he resigned from his job at BHP but that, nevertheless, seems to have remained a source of anxiety or anger for him. Even on the day that he died, he seems to have been harking back to his work at BHP. In any event, over the years he had a number of admissions. He had treatments but, by the time he died, it seems that he had either given up or failed to comply with his treatment regime. Certainly no antipsychotic medication was found in his system after he died.

In the period leading up to his death he had been making threats of self harm. For example, he had told his brother, M, that he would throw himself under a train if he didn't get money from BHP.

The fact that he ultimately took his life on railway tracks lends special significance to those threats. He had had a number of encounters with police initiated by his family concerned about the deterioration of his mental health, but he also seemed to have the ability, both with police and the community mental health team, at least for a short period when he was dealing with those in authority, to simulate well-being, despite episodes of erratic behaviour and irrational behaviour. He certainly disguised any signs of suicidal ideation from the community mental health team and police and, therefore, he was never scheduled, at least in this period shortly before his death, because there was no apparent legal basis for doing so.

There were, however, some signs that he had been planning. Counsel assisting, Ms Edwards, as referred to some of them. For example, on 2 November, he telephoned his mother and said something to the effect of, "I'm sorry. They have left me alone and I won't be coming back." He also told M that he was buying a ticket back to Morocco. On 4 November he went to the Big W at Campsie and bought a large carving knife - and this is something of a small mystery in the case - five pairs of socks.

On that day he travelled to Central Railway. He arrived at about 12.34. He was on the tracks at 12.52 and, by 1 o'clock, he was on the tracks and dying; he had cut his own throat. Ms Edwards, I think very correctly, has submitted that he took his own life.

The scene, as it unfolded, as far as the police were concerned, was this. An emergency call was made at around about 12.50. The police immediately left their post at Central Station. The evidence from them was that they ran up to platform 8 and 9. They were on the platform by 12.52. By this time, XX had jumped onto the tracks. Trains were still running at that stage; the tracks were live, although, as soon as possible, the transit police and rail authorities had the trains stopped.

But, as far as the involved police were concerned, at the time that they were dealing with XX , the tracks were still live.

XX was walking slowly in the direction of Redfern. He was seen by various people to make throat-cutting motions, although not, at that stage, cutting his own throat, and this was also seen by the police officers that arrived on the scene. The first officer to reach the vicinity of XX was Constable Milne whom I have previously mentioned. He had been an 10 officer only for about two years. He was not a trained negotiator but he immediately recognised the urgency of the situation and the need to try to talk XX out of his dangerous behaviour.

Other police behind him also recognised that the main threat posed by XX was to himself. It was striking - and it is something that counsel assisting has mentioned and it struck me too - that the principal concern displayed by all these police officers was not for their own safety but for the safety of XX, this, despite the fact that he was carrying a large and obviously dangerous weapon on him.

In such a situation there is clearly considerable potential for harm to police officers. While this was not what has been sometimes called a “suicide by cop” case, the officers could not know what was in XX’s mind at the time that they confronted him.

Nevertheless, they stayed with him, staying at a little distance from him so as not to threaten him, all the while trying to calm him down as he continued to make his throat-cutting gestures and to tell them to go away. Constable Milne’s evidence in particular was that he was trying to make XX not feel threatened, and a number of witnesses demonstrated that Constable Milne was making calming down type of gestures with his palms out and in downward motion.

Counsel assisting asked - and I believe it was Leading Senior Constable Krummins - why the police did not simply let him go at that stage. He explained that the trains were still running, so they wanted to get XX off the tracks. She also asked whether they had considered calling in negotiators of the tactical operations unit. The explanation that they gave was that there was simply insufficient time, that if they had been able to settle XX, or at least get him to stop where he was, that they would have considered doing so.

In her final submissions, counsel assisting agreed with those answers and submitted that there simply had not been time for the police on the scene to take any further and better action to manage the situation. I agree with those submissions. In the circumstances, the responses of the police to the situation as it confronted them were very reasonable, in my opinion.

Constable Milne was still trying to talk to XX when, suddenly, he drew the blade right across his own throat. There have been differing accounts about how exactly he did this. One of the witnesses, Mr Williams, described a sawing motion. Another witness described a kind of stabbing motion.

Constable Milne himself was horrified to see a dark red line appear on XX’s throat after he had drawn the knife across his neck. He realised that XX had cut his own throat.

At the point, he fired his taser at XX, not to cause him any harm but to prevent him from doing further harm to himself and to try to get him to drop the knife. He was successful in getting XX to drop the knife. XX collapsed. The police immediately rushed forward to help him. They tried to staunch the wound with a sock that they removed from XX and with a bandage that was provided from a first aid kit by one of the transit officers.

The autopsy report makes very grim reading; in fact, it makes somewhat astonishing reading, really. The summary version, an incised wound of the neck, does not describe the full gravity of the wound that XX has inflicted on his own throat. The forensic pathologist described finding: “A large horizontal and gaping incised wound transversely on the neck just above the level of the larynx and, to the left side, further shallow linear incisions within the skin. He had completely transected the larynx between the hyoid bone and the thyroid cartilage, the pharynx, the larynx, the trachea, and major airways contained a large amount of apparent fresh blood.”

He had done terrific and horrific damage to himself and it must have been an extraordinarily painful wound to inflict on oneself.

Despite the best efforts of the police, there was nothing that they could do to save XX’s life after such an horrendous wound had been inflicted on him, and perhaps it was a merciful release for XX that he died very quickly afterwards.

Constable Milne has used his taser to prevent him harming himself further. There is absolutely no suggestion - and counsel assisting made this submission - that his death was caused by or in any way contributed to by the use of the taser. The incident was immediately declared a critical incident and was investigated by officers of the Harbourside Local Area Command. Before they arrived, however, due only to inexperience in the procedures that apply to critical incidents, involved officers - at least one of them - spoke to independent witnesses.

In most cases this would have been standard police procedure. In this case, however, it was not in accordance with the guidelines. No harm has resulted from this but, obviously, it is a point that needs to be made and, indeed, has been made in the time since. New guidelines have been issued from the Professional Standards Command and they have been circulated to all New South Wales Police officers.

In the circumstances, and particularly given the inexperience of the officers involved and their shocking experience, I make no criticism of them at all. The critical incident was investigated thoroughly and professionally. As we have heard in submissions this morning, one suggestion made by counsel assisting to the officer in charge, Detective Sergeant MacKillop, in evidence yesterday, was that the records of interviews with involved officers might usefully have included questions referring to the separation of the officers, any contact they may have had with other witnesses, and other matters relating to the non-contamination of evidence.

As Mr Haverfield has correct said this morning, the key issue in these investigations of critical incidents is the non-contamination of evidence. How that is achieved in practical terms will generally depend on the circumstances. In any event, Detective Sergeant MacKillop agreed with the suggestion put to him by counsel assisting.

I should say, and I digress to say, that the suggestion in no way implies any fault or failure on the part of the investigators; I would like to emphasise that. As I have said, the Professional Standard Command last year in August issued new clarified critical incidents guidelines circulated to all in the New South Wales Police Force. This meets one of the relatively minor issues that has arisen in the case.

The two main issues raised in her opening by counsel assisting were, how and why was XX on the tracks cutting his own throat? It is not entirely clear why he did this. He was mentally ill. He was off his medication. As I have mentioned, his main sources of support, his extended family, were largely overseas and I surmise, as I have said, that his ties with them had largely disintegrated. This is the unfortunate experience of many mentally ill persons, particularly if they are off their medication and are not receiving the treatment that is prescribed for them.

It is also well known - a matter of common knowledge, really - that mentally ill persons are at much higher risk of suicide and self harm than others in the community.

But why XX chose that time and that place to harm himself in such a radical way remains something of a mystery that has not been explained to us and he is the principal witness to what was in his mind at the time; he is unavailable, of course, to say what he was thinking, except that it is evidence that he was in tremendous mental distress.

Could anything have been done to prevent the tragedy? I doubt it. It is very difficult to see what more the police on the spot could have done. I cannot see anything more that they could have done and, in fact, I believe that they did everything that was humanly possible to be done for him. In the end, despite their best efforts, the police were unable to prevent this tragedy. I am sorry, I should have written up my formal finding under the Coroners Act

I make the following finding:

Formal Finding

THAT XX DIED ON THE RAILWAY TRACKS AT THE SYDNEY CENTRAL STATION, NEW SOUTH WALES, ON 4 NOVEMBER 2011 AFTER DELIBERATELY CUTTING HIS OWN THROAT, WITH THE INTENTION OF TAKING HIS OWN LIFE, WITH A LARGE CARVING KNIFE.

Recommendation

To the Commissioner of Police: That the checklists appended to the August 2012 edition of the critical incident guidelines (page 50) be amended to include a requirement that interviews with involved officers include questions directed to the separation of involved officers and any other measures taken to ensure their evidence was not contaminated.

15. 407907 of 2011 s75 Non Publication Order

Inquest into the death of XX. Finding handed down by Deputy State Coroner Dillon at Glebe on the 2nd September 2013.

XX was a 30 year old male who was an inmate at Parklea Correctional Centre. He was born in Orange 25 February 1981 to DR and DB. He grew up in a violent alcohol and drug fuelled environment.

B recalls DB burning XX's arm with cigarettes when he was in Year 1 at Primary School. The most significant abuse was directed towards B and D. As a result of the abuse, the siblings were very close. The family moved around a lot with the next destination being Batemans Bay. XX was reported to be a happy child who managed to stay out of trouble the majority of the time. The family moved to Coffs Harbour when XX was about 12 years of age.

XX remained in Coffs Harbour for a number of years fathering two children. His first child is of school age. The mother left with the child after her birth and XX had nothing to do with her after this time. His second child was born in 1999 and kept in regular contact with XX. XX and the child's mother separated after she was born.

XX moved to Western Australia around 2001 to live with his father. He quickly found himself in trouble being arrested after committing a number of offences with his father, including armed robbery. Records indicate that XX returned to NSW during 2006 residing in Port Macquarie, Cowra and Coffs Harbour, before moving to QLD around 2009. Drug abuse caused further problems with Police in the following years in QLD before XX returned to NSW in 2011. He moved to his brother's premises in Cowra in country NSW.

After further problems with Police, XX moved to his sister's premises at Ourimbah. He continued to have problems with authorities whilst living with his sister. It was at this address XX met his girlfriend TP. XX was asked to leave by his sister after a short period due to the problems with Police and his ongoing drug addiction. He moved to an address nearby at Wyoming. He continued to find himself in trouble with Police, which eventually led to his incarceration.

XX's criminal history covers a wide range of offences including traffic and drink driving, drug possession, serious assault, break and enter, stealing, fraud and other property related offences. At the time of his death he was an unsentenced prisoner on remand for 3 different charges, which involved a total of 23 separate offences. XX was received into custody on 04 August 2011 at Gosford Court Cells and transferred to MRRC Silverwater that same day. He had previously been in custody in QLD in 2009 and been held in remand at MRRC for 10 days in March 2011.

At reception he disclosed that he was allergic to seafood and that he had a history of back problems for which he had been treated with prescription medication. He was a daily smoker and occasionally consumed alcohol. He was recommended for normal cell placement.

On 14 August 2011 he was transferred to Parklea Correctional Centre. During transfer he disclosed he was asthmatic and was referred to nursing staff for review. XX was bail refused on 16 December 2011 and was scheduled to appear before the Court on 17 February 2012 for a bail application. A review of the Corrective Services Case Management File indicates that he was classed as a maximum security prisoner with no internal disciplinary incidents.

Circumstances of Death

About 12.30pm on Monday 19 December 2011 XX, along with all inmates in Area 2 were let go from their cells and given access to the yard area of Parklea Correctional Centre. Inmates are locked out until 2.00pm unless they have special permission to access the area. About 1.30pm, XX attended the Area 2 B/D gate and spoke with Correctional Officer Maria VILLANUEVA. He informed VILLANUEVA that he required his asthma puffer as he was asthmatic. He was granted permission to retrieve his puffer and attended Area 2D with her. XX asked if she was going to lock him in.

She advised him that she was not and told him to get his puffer and get out. VILLANUEVA returned to the Area 2 office to assist under the belief that he would retrieve his puffer and return to the Area 2D gate to be let back into the yard. Due to the amount of work required she forgot about him and continued with her duties.

The inmates were allowed back into the common areas and their cells about 2.00pm. About 2.30pm inmate Bassam HELOU was returning to his cell from an AVL Court appearance to file his court papers. As he approached cell 34, the cell he shared with XX, he observed a white towel covering the Perspex observation window on the cell door. The towel usually means that privacy is required. HELOU opened the door and discovered his cell mate hanging from a point just above the inside of the door frame. HELOU called for help and as a result a number of inmates attended to assist. Inmates Zane REIDY and Charbell BOUMELHEM have run to the cell area. REIDY attempted to lift XX's legs whilst BOUMELHEM attempted to obtain a razor blade to cut him down.

XX was located hanging by the neck via a ligature made from light green bed sheets. The knot was tied to the right hand side of his neck. He was located facing away from the door towards the back of the cell approximately one to two feet off the ground. Inmates informed investigators that the ligature was cut about 10cm above his head. Once cut they further stated that XX fell and struck the right hand side of his head on the shelving located within the cell. As this occurred staff had been notified and attended. Both Correctional Officers and Justice Health staff performed CPR without success. Ambulance were contacted and attended with nil signs of life present. Police attended and made an examination of the scene. There were no signs of struggle or foul play.

Following initial investigations conducted within the cell, all inmates from Area 2D where XX was housed were spoken to by Police. During these interactions there was no suggestion he had an issue or problem with any other inmate. During his incarceration he discussed personal details about his family and girlfriend with other inmates.

In what appears to be an attempt to gain sympathy from his girlfriend he informed her he was suffering from brain cancer and was recovering from it. According to his health records this is untrue. He further told inmates that his girlfriend had breast cancer and had stolen his bail money, both of which are untrue. It appears that he concocted this story to gain sympathy from his fellow inmates and also possibly the Court in support of his upcoming bail application.

After reviewing the evidence investigators are satisfied that XX was screened sufficiently and that his placement in a two out cell was appropriate. All protocols were followed by Corrective Services and GEO Group with regard to deaths in custody. The Crime Scene was managed by GEO staff in an efficient and competent manner. In relation to Justice Health it appears he received satisfactory treatment.

The post mortem examination was conducted by Dr Rebecca IRVINE. The cause of death was a result of hanging.

There are no suspicious circumstances surrounding the death of XX. He died as a result of hanging.

XX meticulously planned his death. This is supported by the numerous suicide letters written to his family indicating what funeral requests he had and telling them that he was sorry for taking his own life. He entered his cell under the guise of obtaining his ventolin puffer with the purpose of taking his own life.

This is further supported by his actions of placing the towel over the observation window of the cell door as well as asking to be locked into his cell. It appears that if he had not taken his life on this day he would have taken it at the next available opportunity.

Formal Finding:

I find that XX died on 19 December 2011 at the Parklea Correctional Centre taking his own life by intentionally hanging himself.

16. 414027 of 2011 s 75 Non publication Order (see also 17)

Inquest into the death of XX. Finding handed down by Deputy State Coroner Forbes at Albury on the 25th July 2013.

This is an Inquest into the sad and tragic death of XX. XX died as result of shotgun wounds. Her husband XX inflicted those wounds upon her shortly before he turned a shotgun upon himself and subsequently died as a result of a self inflicted shotgun wound.

The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

- the identity of the deceased;
- the date and place of the person's death;
- the physical or medical cause of death; and
- the manner of death, in other words, the circumstances surrounding the death.

The issues in this case as to identity, date, place, cause and manner are uncontroversial.

The Act requires a Coroner to conduct an inquest in circumstances where a person died as a result of a homicide. (s. 27) In this case there is no further investigation required in relation to the homicide. The Act also requires a Coroner to conduct an inquest where the death appears to have occurred "*in the course of police operations".* (s.23, s.27). In this case the police had been contacted prior to the deaths and arrived at the scene as this tragic event unfolded. In those circumstances this inquest has been a close examination of their actions and pursuant to s.37 of the Act a summary of the details of this case will be reported to the Minister.

It should always be borne in mind that inquests are not criminal investigations, nor are they civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. XX was 35 years old and XX was 58 years old at the time of their deaths.

XX was born at Urana Hospital to J and KM on 22 August 1976. She was the second of two children and their only daughter. Her childhood was spent in Urana, where she attended the Urana High School until Year 10. She completed her High School Certificate at Wagga Wagga High School, boarding with family friends during the school week and returning to Urana for the weekends.

After she completed school she returned to live with her parents in Urana and took up an apprenticeship as a spray painter.

Within the year she was offered a job on the XX family property. It was at around this time that she commenced a relationship with XX.

She was 19 years old. Initially she moved in with XX and his parents and then about 6 months later, the couple moved to Kia Ora and began farming.

On 6 March 1998, she gave birth to their first child at Corowa Hospital. Their second child was born at Corowa on 28 August 2000 and their youngest son was born at Narrandera on 24 February 2005.

Within 12 months of moving out to Kia Ora, there is evidence that XX complained to her parents about XX's alcohol consumption and his treatment of her. There was also an occasion in December 2002, when XX attended the Urana Police Station upset following an argument. She reportedly explained to police that she and XX were in the process of separating and required assistance in contacting professional help.

XX and XX did not ultimately separate at that time, but continued to live and work together on Kia Ora for another 9 years and to bring up their 3 children.

Sometime in about 2009, she began to speak to her mother about separating from XX. By September 2011, the relationship had irreparably broken down and XX told XX that she was going to leave him.

From about October 2011, XX and XX began the process of arranging for their separation. XX met with the McFarlane family, who lived on a property approximately 50 km from Kia Ora and arrangements were made for her to take up a position working with them and to live with her children on a house on the property that was about 10 km from the main house. XX contacted a stock agent to arrange for the sale of a large quantity of stock, presumably in anticipation of a financial settlement of the property.

XX engaged a firm of solicitors to prepare a Financial Agreement to effect a settlement of the property. In early December 2011, XX's solicitors forwarded a draft Financial Agreement to XX's solicitors. It appears the terms of the draft Financial Settlement may have been an area of dispute, particularly in so far as the inclusion of particular assets in the pool of assets of the parties.

Arrangements had been made for XX to meet with his solicitors in Wagga Wagga on the morning of 22 December 2011 and XX was going to drive him to that appointment, an appointment that was not kept.

In late November 2011, XX spoke with Christine Simpson, a community nurse at the Urana Community Health Centre. During the course of that conversation, she told Nurse Simpson that she was leaving XX after Christmas and that he was not happy that the farm would have to be sold as a result of their separation.

Later that same day, Nurse Simpson spoke with XX by telephone. She asked him how he was coping and offered to refer him for counselling. XX told Nurse Simpson he was fine and said that he did not want counselling.

XX's assurances did not abate Nurse Simpson's concerns and on 2 December 2012, she approached S/Const David Dechene, who had recently taken up the position as Urana's single police officer.

The concerns Nurse Simpson raised with S/Const Dechene were that XX and XX were going to separate in the new year, with XX and the 3 children moving out to the McFarlane's property at Bidgeemia; that XX was drinking heavily and that XX had told her she was concerned about how XX would react when they separated. S/Const Dechene suggested to Nurse Simpson that she advise XX to come and see him and, if necessary, he would apply for an apprehended violence order (AVO).

XX often visited his mother who was a resident in the aged care facility attached to the Urana Community Health Centre. On about 5 December 2011, Nurse Simpson spoke with him in the car park. She asked him whether he was going to kill himself and he denied that he had any such plans.

Either that same day or the next day, Nurse Simpson saw XX in the car park of the Urana Community Health Centre. She told her that she had spoken with police and that the police had recommended she contact them to obtain an AVO. Nurse Simpson says that XX told her that she was not keen to contact Police to obtain an AVO as she knew how much XX disliked the police.

It appears that either on or shortly before 13 December 2011, XX contacted Marc Williams, who was previously the Drought Community Liaison Officer with the Border Division of GPs. Marc Williams subsequently contacted Nurse Simpson and told her that he had been contacted by XX, who had expressed concern for XX and the safety of her children. According to Nurse Simpson, XX had told Marc Williams that XX was in denial that she was leaving him and was drinking heavily.

Nurse Simpson contacted XX and told her that she should contact the Police and take out an AVO as soon as possible.

Later that afternoon, XX attended the Urana Community Heath Centre and enquired about counselling options. Nurse Simpson provided her with information, including the contact details of a drug and alcohol worker and generalist counsellor, Adele Kennedy and Access Line.

It appears that some further steps were taken to refer XX for counselling. Albury Mental Health Service received a referral due to some suicidal ideation and concern that he was depressed due to the breakdown of his marriage. On 15 December 2011, Louise Wilson, a Clinical Nurse Specialist with the Albury Mental Health Service faxed a letter to the Visiting Medical Officer (VMO) for Urana, Dr Khan recommending he commence XX on anti-depressants and advising that XX had declined to engage with the service, but had agreed to have some counselling for his grief and loss due to the marriage breakdown.

Nurse Simpson again spoke with XX in the car park of the Urana Community Health Service on 16 December 2011, at which time he denied he planned to harm himself and said that he would never harm his family.

On 19 December 2011, Nurse Simpson spoke with Dr Khan at his surgery, at which time, Dr Khan told him that he had received contact from the mental health service regarding XX, but had been unable to contact him.

Dr Khan asked Nurse Simpson for a contact number and she later forwarded a fax with the mobile telephone numbers for both XX and XX and a brief summary of her conversations with both of them.

XX had also taken some steps to try to reduce the amount of alcohol available to XX. Since about mid to late-2011, XX and his friend GR, who worked as a farmhand at Highview and with whom he often consumed alcohol, had arranged to have beer delivered to the Highview property once or twice a week by the owners of the IGA supermarket in Urana, Ralph and Karen Ciccia.

Ralph Ciccia estimates that he would deliver 2 – 3 slabs of 30 VB cans and up to 5 slabs a week. Karen Ciccia estimates that the figure was between 8 and up to as much as 12 slabs per week.

One or two weeks prior to her death, XX called in at the Ciccia's IGA and asked them to stop delivering alcohol to Highview. According to Karen Ciccia, she said words to the effect, "If you don't stop, tell Ralph the blood is on his hands. He will kill me." According to Ralph Ciccia, he agreed to stop delivering grog out to the farm and did not receive any more calls from GR or XX ordering grog. Nevertheless, IGA account records for alcohol purchases on the account for Highview indicate that in the two weeks between 8 December 2011 and 20 December 2011 a total of 18 boxes (slabs) of VB were purchased on the Highview account, 5 of which were purchased on 20 December 2011.

THE APPLICATION FOR AN AVO AND SEIZURE OF FIREARMS

On the morning of 14 December 2011, XX attended the Urana Police Residence and introduced herself to S/Const Dechene. She told him that she and XX had been together for about 17 years but that they were going to separate in the New Year and she did not think he would handle it well.

S/Const Dechene made enquiries on the police computer system (known as COPS) and noted the 2002 incident as well as a warning placed on the system in 2008 to the effect that XX may carry a firearm in his vehicle and had a hatred for police. When he raised these with XX, she confirmed that XX disliked police. She also told S/Const Dechene that XX was a heavy drinker and that she had asked Karen Ciccia to stop delivering beer for a couple of weeks until she sorted things out.

She was worried XX was going to do something and that she had stolen the key to his gun cabinet because he had been saying weird things like he'd take the kids for a long drive and not come back. She said that he had never assaulted her and, notwithstanding S/Const Dechene's suggestions that she take out an AVO, she declined to do so.

S/Const Dechene conducted a search of the Integrated Licensing System (ILS) and noted that there were 4 firearms registered to XX. He suggested that XX go home and bring back the 4 firearms and any ammunition she could locate.

Later that same day, XX returned to the Urana Police Station with 3 of the 4 firearms, which she handed to S/Const Dechene. She told him that the fourth firearm was an air rifle and that she was not scared of it.

However, she undertook to hand it in to police when she located it. She then made a short statement regarding the handing in of the firearms.

S/Const Dechene took steps to apply for an urgent AVO and made an ex parte application for a provisional AVO. At about 6:30 pm that same day, S/Const Dechene and another officer, S/Const Thorpe attended 'Kia Ora' in order to serve the interim AVO and to seize the remaining firearm, but nobody was home at the time.

At 6:00 pm the following day (15 December 2011), S/Const Dechene and S/Const Thorpe again attended 'Kia Ora' to serve the interim AVO and seize the remaining firearm. This time, both XX and XX were at home. S/Const Dechene explained the AVO to XX and that he was required to surrender his firearms and firearms licence. S/Const Dechene then went to the shed with XX and took possession of the remaining firearm (air rifle) and a quantity of ammunition.

On 19 December 2011, XX consented to an AVO at the Albury Local Court for a period of 6 months without admissions. In addition to the mandatory orders, the conditions of the AVO included a condition that he not approach XX and the children or any premises where they lived or worked within 12 hours of consuming intoxicating liquor.

The events of 21 and 22 December 2011

On 21 December 2011, XX attended the McFarlane property at Bidgeemia with her three children to see the house into which they were going to move and where they would live. She later attended the Urana IGA and spoke with Karen Ciccia, who has reported that XX appeared happy because XX appeared to have come to terms with the fact that they would be separating. Whilst there she used the internet to search for beds for the house where she would be living.

An appointment had been made for XX to attend his solicitors offices in Wagga Wagga in relation to the property settlement at 9:00 am on 22 December 2011. XX was going to drive him to Wagga Wagga and so arrangements were made for the children to stay with her parents on the night of 21 December 2011 as XX and XX would be leaving for Wagga early the next morning.

At about 9:30 am on 22 December 2011, KM and JM set off for Wagga Wagga with the children, to do some shopping for Christmas. Sometime after 10:00 am, whilst on route to Wagga Wagga, KM received a text message from XX's mobile telephone service that simply read, "*Where you*".

Shortly after receiving that text message, KM responded with a text message that read, "*Half 2 wagga*". According to the information downloaded from the mobile telephone itself, this message was marked as having been read.

KM did not receive a response to his text message and made further attempts to contact her by calling her at about 10:40 am and after arrival at Wagga at about 12:20 pm.

At 12:45 pm, KM sent a text message that read, "*Didn't u go 2 Wagga*". According to the information downloaded from XX's mobile telephone, this message was marked as having been read.

At 1:17 pm, a text message was sent from XX's mobile telephone service to that of KM. It read, *"I need police he has gun no siren he will kill me"*

KM did not become aware of the text message until about 10 minutes after it had been sent. At 1:26 pm, he telephoned triple-0. KM initially told the operator that his daughter had "just rung up. She's on Doctors Road, Urana. He's got a gun and she's frightened he's gonna shoot her." Later in the telephone call, KM told the operator that his daughter had "just text me, text me and said get the police, he's got a gun". He also provided the names of his daughter and XX and directions to the property 'Kia Ora'.(Vol x Tab X)

The brief contains copies of the Police Computer Aided Dispatch (CAD) Incident Log (V2/70) as well as relevant police radio (VKG) recordings and transcripts relating to the police response.

According to the Incident Log the triple-0 call was received by Police at about 1:26 pm on 22 December 2011. From that call, a job or incident was created on the Police CAD system and information to the following effect was broadcast over police radio at about 1:28 pm: (Vol X Tab X)

"The first house down Doctors Road at Urana, 4 miles from Jerilderie Road, concern for welfare of a female occupant there. The female has texted her father from the Urana address saying that the ex has turned up at the premises armed with a firearm and is currently with her. POI is XX about 50 old. Victim is a XX."

The job and information was broadcast with a priority of 2.

A number of police officers responded to the broadcast. These included:

Sgt Andrew Robertson (V1/26-27) and S/Const Matthew Smith (V1/32), who responded from Corowa Police Station in a fully marked police 4WD vehicle having the call sign Corowa 19 (COR19);S/Const Russell Morris (V2/33-34) and Prob Const Justin Dickson (V2/35-36), who also responded from Corowa Police Station in a fully marked police 4WD vehicle having the call sign Rand 21 (RND21) – It was Prob Const Dickson's first shift out on the road as a police officer, having only graduated from the NSW Police Academy on 16 December 2011;

S/Const Steve Thorpe (V1/28-29) and S/Const Douglas Nyholm (V1/30-31), responded from Mulwala Police Station in a fully marked police 4WD vehicle having the call sign Mulwala 24 (MWA24); and finally

S/Const Gregory Lawler (V2/37-38) and Const Daniel Coates responded from Finley Police Station (which is in the neighbouring LAC of Deniliquin) in a fully marked category 1 highway patrol vehicle having the call sign Finley 205 (FIN205).

Those 4 police vehicles and their occupants were coming from some distance away from Kia Ora: Corowa Police Station is approximately 80 km south southeast of Urana; Mulwala Police Station is approximately 95 km south southwest of Urana; and Finley Police Station is approximately 92 km to the west of Urana.

All vehicles proceeded code red, that is, with their lights and sirens activated and at speed. In the case of Finley 205, the activation of the lights and sirens activated an in car video (ICV) that recorded their journey up to shortly prior to their arrival at the intersection of the Urana-Jerilderie Road and Doctors Road.

In addition, detectives at Albury Police Station monitored the situation and sought to obtain further information that might assist the vehicles en route to Kia Ora. These included D/S/Const Matthew Kelly (V2/39) and a trained police negotiator, D/Sgt Chris Wallace (V2/41).

D/S/Const Kelly spoke to KM at about 1:45 pm and obtained further information, including that his daughter's three children were with him; he had not heard from his daughter for at least 2 hours before he received a text message from her mobile service. KM also provided D/S/Const Kelly with his daughter's mobile telephone number and descriptions of three motor vehicles and he told D/S/Const Kelly that XX's firearms had been seized previously but that he may have sourced another firearm from somewhere else. D/S/Const Kelly subsequently broadcast that information for the benefit of the police en route to Urana at about 1:57 pm. He also attempted to contact XX on her mobile telephone but it went through to her message bank service and he left his contact details.

At about 2:00 pm, D/S/Const Kelly briefed Sgt Wallace in relation to the incident. D/Sgt Wallace instructed D/S/Const Kelly to contact KM again in order to obtain his and his grandchildren's whereabouts; instruct KM not to go to the property where his daughter and XX may be; and to obtain a mobile telephone number for XX.

D/S/Const Kelly then contacted KM again and instructed him not to return to his daughter's property. KM told D/S/Const Kelly that he would take his grandchildren back to his place and wait to hear further from Detective Kelly in relation to the welfare of his daughter.

D/S/Const Kelly experienced a number of difficulties communicating with KM as a result of poor mobile phone reception or the phone cutting out. At about 2:10 pm, D/S/Const Kelly spoke with KM and obtained from him a mobile telephone number for XX, which he subsequently passed on to D/Sgt Wallace.

At about 2:15 pm, D/S/Const Kelly again contacted KM and asked him to read out the text message KM had received from his daughter XX. This was the first time at which the full detail of the text message was obtained and it was broadcast over Police VKG radio at about 2:20 pm. D/Sgt Wallace made enquiries of his own on the police computer system, and obtained a landline number for Kia Ora. He made attempts to contact Kia Ora on the landline at 2:28 pm and 2:32 pm but there was no answer and he did not leave a message.

At 2:37 pm, D/Sgt Wallace attempted to contact XX on his mobile telephone service, having obtained that number from D/S/Const Kelly. Again, there was no answer and D/Sgt Wallace did not leave a message.

The arrival of police at the intersection of Doctors Road and the Urana-Jerilderie Road

The first police to arrive in the vicinity of Urana were Senior Constable Lawler and Constable Coates in Finley 205.

They arrived at the intersection of the Urana-Jerilderie Road and Doctors Road, approximately 4.5 km to the north of Kia Ora at about 2:12 pm, that is, before the full content of the text message had been broadcast over police VKG radio.

The police in Corowa 19, Rand 21 and Mulwala 24 arrived at the other end of Doctors Road at the intersection with the Urana-Oaklands Road, approximately 10.7 km to the south of Kia Ora at about that same time or very shortly thereafter. At that location, there was some discussion about how next to proceed. Because of the report that a firearm may be involved, all of the officers put on their bulletproof vests.

Only one of the officers present at that location had prior knowledge of the property Kia Ora. S/Const Thorpe had attended the property with S/Const Dechene on 15 December 2011 to serve the AVO and seize the firearms. S/Const Thorpe provided the other officers with a brief description of the farm and there was some discussion about moving to a position closer to the property. S/Const Thorpe had approached from the other end of Doctors Road and he had never before driven along Doctors Road from the location at the intersection with the Urana-Oaklands Road.

The move to a position closer to 'Kia Ora'

In any event, it appears that a decision was made to proceed to a position closer to the property. This was communicated to Police VKG at about 2:21 pm.

The three 4WD police vehicles then proceeded along Doctors Road towards Kia Ora. S/Const Thorpe and S/Const Nyholm were the lead car in Mulwala 24, followed by S/Const Morris and Probationary Constable Dickson in Rand 21 and finally Sgt Robertson and S/Const Smith in Corowa 19.

The three cars inadvertently proceeded further than initially intended, so that they were directly adjacent to the fence line along the front paddock of the residence on Kia Ora. Upon realising this fact, Sgt Robertson instructed the others to pull back to a position a few hundred metres from the south-western corner of the front paddock. At about 2:33 pm, Mulwala 24 advised Police VKG radio that they were all about a kilometre south of Kia Ora. Finley 205 advised they would start making their way towards the property from the northern end of Doctors Road, but was instructed by VKG to remain in their position for the time being.

A change of circumstance – the sighting of the white utility in the front paddock

At about 2:39 pm Mulwala 24 informed police VKG that they had sighted a vehicle heading their way.

The three vehicles proceeded towards the property immediately. S/Const Morris and Prob Const Dickson in Rand 21 turned right on to a road adjacent to the southern fence line of the front paddock, while Mulwala 24 and Corowa 19 proceeded directly to the front gate and into the front paddock.

The shooting

Mulwala 24 and Corowa 19 entered onto the front paddock of the property via the entrance to the driveway at the northwestern corner of the paddock and turned off the driveway towards the two cars that were stationary towards the southwestern end of the paddock, generally adjacent to each other but facing in opposite directions a little over 120 metres from the driveway.

The police observed a male XX at the drivers side of the white utility. He was seen to take a firearm from the white utility and point it in through the driver's side window of the green Ford falcon sedan .

They called on the male XX to stop and to drop the gun and they saw him raise the rifle above his head as if he was about to surrender, but then suddenly turn the gun towards the right side of his head and pull the trigger, his body immediately slumping against the open driver's side area of the white utility.

The police officers then moved up to the two cars and determined that XX appeared to be deceased with a single gunshot wound to his head. They also observed a XX deceased in the drivers seat of the green Ford falcon sedan, with what appeared to be gunshot wounds to her chest and head.

REPORTING OF DEATH TO KM and JM

Regrettably, KM and JM were first told of their daughter's death not by police, but by other members of the local community, who had apparently been monitoring police broadcasts that afternoon on police scanners.

I understand steps are being taken to provide for encryption of police radio broadcasts in rural areas. Whilst the first stage of that process – the installation of digital radio – has recently been completed in the Albury and Wagga Wagga areas, the actual encryption of that police digital radio broadcasts in the Albury area is expected to take up to 3 years.

POST MORTEM EXAMINATIONS AND BALLISTICS

Dr Istvan Szentmariay conducted autopsies on each of XX and XX on 27 December 2012. (Ex 1) On the basis of his examinations, Dr Szentmariay concluded that in the case of XX, the cause of death was gunshot wounds to the chest and head.

In the case of XX, Dr Szentmariay concluded the cause of death was a shotgun wound to the head (loose contact wound).

A ballistics expert from the NSW Police Force Forensic Ballistics Section, Mr Elton Potgieter and made the following conclusions:

- the wounds to XX's right upper arm and right side of her chest were consistent with having been caused by the singe discharge of a shotgun with a trajectory of right to left;[18]

- the gunshot entry wound under XX's chin was consistent with having been caused by the single discharge of a shotgun, the muzzle of which was in contact or near contact with her at the time of discharge with the trajectory being upward, front to back and right to left;[19] and

- the gunshot entry wound to XX's right temple was consistent with having been caused by the single discharge of a shotgun, the muzzle of which was in angled near contact with him at the time of the discharge with the trajectory being upward, front to back and right to left.

An important issue that has been explored at this inquest is the appropriateness of police actions in the circumstances. This is not limited to the moments immediately prior to the entry onto Kia Ora just prior to the fatal shooting. It extends to a consideration of the conduct and actions of police in their response to the situation as it unfolded, including possible alternative tactical options that may have been available at different points along the way.

CONCLUSION

Clearly an incident such as this attracts significant attention, interest and scrutiny from the community. It is hoped the inquisitorial process that has been embarked upon will allay any such concerns by thoroughly examining the evidence and material available both in documentary form as produced in the coronial brief and in the oral testimony to be given by the various witnesses.

MATTERS OF ADMINISTRATION

Non-Publication Orders

For the benefit of members of the public and any members of the press who may be present, I note that YH has already made the following non-publication orders in the matter:

> An order pursuant to section 75 of the Coroner's Act prohibiting publication of the names of the children.

[18] V1/22 – Elton Potgieter 28/05/12 at [5(b)].
[19] V1/22 – Elton Potgieter 28/05/12 at [5(c)].

An order pursuant to section 74 of the Coroner's Act preventing publication of the documents at tab 79 and 80 of the brief and pages 145 to 146 of the brief (being paragraphs 120 to 122 of the statement of Detective Rod Smith).

Photographs, ISRAPS and DVD material

There is an amount of DVD, audio and photographic material that will be tendered, as a part of this inquest – some of it is both sensitive and distressing – As the parties are aware access may be obtained via request of my instructing solicitors. Furthermore YH, and as a matter of caution, I ask that at the time of tender of that material YH make a non publication order that:

> *"There be no publication of any exhibit or material including photographs, DVDs, and/or any other footage tendered in these proceedings, that contains any image of XX or XX in a deceased state."*

Formal Finding

I FIND THAT XX DIED ON 22 DECEMBER 2011 AT 'KIA ORA' NEAR URANA' NSW. THE CAUSE OF HER DEATH WAS SHOTGUN WOUNDS TO HER HEAD AND CHEST. THE MANNER OF HER DEATH WAS HOMICIDE.

17. 414031 of 2011 s75 Non Publication Order (see also 16)

Inquest into the death of XX

This is an Inquest into the sad death of XX. On the 22 December 2011, XX died as result of a self-inflicted shotgun wound at his property known as "Kia Ora", which is near Urana in NSW. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

- the identity of the deceased;
- the date and place of the person's death;
- the physical or medical cause of death; and
- the manner of death, in other words, the circumstances surrounding the death.

The issues in this case as to identity, date, place, cause and manner are uncontroversial.

The Act, however, requires a Coroner to conduct an inquest where the death appears to have occurred "*in the course of police operations".* (S.23, s.27). In this case the police had been contacted prior to XX's death and arrived at the scene as this tragic event unfolded.

In those circumstances this inquest has been a close examination of the police actions on the day. Pursuant to s.37 of the Act a summary of the details of this case will be reported to the Minister.

It should always be borne in mind that inquests are not criminal investigations, nor are they civil liability proceedings intended to determine fault or lay blame on persons involved in the incident.

XX was 58 years old at the time of his death. Minutes before he took his own life he had inflicted two fatal injuries on his partner, XX. XX was 35 years old. They had been together for about 17 years and had three children.

XX was born in Ardlethan District Hospital to GH and AH on 19 September 1953, the third of four children. Most of his childhood was spent at Ardlethan, where he attended St Joseph's Primary School and later Ardlethan High School before the family moved to a property called "Highview" near Urana in about 1966 where he completed his schooling at Urana High School.

After completing his schooling, XX worked on a neighbouring property and performed various other jobs, including truck driving, shearing and working on the family farm. In about 1980, he purchased a property then called "Burroo Tree", which he renamed "Kia Ora". However, he continued to live on the family farm with his parents.

In about 1995, he met XX. She was offered a job on the XX family property and they commenced a relationship. She was 19 years old. Initially she moved in with XX and his parents and then about 6 months later, the couple moved to Kia Ora and began farming.

On 6 March 1998, she gave birth to their first child at Corowa Hospital. Their second child was born at Corowa on 28 August 2000 and their youngest son was born at Narrandera on 24 February 2005.

In December 2002, XX attended the Urana Police Station upset following an argument. She reportedly explained to police that she and XX were in the process of separating and required assistance in contacting professional help.

XX and XX did not ultimately separate at that time, but continued to live and work together on Kia Ora for another 9 years and to bring up their 3 children.

From September 2011 XX had told XX that she was going to leave him. XX's brother, R said that from that time XX became really flat and down.

From about October 2011, XX and XX began the process of arranging for their separation. XX met with the McFarlane family, who lived on a property approximately 50 km from Kia Ora and arrangements were made for her to take up a position working with them and to live with her children on a house on the property that was about 10 km from the main house. XX contacted a stock agent to arrange for the sale of a large quantity of stock, presumably in anticipation of a financial settlement of the property.

XX engaged a firm of solicitors to prepare a Financial Agreement to effect a settlement of the property. In early December 2011, XX Martin's solicitors forwarded a draft Financial Agreement to XX's solicitors. It appears the terms of the draft Financial Settlement may have been an area of dispute, particularly in so far as the inclusion of particular assets in the pool of assets of the parties.

Arrangements had been made for XX to meet with his solicitors in Wagga Wagga on the morning of 22 December 2011 and XX was going to drive him to that appointment, an appointment that was not kept.

In late November 2011, XX spoke with Christine Simpson, a community nurse at the Urana Community Health Centre. During the course of that conversation, she told Nurse Simpson that she was leaving XX after Christmas and that he was not happy that the farm would have to be sold as a result of their separation.

Later that same day, Nurse Simpson spoke with XX by telephone. She asked him how he was coping and offered to refer him for counselling. XX told Nurse Simpson he was fine and said that he did not want counselling.

XX's assurances did not abate Nurse Simpson's concerns and on 2 December 2011, she approached S/Const David Dechene, who had recently taken up the position as Urana's single police officer.

The concerns Nurse Simpson raised with S/Const Dechene were that XX and XX were going to separate in the new year, with XX and the 3 children moving out to the McFarlane's property at Bidgeemia; that XX was drinking heavily and that XX had told her she was concerned about how XX would react when they separated. S/Const Dechene suggested to Nurse Simpson that she advise XX to come and see him and, if necessary, he would apply for an apprehended violence order (AVO).

XX often visited his mother who was a resident in the aged care facility attached to the Urana Community Health Centre. On about 5 December 2011, Nurse Simpson spoke with him in the car park. He denied having any plans of self harm.

Either that same day or the next day, Nurse Simpson saw XX in the car park of the Urana Community Health Centre. She told her that she had spoken with police and that the police had recommended she contact them to obtain an AVO. Nurse Simpson says that XX told her that she was not keen to contact Police to obtain an AVO as she knew how much XX disliked the police.

It appears that either on or shortly before 13 December 2011, XX contacted Marc Williams, who was previously the Drought Community Liaison Officer with the Border Division of GPs. Marc Williams subsequently contacted Nurse Simpson and told her that he had been contacted by XX, who had expressed concern for XX and the safety of her children. According to Nurse Simpson, XX had told Marc Williams that XX was in denial that she was leaving him and was drinking heavily

Nurse Simpson contacted XX and told her that she should contact the Police and take out an AVO as soon as possible.

Later that afternoon, XX attended the Urana Community Heath Centre and enquired about counselling options. Nurse Simpson provided her with information, including the contact details of a drug and alcohol worker and generalist counsellor, Adele Kennedy and Access Line.

It appears that some further steps were taken to refer XX for counselling. Albury Mental Health Service received a referral due to some suicidal ideation and concern that he was depressed due to the breakdown of his marriage. On 15 December 2011, Louise Wilson, a Clinical Nurse Specialist with the Albury Mental Health Service faxed a letter to the Visiting Medical Officer (VMO) for Urana, Dr Khan recommending he commence XX on anti-depressants and advising that XX had declined to engage with the service, but had agreed to have some counselling for his grief and loss due to the marriage breakdown.

Nurse Simpson again spoke with XX in the car park of the Urana Community Health Service on 16 December 2011, at which time he denied he planned to harm himself and said that he would never harm his family.

On 19 December 2011, Nurse Simpson spoke with Dr Khan at his surgery, at which time, Dr Khan told him that he had received contact from the mental health service regarding XX, but had been unable to contact him.

Dr Khan asked Nurse Simpson for a contact number and she later forwarded a fax with the mobile telephone numbers for both XX and XX and a brief summary of her conversations with both of them.

XX had also taken some steps to try to reduce the amount of alcohol available to XX. Since about mid to late-2011, XX and his friend GR, who worked as a farmhand at Highview and with whom he often consumed alcohol, had arranged to have beer delivered to the Highview property once or twice a week by the owners of the IGA supermarket in Urana, Ralph and Karen Ciccia. Ralph Ciccia estimates that he would deliver 2 – 3 slaps of 30 VB cans and up to 5 slabs a week. Karen Ciccia estimates that the figure was between 8 and up to as much as 12 slabs per week.

One or two weeks prior to her death, XX called in at the Ciccia's IGA and asked them to stop delivering alcohol to Highview. According to Karen Ciccia, she said words to the effect, "If you don't stop, tell Ralph the blood is on his hands. He will kill me." According to Ralph Ciccia, he agreed to stop delivering grog out to the farm and did not receive any more calls from GR or XX ordering grog. Nevertheless, IGA account records for alcohol purchases on the account for Highview indicate that in the two weeks between 8 December 2011 and 20 December 2011 a total of 18 boxes (slabs) of VB were purchased on the Highview account, 5 of which were purchased on 20 December 2011.

On the morning of 14 December 2011, XX attended the Urana Police Residence and introduced herself to S/Const Dechene. She told him that she and XX had been together for about 17 years but that they were going to separate in the New Year and she did not think he would handle it well.

S/Const Dechene made enquiries on the police computer system and noted the 2002 incident as well as a warning placed on the system in 2008 to the effect that XX may carry a firearm in his vehicle and had a hatred for police. When he raised these with XX, she confirmed that XX disliked police.

She also told S/Const Dechene that XX was a heavy drinker and that she had asked Ralph and Karen Ciccia to stop delivering beer for a couple of weeks until she sorted things out.

She also told S/Const Dechene that she was also worried XX was going to do something and that she had stolen the key to his gun cabinet because he had been saying weird things like he'd take the kids for a long drive and not come back. She said that he had never assaulted her and, notwithstanding S/Const Dechene's suggestions that she take out an AVO, she declined to do so.

S/Const Dechene conducted a search of the Integrated Licensing System (ILS) and noted that there were 4 firearms registered to XX. He suggested that XX go home and bring back the 4 firearms and any ammunition she could locate.

Later that same day, XX returned to the Urana Police Station with 3 of the 4 firearms, which she handed to S/Const Dechene. She told him that the fourth firearm was an air rifle and that she was not scared of it.

However, she undertook to hand it in to police when she located it. She then made a short statement regarding the handing in of the firearms and left the station.

S/Const Dechene subsequently took his own steps to apply for an urgent AVO and made an ex parte application for a provisional AVO. At about 6:30 pm that same day, S/Const Dechene and another officer, S/Const Thorpe attended 'Kia Ora' in order to serve the interim AVO and to seize the remaining firearm, but nobody was home at the time.

At 6:00 pm the following day (15 December 2011), S/Const Dechene and S/Const Thorpe again attended 'Kia Ora' to serve the interim AVO and seize the remaining firearm. This time, both XX and XX were at home. S/Const Dechene explained the AVO to XX and that he was required to surrender his firearms and firearms licence. S/Const Dechene then went to the shed with XX and took possession of the remaining firearm (air rifle) and a quantity of ammunition.

On 19 December 2011, XX consented to an AVO at the Albury Local Court for a period of 6 months without admissions. In addition to the mandatory orders, the conditions of the AVO included a condition that he not approach XX and the children or any premises where they lived or worked within 12 hours of consuming intoxicating liquor.

On 21 December 2011, XX attended the McFarlane property at Bidgeemia with her three children to see the house into which they were going to move and where they would live. She later attended the Urana IGA and spoke with Karen Ciccia, who has reported that XX appeared happy because XX appeared to have come to terms with the fact that they would be separating. Whilst there she used the internet to search for beds for the house where she would be living.

An appointment had been made for XX to attend his solicitors offices in Wagga Wagga in relation to the property settlement at 9:00 am on 22 December 2011. XX was going to drive him to Wagga Wagga and so arrangements were made for the children to stay with her parents on the night of 21 December 2011 as XX and XX would be leaving for Wagga early the next morning.

At about 9:30 am on 22 December 2011, KM and JM set off for Wagga Wagga with the children, to do some shopping for Christmas. Sometime after 10:00 am, whilst on route to Wagga Wagga, KM received a text message from XX's mobile telephone service that simply read, "*Where you*". (Vol 3 Tab 89)

Shortly after receiving that text message, KM responded with a text message that read, "*Half 2 wagga*". (Vol 3 Tab 88) According to the information downloaded from XX's telephone this message was marked as having been read.

KM did not receive a response to his text message and made further attempts to contact his daughter by calling her at about 10:40 am and after arrival at Wagga at about 12:20 pm. At 12:45 pm, KM sent a text message that read, "*Didn't u go 2 wagga*". (Vol 3 Tab 88) According to the information downloaded from XX's mobile telephone, this message was marked as having been read.

At 1:17 pm, a text message was sent from XX's mobile telephone service to that of KM. It read, *"I need police he has gun no siren he will kill me"* (Vol 3 Tab 89)

KM did not become aware of the text message until about 10 minutes after it had been sent. At 1:26 pm, he telephoned triple-0. KM initially told the operator that his daughter had "just rung up. She's on Doctors Road, Urana. He's got a gun and she's frightened he's gonna shoot her." Later in the telephone call, KM told the operator that his daughter had "just text me, text me and said get the police, he's got a gun". He also provided the names of his daughter and XX and directions to the property 'Kia Ora'. (Vol 2 Tab 68)

The brief contains copies of the Police Computer Aided Dispatch (CAD) Incident Log (Vol 2 Tab 70) as well as relevant police radio (VKG) recordings and transcripts relating to the police response. (Vol 2 Tab 69)

According to the Incident Log the triple-0 call was received by Police at about 1:26 pm on 22 December 2011. From that call, a job or incident was created on the Police CAD system and information to the following effect was broadcast over police radio at about 1:28 pm:

> *"The first house down Doctors Road at Urana, 4 miles from Jerilderie Road, concern for welfare of a female occupant there. The female has texted her father from the Urana address saying that the ex has turned up at the premises armed with a firearm and is currently with her. POI is XX about 50 old. Victim is a XX."*

A number of police officers responded to the broadcast. These included:

- Sgt Andrew Robertson (V1/26-27) and S/Const Matthew Smith (V1/32), who responded from Corowa Police Station in a fully marked police 4WD vehicle having the call sign Corowa 19 (COR19);

- S/Const Russell Morris (V2/33-34) and Probationary Const Justin Dickson (V2/35-36), who also responded from Corowa Police Station in a fully marked police 4WD vehicle having the call sign Rand 21 (RND21) – It was Probationary Const Dickson's first shift out on the road as a police officer, having only graduated from the NSW Police Academy on 16 December 2011;

- S/Const Steve Thorpe (V1/28-29) and S/Const Douglas Nyholm (V1/30-31), responded from Mulwala Police Station in a fully marked police 4WD vehicle having the call sign Mulwala 24 (MWA24); and finally

- S/Const Gregory Lawler (V2/37-38) and Const Daniel Coates responded from Finley Police Station (which is in the neighbouring LAC of Deniliquin) in a fully marked category 1 highway patrol vehicle having the call sign Finley 205 (FIN205).

Those 4 police vehicles and their occupants were coming from some distance away from Kia Ora: Corowa Police Station is approximately 80 km south southeast of Urana; Mulwala Police Station is approximately 95 km south southwest of Urana; and Finley Police Station is approximately 92 km to the west of Urana.

The vehicles proceeded code red, that is, with their lights and sirens activated and at speed.

Rand 21 lights and sirens were not working and they travelled behind Mulwala 24. Mulwala 24 turned off their lights and sirens as they went through Oaklands, about 20 k from Kia Ora. Corowa 19 turned off their lights and sirens shortly before they met up with Mulwala 24 and Rand 21 at the intersection of the Oaklands-Urana Road and Doctors Road. This meeting place was 10.7 k from the property Kia Ora.

In Finley 205, the activation of the lights and sirens activated an in car video (ICV) that recorded their journey. They turned off their lights and sirens shortly prior to their arrival at the intersection of the Urana-Jerilderie Road and Doctors Road, which was 4.5 k from Kia Ora.

The Officer in Charge of the investigation Detective Inspector Smith gave evidence that no one at the property Kia Ora would have been able to hear the lights and sirens of any of the police vehicles before they were turned off. His evidence is not in dispute and I am satisfied that it is most unlikely that either XX or XX heard any police sirens on this day.

Detectives at Albury Police Station were remaining in contact with KM and attempting to make contact with XX and XX by telephone. These included D/S/Const Matthew Kelly (V2/39) and a trained police negotiator, D/Sgt Chris Wallace (V2/41).

D/S/Const Kelly spoke to KM at about 1:45 pm and obtained further information, including that his daughter's three children were with him; he had not heard from his daughter for at least 2 hours before he received a text message from her mobile service. KM also provided D/S/Const Kelly with his daughter's mobile telephone number and descriptions of three motor vehicles and he told D/S/Const Kelly that XX firearms had been seized previously but that he may have sourced another firearm from somewhere else. D/S/Const Kelly subsequently broadcast that information for the benefit of the police en route to Urana at about 1:57 pm. He also attempted to contact XX on her mobile telephone but it went through to her message bank service and he left his contact details.

At about 2:00 pm, D/S/Const Kelly briefed/Sgt Wallace in relation to the incident. D/Sgt Wallace instructed D/S/Const Kelly to contact KM again in order to obtain his and his grandchildren's whereabouts; instruct KM not to go to the property where his daughter and XX may be; and to obtain a mobile telephone number for XX.

D/S/Const Kelly then contacted KM again and instructed him not to return to his daughter's property. KM told D/S/Const Kelly that he would take his grandchildren back to his place and wait to hear further from Detective Kelly in relation to the welfare of his daughter.

D/S/Const Kelly experienced a number of difficulties communicating with KM as a result of poor mobile phone reception or the phone cutting out.

At about 2:10 pm, D/S/Const Kelly spoke with KM and obtained from him a mobile telephone number for XX, which he subsequently passed on to D/Sgt Wallace.

At about 2:15 pm, D/S/Const Kelly again contacted KM and asked him to read out the text message KM had received from his daughter. This was the first time at which the full detail of the text message was obtained and it was broadcast over Police VKG radio at about 2:20 pm.

D/Sgt Wallace made enquiries of his own on the police computer system, and obtained a landline number for Kia Ora. He made attempts to contact Kia Ora on the landline but there was no answer and he did not leave a message.

D/Sgt Wallace attempted to contact XX on his mobile telephone service, having obtained that number from D/S/Const Kelly. Again, there was no answer and D/Sgt Wallace did not leave a message.

The first police to arrive in the vicinity of Urana were Senior Constable Lawler and Constable Coates in Finley 205. They arrived at the intersection of the Urana-Jerilderie Road and Doctors Road, approximately 4.5 km to the north of Kia Ora at about 2:12 pm.

The police in Corowa 19, Rand 21 and Mulwala 24 arrived at the other end of Doctors Road at the intersection with the Urana-Oaklands Road, approximately 10.7 km to the south of Kia Ora shortly after. At that location, there was some discussion about how next to proceed. Because of the report that a firearm may be involved, all of the officers put on their bullet-proof vests. They adapted a plan of containment and negotiation. They decided that the best option was to move to a location closer to Kia Ora but to remain at a safe distance in a position to respond if necessary.

Only one of the officers present had prior knowledge of Kia Ora. S/Const Thorpe had attended the property with S/Const Dechene on 15 December 2011 to serve the AVO and seize the firearms. S/Const Thorpe provided the other officers with a brief description of the farm and there was discussion about moving to a position closer to the property. S/Const Thorpe had approached from the other end of Doctors Road and he had never before driven along Doctors Road from the location at the intersection with the Urana-Oaklands Road.

A decision was made to proceed to a position closer to the property. This was communicated to Police VKG at about 2:21 pm.

Finley 205 advised they would start making their way towards the property from the northern end of Doctors Road, but was instructed by VKG to remain in their position for the time being. As part of the containment strategy they were to stop any vehicles leaving or entering Doctors Road.

The three 4WD police vehicles then proceeded cautiously along Doctors Road towards Kia Ora. S/Const Thorpe and S/Const Nyholm were the lead car in Mulwala 24, followed by S/Const Morris and Probationary Constable Dickson in Rand 21 and finally Sgt Robertson and S/Const Smith in Corowa 19.

The three cars inadvertently proceeded further than initially intended. They were directly adjacent to the fence line along the front paddock of the residence on Kia Ora. when S/Const Thorpe recognised the property. Upon realising this fact, Sgt Robertson instructed the others to pull back to a position a few hundred metres from the south-western corner of the front paddock. They had put themselves at risk by overshooting the mark and appropriately decided to pull back. They maintained a position that was out of range of a firearm but in a position to respond if necessary. They were still not aware if anyone was at the property.

It is possible that either XX or XX saw or heard the police vehicles at this point. While the visibility of the road from the house is extremely limited,

it is possible that XX was keeping an eye or ear out for police as she had received a text from her father at 2:50 pm to say they were on their way. Whether or not anyone at the property was in fact aware of the police presence would be speculation.

At the pull back position Sgt Robertson was on the phone trying to obtain confirmation of whether the Albury detectives had made contact with XX or XX. The weight of evidence is that the other officers had discussed a plan that if required to respond Mulawa 24 and Corowa 19 would proceed directly to the property and enter it from the front driveway. Rand 21 would take the laneway on the southern boundary of the property and enter it from the rear.

At about 2:39 pm events changed rapidly. Mulwala 24 informed police VKG that they had sighted a vehicle. The vehicle was XX's white utility and it was moving in the front paddock.

The three vehicles proceeded towards the property immediately. S/Const Morris and Prob Const Dickson in Rand 21 turned right on to a road adjacent to the southern fence line of the front paddock, while Mulwala 24 and Corowa 19 proceeded directly to the front gate and into the front paddock.

Upon entering the property and turning sharp right the officers saw a second vehicle, a green Ford. Sgt Robertson said that he first saw the green Ford from Doctors road as he was passing and that it was rolling forward. The shattered glass to the drivers window of that vehicle was found about 10-15m to the rear of the car.

The Toyota and the Ford were generally adjacent to each other but facing in opposite directions a little over 120 metres from the driveway.

The police observed a male (XX) lean in towards the Ford and then pull back out. Police then saw XX at the drivers side of the white utility. He was seen to take a firearm from the white utility and point it in through the driver's side window of the green Ford. None of the officers heard a shot . They then saw XX take the weapon back to the utility. Some thought he was going to put the gun away and surrender, some thought he might be re-loading.

They called on the male (XX) to stop and to drop the gun and they saw him raise the rifle above his head as if he was about to surrender, but then suddenly tilt the gun towards the right side of his head and pull the trigger, his body immediately slumping against the open driver's side area of the white utility.

The police officers then moved up to the two cars and determined that XX was deceased with a single gunshot wound to his head. They also observed XX deceased in the drivers seat of the green Ford, with what appeared to be gunshot wounds to her chest and head.

Dr Istvan Szentmariay conducted autopsies on each of XX and XX on 27 December 2012. On the basis of his examinations, Dr Szentmariay concluded that in the case of XX, the cause of death was two gunshot wounds to the chest and head (Ex 1). Dr Szentmariary also reported that he believed either of the gunshot wounds were individually fatal (Ex 6). In the case of XX, Dr Szentmariay concluded the cause of death was a shotgun wound to the head (loose contact wound). (Ex 2)

A ballistics expert from the NSW Police Force Forensic Ballistics Section, Mr Elton Potgieter and made the following conclusions (Vol 1 Tab 22):

- the wounds to XX's right upper arm and right side of her chest were consistent with having been caused by the singe discharge of a shotgun with a trajectory of right to left;

- the gunshot entry wound under XX's chin was consistent with having been caused by the single discharge of a shotgun, the muzzle of which was in contact or near contact with her at the time of discharge with the trajectory being upward, front to back and right to left; and

- the gunshot entry wound to XX right temple was consistent with having been caused by the single discharge of a shotgun, the muzzle of which was in angled near contact with him at the time of the discharge with the trajectory being upward, front to back and right to left.

The position of the glass from the window of the green ford is consistent with the first shot to XX being fired while the police were outside the property and driving along the fence line. The second shot as the police entered Kia Ora.

The important issue that has been explored at this inquest is the appropriateness of police actions in all of the circumstances. This was not limited to the moments immediately prior to the fatal shooting.

In this case I am satisfied that the police actions did not contribute to the events in the sense that they were in any way the cause of what happened. XX was:

- very unhappy about the pending separation,
- very unhappy about the possible pending sale of Kia Ora to facilitate the property settlement,

- had made changes to his will two days before this incident,
- In the preceding weeks XX, the local police and the local community nurse were all concerned that an event of this nature might occur,
- All of his firearms and ammunition, known by XX, had been seized by police one week earlier,
- Since that time he obtained a further firearm and ammunition,
- He did not attend the solicitors appointment at 9am on the morning of the incident to sign the property settlement,
- During the course of the day he prevented XX communicating freely on her phone and was using a gun as a threat
- After the incident police found two full cans of fuel in the pathway between the driveway and the front door of the house which may or may not have been part of his plans (Vol 3 Tab 72)

Nothing further could have been done by the officers involved in this tragedy. Each of them carried out their duty in a professional and appropriate manner.

Formal Finding:

I find that XX died on 22 December 2011 at Kia Ora' near Urana, NSW. The cause of his death was a shotgun wound. The manner of his death was suicide.

18. 12332 of 2012

Inquest into the death of John Francis Leaver. Finding handed down by Deputy State Coroner Dillon at Glebe on the 3rd April 2013.

John Francis Leaver was a man of 71 years of age at the time of his death. He was a long term prisoner serving both a life sentence and sentences or a sentence for another offence. At the time of his death he was housed at the Dawn de Loas Correctional Centre in Silverwater in the Silverwater Prison Complex. This is a minimum security gaol. He was a prisoner who at least while an inmate appears to have been relatively compliant and trusted.

He was classified as a prisoner who needed to reside two out in a cell. This is for health reasons. He suffered from chronic heart disease and other conditions.

One of the reasons, as Sergeant McMaugh outlined both in his brief and in his oral evidence today, for prisoners being classified in that way or categorised in that way is perhaps more accurate, is to enable prisoners who need some sort of supervision, if you like, for their health have a cellmate. A Mr Nackler was the allocated cellmate for Mr Leaver.

Mr Leaver it has to be said may in some ways have been an unpleasant cellmate. He did not like to wash very much and Mr Nackler, although he tried to help Mr Leaver, appears to have preferred to sleep elsewhere. Mr Leaver also was a very heavy smoker and that may have had something to do with Mr Nackler's desire to sleep elsewhere.

Each cell is fitted with a knock-up button. This enables a prisoner or his cellmate to communicate with an on duty officer overnight who can bring help if required and that is one of the reasons why it is both a good idea and important that the cellmate be there because if a prisoner collapses, as apparently Mr Leaver did and was unable to reach the knock-up button himself.

Whether or not this would have made any different in Mr Leaver's case cannot be said. The medical evidence suggests that Mr Leaver may well have died suddenly. He may have suffered such a powerful heart attack, if I can use that term loosely, as to be beyond help. Certainly, people who have atherosclerotic cardiovascular disease and who are heavy smokers and who suffer from other significant medical conditions can die very suddenly and that may well have been what happened to Mr Leaver. Even a prisoner who had been trained in and have the capacity to conduct CPR on a person such as Mr Leaver may not have been able to save him or at least keep him going until help arrived. So I do not think any blame can be attached to Mr Nackler, but certainly, this was not desirable for him to have absented himself from his allocated cell.

Mr Leaver seems to have lived a long and troubled life. Sadly, he has no one really to mourn him.

It is therefore all the more important as I just said to Sergeant McMaugh a few moments ago that the State which has a duty of care for such people as Mr Leaver in our custodial institutions to ensure that such people who are vulnerable are protected insofar as they can be and if they do die suddenly, as Mr Leaver did, that their deaths are fully investigated, that they not just be dismissed or regarded as lives whose value is either very little or none, but that an official of the State takes care and takes the effort to investigate the deaths to ensure that they have not come to an end which is homicide, perhaps, by another prison or that their deaths have not been caused by the negligence of those charged with their proper care.

In this case, Mr Leaver, it seems to me, was properly cared for by the Department of Correctional Services. Of course, as this case has revealed, there is perhaps more that could have been done, but there is no - there was no absence of care, there was no negligence of any serious nature and certainly, there was no misconduct, which contributed to or caused Mr Leaver's death.

As I said right at the start, an inquest into a case of this nature is mandatory. The former State Coroner, Kevin Waller, observed in his textbook many years ago now why it is important that these cases be investigated and he said,

> "The answer must be that society having effected the arrest and incarceration of persons who have seriously breached its laws owe the duty to those persons of ensuring that their punishment is restricted to this loss of liberty and is not exacerbated by ill-treatment or prohibition 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."

I agree with all those sentiments. It is also as I implied or expressed really, the mark of a civilised society that a dutiful and thorough police officer such as Sergeant McMaugh will investigate a death, even of those who are unpopular or smelly, for that matter.

Those for whom most people in society have no interest and about whom most people in society do not care, it is the way we treat people in such positions who are so low on our social totem pole that distinguishes our kind of society from a society which is uncivilised and abhorrent. If we believe in the rule of law and if we believe in democracy, then at least in principle, the lives of every single one of us is of equal value and important and we demonstrate that principle in practise by Sergeant McMaugh conducting such an investigation which I may commend him for in its thoroughness and by a State official judicial officer such as myself conducting an inquest with the assistance of people like Sergeant Mulligan and the help of the two lawyers sitting at the bar table.

There is no one to hear these comments and perhaps that is not a secret. We do not conduct these inquiries in secret. This is a public and open inquiry.

The fact that there is no one here to see this occurring makes it nonetheless significant and I thank all those and particularly you, Sergeant McMaugh, who have contributed so much to the investigation of Mr Leaver's death.

Formal Finding

I FIND THAT JOHN FRANCIS LEAVER DIED ON OR ABOUT 11 JANUARY 2012 AT THE DAWN DE LOAS CORRECTIONAL CENTRE, SILVERWATER, NEW SOUTH WALES AS A RESULT OF ATHEROSCLEROTIC CARDIOVASCULAR DISEASE. THERE ARE NO SUSPICIOUS CIRCUMSTANCES SURROUNDING HIS DEATH.

I make the following recommendation to the Minister of Corrective Services.

That the standard operating procedures at the Dawn de Loas Centre be amended to ensure that empty cells in the centre are secured and that empty cells are checked at evening muster and that all reasonable steps are taken to ensure that inmates sleep in their allocated cells overnight.

19. 47897 of 2012

Inquest into the death of Carsten Flatow. Finding handed down by Deputy State Coroner Truscott at Glebe on the 14th March 2013.

Having read the brief I also wish to make a notation that I have read the family's submissions points one to five. I agree with the advocate's submission that in relation to the family's request for me to take into account the matters they had submitted it is not accompanied by an application to adjourn the proceedings. I do note that the officer in charge has made considerable effort to engage with the next of kin without much success.

The receipt of the document yesterday that was made available to us today is certainly late in the piece but having received it both advocate assisting and I have attempted to examine the brief to answer some of the submissions that the family have made.

I am taking the last point first, the Parole Board's refusal that was notified to the deceased on 20 January 2012 is not a matter of coronial jurisdiction. I do note that the deceased's advocate applied for a further compassionate release on 27 January, unfortunately the deceased passed away prior to the Parole Board having consideration of that application.

There is no material on the briefs before me in relation to the visits at the Prince of Wales Unit either during week days or weekends, it seems to me that if the family had concerns at that time they could have been and should have been raised. I do not propose to adjourn these proceedings to engage in an inquiry about record keeping, any of those documents being on the file, I do not think it is necessary to do so.

It seems to me from looking at the records that are on the file that there have been numerous visits by the family in the later weeks of Mr Flatow's death, there is certainly no adverse comments in relation to those visits in terms of who was present and the duration or frequency of those visits raised by Mr Flatow. He was in a position to raise them because he made requests for extended visits and telephone calls, all those applications were granted.

The family have made a complaint about communication between Corrective Services and Justice Health. The complaint is completely unsubstantiated. The fact that they have limited availability in terms of being able to call into the gaol is really just a matter of fact. The gaol system though housing terminally ill people cannot be expected to facilitate phone calls in the way the family has submitted in any event, in terms of the hospital that they can only ring into the hospital, likewise the communication system at the Prince of Wales Hospital is not a matter which I intend to engage in.

The first point that they make that the family's perception that Mr Carston Flatow had to admit his guilt to proceed through some program for a release on parole and an admission of guilt in circumstances where he was innocent has caused him to

become terminally ill is in my view completely misguided and there is no foundation whatsoever to that submission. I do note that prior to sentencing he made full admissions to both the psychologist and it is contained in the presentence report. I note that due to the structure of his sentence he would not have been eligible for participation in any program referrable to the nature of the offences until shortly after he passed away in any event.

In terms of dietary changes once he was diagnosed likewise that is not a matter with which I wish to engage and there is certainly no documentation on the files before me that that was an issue whilst Mr Carston Flatow was alive and receiving treatment. I note that the diagnosis of metastatic melanoma was made very late in 2011. Every possible treatment that could be made available to him was made available to him, unfortunately he succumbed very quickly to his illness.

From reviewing the material I am satisfied that there are certainly no suspicious circumstances and no care and treatment issues that need any resolution.

Formal Finding

THE FINDINGS THE CAUSE OF DEATH FOR CARSTEN FLATWON IS METASTATIC MELANOMA, DATE OF DEATH IS 13 FEBRUARY 2012 AND THE PLACE OF DEATH IS THE LONG BAY PRISON HOSPITAL.

20. 49722 of 2012 s 75 Non Publication Order

Inquest into the death of XX. Finding handed down by Deputy State Coroner Dillon at Glebe.

XX was a young man aged only twenty-two when he died at the Bathurst Correctional Centre on the 13th of February 2012. XX had been in trouble before with police and he had been refused bail. He was a young man who had had something of a troubled life up to then in some respects. He certainly was not happy to have been refused bail. It is a matter almost of common knowledge that prisoners are at greatest risk of self-harm in the short period after they are first placed in custody, the first few days.

We have heard evidence from Detective Roberts that XX's brother, thought that XX was in an unstable mental condition, if I can put it that way, and that more ought to have been done to protect him from himself, perhaps. Certainly, it seems that it became clear very soon after he was assessed at Bathurst that he may be at risk.

I should say that even people who are assessed as being at high risk or reasonably high risk, mostly do not harm themselves, or at least do not take their own lives. But of course, corrective services does have a duty of care and in good faith I think tries its best to protect prisoners who are in many cases quite vulnerable. XX was, as I say, only twenty-two, quite a young man and possibly immature in some respects. But it is clear that going back into gaol was a disturbing experience for him. After he died a note was found in his pocket and it read,

"To Mum, Hey sorry for not listening to you. You should -
I should've just stayed with you in Sutton but I wanted to spend
some time with Germaine, so very, very sorry. Hey, but I told you
if I ever come to gaol again I would not make it out alive, sorry."
He also wrote "Tell everyone I love them." He finished the note,
"Love, Your Son, ." On the cell wall was
a drawing consisting of a smiling hangman with the words "I H8 my life."

Now that may or may not have been written by XX, but it seems to sum up the situation he found himself in at that particular time. Having been assessed on his self-report form as being at high risk, he was referred to the mental health nurse. Unfortunately, for whatever reason, he did not make it to see the nurse.

That may or may not have made any difference ultimately, but it is unfortunate that he could not be seen immediately by the mental health nurse or he could not wait to see the nurse.

But he was placed in a cell with another prisoner, Mr Dempsey, no doubt the thinking behind that at least in part was that a prisoner is generally safer in a cell with another inmate than by him or herself. Certainly, one of the hopes is that the prisoner may be able to either help the prisoner deal with his problems, that is the troubled prisoner, or will be able to hit the knock-up button and bring corrective staff to assist the prisoner if he or she does attempt to self-harm.

In this case it is not quite clear why Mr Dempsey was unable to do that. It is pretty clear that XX tore a piece of sheet and used it as a ligature, as a noose. He also managed to tie his own hands up, no doubt that was to stop himself from trying to get out of the noose once he started to strangle himself. It is very unfortunate and I think obviously it is saddest and most unfortunate for XX's mother and his family that a young man of twenty-two can see nothing better ahead of him and despairs thinking that his life is not worth living.

How those ideas form in people's minds, particularly young people's minds is difficult to say, but clearly, that is what happened in XX's case. That is really a major part of this tragedy that he lost belief in life worth then living, of course, at that age he had not had the experience that leads most adults to survive their troubles and to develop the resilience that they need to deal with their troubles. That tends to come with maturity. In any event, he did not make it.

Detective Roberts said, and I agree with the opinion, his opinion was that there had been no failure on the part of corrective services to do its practical best to protect XX. In the most ideal of worlds, I suppose, we would have hot and cold water running counsellors (as said) and so on, in prisons. We would have more help available and it would be available whenever it was needed. But the reality is that resources are limited and spread quite thinly, and particularly, in such a large organisation as the Department of Corrective Services.

Since XX's death the efforts by corrective services to reduce the number of obvious hanging points in correctional centres has progressed. That is an ongoing program. This is not an easy program to complete and it is not an easy task to execute to ensure that there are few, if any, hanging points in cells. A very large number of the buildings that they operate or occupy are old buildings, which were built before close attention was paid to such things as protection of prisoners against self-harm. But that program is ongoing and the program of trying to identify, manage and treat prisoners who are at risk is also ongoing, and to my observation, in not only this inquest but in others, it is a good program that is constantly under review and constantly being improved.

At the end of the day, however, it is difficult to predict whether someone will commit suicide and if it is difficult to predict, it is difficult to prevent completely and that is a shame. That is a particular shame for the families of young people who take their own lives. Nothing really, I think, compares with the loss of a child for a parent. I now turn to my formal findings.

Formal Finding

I FIND THAT XX DIED ON THE 13TH OF FEBRUARY 2012 AT THE BATHURST CORRECTIONAL CENTER TAKING HIS OWN LIFE BY HANGING HIMSELF WITH TORN BEDDING ATTACHED TO THE BUNK IN HIS CELL. HE DIED BY ASPHYXIATION.

21. 58625 of 2012

Inquest into the death of Housam Ismail who died on the 22 February 2012 at Westmead. Inquest suspended by State Coroner Jerram.

Having considered the evidence I am satisfied that a known person has been charged with an indictable offence within the meaning of section 78 (1) (a) of the Coroners Act 2009. The inquest is suspended.

22. 69319 of 2012

Inquest into the death of Jane Mary Porter. Finding handed down by Deputy State Coroner Forbes at Glebe on the 6th March 2013.

Jane Mary Porter was found dead in the public pathway outside of 220 Hudson Parade, Avalon, on 1 March 2012. A post mortem was carried out and the cause of death was said to be the toxic effects of alcohol, benzodiazepines and doxylamine.

This is a very sad case because Jane was only 32 years of age at the time of her death. She was born in Canberra, one of the three children, and she grew up in Canberra. She came to Sydney and attended the Universality of New South Wales and also the Australian Academy of Dramatic Art. She did commence a career in acting and had some part-time work but I am told that she a change was noticed by her parents from about 2007 I think the initial change began - and she was beginning to become depressed and she was not participating in the career as she hoped it may unfold.

In an effort to support her, her parents moved from Boorowa to Clareville to be closer to her and she in fact moved in with them in 2008. They could see that she was, her depression was beginning to become serious and that she was drinking.

By July 2009 her drinking had overtaken her life. She admitted herself to the Sydney Clinic at Bronte for treatment in 2009 and then in November 2009, on 18 November, the police responded to a call stating that she was attempting self-harm. When the ambulance arrived at the scene they informed the police that she was not violent or threatening harm, but she was highly intoxicated, she was distressed and she was taken to hospital for a mental health assessment.

On 24 December 2009 she attended her first of several appointments with Dr Phorpher who was a GP who became involved in her treatment. He referred her to a detox clinic. I am not sure what happened with that but on 9 March 2010 I note she was admitted to Royal North Shore hospital, she was highly intoxicated and she was assessed for a home-based detox therapy. On 10 March she presented to Dr Phorpher. She was once again intoxicated.

He placed her on a home-based detox therapy which was to be supervised by her parents. On the 11th, 12th and 13 March Dr Phorpher visited her at home each day to supervise the detox and he noted that there were some improvements but that the treatment ultimately failed because she did not want to participate any longer.

On 23 March 2010 she once again went to Dr Phorpher as she was intoxicated. She was then assessed at hospital as she had had epileptic type episode and on examination she was found to have reduced reflexes in her lower limbs and an abnormal liver function. On 6 April 2010 she once again attended Dr Phorpher and she had a head injury after an alcohol binge it was described. He prescribed Valium for her that was to be supervised by her father and assisting her in further home detox.

On the 8th, 9th, 12th, 13th and 14 April 2010 Dr Phorpher attended the residence to assist supervising the detox and once again the detox was unsuccessful and she was referred to the Sydney Clinic for detox and rehabilitation. On 15 April she attended the Sydney Clinic and I think she was there until 14 May 2010. But unfortunately on 21 May 2010 she was found by police intoxicated at Ingleburn railway station and on 22 May - the police released her into her parents' care on the 21st. On the 22nd she was found intoxicated at Leichhardt and the ambulance transferred her to Royal Prince Alfred hospital for treatment.

Then later in that year, on 19 September, she was admitted to the John Hunter hospital for detox. From the 22nd to 31 October she was at the Sydney Clinic and then on 9 November she was taken to the Prince of Wales hospital, the Kiloh Centre. She was refused admission there because of her level of intoxication and was taken to the emergency department of the hospital where she was admitted.

Then on 10 November she was found asleep underneath a stairwell of a block of units in Bondi and she was taken back to the Kiloh Centre for assessment. On 18 November 2010 her parents took her to the alcohol-rehabilitating unit at the Wesley Private hospital. After the admission process Mr and Mrs Porter left the hospital and unfortunately Ms Porter left of her own accord later in that day and on 21 November she had not been seen for a couple of days.

Her parents lodged a missing person's report but on 22 November she did make contact and then on 24 November police were called about a person in a vacant block of land at Casula who appeared to be drug-effected and police found her. She was described as being distressed and highly intoxicated and an ambulance was organised to take her to Liverpool hospital. On 25 November she went and saw Dr Phorpher again and he made a referral for counselling.

On 30 November she was admitted to the Wesley Private hospital again and on 9 December she was admitted to Concord hospital as she had had an epileptic episode and was found to be intoxicated.

In January 2011 she was a patient at the Northside West Clinic in Wentworthville and when she was at that clinic she met Mr Maillier and they formed a relationship. On 21 January 2011 the police received a phone call from a taxi driver who had a female passenger in his taxi who he could not wake. The ambulance took her to - told police that they would take her to the nearest hospital. Later on in that morning, at 11am, the police received another call that there was a drug-affected person in Ashfield. As Ms Porter was unresponsive an ambulance was called then and she was conveyed to hospital for treatment.

On 27 January 2011 it appears she was scheduled under the Mental Health Act because of threats of self-harm and she was taken to Manly hospital. On 28 January the police attended Manly wharf after a call from a concerned member of the public as she was lying on her side in a garden bed and Mr Porter I think took her home. On 29 January she was admitted to Mona Vale hospital as she had collapsed from acute alcohol intoxication and then on 1 February to 8 March she had rehabilitation treatment at the Northside Clinic and she was transferred to Concord hospital because of an epileptic episode provoked or brought on by the alcohol intoxication.

From 10 March to 11 April she received rehabilitation treatment at Northside Clinic and from 24 May to 2 July she received rehabilitation treatment at Wesley Private hospital. On 6 July she once again saw Dr Phorpher, said she as suffering anxiety from alcohol withdrawals and Dr Phorpher prescribed Valium for home detoxification with her parents. On 7 July she was admitted to Mona Vale hospital as she had had an epileptic episode On 8 August she visited a friend at the Northside Clinic and the staff there called the police who took her to the Westmead hospital because she was unresponsive and had told the nurse there that she had taken a Seroquel tablet.

From 10 August to 12 August Jane was admitted to Belmont District hospital with pneumonia and alcohol intoxication. From 23 November to 26 November she was treated at Mona Vale hospital for alcohol intoxication. On 4 January 2012 she was admitted to Mona Vale for alcohol intoxication and on 24 January she was found intoxicated and admitted to Mona Vale hospital.

On 31 January she was once again found. She was found by staff at a hotel and she was admitted for a third time that week to Mona Vale hospital. On 2 February at around 1.30pm police were called to some apartments in Manly where they found Jane intoxicated. They treated her at the scene and took her to Manly hospital. She left the hospital and another member of the public called and she was unfortunately passed out at the entrance to the Manly gym. The police attended the scene and found her. An ambulance was called and she was taken back to Manly hospital.

On 4 February, so only two days later, the police were again called to the Oceanside apartments at Manly and saw her lying on a couch, drifting in and out of consciousness. An ambulance was called and she was taken to Manly hospital.

She then saw Dr Phorpher again on 6 February but on 7 February she presented to the Mona Vale hospital emergency department with seizures and on 9 February she went to see Dr Phorpher ad she was intoxicated and drowsy and semi conscious. An ambulance was arranged, and then on 10 February he was picked up at Woolworth's at Mona Vale where she had shoplifted. Two of the things of concern I think were two bottles of vanilla essence, because of the high alcohol content. I don't know how relevant that was for Jane but it seems to be a possible motive. She was detained by police. She was taken to Mona Vale hospital and on 11 February she was admitted to the emergency department of Mona Vale hospital after she was once again found shoplifting in a pharmacy this time and she'd collapsed to the ground and was taken to the hospital by ambulance.

From the 18th to 19 February she as at Mona Vale hospital in the emergency department for alcohol intoxication. She had been discharged from the Manly hospital by the psychiatry team after being sectioned overnight by the emergency department. It seems that it was at this point that an application under the Inebriates Act was made at Manly Court, it seems by Mr Porter, I think it was on 16 February and that application was listed before the court on 16 March.

The application of course under the Inebriates Act was for long-term involuntary rehabilitation and that was an application that was supported by medical evidence and affidavit material setting out this background, Jane's unfortunate background definitely supporting and laying the groundwork for the application.

It is very sad to look back now and see that that application was never heard. It was listed for two weeks after she passed away and the legislation framework since date has changed and whilst that act is not repealed it is, I think the word they are using is “suspended” and it only applies to minors at this point. And the new legislation is what would have been - the new legislation sets up a framework that would have applied had this situation occurred after the change.

The new legislation is called the Drug and Alcohol Treatment Act and under that Act a medical practitioner can make an order requiring compulsory treatment by a patient and it would have put the doctors in a position at the time when Jane completely hit rock bottom by the admissions, all those admissions in February 2012 to have made an order for her involuntary treatment. Initially that treatment under the new regime would have been for a 28 day detoxification period and then looking at the circumstances as they unfolded.

So in light of the change in the legislation and the change in the framework, I do not propose that there is any recommendations that I can make because there may be criticisms of the new legislation or framework, however we don’t know because we haven’t seen the matter go though that system but there is no, nothing to be gained by us looking closely and criticising the old regime at this point as it’s been repealed and a new one has been put in place.

On 21 February Jane was at Woolworths at Avalon, once again observed to be shoplifting and the police attended her premises on the 22nd and interviewed her where she made admissions. A court attendance notice was issued and the matter was listed before the court on 29 February.

On 24 February she was admitted to the emergency department of Mona Vale hospital after she as found on the floor in a bathroom at the medical centre.

On 27 February she was admitted to the emergency department of Mona Vale following a collapse due to alcohol intoxication. There is some issue about an incident having occurred around that time and there are certainly some injuries that have been raised, she had raised I think, with the medical centre about a possible assault and certainly we see that at that time in February 2012 that - from 24 January 2012 to 29 February she was admitted to hospital ten times in relation to her alcoholism, so it was quite an extreme period in her treatment. In February she was admitted to the Emergency Department at Mona Vale Hospital after she was found intoxicated in public toilets I think near the Manly library and it was after that - that admission was the night before she was found on the pathway the next day.

Now the hospital has explained that the nurse that was looking after her at that time said that he wheeled her into the bathrooms and she was independently having her shower and that was the last he saw of her. She appears to have left the hospital via the main ward. Certainly there are phone records to indicate that she rang Mr Maillier on a number of occasions that morning and she left messages on his phone. He never spoke to her, he said his phone was on “silent” and he was not aware of the calls.

We also know that at about 10 past 11 she rang her father, Mr Porter, and then also at 11.50am she entered a bottle shop in Mona Vale and purchased two bottles of wine. Also about nine minutes later she boarded the bus on Barrenjoey Road, Mona Vale, travelling north towards Avalon or Clareville, towards home, and then at about 12.28pm she boarded the 191 bus at Avalon Parade Mona Vale. The bus driver indicated that she was unsteady on her feet and pale.

The next sighting of Jane was at about 1.30 when Mrs Chapman who lived at 2.20 Hudson Parade Avalon observed Jane outside and she, when she went to leave her home with her mother at about 1.30 she rang her husband and asked her husband to contact the police. Her husband did contact the police and the officer Reeves took the call. He understood that he was getting second-hand information from someone who was not at the scene. That there was nothing raised about the welfare of the person who had been observed and he had formed the view that no crime was taking place so he did not see any need for a police response.

Of course the call that was made was not made to Triple-0, it was made directly to the police station through a directory service and he formed the view that the person who had observed Jane would be ringing him back if she was still there when they returned home. Mr Chapman who rang the police on behalf of his wife, said that he understood from the conversation that a police car would be going round to check on Jane and that did not occur. He says that when his wife returned, Mrs Hudson (as said) returned from picking up the children from school, that was about three hours later, about 4.30, that she saw that Jane was still there and had not moved and was very concerned because her feet appeared to be purple. She rang her husband, her husband rang the police again. He thought the police, Constable Reeves, had said to him that he sent a car round. He said that he was angry that no car had been sent around and that he was told to ring the Triple-0 which he did.

In any event, at that time, at 4.30, Triple-0 was called. A CIDS report was made by Constable Reeves and a police officer who was driving home from shift, Constable Robinson, heard the radio call and attended the scene and also two police officers from the police station went and attended the scene. It is such a sad story to be told and I note that Dr Judith Perl, an expert, gave some time to look carefully at the circumstances surrounding this death and also looked carefully at the post mortem report and the toxicology report that included the levels of the different, of the alcohol and different drugs and she concluded in summary and I quote her from paragraph 19 of her report: “Given the extremely high blood alcohol concentration in the deceased at the time of her death and the high concentration of doxylamine, the respiratory and/or cardiac depressant effects are highly likely and could certainly have resulted in death.

The respiratory depression may have been irreversible from the first time she was noted to be slumped on the ground. Furthermore the absence of sodium valproate epilim as indicated by the absence of valproic acid in her blood screening results suggests the deceased had not been taking her epilim and therefore control of seizures would have been inadequate. Since very high VAC such as .382 grams in 100 mls or higher at an earlier time as 5 indicated by the vitreous humor can induce seizures, it is certainly possible the deceased may have suffered a seizure which resulted in her death.

Given her apparent condition around 1.30pm, emergency medical attention would have been appropriate, however she may have already been past a stage of recovery, especially if she had suffered a seizure".

The primary purpose of any inquest is to make formal findings concerning the identity of the person who has died, when and where the death took place and the cause and the manner of the death. The manner of the death refers to the surrounding circumstances of the death and because the police had been called before Ms Porter passed away, Ms Porter's death is considered to have occurred during a police operation and in those circumstances, according to s 23 and 27 of the Coroner's Act, an inquest is required to be held.

It has been very important to look closely at the circumstances surrounding Jane's death to see if anything can be learned, to see if anything can be done in the future to prevent a similar situation occurring for someone going through the same circumstances.

In relation to this case we have learnt that the legislation framework has changed in relation to involuntary long-term treatment and there are no changes at this point that can be recommended or made in relation to that. In relation to the other missed opportunities such as perhaps someone in the street noticing Jane earlier and getting attention, Triple-0 straight away, or Mrs Chapman getting Triple-0 straight away or Inspector(as said) Reeves becoming aware of the seriousness of the situation and sending a car around or Triple-0 being called, they are all missed opportunities, but I do not think there are any opportunities that are anything other than hindsight missed opportunities and as Mr Porter so graciously put it, there is no reason for any recriminations today.

In those circumstances there are no recommendations that I can make that would in the future assist in this situation and prevent a recurrence. Unfortunately it is a problem that many families in our community are faced with and that is why there has been standing committees looking at the best way to deal with this situation and at the moment they've come up with this new regime and hopefully this new regime will assist more rapidly.

It places me in a position now where I need to make the formal findings and the formal findings that I do make are that:

Formal Finding

THAT JANE MARY PORTER DIED ON 1 MARCH 2012 OUTSIDE 220 HUDSON PARADE, AVALON, NEW SOUTH WALES, FROM THE COMBINED ACUTE EFFECTS OF ALCOHOL, BENZODIAZEPINES AND DOXYLAMINE. IN RELATION TO THE MANNER OF HER DEATH I NOTE THAT IT WAS A DRUG AND ALCOHOL-RELATED DEATH.

23 71862 of 2012 s 75 Non Publication Order.

Inquest into the death of XX. Finding handed down by Deputy State Coroner Freund at Glebe on the 28th February 2013.

XX was forty-nine years old when he died after sustaining serious injuries when the car he was driving impacted with a large eucalyptus tree at a high speed just off Possum Brush Road, Possum Brush, approximately twenty kilometres northwest of Forster. He is survived by his mother JF, his son and his then girlfriend, JD, who I note has attended the whole of this inquest. XX was born in Paddington, Sydney, to Ms JF and grew up in Canley Heights in Sydney's western suburbs, leaving school in year 10 to train as a butcher.

After completing an apprenticeship, XX went on to work in a number of butcher shops and over time owned and operated several butcher shops. At the time of his death, XX had been working at Forster Quays as a butcher. He continued to have an interest in boats, enjoyed fishing from his kayak and watching football. What is clear is that XX's death marked the culmination of a complex series of events which included a number of interactions with New South Wales Police officers. These events gave rise to a number of potential issues regarding XX's contact with police, both on the day of his death and in the period leading up to it.

On 11 February 2000 XX was arrested and charged with a number of sexual offences. He was, following a trial, convicted of those offences and sentenced to an aggregate term of ten years imprisonment. XX was ultimately released from prison on or about 30 July 2009. On 25 February 2010 he was placed on the Child Protection Register pursuant to the **Child Protection Offenders Registration Act** 2000 for a period of fourteen years 20 and 158 days.

The conditions attached to that registration required him to advise police fourteen days prior to any change to his address. He was also required to advise police of changes to any of his other personal information within fourteen days of that change occurring. In August 2009 XX met JD and by March 2010 they were in a relationship.

In late 2010 XX informed Ms D that he had been convicted of offences of sexual assault of a child. Up until this time, Ms D had not been aware of the precise nature of his offending or the reason for his incarceration. As a result, Ms D ended the relationship. However, XX sought to continue and pursue the relationship.

In early February 2011 XX began to make threats of self harm together with threats of violence against Ms D and her son, apparently in an attempt to dissuade Ms D from ending the relationship. Ms D reported the threats to police and an apprehended violence order prohibiting XX from approaching or contacting Ms D was made on 9 February 2011. Thereafter, XX was convicted of breaching that order the following day.

On 26 March 2011, XX sent Ms D a number of text messages including messages in which he stated that he was feeling upset and considering taking his own life. Once again, Ms D reported these threats to police.

After visiting Ms D to ensure her welfare, the police went to see XX at his workplace. XX indicated that he had no intention of carrying out the threats and the police determined his mental state was not such as to justify his involuntary admission to hospital pursuant to the Mental Health Act 2007.

In the months that followed, XX began to see a psychiatrist, Dr Anderson, and in or about June 2011 Ms D agreed to see XX again. Ms D found XX to be a changed man and after some time, they resumed the relationship. Until January 2010 XX remained under the treatment of Dr Anderson. Dr Anderson described XX's mood at this time as having stabilised and reported that in his final review of XX, had indicated that he had no thoughts of self harm and that there was no evidence of psychosis. It was planned that XX would continue therapy and he was provided with details for Relationships Australia. Dr Anderson did, however, describe XX as continuing to be at future risk of impulsive harm to himself in the context of threat or loss, such as relationship breakdown or threats from authority figures such as police.

In the later stages of 2011, Ms D decided to move to Smiths Lake, approximately 30 kilometres south of Forster. She made the move on 16 January 2011. Subsequently, Ms D permitted XX to move in with her while he looked for his own place. On 23 February 2012, upon Ms D application, the apprehended violence order was varied to allow XX to reside with her at Smiths Lake. On 1 March 2012, Ms D spoke with Ms Louise Webber, the assistant coordinator at Mid Coast Women's Domestic Violence Court Advocacy Service. Ms D sought advice from Ms Webber as to the steps she would take to protect herself should she decide to end her relationship with XX. During the course of her conversation with Ms Webber, Ms D expressed concern that XX would harm himself if she left him.

Sometime after moving to Smiths Lake, XX made an appointment to see an officer at Taree Police Station to discuss his obligations under the Child Protection Register.

That appointment was scheduled for 9am on Friday, 2 March 2012. XX voluntarily attended the Taree Police Station in accordance with this appointment on 2 March 2012. Prior to this appointment, XX had spoken on two occasions to Detective Sergeant Frith regarding his reporting obligations and his address. On the second occasion, he told Detective Sergeant Frith that he was living at a guesthouse in Taree. That information was clearly false and accordingly, he was deemed to be in breach of his reporting requirements pursuant to the **Child Protection Offenders Registration Act** 2000.

XX was then charged with failing to comply with his reporting obligations under the **Child Protection Offenders Registration Act** regarding his address and employment. Later that same afternoon, XX was released on bail following the provision of $1,000 surety by his mother. The further conditions of XX's bail included that he was required to reside with his mother and that he was not to contact Ms D by any means.

After his release on bail, XX did not travel to his mother's house. He instead at approximately 6pm that evening attended Ms D's home and asked if he could stay the night. Ms D refused and persuaded XX to leave a short time later.

The following morning, at about 8am, XX telephoned Ms D. He asked if he could visit Ms D refused. Shortly thereafter, XX arrived at Ms D's house. Ms D locked herself in the bathroom and telephoned police at about 8.34am to advise them that XX had arrived at her home.

Constable Barber answered this call and spoke to Ms D. While she was on the phone to police,XX broke into Ms D's house and managed to unlock the door using a butter knife. XX observed that Ms D was on the phone, took the telephone from her and ended the call. After hanging up the phone, XX took Ms D's car keys and told her that he was going to take her car to his car, which he said was parked at Frothy Coffee, a cafe not far from her house. Before driving away in Ms D's car, XX made a number of statements suggesting he may harm himself such as, "You fucking killed me, you've fucking killed me, you've done this baby". Thereafter, Ms D had a further telephone conversation with police.

While she was doing so, XX left a message on her answering machine. The message was in similar terms to the statements XX made before he left Ms D's residence. At about 8.47am police broadcast the registration details of both Ms D's and XX's vehicles with a warning that XX had threatened to harm himself. Accordingly a number of police officers were despatched to the area. At approximately 9.06am Leading Senior Constable Cusack and Constable Houston arrived at Ms D's home. They asked Ms D for XX's phone number. Leading Senior Constable Cusack relayed XX's telephone number over police radio with a view to having XX's position triangulated by reference to his mobile phone. Shortly thereafter XX called Ms D's phone. Leading Senior Constable asked Ms D to attempt to calm XX down and to find out where he was. This conversation occurred on speakerphone and both Leading Senior Constable Cusack and Constable Houston could hear the conversation. XX sounded irate and made a number of threats upon himself by driving the car into a truck or tree during the course of this conversation.

After this conversation ended, police requested that Ms D telephone XX again. She did so. During the course of the second conversation at approximately 9.39am, Detective Sergeant Natalie Stephens arrived and began recording the telephone conversation between Ms D and XX on a hand held device. XX said repeatedly that he would not go back to gaol. He again made a reference to the likelihood that he would die and commented that there were a number of trucks on the road travelling in the opposite direction.

During the course of this conversation, XX requested that Ms D telephone his mother and hung up the phone. Before Ms D could call XX, XX called Ms D. After that conversation, Leading Senior Constable Cusack asked Ms D to telephone XX again. She did so. Again, XX made reference to his intention to harm himself. By this stage Ms D - quite understandably - became distressed.

As a result, Leading Senior Constable Cusack took the phone from Ms D and began speaking to XX. XX again reiterated during the course of this conversation that he was not willing to go back to prison and would ram his vehicle into a tree to avoid it. Moreover, XX threatened that if he was able to find his ex-wife he would kill her before he killed himself. After this conversation, Constable Houston took Ms D to the Taree Police Station.

Leading Senior Constable Cusack and Detective Sergeant Stephens then secured Ms D's house and left in an unmarked police car, call sign Manning 101, carrying Ms D's telephone. Detective Sergeant Stephens was the driver of Manning 101.

As they were leaving Ms D's residence, XX called Ms D's telephone however he hung up when Leading Senior Constable Cusack told him that Ms D was no longer there. Shortly thereafter, Leading Senior Constable Cusack received information over the radio that the triangulation had been performed on XX's phone namely that XX was north of Nabiac on Tuncurry Road. Detective Sergeant Stephens turned Manning 101 around and travelled north back towards Forster Police Station.

As they passed Coolongolook XX called Ms D's telephone again. XX refused to talk with Leading Senior Constable Cusack and hung up the hone. After passing Tritton Road, Leading Senior Constable Cusack and Detective Sergeant Stephens saw Ms D's Mazda driving south on the Pacific Highway at Possum Brush. Manning 101 turned and followed the gold Mazda. Leading Senior Constable Cusack and Detective Sergeant Stephens saw the gold Mazda turn right into Tritton Road which was, and still is, an unsealed road. Leading Senior Constable Cusack notified the other officers over the police radio that they had seen the gold Mazda turn down Tritton Road and it was travelling at a speed of approximately forty kilometres an hour in a normal, non erratic manner.

By that time, Manning 101 was between thirty to fifty metres behind the gold Mazda. XX was driving within the speed limit and appeared to be carefully navigating potholes and puddles on the dirt road. The vehicle driven by XX then approached the T intersection between Tritton Road and Possum Brush Road. XX's vehicle was observed to have stopped at the intersection. Detective Sergeant Stephens, having made a decision to pull over XX, drove around the right hand side of the gold Mazda so that the front nearside of Manning 101 was slightly in front of the front of it. Leading Senior Constable Cusack took off his seatbelt and began to open the door. Before he could do so, XX swerved his car to the left, avoiding Mannning 101 accelerated away. Detective Sergeant Stephens straightened Manning 101 and followed XX. The lights and sirens of Manning 101 were activated and Leading Senior Constable Cusack announced over the radio that they were in pursuit of the Mazda driven by XX.

A few seconds later, at approximately 11.37am, the Mazda veered to the right, crossed the roadway and collided with a tree close to the side of the road. There was no indication that the Mazda had swerved out of control or that the vehicles brakes had been activated. Leading Senior Constable Cusack got out and went to check on XX and administer first aid. He observed that the driver's side door and bonnet were caved in and the driver's side door would not open. XX did not have a pulse. Ambulance officers arrived at the scene at approximately 11.53am and declared XX to be deceased.

A Coroner's function is to seek to answer five questions; namely who died, when they died, where they died and the manner and cause of their death. The cause of death refers to the direct physical cause and the manner of death relates to the surrounding circumstances.

As this is a death arising out of a police operation, it becomes a central issue for this inquest to determine whether the police who were directly or indirectly involved with XX prior to his death could have taken steps to prevent the ultimate tragic outcome.

To that end, the Coroner, pursuant to s 82 of the **Coroners Act**, has the power to make recommendations, not in an attempt to lay blame but to look forward in an attempt to prevent future similar deaths and the pain and suffering that has been experienced by XX and his family and loved ones being experienced by others in the future. I stated at the start of this inquest there is no controversy in relation to the identity of XX or where, when and how he died. The primary issue to be considered by this inquest is what were the surrounding circumstances that led to the fateful outcome for XX, namely what were the precursors leading up to his decision to drive into a tree; could they have been avoided? In particular: (1) Whether the police acted appropriately in their dealings with XX following his arrest on 2 March 2012, particularly (a) what steps did the police take to investigate the mental health of XX and/or the potential that he might seek to harm himself; and (b) were these steps appropriate in the circumstances and in accordance with the applicable policies; Whether the police appropriately in response to the incident on 3 March 2012 and in particular:

- Did police appropriately manage the telephone discussion with XX ?

- Should a specialist negotiator have been involved?

- Should the police have contacted mental health services pursuant to the memorandum of understanding for mental health emergency response dated July 2007 ?

- Were the attempts by police to obstruct the vehicle that XX was driving appropriate and/or sufficient; and (e) did the police comply with the New South Wales Police Force safe driving policy and any other relevant protocols during their attempt to locate and arrest XX?

- Was XX's death in fact self inflicted?

I will deal with the events of 2 March and 3 March 2012 in turn. Firstly was the arrest and bail of XX on 2 March 2012 appropriate and could any further steps have been taken by police to investigate the potential of XX to harm himself.

XX voluntarily attended Taree Police Station on 2 March 2012. Prior to his attendance on the police station, the evidence indicates that XX had two separate telephone conversations with Detective Sergeant David Frith with respect to his reporting requirements pursuant to the **Child Protection Offenders Registration Act**. During the course of this conversation with Detective Frith, XX had indicated (a) he was residing at a guesthouse in Taree; and (b) that he was not working. This information was false.

Detective Sergeant Frith made inquiries and on satisfying himself that the information that had been provided to him by XX was false and that he was in breach of the reporting requirements under the **Child Protection Offenders Registration Act**, ultimately arrested and charged XX who was eventually granted conditional bail at Taree Police Station. I am satisfied that no criticism can be levelled at Detective Sergeant Frith in his decision to charge XX or in relation to the imposing of bail conditions.

Both appear to have been reasonable executions of his duty as a police officer to enforce the law and prevent harm to others. I do note that whilst XX was in custody there was no additional investigation of his mental state, history of mental illness and potential for self harm beyond that which appears on the custody record. Both Detective Sergeant Frith and Senior Constable Jones gave evidence to the effect that this was due to the fact that XX was not displaying any outward signs of mental illness. It is clear that neither officer who had come into contact with XX on 2 March 2012 appears to have been aware of XX's prior threats of self harm, in particular threats that XX made as recently as 2011 as these were not recorded as warnings on the police COPS system despite such provision being available and it is arguable that they should have been.

The guidance to officers in relation to when a warning regarding self harm should be placed on the COPS system is, in my view, less than clear. The various guidelines currently state - and I have actually quoted the code of practice for crime which is set out in tab 68B and also the warning guidance from the New South Wales Police Force intranet and I have quoted them within the judgment.

However the evidence from both Detective Sergeant Frith and Senior Constable Jones was that no additional steps would have been taken by them in relation to his mental health issues if there had been a warning of previous threats of self harm on the COPS system as his demeanor on the day did not raise any concerns. ACCORDINGLY, I AM SATISFIED THAT THE CONDUCT BY POLICE ON 2 MARCH 2012 WAS APPROPRIATE IN THE CIRCUMSTANCES. Did the police act appropriately in their response to the incident on 3 March 2013 and I will deal with each of the headings that I have indicated beforehand. Firstly, the telephone conversations with XX. Police were originally summoned to Ms D's residence as a result of her call to police that XX had arrived at her home, had broken in and was looking for her.

The police officers who arrived first on scene, namely Leading Senior Constable Cusack and Probationary Constable Houston urged Ms D to speak with him on the speakerphone as they were aware of the threats that he had made and continued to make, to take his own life by either driving into a tree or a truck on the road.

I have no doubts that this would have been distressing for Ms D in the circumstances where she herself had recently felt threatened and emotionally vulnerable, but in my view, it was an appropriate use of a resource who knew and had an ability to communicate with a man who was clearly at the time also distressed and unpredictable. Unfortunately, it was not successful. When it became apparent to Leading Senior Constable Cusack that Ms D's attempts to calm XX were not successful and that she herself was becoming too distressed.

Leading Constable Cusack took over the conversations. I note that he is not a trained negotiator. I have read the transcripts of part of the conversations with XX that Leading Senior Constable Cusack was involved in. He was moderate in language, calm in demeanor and his responses were considerably mature. He did nothing, in my view, to further inflame the situation that was highly volatile. His actions were commendable in a highly emotional setting and it was unfortunate that his attempts to calm XX down were not successful.

Should a specialist negotiator have been engaged? At about 10.30am Inspector Christine George, who was not on duty at the time, was notified about the incident that was developing in relation to XX. She was essentially advised inter alia, that XX (1) was a person of interest in relation to an aggravated break and enter at Smiths Lake that morning; (2) had taken his partner's car, (3) was driving around threatening to kill himself; and (4) they were attempting to triangulate his location by use of his mobile phone. Thereafter, Inspector George attempted to engage the services of a specialist negotiator. These steps were clearly still in train when it was reported that the car XX was driving had collided with a tree. It is important to note that Detective Sergeant Frith was a trained negotiator and that Inspector George was made aware of this fact during this critical period.

However, as Detective Sergeant Frith had been the person to arrest and charge XX the day before, it was deemed inappropriate for him to liaise with XX in these circumstances. This is a decision which, in my view, was correct.

Should the police have contacted mental health services pursuant to the memorandum of understanding for mental health emergency response, the MOU dated July 2007? It is arguable that pursuant to the MOU, the local mental health service should have been contacted in relation to the evolving situation.

However XX, although a mental health consumer elsewhere in New South Wales, was not known to the local area mental health team, so what assistance they would have been able to provide while the situation continued to evolve and XX on a mobile is unclear. Moreover, until he could be located and they were able to attend and assess him, such engagement was, in my view, not possible. Were the attempts by police to obstruct the vehicle that XX was driving appropriate and/or sufficient? I find the evidence just prior to XX's vehicle colliding with the tree to be as follows:

(1) Detective Sergeant Natalie Stephens and Leading Senior Constable Cusack were in a police vehicle known as Manning 101;

(2) Detective Sergeant Stephens was driving;

(3) They observed a vehicle that appeared to be Ms D's vehicle turn right from the Pacific Highway into Tritton Road which was, and is, an unsealed road;

(4) They followed the vehicle into Tritton Road;

(5) The vehicle being driven by XX was being driven in a safe and controlled manner; he was travelling at about 40 kilometres per hour and avoiding potholes;

(6) Manning 101 was following at a distance of about 50 to 100 metres;

(7) The vehicle being driven by XX stopped at the intersection of Tritton Road and Possum Brush Road;

(8) A split second decision was made by Detective Sergeant Stephens to pull alongside and in front of the vehicle being driven by XX in order to make him get out of the car;

(9) Just as Manning 101 came to a stop at the front driver's side of the vehicle being driven by XX and he noticed Leading Senior Constable Cusack's uniform, he took off and accelerated down Possum Brush Road towards the Pacific Highway.

General duties police and detectives are not trained in performing stops on persons by blocking them with their vehicles. Such a manoeuvre could put the officers themselves at risk. The decision by Detective Sergeant Stephens to try and get XX to stop and alight from the vehicle he was driving was a sound one in the circumstances. Unfortunately, it proved unsuccessful. Did the police comply with the New South Wales Police Force safe driving policy and any other relevant protocols during the attempt to locate and arrest XX? The New South Wales Police Force safe driving policy ("the policy") defines a pursuit as commencing at the time that it is decided to pursue a vehicle that has ignored a direction to stop.

Accordingly, applying the facts of this matter, the policy did not apply until XX swerved around Manning 101, drove down Possum Brush Road and was followed by Manning 101. I am satisfied that the specific requirements as set out in the policy were met, namely: 15 (1) the category of vehicle;

- The qualification of the driver;
- The activation of the warning lights and sirens;
- The declaring of a pursuit over the radio.

The further requirements which relate to the procedure for approval for the continuation of a pursuit or its termination were not able to be implemented as sadly, XX's vehicle had crashed into the tree before there was any opportunity to do so. Did XX take his own life by causing the vehicle he was driving to collide with the tree? In order to make a finding that XX's death was self inflicted, I need to be satisfied to the **Briginshaw** standard, namely that not only is it established on the balance of probabilities but there is a clear cogent and exact proof of the act in question.

The evidence in this regard can be summarised as follows:

(1) XX made numerous references during various telephone calls to killing himself in the hours before his death by either driving the car into a tree or a truck;

(2) That the collision with the tree was witnessed by Detective Sergeant Stephens and Leading Senior Constable Cusack and their respective evidence was that prior to the collision with the tree, the vehicle was speeding excessively, going at least 100 kilometres per hour, there were no brake lights prior to the vehicle hitting the tree and there was no attempt by the driver to avoid the tree;

(3) The evidence of both officers was corroborated by the fact there were no skid marks, which would indicate braking, on the roadway;

(4) There was no evidence of mechanical failure of the motor vehicle or that XX had lost control of the vehicle prior to it turning to hit the tree.

ACCORDINGLY, I AM SATISFIED TO THE **BRIGINSHAW** STANDARD THAT XX TOOK HIS OWN LIFE BY INTENTIONALLY CAUSING THE VEHICLE HE WAS DRIVING TO COLLIDE WITH THE TREE.

Formal Finding:

I FIND THAT XX DIED ON 3 MARCH 2012 AT ABOUT 11.36AM FROM MULTIPLE INJURIES SUSTAINED AS A RESULT OF DELIBERATELY DRIVING THE MOTOR VEHICLE HE WAS DRIVING INTO A TREE ON POSSUM BRUSH ROAD BETWEEN TRITTON ROAD AND PACIFIC HIGHWAY, TAREE.

I make the following recommendations pursuant to *s 82 of the Coroners Act 2009*:

TO THE COMMISSIONER OF NEW SOUTH WALES POLICE FORCE:

THAT THE RELEVANT PROTOCOLS, POLICIES AND TRAINING BE REVIEWED SO AS TO INCLUDE DIRECTION TO POLICE OFFICERS THAT WHERE (A) A POLICE OFFICER BECOMES AWARE THAT A PERSON HAS ATTEMPTED SELF HARM, OR (B) A POLICE OFFICER CONDUCTS A CONCERN FOR WELFARE CHECK IN RELATION TO A THREAT OF SELF HARM BY A PERSON, A WARNING IS REQUIRED TO BE PLACED ON THE COPS SYSTEM.

24. 86730 0f 2012

Inquest into the death of Deane Manning. Finding handed down at Glebe by Deputy State Coroner Freund on the 13th May 2013.

My findings in relation to the inquest into the death of Deane Manning.

Deane Manning was twenty-seven years old when he died after the vehicle, which he had purchased and was driving overturned on the side of the Pacific Highway in Nabiac. He is survived by his daughter, Jasmine, his parents Lynne and Rick, sister Melissa and his former partner, from whom he had been separated for about a year at the time of his death, Ms Cutajar.

Deane's manner of driving had come to the attention of police who were parked on the median strip between the northern and southern bound lanes of the Pacific Highway at a point colloquially titled, "the hump", in order to carry out radar or LIDAR duties.

Deane's vehicle was first observed from this site veering from lane two to lane one of the southern bound lanes and onto the grass, which divided the dual carriageway. Thereafter, the vehicle was observed by police to commence driving in an erratic yet controlled manner, which is often described as donuts or circle work.

The police who observed Deane's manner of driving then firstly got into their vehicle, secondly, immediately turned on the in car video, thirdly, began to drive on the southern bound side of the highway towards Deane's vehicle and as they approached, they activated their lights on the police vehicle.

Upon the police vehicle approaching Deane's vehicle, Deane's vehicle is then observed crossing the southbound lanes of the Pacific Highway at about a 45 degree angle going onto the grass verge at the side of the road where it ultimately rolled over. As a result of the police involvement prior to Deane's vehicle rolling over, Deane ultimately died during the course of a police operation. Accordingly, this is a mandatory inquest pursuant to s 23 (1)(c) of the **Coroners Act** 2009.

A coroner's function is to seek to answer five questions namely, who died, when they died, where they died and the manner and cause of their death. The cause of death refers to the direct physical cause where the manner of death relates to the surrounding circumstances. A coroner, pursuant to s 82 of the **Coroners Act** 2009, has the power to make recommendations not in an attempt to lay blame but to look forward in an attempt to prevent future similar deaths and the pain and suffering that has been experienced by Deane's family being experienced by others in the future.

As stated at the start of this inquest, there is no controversy in relation to the identity of Deane, where or when he died, nor in relation to the exact cause of his death. The sole issues to be determined by this inquest firstly relate to the manner of Deane's death and its surrounding circumstances namely, how did he come to be driving his newly purchased motor vehicle in such an erratic and dangerous manner prior to it rolling over.

And secondly, to conduct a review of the police involvement to ensure that the appropriate procedures and policies were followed and whether any steps could have been taken by the police which could have resulted in a different outcome for Deane. I will deal with each of these in turn.

Firstly, how did Deane come to be driving in a manner, which was clearly dangerous and risky prior to his death? It was clear from the evidence of Mr Manning, Deane's father, that Deane was an intuitive, experienced and talented driver who knew how to assess risks and to avoid them. Accordingly, Deane's manner of driving immediately prior to his death was out of character. We will never know what caused Deane to drive onto the grass median strip, perform the manoeuvres in his vehicle and then drive across the southern bound lanes of the Pacific Highway into the grass where his car ultimately rolled.

What we do know is the following:

- That the methylamphetamine is a drug that can cause risk taking behaviour,
- That Deane had recently been diagnosed with epilepsy and had two seizures that resulted in a consultation with Dr Matkovic. It was the evidence of Dr Matkovic that Deane could not have suffered a complex or partial seizure during the course of his driving on the grass median strip as the driving required control, which he had never observed in a patient during either type of seizure.
- I note that it was the evidence of Senior Constable Carney that the driving that Deane undertook on the grass median strip was controlled and I accept his evidence in this regard,
- That the manner of his driving on the grass median strip did not accord with someone having a full or partial seizure as he was clearly in full control of his vehicle at this point.

Despite evidence from Ms Kustura, who had had a number of telephone conversations with Deane during the course of his drive south towards Sydney, that he was normal, happy and excited, the toxicology cannot be disputed.

We will never know how much methylamphetamine Deane consumed or when it was consumed during his final hours. I can only be satisfied that his consumption of the methylamphetamine together with his lack of sleep somehow impaired his decision making which resulted in the manner of driving that ultimately led to his death in the early hours of 18 March 2012. Did the police that observed Deane's manner of driving adhere to the policy and procedure and conduct themselves appropriately under the circumstances?

As a result of the police activating there in car video much of what occurred in the early hours of 18 March 2011(as said) was recorded. I note that the whole incident in total occurred in less than one minute. I am satisfied that the time that the police observed the nature of Deane's driving, from when he veered from lane two to lane one and drove onto the grass median strip, that it was unlikely that Deane would have seen their position as they were secluded by the mound of dirt known as "the hump" on the median strip.

Upon viewing the erratic driving on the median strip, they took the initial steps to stop him by getting into their vehicle, activating the lights on approach. What happened then could not have been anticipated. It was not a pursuit as they had no time to attempt to cause Deane to stop and the roll over of the vehicle occurred within seconds of the lights being activated. The attending officers upon seeing the vehicle roll over alighted from the vehicle to attend to Deane. The ensuing investigation was both thorough and detailed and all involved can only be commended. Accordingly, I now turn to the findings I am required to make pursuant to s 81 of the **Coroners Act** 2009.

Formal Finding

I FIND THAT DEANE MANNING DIED ON 18 MARCH 2012 AT PACIFIC HIGHWAY, NABIAC, AS A RESULT OF HEAD INJURIES CAUSED BY HIS VEHICLE ROLLING OVER AND HIS NOT BEING RESTRAINED BY A SEATBELT. AS TO THE MANNER OF DEATH, I NOTE THAT HE WAS UNDER THE INFLUENCE OF METHYLAMPHETAMINE AT THE TIME THAT HIS VEHICLE ROLLED OVER AND THE AMOUNT OF THIS SUBSTANCE WOULD HAVE IMPAIRED HIS DRIVING AND DECISION MAKING ABILITY.

25. 89740 of 2012

Inquest into the death of Joseph Gavin. Finding handed down by State Coroner Jerram at Glebe on the 9th August 2013.

Mr Gavin was incarcerated with Corrective Services. Prior to his incarceration he did suffer from certain illness related to his heart, cardiac related issues. During the course of his incarceration he spent time under the treatment of Justice Health within the Long Bay Hospital and at the time of his death he was housed within an area known as the annexe of the Prince of Wales Hospital. That area's best described as part of the public hospital for more serious treatment in care of inmates suffering from significant issues. He was under a palliative care treatment.

A Coroner's certificate was provided giving the cause of death as combined effects of aspiration, pneumonia and cardiac failure and secondly a contributing vascular dementia.

Formal Finding

I MAKE THE FINDING THAT JOSEPH GAVIN DIED ON 20 MARCH 2012 AT THE ANNEXE, PRINCE OF WALES HOSPITAL AT RANDWICK OF COMBINED EFFECTS OF ASPIRATION PNEUMONIA AND CARDIAC FAILURE AND VASCULAR DEMENTIA

26. 89735 of 2012

Inquest into the death of James IVIMY. Finding handed down by State Coroner Jerram at Glebe on the 9th August 2013.

Mr Ivimy was incarcerated Corrective Services for an extended period of time due to various offences. Over that time, prior to his incarceration he had a number of health issues.

This led to during his incarceration being hospitalised within Long Bay Hospital, which is part of the MSPC for Corrective 25 Services. Inside the hospital he passed away from what is clearly a death by natural causes.

There appears to be no care and treatment issues. I will just make the formal finding,

Formal Finding

THAT JAMES IVIMY DIED ON MARCH 2012 AT THE LONG BAY PRISON HOSPITAL OF PULMONARY FIBROSIS.

27. 121233 of 2012

Inquest into the death of Ryan Pringle. Finding handed down by Deputy State Coroner Dillon at Parramatta on the 27th November 2013.

I now come to the formal conclusion of this inquest. Ryan Neil Pringle died on 15 April 2012 at the property known perhaps with unconscious irony as the School of Happiness on the Rocky River about 27 kilometres from Tenterfield.

Mr Pringle had been hit by one bullet fired by Sergeant Carter Knyvett, which severed an artery causing him ultimately to bleed to death. Because Mr Pringle had been shot by police, an inquest into his death is mandatory. Police are of course accountable to our society and if someone dies in the course of a police operation, an inquest, which is an independent judicial inquiry, will be held to determine how that death came about and whether the circumstances justified the police conduct and of course, it would be commonsense, but also we have heard from expert witnesses, that the use of firearms by police is a last resort and must be scrupulously justified.

There can however be no doubt in this case that the two involved officers went to extraordinary lengths not to use deadly force despite the terrifying and astonishingly threatening circumstances in which they found themselves before Sergeant Knyvett eventually shot Mr Pringle. Neil Pringle, Ryan's father, spoke very eloquently and very movingly shortly before I adjourned about Ryan Pringle and he pressed the point and I completely agree with him, that the last 48 hours of Ryan's life should not sum him up.

This is part of the tragedy of this whole situation. So many people have come and given evidence over the last few days, obviously deeply affected by Ryan's death and the way it came about. Many of those who have given evidence are saddened not only because of his death, but because his death was so uncharacteristic of what they knew of him.

Of course, the Rainbow people only saw one aspect of Ryan, but those who knew him well have described him in very different terms from the person that we have heard described by the eyewitnesses to the events of 15 April 2012. Neil Pringle spoke about Ryan's mental health. There is no doubt that he had a mental illness, that he had been diagnosed with schizophrenia although he was being treated for that and in other circumstances, it seems that he had a reasonable control, good control, over the symptoms.

He was obviously a very handsome young man, a very healthy young man, a young man who lived life to the fullest, was extremely active, was charming, was attractive to others, had a wide circle of friends. Jan De Smet and Andrea Messina yesterday described this charismatic character that they had met at a festival with whom they kept in touch.

Monique Wilmann described a man who met her suddenly, announced that he was in love with her and with whom she fell quickly in love and from whom she was inseparable for four years.

His family here today demonstrates by their grief. How loving and warmly they felt towards him and he towards them. He has been described a number of times as a beautiful young man. His loyalty, affection, generosity, concern for others and so forth have been described as well as his skill, his love of music, his ability to perform circus tricks and so forth as well as to range around the bush, his life of wildlife and so on.

This is a very different picture, of course, from the picture that has been received which is only the last - which is a picture, a very disturbing picture it must be said of a man whose mind was perhaps out of control and certainly, ultimately, it certainly was out of control, I think. Ryan was, the real Ryan, the Ryan described by those who knew him best and who love him most was not on show at the School of Happiness on this particular weekend.

The story told about this weekend is astonishing really. It would be difficult I think to construct a more alarming and frightening scenario than the one that unfolded the night that Ryan died at the School of Happiness. Witness after witness has described the scene, Ryan emerging from the dark armed with a crossbow, screaming threats to kill the police, ordering them to lay down their weapons, people hiding under vehicles to avoid being shot, Ryan stalking the police around a vehicle, police retreating, police torches being flashed on and off from time to time illuminating this frightening figure, a failed attempt to disable him with a taser and finally, Sergeant Knyvett shooting into the darkness believing that Ryan had shot his partner, Ryan screaming in pain, collapsing, being given CPR but dying of blood loss before an ambulance or helicopter could arrive. Ryan's death was the final act in what had started out as a peaceful and pleasant event, in what was intended to be a peaceful and pleasant event.

Jan De Smet and Andrea Messina had invited Ryan and his partner, Monique, to their property. By coincidence they had previously also invited the Rainbow people to a Rainbow gathering, the Rainbow gathering to be held on the property, one and a half or 2 kilometres away from the homestead or the compound. The Rainbow people were old-fashioned hippies perhaps or new age people who live an alternative lifestyle and who have a generally peaceful and nature loving outlook. Ryan, for someone reason or rather, possibly because he took drugs, possibly because his schizophrenia was starting to take a grip on him, became agitated in part because of what he perceived to be the disrespectful behaviour of some of the Rainbow people.

One of the difficult issues no doubt for his family most of all, but also for those of us who did not know Ryan as he was known by his family and those who loved him, is to try to understand what exactly went wrong, why did he start behaving as he did and why did his behaviour become more and more uncontrolled, unstable, irrational and ultimately very threatening and violent. He had, as I have mentioned, been diagnosed with schizophrenia but he was being treated with antipsychotic medication.

Indeed, after he died he was found to be using his amisulpride, but after his death it was also found that at least in the hours before he was shot he had taken OxyContin, methylamphetamine or speed, cannabis, alcohol and amphetamine.

The amphetamine was probably for his ADHD and the amisulpride of course was for his schizophrenia. Although it was not detected in his system and there is no evidence of it being found later on by the police, there is some evidence and plausible evidence that on top of the cocktail of drugs that was found in his system after he died that he had also taken LSD. We heard from Dr Farrar yesterday that a person who takes methylamphetamine may act extremely unpredictably because the affects are unpredictable. Some people have a pleasant experience taking LSD, but others can and especially if they take a significant quantity of it become quite paranoid. When one looks at the behaviour that Ryan was exhibiting that particular weekend, it might be thought that he was in an increasingly - in the grip of some sort of psychosis or some sort of irrational paranoia, something of this nature.

In any event, it is clear that throughout the time he was at the property he was acting erratically and irrationally and he became increasingly irritable, agitated, threatening and violent as time went on.

In my view, the evidence shows that he was losing control of his mind. It is difficult to say exactly what he was thinking throughout the time he was at the property, but his behaviour became increasingly unpredictable and dangerous.

Before the final act, he confronted the Rainbow people, he threatened dogs, he assaulted a number of women, he chased one of the men with a knife, he threatened others with a knife and he exhibited signs, as I say, of what seems to me was probably a psychotic episode. For example, he began to accuse people of being in the possession of the devil or being under the influence of demonic forces. Whatever people may think of the Rainbow people and their lifestyles, they were the polar opposites of Satanists.

Ryan developed and displayed grandiose ideas of leadership seeming to think that he had command over this group, having some sort of messianic status with the responsibility to exorcise satanic forces that he apparently perceived to be gathering on the School of Happiness. Given his predisposition to psychotic illness it appears, it seems to be a reasonable conclusion that his drug taking that weekend pushed him well over the edge. In any event, certainly Vera Breier and Nicole Delaine, two of the Rainbow people, recognised a man who seemed to be potentially explosive and unstable and perhaps likely to become increasingly violent. They decided with Jean-Eric Mamet to seek the protection from the police in Tenterfield. They went into town having taken one of their party who had been injured running away from Ryan and called the police. The Tenterfield Police Station was unattended at the time, but Sergeant Knyvett was called back to duty.

He spoke to the young women and to Mr Mamet for some period taking notes. He also realised that the property they were staying on was remote and that in the dark he needed a partner for officer safety and also perhaps to assist in arresting someone or protecting the people who were staying on the property.

The young women told him about Ryan threatening people with a knife, threatening to kill people, chasing Antonio into the bush, Antonio dislocating his shoulder and so forth and that dogs being threatened and what not.

Sergeant Knyvett did seek to raise another male police officer, Senior Constable Cosgrove, but was unable to. So with very few other resources available, he asked Senior Constable Peasley, his de facto partner, to come with him out to Rocky Creek. She was recalled to duty and she accompanied Sergeant Knyvett out to the property.

When the police arrived they acted, in my view, with great restraint and patience, with great moderation in an attempt to diffuse the situation they had found. What they found at that time was frightening enough. They found Andrea Messina cowering on her knees apparently being threatened by Ryan who was armed with a long carving knife. Sergeant Knyvett ordered Ryan to drop the knife and a sharpening steel that he was holding and he did so. At that point, it seemed that Ryan was quite compliant and that the situation could be diffused without very much more drama. But at some point Ryan decided that he was not going to comply. While he had dropped his knife, it appeared that he was advancing to pick it up again and this caused the police to become more alarmed and to take more forceful command of the situation.

However, Ryan retreated into the darkness. He was also shouting threats to the police and to Monique and others perhaps. Quite wisely and very reasonably, the police decided not to chase him into the darkness in the bush but to get the people away from the homestead and also the campers off the property. They had reasonable cause to believe that Ryan, who had said at that point that he was going to get a gun, was not thinking clearly and might well be very dangerous. To clear the property of potential victims was the most sensible course.

They went down to the campsite having got the people who were up at the homestead to leave immediately. They went down to the campsite and asked everybody to pack up and leave as quickly as possible. It seems that even under such circumstances, the Rainbow people were rather slow to get moving. I think one of the Rainbow people said it took about ten minutes to load his vehicle, but the police thought it took more like half an hour. I would be more inclined to accept the police evidence on that.

In any event, just as the group was about to leave in convoy in their vehicles, Ryan emerged from the darkness and it was seen after a short time that he was armed with a crossbow, which he held in the ready position, the firing position. But again, the police acted with great restraint. They asked him - told him to drop his weapon and Sergeant Knyvett a number of times did this and also was trying to assure Ryan that if he did so nobody would get hurt.

Clearly, the police were worried not only about Ryan that they did not want to hurt him, but about the Rainbow people as well, no doubt, as themselves. Both the police officers acted with great courage and professionalism in the face of what they both perceived to be a genuine and terrifying threat.

In my view, they placed their own lives in jeopardy to protect the Rainbow people and indeed this was acknowledged by several of the Rainbow witnesses some of whom even went so far as to say that they would have shot Ryan had they been in the police's position much earlier than any police officer did.

The courage of the police I think is highlighted by the fact that Sergeant Knyvett who was in this pitch darkness had to get lights off, could only flash his torch from time to time as could Senior Constable Peasley. Out in this darkness was a man they did not know, had no idea what was in his mind, but what they did know was that he was armed with a deadly weapon and whenever he could Ryan would aim it at them.

Sergeant Knyvett tried to get Senior Constable Peasley to come to him so that if he had to fire or she had to fire neither of them would get caught in a crossfire, but to give her the opportunity because she had gone off to assist and warn some of the Rainbow people including to tell them to turn their lights off so that they would not become targets, he had to expose himself by turning on his own torch to illuminate himself thus becoming a potential target. This was to give her an opportunity to reach him by running across the open ground in the dark.

From their point of view, the man with the crossbow was now playing some sort of cat and mouse game with them, stalking them around the vehicle or one of the vehicles, first the police vehicle and then one of the Rainbow vehicles. They would turn on their torches, try to find him in the dark, turn it off again and try to no doubt listen for movement and so on. The anxiety and tension of this particular scene must have been absolutely extraordinary. When the video was shown yesterday of the aftermath at one point Sergeant Knyvett spoke and said that he was - I think he said, "Sweating like a pig" or "Sweating profusely", something like that and then there was an image shown, he was absolutely drenched in sweat no doubt from the tension of this relatively short period of potential danger.

Finally, Sergeant Knyvett urged Senior Constable Peasley to try and get a shot in with her taser. This again I think shows the extraordinary restraint of the police. Even in those circumstances, they were trying to use non-lethal force. Unfortunately, the taser shot went wide. It is not clear where one of the probes went, but certainly one of them missed completely and hit the tyre of the vehicle.

In any event, in the darkness, Sergeant Knyvett heard something that sounded like a twang. He thought that Ryan had fired his crossbow at Senior Constable Peasley and at that point he lost sight of Senior Constable Peasley. She moved backwards and he thought that she had been shot with the crossbow and it was only then that he fired into the darkness. He had dropped his torch by then, there were no lights, he fired into the darkness at the point that he had last seen Ryan. One of the shots hit Ryan who screamed in pain, collapsed and shouted abuse at the police.

This was obviously a very traumatic event not only for the police at the time and the Rainbow people, as well obviously as for Ryan, but for all those who have had to think about and in some way after the event experience it, in particular Ryan's family and friends and his fiancee, Monique.

All of those who have been here remembering the real Ryan that they loved and cared about have been generous and understanding and indeed very appreciative of the dilemmas faced by the police, the terrifying nature of the situation, the thoroughness of the critical incident investigation and of the anguish that the police, the two involved police, Sergeant Knyvett and Sergeant Peasley, have been through and continue to undergo.

To their very great credit, this family, this extraordinarily dignified family and generous family have illuminated the real Ryan Pringle. I accept that Ryan Pringle acted out of character. He was not a character out of Deliverance or Wake in Fright or something like that, not some sort of monster who just shares a human form with the rest of us. He was a man who had lost his mind and it is a genuine tragedy that this man who had so many gifts and who was so loved lost his mind and as a result lost his life. The experience of this particular night will no doubt linger for a long time in the minds of all those who were there, perhaps most especially, Sergeant Knyvett and Sergeant Peasley. I honour them for their devotion to duty and their courage and I propose to recommend to the Commissioner of Police that each receives a bravery award for their actions that night.

It is also a credit to them, I may say, that they have returned to duty. I know, just having observed how upset Sergeant Peasley was, that she remains deeply affected by this, by this experience. I think sometimes it is forgotten but it was recognised by the Rainbow people that police are just human beings like the rest of us, but they are called upon to do things that the rest of us do not have to do. They are not only society's guardians, but they literally sometimes have to step up and place their lives on the line for us and it is unfortunate, I think, that this is not always recognised. I hope that a bravery award will be made to Sergeant Knyvett and Sergeant Peasley as a recognition not only of their devotion to duty and their bravery and their professionalism on this night, but as a, in a way, a commendation to all country police who undertake these very dangerous and lonely kinds of duties. I now turn to the formal findings that I need to make under the **Coroners Act**.

I am sorry I did mean to deal formally with the issues that were touched on by counsel assisting and I need to do that too. As to the question of whether the police were justified, I think I have already made clear my findings in relation to that. The police obviously acted appropriately and in accordance with police training and policy. Neil Pringle raised the question of staffing and communications in remote areas. This remains a problem. It is a problem because Australia is a big and very diverse country. I do not think it would be appropriate for me to advise the Commissioner of Police how to staff local area commands.

I think the police management, senior management, are in a far better position than I am to assess these things, but obviously I recognise that in these very remote areas that police can be placed in very difficult situations and have to be perhaps in many instances far more self-reliant than perhaps their city colleagues are. Sometimes the bush looks very, very attractive and peaceful, but it of course can hold great terrors. Communications ultimately is a question for I suppose government and telecommunication companies. The police did have police radio. It worked to some extent. It worked better than the phones did anyway.

Senior Constable Peasley was able to get through to some degree, but again, I recognise that sometimes police may have to go into black spots and I am sure the police commissioner will look at this case or the police senior management will look at this case and see whether the police in remote areas need to be better equipped if they can be better equipped.

That said, in this particular situation it seems that even a satellite phone would not operate. As for Senior Constable Peasley being called out, I have absolutely no criticism. She did her duty. Sergeant Knyvett did his duty. The fact that they were in a relationship I do not think had any affect on their professionalism. It may have even bolstered their professional conduct, looking out for one another and also looking out for the Rainbow people. It certainly did not make the situation more dangerous than it already was. And I have no criticism of the critical incident investigation, Detective Inspector Jubelin consulted the State Coroner about the rather unique set of circumstances, which I have to say in many years as a coroner now, I have not come across. Generally, police are separated but in these circumstances, I think it was reasonable. I accept the evidence of Sergeant Peasley and Sergeant Knyvett that they recognise the sensitivity of the situation and did not corroborate in their evidence.

In any event, their stories were quite different as they described them and I cannot see any grounds for even surmising that they corroborated in their evidence. They were honest and truthful in the way they gave their evidence and there was no tainting of it. So I will come back to where I was just a few minutes ago and make my formal findings and the recommendation I propose to make.

Formal Finding

I FIND THAT RYAN NEIL PRINGLE DIED ON 15 APRIL 2012 AT THE PROPERTY KNOWN AS THE SCHOOL OF HAPPINESS, BILLARIMBA ROAD, ROCKY CREEK, NEW SOUTH WALES, DUE TO A GUNSHOT WOUND HE RECEIVED IN THE COURSE OF A POLICE OPERATION FROM AN OFFICER ACTING IN THE COURSE OF HIS DUTY.

Recommendations

To the Commissioner of Police, I recommend that Sergeants Carter Knyvett and Karen Peasley be nominated for appropriate bravery awards.

28. 128835 of 2012 s 75 Non Publication Order

Inquest into the death of XX. Finding handed down by Deputy State Coroner MacMahon at Glebe on the 29th July 2013.

This has been an inquest into the death of XX I will refer to refer to XX by his first name. I trust that that will be appropriate. XX was born on 12 December 1971. He is the son of …….. who have been here throughout the inquest. He is also the brother of …… ….. …. who has also been here. XX was the father of five sons. They were from a relationship with a MW but he had been separated from her for some time.

In more recent times, he had been in a relationship with NM. Although they did live together at times, they did not do so in 2012. XX was declared deceased on 21 April 2012. The cause of death were incised wounds to the neck. It is important to understand the role and function of a coroner. And so it is necessary for me to refer to some legislation. The **Coroners Act** 2009 is the relevant legislation. S 35 of the Act requires that all reportable deaths be referred to a coroner or be reported to a coroner. Reportable deaths are variously defined in s 6. It includes a death, which is violent. XX's death was violent and his death is therefore reportable to a coroner.

S 21 provides a coroner with the jurisdiction to conduct an inquest into a reportable death. Certain inquests are the exclusive jurisdiction of the State Coroner or a Deputy State Coroner. One of those such deaths, which are set out in s 23, is a death, which occurs in the course or as a result of a police operation. XX's death was, as I have already said, a reportable death. At the time of his death, police were in attendance. His death therefore occurred in the course of a police operation.

An inquest is therefore mandatory in accordance with the Act and must be conducted by the State Coroner or a Deputy State Coroner. Other legislation, which is relevant in these proceedings, is s 74, which authorises a coroner conducting an inquest to prohibit the publication of evidence in the proceedings if he or she is of the opinion that it would be in the public interest to do so. S 75 deals with deaths, which are self-inflicted. XX's death was self-inflicted. S 75 prohibits the publication of the report of an inquest where a finding that the death was self-inflicted is made.

Such a report may however, and to the extent allowed, be made where an order is made by a coroner conducting the inquest.

Section 81(1) sets out the primary function of a coroner at the conclusion of the inquest and that primary function is to make findings in respect of five matters. They are the identity of a deceased person, a date and place of their death and the manner and cause thereof. S 82 allows a coroner conducting an inquest to make recommendations as he or she considers necessary or desirable or connected in any way in respect of matters which are connected in any way with the death with which the inquest is concerned.

The purpose of that discretion is to allow an inquest to be forward-looking and endeavour to make recommendations that might prevent deaths in the nature of the one, which the coroner is examining. Exhibit 1 in the proceedings shows that XX's death was reported to the coroner on 21 April 2012.

The day after he was identified by his father. A life extinct certificate was issued by Dr Sion and an autopsy was undertaken on 22 April 2012 by Professor Duflou, the chief forensic pathologist at the Department of Forensic Medicine at Glebe.

Professor Duflou found that the cause of XX's death were incised wounds to the neck. Specifically he found "incised wounds to the right and left sides of the neck with injury to multiple structure of the neck." Dr Duflou also found toxic levels of Oxycodeine in the blood, specifically 1.8 milligrams per litre. He found however that the fatality of the incised wounds to the neck were such that the potentially lethal levels of the Oxycodeine was such as to play no direct role in causing his death.

It is clear from the evidence that the place of XX's death was in Nowra. As such the issues relating to identity, date and place and direct cause are not controversial. As to manner, looking at that issue in a limited sense or in a narrow sense, it is clear that XX's death was caused - or the manner of XX's death was due to self-inflicted wounds. It is also clear on the evidence that XX has intended to take his own life.

He left a suicide note, which was found, on the vanity table in the ensuite. That note says, I quote:

"I am at peace. Sorry, everyone. Can't live with the same of my actions. It's okay. I was ready and had a good life thanks to you all. XX"

It is also the case that as I have said, XX consumed an overdose of Oxycodeine. In the ensuite were found in excess of ninety empty blister packs of the drug. That consumption was the cause of the level of the drug found at autopsy and would, on balance, have likely to resulted in his death over time. However, other matters intervened. The other matters that intervened were that XX was observed to cut himself in the throat with a knife by the officers. On a narrow view, the manner of XX's death is therefore suicide. Manner however has a wider context and that includes the circumstances of the death.

It was discovered on investigation that XX was released from Mirrabooka Mental Health Unit at the Shellharbour Hospital the day before his death. And as I said, the police were involved and at his home at the time of his death. It was therefore necessary to examine as to the circumstances of XX's death, the circumstances of his release from the mental health unit, his condition on release, and whether or not the treatment he received whilst in that unit was appropriate and whether or not that treatment or any lack of it contributed to the events that followed the day after.

As I have said, where a death occurs during the course of a police operation, an inquest is mandatory. It is mandatory for a number of reasons but primarily so that the actions of the officers involved can be examined with a view to the public being comforted that the actions of those officers were appropriate in the circumstances.

The police have an important role to play in society and it is therefore important for society to be able to examine the actions of police where a death occurs.

Firstly to ensure that the police involved have acted appropriately, acted in accordance with the law, acted in accordance with guidelines and regulations that they are bound by. And also, to try and learn from such situations to see whether or not even where police act appropriately, their actions or their training can be improved in the interest of the public.

XX's mental health. To assist me to understand XX's mental health prior to 21 April 2012, I had the assistance of - available to me hospital records for his admission to Mirrabooka on 15 August 2010, 10 April 2012, and 19 April 2012. I also had access to the admission records at St Vincent's Hospital on 18 April together with a review prepared on behalf by forensic psychiatrist Dr Christopher Ryan.

I had statements from Nurse Miller, Dr Garg, Dr Austin-Woods and Dr Tehseen and as I have said, a review conducted by Dr Ryan. Nurse Miller, Dr Tehseen, Dr Austin-Woods and Dr Garg and Dr Ryan each gave evidence during the course of the proceedings. I was also assisted greatly by the evidence of XX's mother and his father who each made statements and assisted by giving evidence. The investigation identified that XX had suffered from mental health issues for many years. As I have said, he was admitted to Mirrabooka on 15 August 2010 and he remained there as an in-patient until 20 August 2010.

During that admission, he was under the care of psychiatrist Dr Garg. He was during that time a voluntary patient. He was identified at that time as having a history of drug-induced psychosis, chronic back pain, poly-substance abuse and alcohol abuse. At the time of his admission, he was experiencing paranoia and persecutory feelings. He thought he was being tracked by an unknown person through his mobile. He did not feel safe and that is the reason why he presented at emergency for assistance.

The history also showed that the events that preceded his admission followed a heavy use of cannabis. He was diagnosed at the time as having suffered from a cannabis-induced psychosis. As I mentioned, he remained in hospital until 20 August 2010 as a voluntary patient when he was discharged. It would seem that following his discharge, his mental health appears to have been somewhat ignored. XX was next admitted on 10 April 2012.

Once again, he self-presented at emergency because he was feeling unsafe. Once again, he was suffering from paranoia and once again he came under the care of Dr Garg. The history was that he had increased his use of Oxycodeine that had been prescribed to him for back pain. He was once again diagnosed by Dr Garg as suffering from drug-induced psychosis, which he considered, was resolving.

XX was discharged on 17 April 2012, the plan being that he would continue with Zyprexa, an antipsychotic medication for a month. He would attend drug and alcohol service. He would attend his GP for assistance and support within the week.

The community mental health service would follow him up and efforts would be made to reduce and then cease his use of Oxycodeine.

He was also advised as to the deleterious effects that the use of cannabis can have. Dr Ryan reviewed the treatment XX received during the course of these two admissions. He also reviewed the diagnosis. Dr Ryan considered that the treatment and the diagnosis was appropriate and the treatment received and the plan for future was also appropriate. I accept Dr Ryan's opinion. It would not be necessary for me to re-examine those admissions further other than noting that those admissions set the scene for what was to follow.

XX was discharged on 17 April 2012. He returned home. To the observations of his mother, everything seemed to be normal. When she awoke the next morning, however, he was not there. She was somewhat concerned because he had not told anybody where he was going and he couldn't be contacted because he had left his phone. The evidence shows that a little after 5 o'clock, XX rang triple-0. He told the operator that people were following him, his emails and Facebook had been hacked and he asked that the police find him at the taxi rank at Central Railway Station to assist him.

It would seem that sometime between him going to bed and 5 o'clock, his psychosis had once again become active or acute. At 6.30 or thereabouts that evening, XX was approached by Constables Hanna and Bambrick at Central Railway Station. He said to them – and I quote - "Someone has used thirty-seven devices on me. People are following me."

The officers correctly inferred that XX was unwell and called an ambulance. He was assessed by ambulance officers who in accordance with s 20 of the **Mental Health Act** transferred him to St Vincent's Hospital for assessment. The St Vincent's Hospital records are as follows - and I quote: "Cut inner arms, feeling suicidal tonight. Denies feeling depressed but convinced bikies are going to kidnap and torture him. Displays paranoid persecutory delusions. States if discharged will commit suicide. Came to Sydney to get heroin to have overdose. Was unable to get it." Under "Thought Content", the quote is: "Suicidal ideation. States as soon as discharged will complete." The overall clinical impression or diagnosis was, I quote, "Forty year old male with suicidal ideation, auditory and visual hallucination of persecution and paranoid thoughts." There is no issue as to the care provided to XX at St Vincent's who arranged for him to be transferred to Mirrabooka. XX refused to get into the ambulance to transfer him to Mirrabooka, he was fearful about where he might be taken and what might be done to him. And his sister was contacted to speak to him and was able to persuade him to cooperate in his transfer.

He arrived at Mirrabooka in the early hours of the morning, arriving at about 3.30am on 19 April. He was again reviewed by Dr Garg at about 11.30 that morning. Dr Tehseen, a career medical officer in psychiatry was also present. XX at that time informed Dr Garg, "I am feeling better now."

He also denied at that time any suicidal thoughts or any paranoia. Dr Garg was unable to detect any evidence of active psychosis.

XX agreed to stay at Mirrabooka as a voluntary patient. Dr Garg stated in his evidence he was surprised that XX had relapsed so quickly after his earlier discharge.

XX the next day spoke to Dr Charles Austin-Woods, a registrar in psychiatry at Mirrabooka. He asked if he could be discharged. Dr Austin-Woods quite properly spoke to Dr Garg who indicated to him that XX could be discharged if - and I quote - "if appropriate" after a review. Dr Garg asked Dr Austin-Woods to conduct a review. The review of course was a mental health review. Dr Austin-Woods found XX to be feeling - quote - "feeling safe, no thoughts of self-harm or harm to others, no strange experiences." Dr Austin-Woods gave a diagnosis of "acute crisis from which he had recovered." He devised a discharge plan, which was to provide him with an emergency contact number, arranged for community mental health follow-up and for him to be followed up by his general practitioner. Dr Austin-Woods stated - and Dr Garg agreed - that he discussed his findings and his plan for discharge with Dr Garg prior to XX being discharged.

Dr Ryan has criticised the care provided to XX in this third admission for a number of reasons which are outlined in his report. It is not necessary for me to go to all of the criticisms made by Dr Ryan but of relevance to the matters which I am required to consider, Dr Ryan was critical of the apparent (from the hospital records) change in the diagnosis that had been given to XX. Dr Ryan could not understand that change that had occurred. Dr Ryan was also critical of the fact that it appeared possible (from the confused hospital records) that the antipsychotic medication prescribed for XX had been discontinued. He also criticised the fact that XX was discharged without the involvement of his family in the preparation for discharge. He also criticised the lack of documentation of the clinical reasoning of the doctors involved in the decision to discharge him.

Dr Garg, Dr Austin-Woods and the Local Health District, all of whom appeared - gave evidence and appeared in the proceedings conceded that the documentation was unsatisfactory. Dr Ryan did not believe on the information that was available to him that XX suffered from a situational crisis or an adjustment disorder. It was his view, having examined the records, that XX's psychosis continued although not in an acute phase and having regard to the history of what had occurred after the discharge on the second admission, it was his view that it was likely or possible that the psychosis could become acute at any time.

Because of this, Dr Ryan considered that it was imperative that the antipsychotic medication be continued and that his family be involved in the planning for his discharge. XX was, as I have already mentioned, a voluntary patient. After his examination by Dr Garg on the 19th, he could as a matter of right leave the hospital if he wished unless it was considered that he was a risk to either himself or to others and could be scheduled in accordance with the provisions of the **Mental Health Act**.

It does not seem to be an issue that at the time XX sought to be discharged, the circumstances did not exist that would have allowed him to be scheduled.

Dr Ryan is somewhat ambivalent on that point but on balance it is his view that whilst XX could not be scheduled, active efforts should have been made to encourage him to stay in the hospital for a further period. Had such efforts been made, it may well be that XX would have stayed. There is no evidence in the records to show that any effort was made to convince him to remain. Dr Garg and Dr Austin-Woods do not record any efforts being made. And Dr Garg suggests that such discussions would have occurred. However, on balance it seems to me that XX having requested a discharge and Dr Garg having indicated that discharge was appropriate after review to determine whether or not he should be retained under the **Mental Health Act**, the discharge was to occur or assumed to be appropriate.

Lack of documentation once again fails to assist us to understand what happened at this point. What is absolutely clear is that there was no effort made to involve XX's family in his discharge planning. Mrs B gave evidence that when she picked XX up from the hospital, she had no idea as to his diagnosis and because he appeared to be okay, she went about her ordinary activities as did XX's father. Subsequent events were to show that XX's discharge without the appropriate preparation and support was likely to have devastating consequences or did have devastating consequences.

As I have indicated, the records of the hospital created confusion. The first issue of confusion was the diagnosis made at the time of discharge on 20 April. As I have indicated, the diagnosis on discharge was "acute crisis from which he had recovered." No reference was made to the previous diagnosis from only a few days before of drug-induced psychosis or the relationship between the two. Dr Garg and Dr Austin-Woods both said that they were aware and had in mind the previous diagnosis. But they did not record their clinical consideration as to the relationship between the previous diagnosis and the new diagnosis.

They did not record - in - by recording the diagnosis as "acute crisis from which he had recovered", it contained the suggestion that all was well. In their mind, they may have understood that the previous diagnosis of drug-induced psychosis - thus in remission - was there. But that created confusion. If the previous diagnosis was now superseded by the new diagnosis, there was perhaps good reason for the discontinuance of an antipsychotic, particularly where an antidepressant was prescribed. It would seem the nursing staff from the records understood the antipsychotic had been discontinued.

XX is recorded as being surprised himself that the antipsychotic had been discontinued. On balance it would seem to me that when XX was discharged, he did so without the assistance of antipsychotic medication. This confusion in a manner is shown also by the referral letters after each discharge which was sent to different general practitioners. I accept Dr Ryan's opinion. On balance I am satisfied that it is more likely that on 20 April 2012, XX was suffering from - and continued to suffer from a psychosis which was likely to have been drug induced. However at the time of his discharge, it is possible that that psychosis was in remission. There is another possibility which I will come to later.

Dr Ryan raises the possibility that in fact XX was suffering from schizophrenia and that was the cause of the psychosis and that the use of substances aggravated that condition and that that is not something which we can make a finding about and in fact it does not have any direct bearing on the circumstances of his death. It is unfortunate that there is no record of the clinical considerations because one would have thought that on a third admission in the nature of XX's admissions, consideration ought have to been given to that possibility. But there's no record that it was.

As I have said, on his discharge he was probably not receiving any antipsychotic medication. He was given anti depressant medication which Dr Ryan was critical of. I do not need to go into and make any findings about that matter. But most importantly, his parents who were in effect his carers were not given any assistance to allow them to identify what seemed likely or possible based on recent history of his psychosis once again becoming acute.

XX was thus vulnerable because of his mental health. His vulnerability was contributed to by the failure of those treating him, proving him with inadequate level of care. It seems to me that it is likely that that failure was a contributing factor to the tragic events that were to unfold the next day. Failure as identified in XX's care would in ordinary circumstances have resulted in recommendations in accordance with s 82. The evidence before me however is that the Local Health District has taken active steps to address those issues that have been identified and they are to be commended for their action. In the circumstances, I do not consider it necessary to make recommendations.

XX's mother and father each made statements gave evidence. Mrs B stated that on 20 April she picked XX up from hospital a bit after 3pm. To her, he appeared fine. They had dinner. They watched the football together, that is Mrs B and XX. Mr B said that he might have been there for a short time but he does not like television and so he went about his own business and probably went to bed. The discussion between Mrs B and XX was that he was to - he planned to watch his sons play football the next day.

The next morning Mrs B woke at about 7am and left for work at 8am. She spoke to XX briefly before she left. To her, everything seemed fine. She asked him to hang the washing. Later while she was at work, she spoke to him on the phone. However, at about 2.15 that afternoon she received an SMS message to the effect that - from him saying that he was not going to go and watch his sons at football. Mrs B went to the football to watch her grandsons.

She sent an SMS to XX while she was there and received no reply. She called him at 3.56pm and once again received no reply. She became concerned. She then spoke to her husband who agreed that he would go home to check on XX. Mr B gave evidence. He said that on 21 April he went to work and returned home at about 1pm. He showered and then decided to go shopping. At the time XX was at home. XX spoke to - Mr B invited XX to go to the shops with him.

However XX declined. As far as he could tell, everything was okay. At about 3 o'clock, Mr B returned home.

The house was locked. Mr B assumed that XX had gone out to the football to watch his sons. He went into the bedroom and then went to go to the bathroom. He found that the door was locked. He said, “XX, are you there?” XX replied, “Yes. I’m having a shower.” Mr B thought nothing more of it and said, “Right o. I’ll be back.” Mr B went out and went to the bowling club and then to go visit a mate. As he was leaving the bowling club, he received the call that I have previously mentioned from Mrs B.

As a result, he decided to go home. When he got home, he could hear that the fan was still going in the bathroom and the door was still locked. He asked XX, “Are you still there?” XX replied, “Yeah.” He then asked, “What are you doing?” XX replied, “I’m having a shower.” Because of the length of the time that had occurred, Mr B became concerned for his son. He asked that the door be opened.

However, XX refused. Mr B was by that time very concerned for his son’s welfare and he decided that it was necessary for him to break the door down. He got a blockbuster and broke a hole into the door. Through the hole he could see that XX was standing on a small chair. He said that he could see lacerations to XX’s neck and that XX had a knife in his hand. He could see that the door was jammed with a shoe rack. Mr B tried to move the rack and XX lashed out at him with the knife. Mr B avoided XX’s action. Mr B was no doubt by this stage in shock.

His evidence was that XX had never been violent towards him before. He called triple-0 for help. Coincidentally XX was also calling triple-0 for help. He told triple-0 to the effect that a person with an axe was trying to kill him. The triple-0 calls made by both Mr B and XX were played and the transcripts of those calls were exhibits in the proceedings. The police responded promptly to the calls for help. It would seem that the call from XX was the message that was received by the police.

To understand what happened next, I received evidence from the officers involved - Sergeant Parfitt, Senior Constable Dillon, Senior Constable McGregor and Constable Ferraris. I also had, as I have said, available to me the recording of the conversation between XX and the triple-0 operator, Claire Isaac. That recording was most enlightening. It is not necessary for me to go into the detail of the evidence given by the various officers. I accept that in giving their evidence, they were reciting the events as to the best of their recollection.

I accept that those recollections will vary as to some of the detail. The events were traumatic and emotional. The evidence of the officers were otherwise consistent. I am satisfied that XX was aware that the officers - the police had arrived at his house. This, it must be remembered, was in response to his request for help. He told Claire Isaac that the police had arrived. I am also satisfied that XX was unresponsive to the efforts of the various officers to have him drop the knives that he was holding.

It is clear that for a considerable period of time, some fifteen minutes or thereabouts, XX engaged in a conversation with Claire Isaac, the triple-0 operator.

It would seem from the evidence available that XX had injured himself with the knives or perhaps with a broken razor blade which can be seen on the vanity table in the photographs taken by the crime scene officer prior to his father and the police arriving.

His father saw the injury when he looked through the hole that had been created in the door. XX in fact told Claire Isaac that he had cut himself.

And Senior Constable Dillon also saw blood. It would seem however that the injuries that had occurred prior to the police arriving were not life threatening although of course the consumption of the Oxycodeine was life-threatening over time.

Senior Constable Dillon and Sergeant Parfitt gave evidence that they were concerned as to the possibility of XX further self-harming and that they considered such a possibility was immediate. That is my word, not theirs. I accept that they considered it necessary as a matter of urgency to disarm him so that he could be cared for.

It was clearly unsafe for the officers to enter the bathroom until XX was disarmed. I accept further that their efforts to disarm XX firstly using OC spray and then a baton to try and knock the knives out of his hand were undertaken with the intention of preventing him further harming himself. Those efforts were unsuccessful and the evidence is that XX moved from his seated position into the bathroom and closed the shower curtain, or pulled the shower curtain across. The shower curtain was removed by the use of an extendable baton and in the shower recess XX began to once again cut himself in the neck on both sides.

The evidence, which I accept, is that Senior Constable Dillon then sought to use the taser to immobilise him to prevent him cutting himself. At the same time Sergeant Parfitt and Senior Constable McGregor acted to remove the door so that they could get access to XX to assist him. Having removed the door the evidence is that XX had slumped in the shower recess. Sergeant Parfitt removed the knives. XX was also removed from the shower recess. A doona was obtained to try and stop the flow of blood and first aid was immediately provided to XX by the officers until the ambulance officers arrived. Unfortunately the injuries were such that XX did not survive them.

The role of a Coroner in circumstances of a death during a police operation I have already outlined is to examine closely the actions of the police involved to ensure that they acted in accordance with their obligations at law, under police directives and in accordance with their training. I am satisfied that in this case the officers did do just that. The officers were operating in a high risk situation. Their actions were directed, and I accept, towards reducing the risk of XX self-harming. They took action that they did after having considered it and with the view to reducing the risk to both themselves and to XX. It cannot be suggested that the action was other than rationale and reasonable.

Counsel assisting wondered whether or not another alternative was available to the actions of the police in seeking to disarm XX.

He wondered whether or not had the officers withdrawn and waited for the trained negotiator who had been called to arrive things might have resolved differently. At first blush this wondering has initial attraction.

XX appeared to be communicating with Claire Isaac on the triple-0 call. Listening to that call shows that he was responding to her in an apparently responsive and rational fashion. In fact, it is clear to my mind that Ms Isaac was a highly trained and quite an effective negotiator. She was, however, notwithstanding that, unable to convince XX to put down the knives that he was holding.

Having thought about this possibility for some time I do not think it is likely that the officers withdrawing and waiting for the negotiator would have had the effect of preventing XX's death. This is because that on balance, it seems to me that XX was probably determined to end his life. This determination was as a result of the irrational state that he was in which was caused by his psychosis. It was nonetheless a determination that he had arrived at. I reach this conclusion because it seems that XX in fact had a plan to end his life. He had barricaded himself in the ensuite to prevent anyone interfering with his plan. He had written a suicide note, it was placed on the washbasin. He had taken an overdose of OxyContin that would, in time, have been likely to prove fatal. There is no doubt that he was aware that the police were there at the house and that they had responded to his call for help. He nonetheless refused to accept their help.

He appeared to be relating to Claire Issac as I have said quite effectively but refused to accept her advice and her imploring him to put down the knife. He was not manic or agitated. The observations of the officers and listening to his conversation with Claire Isaac shows that it was quite the opposite. He was quite deliberate in his actions. I am satisfied that XX was determined to end his life and in fact the only action that the police could take that would have saved his life was for them to be able to disarm him before he carried out his plan. The fact that he had knives with him showed me that he had an alternative plan available over and above the plan of overdose on the Oxycodone.

The actions of the police officers were thus the only appropriate actions for them to take in the circumstances and I have to commend them for their efforts to try and save XX's life. XX was a complex person who unfortunately suffered from mental health issues. He was a much loved member of the family.

His sister spoke lovingly and frankly about her brother during the course of the inquest. His death is a tragedy. He will be missed by his parents, his children, his siblings and others who knew and loved him. His death clearly affected the police officers involved on 21 April 2012 in ways that only they could describe. They each showed their empathy and concern for him.

That is appropriate. Mental health issues are of great concern in the community. There appears to be a lack of understanding or acceptance of the devastating consequences of the use of cannabis in particular.

It is referred commonly as a soft recreational drug. Mental health consequences of the use of this and other drugs is seen however every day by police, ambulance officers and other health professionals as well as Coroners. XX and his loved ones are yet another victim of this curse on society. It is unfortunate that there was confusion at Mirrabooka as to XX's condition when it came time to consider his discharge on 20 April.

It was unfortunate that no effort appears to have been made to get him to agree to remain at the unit. It is unfortunate it appears that he left without antipsychotics. It is unfortunate that his family was not brought into his support network. It is also unfortunate that the likelihood of his psychosis rapidly becoming acute again was not considered. If these matters had been attended to, XX might not have acted as he did and ended his life. We will never know. This of course is speculation.

There is however another possibility which is also speculation and that is that when XX asked to be discharged on 20 April 2012 he did so with the intention of ending his life at the first opportunity. Having been discharged, he waited for an opportunity to do so after everybody had left the house.

The possibility of this being the case, of him hiding his condition, must be real as in fact this is exactly what he told the doctors at St Vincent's he would do. This was in fact the case and the opportunity for preventing was also lost by the confusion that attended his discharge at Mirrabooka. Whatever it is, whatever the circumstances were, his death can only be described as what it really is and that is a tragedy.

During the course of the inquest I made certain orders prohibiting publication of certain of the evidence. I continue those orders, specifically I prohibit the publication of the name of and any evidence identifying XX, his partner, children, parents, siblings and that any report of the proceedings he shall be referred to by the pseudonym, the deceased. I prohibit the publication of the recording of the taser footage contained in exhibit 2, tab 32, the triple-0 calls made by the deceased and his father contained in exhibit 2, tabs 24, 25 and 40, the statement of Detective Chief Inspector Able being exhibit 3, the statement of Senior Sergeant P Davis being exhibit 4 and the photographs of the deceased at exhibit 2, tab 17.

As I have already outlined, s 75 prohibits the publication of a report where a finding of intentional self-harm is made. This is, however, a situation where two public interests compete. The first public interest it the protection of the privacy of the family of a deceased person who has intentionally taken their own life. The second public interest is of course the public interest that society is aware that the actions of police officers involved in a death during a police operation has been thoroughly examined and in this case found to be completely appropriate.

I am obliged in such circumstances to determine whether or not I will allow a report of the proceedings to occur. The continuation of the non-publication orders as to the name of XX and his family would seem to me to meet the requirements of the public interests espoused by the Parliament and allowing a report of the proceedings without their names being published would also meet the public interests in knowing the actions of the police officers involved have been properly examined. It would also allow for a publication if considered appropriate of the matters associated with XX's mental health treatment.

In those circumstances in accordance with s 75(5) of the **Coroners Act**, I make an order that subject to the orders made in accordance with s 74 a report of the findings made in the proceedings and the reasons therefore may be published.

Formal Finding:

That XX born on 12 December 1971, died on 21 April 2012 at 91 Berry Street, Nowra in the state of New South Wales. The cause of his death was multiple incised wounds to the neck that were self-inflicted with the intention of ending his life whilst suffering from a psychosis.

29. 128570 of 2012

Inquest into the death of Kenneth Hardy. Finding handed by Deputy State Coroner Freund at Glebe on the 18th March 2013.

It is a mandatory inquest, because Mr Hardy was in custody at the time of his death. He entered into custody on 15 December 2005 and remained at Parklea Correctional Centre until his conviction from numerous offences on 25 January 2006. On that date, Mr Hardy was given a maximum custodial sentence of seven years with a non-parole period of four years.

A number of the sentences were cumulative so his earliest release date would have been 14 December 2012. On 4 February 2006, Mr Hardy was transferred to the Metropolitan Special Program Centre at Long Bay. This was Mr Hardy's first time in custody and he was 80 years of age at the time of his incarceration. He presented with multiple health conditions including a diagnosis of prostate cancer, emphysema, hypertension, depression, glaucoma and cognitive decline. During his time in custody, Mr Hardy had numerous admissions to Long Bay Hospital and Prince of Wales Hospital and his health continued to deteriorate.

On 26 January 2011, CPR directions were discussed with Mr Hardy who was at that time permanently housed in Long Bay Hospital. Mr Hardy confirmed he did not want to be resuscitated in the event of a cardiac arrest or similar and a Not for Resuscitation form was signed and filed. On 23 March 2012, Mr Hardy's next-of-kin, his daughter, Deborah Shannon, was contacted by Long Bay Hospital to discuss his deterioration and palliative care intentions were explained. At this time, Mr Hardy had progressive generalised deterioration due to dementia, increased lethargy, increased weight loss, decreased oral intake, swallowing difficulties, ongoing aspiration pneumonia and incontinence.

His overall prognosis was poor and Mr Hardy was expected to die as a result of pneumonia and end stage dementia. Mrs Shannon agreed that her father was to remain in Long Bay Hospital and receive palliative care. After receiving that phone call, Mrs Shannon began the process of having Mr Hardy assessed for early release so that he did not pass away in custody. That process had begun but had not been completed prior to Mr Hardy's death. Mr Hardy's condition continued to worsen despite treatment with antibiotics and in the week prior to his death he required full nursing care. At 8.25pm on 22 April 2012, Mr Hardy was found by a nurse in Long Bay Hospital to be unresponsive. CPR was not attempted as per the Not or Resuscitation Order, oxygen and fluids were ceased. At 9pm, ambulance officers in attendance pronounced Mr Hardy deceased. Cause of death was documented on the Form A as aspiration pneumonia, secondary to esophageal dysphagia secondary to Alzheimer's disease.

Formal Finding

I find that Kenneth Hardy died on 22 April 2012 at Long Bay Hospital as a result of aspiration pneumonia secondary to orophageal dysphagia secondary to Alzheimer's disease.

30. 305904 of 2012 s 75 NON PUBLICATION ORDER

Inquest into the death of XX. Finding handed down by Deputy State Coroner MacMahon at Glebe on the 27th November 2013.

Non-publication orders have been made in respect of exhibit 3, those parts of exhibit that refer to the NSW Police Force Safe Driving Policy and exhibit 7.

Findings made in accordance with Section 81(1) Coroners Act 2009:

XX (born 8 December 1987) died on 21 September 2012 at Pipers Creek approximately 1 kilometre north of Mingaletta Road Kundabung in the State of New South Wales. The cause of his death was drowning which occurred whilst swimming across Pipers Creek in an attempt to avoid apprehension by police.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

Reasons for Finding

XX was born on 8 December 1987. In September 2012 he resided in Queensland. He was the son of MT, the nephew of T and T and brother of T and D. He was the Father of M who turned two years of age on 22 September 2012. On 30 September 2012, two fisherman located XX's body in Pipers Creek about 1 kilometer north of Mingaletta Rd, Kundabunag.

XX's body was identified by Sergeant Paul Redman, a fingerprint expert, by comparing fingerprints held with those taken from the body. An autopsy was undertaken on 5 October 2012 by Dr. Beer at the Department of Forensic Medicine, Newcastle.

Dr. Beer provided an autopsy report as to his findings. He concluded that the cause of XX's death was drowning. Detective Sergeant David Firth was subsequently appointed to investigate the circumstances of the death of XX. Det. Sgt Firth is from Taree Police Station. It is important to outline at this stage, the role and function of a coroner. The *Coroners Act 2009* provides that all 'reportable deaths' are to be reported to a coroner (s35).

A "reportable death" includes a death that is "violent and unnatural" (s6).

A coroner has jurisdiction to conduct an inquest concerning a death, which is 'reportable' (s21). Some inquests may be dispensed with (s25). Some inquests are however mandatory. Inquests that are mandatory include deaths that occur

> "*as a result of, or in the course of, Police operations"* (s27 (1)(b) and s23(c)"

Where a death occurs as a result of or in the course of a police operation such inquest, when conducted, must be by either the State Coroner or a Deputy State Coroner. (s22 and s23)

When an inquest is conducted the coroner is obliged to make findings, if sufficient evidence is available as to the :

- Identity of the deceased person
- The dated and place of their death and
- The cause and manner there of

The Coroner is also able to make recommendations as to any matter he or she considers necessary or desirable in relation to the death with which the inquest is concerned.

A coroner may also prohibit the publication of any evidence in the proceedings where he/she is of the opinion it is in the public interest to do so. In this case, there is no contention that the body of the deceased person located on 30 September 2012 in Pipers Creek was XX. I accept the identification by Sgt Paul Redman.

The evidence is, which I accept, that XX was last seen in Pipers Creek on 21 September 2012 by his friend AA and was not seen thereafter notwithstanding a search of the are by police on that day. Dr. Beer, following his autopsy examination formed the view that the cause of XX's death was drowning. That conclusion is consistent with the evidence of AA that XX went under the water and was not seen thereafter. I accept Dr. Beer's conclusion.

I am satisfied that XX died in Pipers Creek on 21 September 2012 and that the cause of his death was drowning. During the course of the inquest that took place between 19 and 21 November 2013 eight police and two civilians gave evidence. In addition XX's mother also made a family statement. The evidence that was drawn during the course of the inquest was to establish the course of events that led to XX's death on 21 September 2012.

It was important to do this because where a person dies as a result of or in the course of a police operation certain investigation protocols are required to put into place and it is obligatory that police notify the on duty coroner of the death. In XX's case this did not occur until his body was located on 30 September 2012. The evidence at inquest was drawn in past in order to investigate whether those protocols should have been actuated earlier.

The evidence available was XX was a young man who had a close, loving and supportive family. Unfortunately due to a number of factors including his use of illicit substance he became involved in the criminal justice system and served time in prison. In September 2012 he was on parole. Whilst in prison, XX met AA. They became friends.

In late September 2012 A acquired a stolen vehicle in Brisbane. He and two female companions picked up XX on 30 September 2012 and then decided to drive to Sydney. XX offered to accompany them and was intending to return to Brisbane for his son's second birthday on 22 September 2012. The group left Brisbane sometime between 3am and 4am.

At about 5:55am they were in South Grafton where they filled the car with petrol at the BP Service Station. They did not pay for the petrol. This was reported to police at 6:04am. They proceeded south on the Pacific Highway.

The evidence established that A who was driving was traveling at significant speed. The group each had reason to avoid contact with the police. A in relation to the stolen vehicle, the theft of petrol and the manner of driving, the two females who were wanted by police at the time, and XX who was on parole.

As they traveled south on the Pacific Highway they were involved in three circumstances of police pursuits. The evidence of those pursuits was provided to the inquest by the officers involved and the player of the relevant in car videos from the pursuing police vehicles. I do not intend to examine the circumstances of the pursuits or make any comments or draw any conclusion as to whether or not the actions of the police involved complied with the relevant NSW Police Force policies and procedures. The evidence was drawn primarily to set the scene for what was to follow and to give it context.

At a point on the Pacific Highway the vehicles in which the four were traveling developed gearbox problems. At the time they were being followed by police but not in signal. Ahead of them police were preparing road spikes to stop the vehicle.

Because of the gearbox problems, A turned off the Pacific Highway into Wharf Road Kundabung. The pursuing police did not see this because of the topography between them and the vehicle. They passed and continued to the point at Telegraph Point where the road spikes were in place. Police then turned back and a search of various side roads commenced.

After entering Wharf Road A drove the vehicle along that road. At a point near where the road crossed the northern railway line it almost came into collision with a vehicle driven by a local resident Fiona Watts who was driving her children to school. She subsequently reported the accident to police.

The stolen vehicle proceeded across the northern railway lane, turned right and then followed the railway lane for a period, crossed a small bridge, broke through a gate, went through a ditch and eventually became bogged in a muddy patch.

The occupants all left the vehicle. They each were to look after themselves and remain in contact by phone. As it turned out the two females went in one direction along side the railway line and the two males went in a different direction towards what is known as Pipers Creek. At about this time the evidence disclosed XX made a telephone call to a friend in Taree and told him he was on the run from police and needed to be picked up. At the time the friend (SM) said that he appeared to be “puffing” as he ran.

When XX and A reached Pipers Creek they entered the water intending to cross to the other side with a view of avoiding subsequent police dog search. A has given different descriptions of what happened next but each is consistent with XX getting into trouble at a point whilst in the water and going under after which he was not seen again.

As a consequence of the searches and a confirmation provided to police by Fiona Watts police eventually arrived at the bogged vehicle. Other police established a parameter to the east and a local resident provided police with a boat that was used to search Pipers Creek. A, and the two females, were apprehended XX was not.

It is from this point that it is important to examine carefully the information that police were gathering to determine if their actions were reasonable based on what was known. It is not my function to second guess the actions of the police present, it is simply to examine what was known with a view to determining whether or not the circumstances required the incident to be classified as a Death in Police Operation at any point prior to 30 September 2012 when XX's body was located.

The senior officer at the scene was Inspector Michael Aldridge. It was his responsibility to assess the information available and if it was thought that the missing person had drowned to advise his superior officers so that police procedures could be put in place. Inspector Aldridge gave evidence that he was aware of the relevant policies and had been involved in critical incidents in the past. I accept that evidence.

Inspector Aldridge also gave evidence that at no time before he was told XX's body had been located on 30 September 2012 did he believe he had drowned. He believed that XX had escaped and was "on the run". He gave evidence as to the information that came to him from the various officers that led him to this conclusion.

From Senior Constable Tim Preston was reported what the two females had been able to contribute. The females could only report what A had told them. That amounted at its highest that XX had entered the water and had not been seen since. A later said that he did not tell the females everything he knew because he did not wish to upset them. From Sergeant Brett Myers it was reported what A had told him. Myers had spent about half an hour walking with A along Pipers Creek and Barrys Creek trying to identify where A and XX had entered the water and was unable to do so.

Myers described that A was wet from waist down and did not appear to be wet in his top half. Whilst the probability of XX drowning was raised A was somewhat obtuse with the information he was giving possibly because at this time he was unsure what had happened to XX and did not want to "dog" on him. From other police was reported to him that a train driver of an XPT that had passed the location shortly before had seen a man on a bridge in the vicinity who had jumped out of the way of the train. That man was reported to have worn a yellow shirt. That was not consistent with the clothing XX was said to be wearing.

The report received from police on the boat that was searching on Pipers creek was that no one had been located. The evidence of that search would suggest the boat passed the point at which XX's body was subsequently located several times. Inspector Aldridge left the scene sometime between 11am and 12noon. He said in evidence that at that point he believed the found person (who at that point was not identified) was "on the run". Was that assessment reasonable? On the information available I think it was.

The question must then be asked should the conclusion have been varied subsequently but before 30 September 2012?

Inspector Aldridge had a meeting later on 21 September 2012 with his Commander Superintendent Fehon. They discussed the matter. Superintendent Fehon's recollection of the discussion includes his advice. 'that if Inspector Aldridge was not able to determine that the person on the railway line was not the fourth person or further information of the person being sighted in the river the matter would need to be declared a critical incident.'

Inspector Aldridge's evidence of the discussion is different to this recollection. He understood that he was to try and make contact with the train driver and obtain further information as to the description of the person on the railway tracks. Inspector Aldridge endeavored to speak to the driver but was informed he had left the train at Taree. Inspector Aldridge was not able to speak to him and the matter was not further advanced.

Inspector Aldridge worked Saturday 22 September 2012. He gave evidence that he made inquiries to whether there had been any break in's or stolen vehicles that might have been committed by the fourth person and that he had driven in the area on his way to work to see if anyone could have observed anyone that was out of place. He then went off duty for a period of time. Inspector Aldridge then ceased his involvement with the matter.

Police procedure is that the investigation is then transferred to the particular officers who charge offenders and it is there responsibility to follow up any additional investigations. In this case the relevant officers were Senior Constables Davison and Buchan. There is no doubt that as time passed A began to realize the consequences of his observations and formed the view that XX had in fact drowned. He made this known to this to various police officers from time to time. It is equally true that he was not believed.

The police facts prepared by Senior Constable Davison in respect of the charges proffered against A (H49656869) recites the following:

> "The accused also stated that he could not be punished as he lost his friend the unknown male, informing police that he drowned in a creek while attempting to avoid police apprehension. This appears to be false as police received information from a train driver indicating a male was sighted running along the tracks. It appears this may be the unknown male XX". The accused assisted police in retracing their tracks in an attempt to locating the missing accused person, known as 'XX'. Police were unsuccessful in locating 'XX'. "

It is unfortunate that this train driver, Robert Amadio, was not able to be located on 21 September 2012. Had he been able to be spoken to he would have stated, as he did on 4 October 2012 when spoken to by Detective Tynan, that the person he observed on the rail tracks was some 10 kilometers south of the bogged vehicle on a bridge near Telegraph Point. This would have raised the question as to whether that person was XX that, together with the differences in the description of the clothing worn may have led to a reassessment of the credibility of A's assertion.

That did not however happen.

Had it happened however it would not have changed the fact of XX's death. The evidence is that XX almost certainly died before police arrived on the scene. The difference may have been that his body was located at an earlier date. I accept the evidence of Inspector Aldridge that at all times he was of the belief that XX had escaped. I am satisfied that on what he knew his belief was reasonable. It is unfortunate that when he was unable to make contact with Mr Amadio he did not delegate the function of doing so to another officer. Had he done so this matter may have been recognized as a death in police operation at a date earlier than it was, however, even if it had occurred there is no certainty that it would?

I have said I have discretion to make recommendations in accordance with s.82 if I consider that they are warranted. The investigation of XX's death has not given rise to the need for such recommendation and I do not propose to do so.

I continue each of the non-publication orders I made during the course of the inquest.

Formal Finding:

XX (born 8 December 1987) died on 21 September 2012 at Pipers Creek approximately 1 kilometre north of Mingaletta Road Kundabung in the State of New South Wales. The cause of his death was drowning which occurred whilst swimming across Pipers Creek in an attempt to avoid apprehension by police.

31. 310066 of 2012

Inquest into the death of Alan Barnes. Finding handed down by Deputy State Coroner Dillon at Glebe on the 2nd September 2013.

The deceased, Alan BARNES was a 69 year old male who was an inmate at Long Bay Correctional Centre. He was born in Footscray 26 March 1943 along with his twin sister (name unknown). He lived in Footscray with his grandmother for the majority of his early life. He first came under the notice of Victorian Police in 1959 at age 16 years for a shoplifting offence. BARNES earned his living as a car salesman. He married at an early age of 18 years to a female known only as 'Dorcas' and they had a child together. The marriage only lasted about a year and he never had anything to do with his son. He left Victoria in the late 1970's moving to New South Wales.

BARNES was charged for his second recorded drink related offence in 1980. He married a woman by the name of 'Helen' and they moved to Perth shortly after. He was charged with a further drink driving offence in Western Australia in 1982. He resided in Western Australia for about four years and was charged with a further two drink driving offences. BARNES moved to Adelaide in the mid to late 1980's four about four years. During this time he did not come under the notice of Police. He moved to Southport in Queensland in the early 1990's where he resided for a lengthy period with a close acquaintance Peter ROBINSON. The pair worked together at the Oasis Car Centre in Queensland before it became Motor Finance Wizard. ROBINSON moved to Sydney in 2004 with his wife and worked with the Sydney branch of Motor Finance Wizard. ROBINSON contacted BARNES and got him a job at the same location. BARNES moved to Sydney and they resided on site at the rear of the Motor Finance Wizard offices in units.

During 2006 BARNES learnt of the death of his estranged twin sister. He appears to have gone "off the rails" from this point. He enjoyed a drink; however his sister's death caused him to become a full blown alcoholic. NSW Criminal Records indicate that BARNES was caught driving under the influence of alcohol in August 2008. This arrest was followed by a myriad of driving offences including further drink driving matters. BARNES was sentenced at Penrith Local Court on 15 May 2012 for a number of offences including drive whilst disqualified, high range PCA and police pursuit - not stop - drive recklessly. The overall sentence for all of these matters commenced on 27 April 2012 and was due to expire on 26 April 2013 with a non parole period expiring 27 October 2012.

BARNES was received into custody on 08 May 2012 at MRRC Silverwater. He was identified as having multiple medical issues including chronic liver disease due to excessive alcohol use, a malignant bladder tumour with pulmonary metastases and abdominal ascites. He had lacerations on his arms due to poor skin tone due to wearing handcuffs which were dressed. He was transferred to Westmead Hospital for assessment on 09 May 2012 and returned the same day and commenced multiple medications. On 16 May 2012 Barnes was transferred to Long Bay Hospital Medical Subacute Unit as his condition deteriorated requiring increased medical intervention.

An early release application to transfer BARNES to a nursing home was approved; however he requested to remain in custody as he felt he could not meet the conditions of his parole. He indicated that he was homeless and without family.

Circumstances of Death
BARNES was admitted to the Prince of Wales Annex for palliative treatment on 04 September 2012 and was returned to Long Bay Hospital on 10 September. On 29 September 2012, his condition markedly deteriorated and his pain could not be managed. As a result he was transferred back to Prince of Wales Annex. After two days of investigations by hospital staff, full palliative care measures were implemented until his death on 05 October 2012.

Formal finding:

That Alan Barnes on the 5th October 2012 at the Prince of Wales Hospital, Randwick died as a result of complications of metastic urothelial carcinoma.

32. 336265 of 2012

Inquest into the death of Allen Garner. Finding handed down by State Coroner Jerram at Glebe on the 4th July 2013.

Allen John Garner a 57 year old inmate of the Bathurst Correctional Centre was serving a full time custodial sentence. Mr Garner was participating in the pups in prison programme and as such he was not locked in his cell at night.

The deceased was on methadone as he had previously been drug dependant. During the night of the 24th a cell mate heard the deceased dog running around the hall inside the premises. In the morning a guard found the deceased cell door ajar and on closer investigation found the deceased on the floor of his cell in a foetal position, he was obviously deceased and no CPR was commenced.

The deceased suffered no major illnesses. A subsequent post mortem determined the cause of death to be 'Hypovolaemic Shock with massive intraperitoneal haemorrhage following ulcerated hepatocellular carcinoma'. The cause of death was natural causes .

There are no suspicious circumstances and my finding is:

Formal Finding:

That Allen John Garner died sometime during the night between 24-25 October 2012 at Bathurst Correctional Facility of natural causes, Hypovolaemic shock with Massive Intraperitoneal Haemorrhage due to Ulcerated Hepatocellular Carcinoma and Cirrhosis.

33. 371767 of 2012 s75 Non Publication Order

Inquest into the death of XX. Finding handed down by Deputy State Coroner Dillon at Albury on the 18th November 2013.

This is a mandatory inquest under the *Coroners Act 2009*. 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.

The law requires an inquest into all deaths of person in custody. An inquest is an independent judicial inquiry into a sudden and unexpected death. By conducting an inquest under the Coroners Act, a coroner seeks to hold government agencies 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.

It is well-known that suicide rates can be cut by reducing the availability of opportunities for impulsive suicides. Where suicides occur in prisons, it is sometimes because a good system has not been established or, if it has, the system has failed in some way. Sometimes, however, a prisoner commits suicide without observable warning signs and at a time when he or she appears to be coping reasonably well with the experience of incarceration.

XX hanged himself in his cell in the Junee Correctional Centre on the night of 27-28 November 2012. His death shocked his family who remain distressed and grieving, wondering why this tragedy happened and hoping that more can be done to prevent others suffering the bitter experience of loss they have had.

Background

XX was 42 at the time of his death. He had two sons SG and LG and a stepson T with his wife Mrs KG. He also had an older son JG to a previous relationship.

Before his back injury, he had worked for the Albury City Council as a meter reader. He had been unemployed since 2005 due to his bad back. Mrs XX described him as being depressed, highly irritable and reliant on analgesics for years following his injury. At one point he was treated the psychiatric unit of the Albury Hospital. In 2012 he underwent surgery.

This provided some relief but did not eliminate his pain. Nevertheless, at that time his life and the life of his family seemed to be improving.

He also began to smoke marijuana quite heavily. While this, no doubt, provided some pain relief, it also appears to have affected his mental state.

Unfortunately, on 17 August 2012, the family house was broken into. This deeply disturbed XX who blamed a neighbouring family. He appears to have become paranoid and angry. Ultimately he was arrested and charged with various offences including damage to the neighbours' vehicles, and assaulting Mrs XX.

XX was remanded in custody pending his trials on the various charges. In November 2012, about two weeks before he took his own life, Mrs XX wrote to him explaining that she had decided to end their relationship. Before his arrest, he had in fact begun another relationship. Mrs XX was aware of this and decided that he would be able to get used to the idea of the end of his marriage while he was in custody.

After initial intake screening at the Junee Correctional Centre, XX was housed in normal discipline area B2 D pod. Whilst housed in D pod XX was the victim of a serious assault, after which he was placed on special protection and housed in B2 B pod.

XX suffered severe back pain for many years as a result of a work related injury. In May 2012, prior to being in custody, he had an operation to stabilise his lower back. His condition was monitored whilst he was in custody. On the 20 September 2012 a decision was made to alter his medication after XX admitted to diverting his narcotic pain medication, MS Contin, on at least three occasions. He complained to a doctor of being nervous, jittery and having muscle spasms.

His MS Contin was slowly reduced and replaced with valium. Medical records indicate XX was amenable to the change in medication.

Correctional Officers describe XX as a quiet, polite inmate who did not cause any problems and received regular visits. Whilst it was documented that XX had some mental health issues he was not considered an inmate at risk of self harm.

Some time before his death, XX sought a move to a one-out cell. A one-out cell is something of a privilege, granting prisoners a rare measure of privacy. The request was granted. At that time, it did not appear to Junee Correctional Centre staff that XX was at risk of self-harm or suicide. He was not, however, given a formal psychological assessment before his request was granted.

The issues

Under the *Coroners Act*, I am required, if possible, to make findings concerning the identity of the person who has died, the date, place, cause and manner of death. In this case, we know who died, when and where he died and the immediate cause of his death. The more complex is issue is the manner or circumstances of XX's death.

The focus of this inquest has been on discovering the circumstances leading up to and concluding with XX hanging himself in his cell and on considering whether more can be done in future to make the Junee Correctional Centre safer.

XX's death

The facts concerning XX's death are not in dispute and are relatively simple.

During the evening of the 27 November 2012 security checks of B2 unit were carried out by Correctional Officers (CO) at around 6.50pm and again at around 10.30pm. During the 10.30pm security check CO Salmon checked cell B09 which housed XX in a one-out cell placement. CO Salmon could not see XX on first inspection. He continued to check the cell and then saw XX sitting on the floor against the cell door. This was apparently not unusual behaviour for inmates in hot weather as it possible to feel cool air through the door vent. The position of XX did not raise the suspicions of CO Salmon and he did not attempt to raise a response from him.

During a check later at about 1.30am on 28 November CO Wattie attended XX's cell. He could not see XX on his bed. CO Wattie looked down through the window and could see the top of XX's head. He looked around the window and saw a shoelace tied to the top door hinge. CO Wattie activated a Code White and obtained permission to open the cell door. XX was located deceased sitting on the cell floor with his back resting against the inside of the cell door. Medical staff and Police were contacted.

CCTV footage obtained from B Pod shows the light in the cell on at about 7pm on the 27 November and movement can be seen in the cell as a shadow against the light. Shortly after 7pm a shadow, presumably caused by XX's body, covers the light coming through the vent at the bottom of the door. No other movement is detected in the cell after this time.

There is no evidence of any suspicious circumstances. No one else was in the cell at the time of his death. It is clear that he took his own life.

Why did XX take his own life?

No one can say for sure why XX ended his own life. Before he was remanded in custody his behaviour had become increasingly irrational and disturbed, although, once in gaol he seemed to settle down somewhat. It is apparent, however, that he was very anxious about the prospect of further serious charges being laid against him and, some time before he died, he had been forced to confront the fact that his marriage was over.

Although he was basically a decent man who loved his children, who had a long-suffering wife who supported him and a family and friends who loved him, he must have felt that he had not only lost the important things in his life but also the prospect of recovering them. As far as he was able to see ahead, he must have only seen the prospect of a long and lonely period in gaol. And perhaps he was unable to see any happy future once his sentence was over.

One of the most tragic aspects of this case is that XX and his family were the victims of a break-in in August 2012. According to KG this drove him "psycho". The break-in started a chain of events that resulted in him becoming violent towards the neighbours whom he blamed for the burglary, towards K, and abusive of the police. He seems to have lost control. Ultimately, he was arrested and remanded in custody. He was a man in great physical and psychological pain. He needed help but seems to have been unable to take the help on offer. Unfortunately, severely depressed people are often unable to see the love and support and professional assistance that are available to them.

Could XX's death have been prevented?

XX hanged himself with his own shoelaces. Whether he could have used something else to hang himself if he had not been provided with shoelaces is difficult to say. His cell had at least one hanging point. He had linen and clothing that could possibly have been torn to create a ligature. Sadly, this happens from time to time in gaols. Depriving inmates of their shoelaces is no guarantee of their safety.

If a prisoner is thought to be at risk of self-harm, he or she will be carefully observed and various steps to prevent harm will be taken by prison and Justice Health staff. The prisoner may be placed in a special cell under close observation. He or she will certainly be carefully assessed by psychological and psychiatric health professionals. A treatment regime will be developed.

The primary difficulty in preventing suicide, in prisons, in hospitals and in the wider community is that it is almost impossible, even for forensic psychiatrists, to predict. Of course, some people are at higher risk than others. People suffering from a serious mental illness such as severe depression are at much higher risk than members of the general population, yet few of them commit suicide. Risk factors, such as depression, male gender, prior attempts or previous self-harm, use of drugs and/or alcohol, unemployment and social isolation, although they indicate that a person *may* self-harm, are not predictive: at any given time, most people with one or more of the risk factors will not go on to commit self-harm or suicide.

Environments, such as gaols and psychiatric units, can, however, be made more protective and conducive to good mental health. Reducing the numbers of hanging points is an on-going program in the NSW prison system. Mental health assessments are made every time a person is taken into custody in a NSW gaol. Justice Health provides mental health support to prisoners across the gaol system. Correctional staff also receive training in suicide prevention strategies. Despite advances in suicide prevention in prisons, and despite a multitude of studies and protective strategies, a small number of prisoners continue to take their own lives every year in NSW gaols.

Of course, it would be theoretically possible to keep prisoners safe from hanging themselves by depriving them of anything that could, potentially, be used to self-harm. But such ultra-safe environments only keep people physically safe. In the long-term, they are mentally damaging and anti-therapeutic. Close observation cells are used for acute cases only.

And, of course, such people have to be identified – not an easy task unless the prisoner him- or herself is open with correctional staff or other inmates. But most who take their own lives are not.

Can the Junee Correctional Centre be made more protective?

Despite the sadness of this case, XX's death forces us to think more about the question of how we, as a society, can do better to protect vulnerable prisoners from their own darkest feelings and thoughts. We owe a legal duty of care to them but we also owe a moral duty to their grieving families to do what is reasonable and practical to save other families from suffering the same terrible burden of sorrow.

During the hearing at Wagga, Sgt Mulligan and I floated a number of possible recommendations that I asked GEO and the Department of Correctional Services to consider.

They were as follows:

- That GEO consider implementing a policy that any prisoner sitting on the floor by cell doors during evening muster or "head counts" be roused to ensure his/her welfare.

- That GEO follow Department of Corrective Services policy and practice in relation to one-out or two-out cells at Junee Correctional Centre. In particular, the formal process of reassessment of inmates should be followed before a change from a two-out to a one-out cell is made.

- That the Department of Corrective Services review GEO's practice in relation to the allocation of one-out and two-out cells at Junee Correctional Centre.

- That the Department of Corrective Services and GEO review the investigation report of Senior Assistant Andrew Sneddon dated 18 February 2013 and implement his recommendations or take such action as is considered appropriate.

I have received responses to the suggested recommendations from both the Department and GEO.

Neither organisation supported the **first** proposal. The Department submitted that the proposal was unnecessary in that inmates at risk are already catered for by the relevant protocols. Perhaps more persuasively, it argued that the proposed checks would involve opening cell doors, turning lights on and off, disrupting sleeping prisoners and requiring an increase in staff levels to manage the process properly. GEO adopted the same arguments.

In effect, both organisations argue that there would be unintended consequences that would significantly outweigh the potential benefits of the proposed procedure. I accept this argument.

Nevertheless, one thing we have learned is that, during the security check at 0138 hours on 28 November 2012, it was possible for CO Wattie to see XX's head and the shoelace attached to the door hinge. It is also notable that, even before he detected the cord, he thought it advisable to try to rouse XX. This was despite the fact that it is apparently common for prisoners to sit or sleep on the floor during hot weather.

While I accept that the security checks carried out during the night are not welfare checks but are, in effect, "head counts", the evidence suggests that XX did not move from the position in which CO Wattie found him. This in turn suggests that, with some effort, it may have been possible for officers conducting security checks at about 7.30pm or 10.30pm to have detected that XX was sitting on the floor with a homemade noose around his neck.

In my view, XX's case demonstrates that whenever a prisoner is sitting or lying on the floor by the vent in the door of his cell at Junee Correctional Centre he may be hanging himself. As CO Wattie's commendable effort demonstrates, it is possible in such cases, perhaps with some effort, to check the prisoner's safety without necessarily disrupting him, entering the cell or disturbing other prisoners.

I therefore recommend that GEO consider implementing a policy that, if during nightly security checks inmates are observed to be sitting or lying beside cell door vents, or in proximity to any other potential hanging points in their cells, the officer(s) check to ensure that the prisoner has not hanged himself.

In relation to the **second** proposed recommendation, GEO has submitted that there was no lack of care in the arrangement for XX to move to a one-out cell. I accept that when this arrangement was made, there was no obvious signs or indications that XX was thinking about harming himself or was especially at risk. Nevertheless, although I do not believe that in this case it would have made any significant difference to the outcome, the more formal process followed by the Department of Corrective Services is another level of potential protection for a vulnerable prisoner. I note that GEO (and the Department) have both accepted this proposed recommendation.

The **third** proposed recommendation, concerning a review by the Department of GEO's practice of the allocation of one-out and two-out cells has been accepted by the Department without protest from GEO.

The **fourth** and final proposed recommendation – that the Department and GEO consider and implement the recommendations of the internal review by Senior Assistant Superintendent Sneddon – has been supported by the Department. GEO, on the other hand, disputes the accuracy of some of Mr Sneddon's findings and questions some of his proposals. When this issue was discussed at the hearing in September, counsel for both parties were unable to assist me in drawing any conclusions about Mr Sneddon's report.

If his findings are accurate, he has identified a certain number of potential flaws in GEO's systems. If he is mistaken in his assessment, nothing is lost. It is not my role to adjudicate this disagreement between GEO and the Department.

My proposed recommendation, if implemented, would require GEO and the Department to confer and, if Mr Sneddon is correct, to take appropriate action. In other words, if Mr Sneddon is correct, which can be worked out by the two parties, I support his suggested course and recommend its implementation.

Conclusion

There is no pain greater than that of a parent who has lost his or her child. But wives, children, family members, partners and friends also share that terrible loss. Only time can soften this profound sense of dumb pain.

But it may be a small crumb of comfort for XX's mourners to know that their concerns have been taken seriously, that in death he has received the respects of his community and that his passing has caused us to think again about how we may better protect the lives of prisoners.

Formal Finding:

I find that XX died on either 27 or 28 November 2012 by intentionally hanging himself in his cell at the Junee Correctional Centre, Junee NSW.

Recommendations s 82 Coroners Act 2009

To the Attorney-General & Minister for Justice:

(i) I recommend that GEO be required to follow Department of Corrective Services policy and practice in relation to the allocation of one-out or two-out cells at Junee Correctional Centre. In particular, the formal process of reassessment of inmates should be followed before a change to a one-out cell is made.

(ii) I recommend that the Department of Corrective Services review GEO practice in relation to allocation of one-out and two-out cells at Junee Correctional Centre.

(iii) I recommend that the Department of Corrective Services and GEO review the investigation report of Senior Assistant Superintendent Andrew Sneddon dated 18 February 2013 and implement his recommendations or take action as appropriate in respect of them.

To the Managing Director, GEO Group Australia Pty Ltd:

(iv) I recommend that GEO and the Superintendent of the Junee Correctional Centre consider implementing a policy that, if during nightly security checks an inmate is observed to be sitting or lying beside cell door vents, or in proximity to any other potential hanging points in his cell, the officer(s) check to ensure that the prisoner has not hanged himself.

(v) I recommend that GEO follow Department of Corrective Services policy and practice in relation to the allocation of one-out or two-out cells at Junee Correctional Centre. In particular, the formal process of reassessment of inmates should be followed before a change to a one-out cell is made.

(vi) I recommend that the Department of Corrective Services and GEO review the investigation report of Senior Assistant Superintendent Andrew Sneddon dated 18 February 2013 and implement his recommendations or take action as appropriate in respect of them.

34. 327351 of 2012

Inquest into the death of Gregory Howard at Glebe on the 30 August 2013. Finding handed down by Deputy State Coroner MacMahon.

Mr Howard was convicted of murder on 5 September 2008. He suffered from hepatitis C, non-insulin dependent diabetes, hypertension and hyperlipidaemia. I custody he was treated for these conditions.

In December 2011 he was transferred to Lithgow CC.

In February 2012 he was diagnosed as suffering from 'significant multi focal hepatoma.' To assist with his care he was transferred to the Long Bay Hospital. He came under the care of Prof David Goldstein.

When first reviewed by Professor Goldstein he was advised that the condition was terminal however treatment was proposed to delay the advancement of the cancer.

In September 2012 Professor Goldstein further reviewed him. At that review it was found that there were further foci throughout the liver and that 'further treatment makes no sense.' Mr Howard was then transferred to a palliative care regime.

On 13 October 2012 he was transferred from Long Bay Hospital to an Aged care Unit within Corrective Services so that his treatment might be better provided.

On 18 October 2012 he had a fall and was transferred to POW A+E for care. On 20 October because of the worsening state of his condition he was admitted to the Dickenson Ward at POW. At about 7:00pm on 21 October 2012 he died.

The death was a natural cause death. The provision of care and treatment to Mr Howard following his diagnosis was examined and considered appropriate. Apart from some minor criticism of Corrective Services about communication the family had no complaints as to the care and treatment provided to Mr Howard. The mother and daughter of Mr Howard were able to spend time with him on the day he died.

Formal finding:

That Gregory Mark Howard (aka Russell) (born 21 December 1956) died on 21 October 2012 at the Prince of Wales Hospital, Randwick in the State of New South Wales. The cause of his death was liver failure and hepatic encephalopathy due to hepatocellular carcinoma and liver cirrhosis with other contributing factors being non-insulin dependent diabetes and chronic hepatitis infection.

35. 207523 of 2013

Inquest into the death of Trevor Coulton. Finding handed down by Deputy State Coroner MacMahon at Glebe on the 28 November 2013.

At the time of his death Mr Coulton was an inmate at Long Bay Gaol with a sentence of 11 years and a non-parole period of 6 years. His earliest release date being the 4th October 2017.

Mr Coulton was being treated for a number of illnesses including squamous cell carcinoma resulting in his left leg being amputated and ischemic bowel disease.

On the 29th June he was transferred to the Long Bay Correctional Hospital complaining of soreness to his bowels, he was confused and suffering a fever. The deceased declined a further operation on his remaining leg to treat the cancer and a CT examination revealed signs of a lifeless bowel. A non-resuscitation order was read and explained to the deceased. On the 8th July he was found deceased in his bed by hospital staff.

The cause of death was natural causes and there are no issues for inquest.

Formal Finding

That Trevor Coulton (born 4 December 1940) died on the 8th July 2013 at the prince of Wales Hospital Randwick. The cause of his death was sepsis due to ischaemic bowel with other significant conditions that contributed to his death but did not cause his death being sqamous cell carcinoma ulcer to his right leg and chronic heart disease. The manner of his death was natural.

36. 39387 of 2013 s 75 NON PUBLICATION ORDER

Inquest into the death of XX. Finding handed down by Deputy Coroner Dillon at Glebe on the 28th October 2013.

XX (dob: 5/10/74) was 32 years of age when he passed away on 7 February 2013. XX was the youngest of five children to J and Pl. He is survived by his brother and two sisters.

Section 81 of the *Coroners Act 2009* requires that I make findings at the conclusion of this inquest, as to: the person's identity, and the date and place of the person's death, and the manner and cause of the person's death.

As I have just explained the Coroner's task at this point is to make those findings of identity, date and place of death and the cause and manner of death, but before I do that I would like just to touch on the evidence. Mr McGorey opened the inquest with a summary of it but I will repeat some of this.

Most importantly, however, I think I need to emphasise that this is a human story, it is not just a legal case decided on legal principles and facts. It is actually a story with a wider context. As I explained right at the start, when a police operation takes place our society requires if someone dies in it that a Coroner examined what happened in part to see that the police have conducted themselves properly or reasonably and in part to see whether there are any ways of learning lessons that could enable us to prevent future deaths.

In this case I have to say that I do not think there are any lessons we could draw which might prevent future deaths. As I have said a few times already, I think the police did an excellent job, did their very best in all the circumstances and it is very clear reading the Rose Bay standard operating procedures and listening to the officers talk this morning that Rose Bay is a very extraordinary Local Area Command because the officers there, young and more experienced, are immediately brought into contact with very troubled people who gravitate to The Gap contemplating literally life and death issues, and some of those people are determined to take their own lives.

Others may be there because, to use the cliché, they are crying for help, and I do not doubt that in both cases, both types of sad people who go out there, the police do a constant and are constantly careful and compassionate job for all those people. If sometimes they do not succeed in preventing a loss of life I cannot sheet - and I cannot believe that anyone else would sheet any blame home to them.

Before I touch on XX himself and the other evidence, it may not be a surprise to any of you that a Coroner sees a lot of cases of suicide, and it has always seemed to me in my six years as a Coroner to be one of the most mysterious events, mysterious ideas that human beings can come up with.

Why we have developed a notion that it would be better for us, better for those around us for us to take our own lives is something I cannot understand and science cannot explain. What I do know is that people have a reservoir of emotional strength and courage and resilience, and at some point or other I think that when people take their own lives, in most cases anyway, when people take their own lives their reservoir of resilience has run dry. All they can see ahead of them is pain and suffering and there is insufficient joy or happiness as far as they can see into their future to balance that awful pain that they are feeling.

Of course in many cases they are wrong and if only they gave themselves a bit more time they might have found that life does indeed get better. We have all suffered great pain, I should imagine, and all come through many experiences and young officers like Constable Reynolds here has a long way to go too, he is only 20, 21, so there will be ups and downs.

I think we need to find meaning in our lives and we need to have a future and it seems to me that XX, although I actually believe he did have meaning in is life, lost the sense of that meaning and lost a belief in the meaning of his life. It is very clear and it must have been particularly poignantly clear at his funeral that he was surrounded by people who loved him. He texted people who loved him just before he died, shortly before he died. He was thinking about people who loved him and yet for all that love by which he was surrounded life had become intolerable to him.

His sister has spoken, I thought most engagingly and indeed very, very articulately and eloquently about XX, describing his personality. The fun loving side of him, the generous side of him, but also the inward dark side of him too. It shows how complex a character he was and maybe how complex the human condition can be. He certainly had a great deal of stress and pain throughout his young life, I think. It must have been difficult for him to come out as a young gay man, to contract AIDS, to have jobs come and go, jobs he liked come and go and also in a period in his life when things seemed to be improving, when he got off drugs, he moved away and started getting a more stable kind of environment, developing around him, to have his flat catch fire and to lose so much that was precious to him. Perhaps at that point his bucket of resilience simply ran out.

In any event, on 7 February this year he went out to The Gap and he must have been out there for at least a little time before the police officers arrived. It seems that at about 5pm he had gone out telling his friend, Sae Foo that he was going out to have dinner with his old boss, he returned home at 10pm. Sae Foo describes him as having - when he got home, the appearance of being a bit depressed and flat but not extraordinarily so. Early in the morning he sent at text at 5.12 to Zoey Torentus saying: “I love you guys so very much, you are both the best friends anyone could ever dream of. Please forgive me, I’m no longer in control of my mind, I can’t handle the pain anymore.” He sent another one a few minutes later, about 11 minutes later, at 5.47, Zoey texted to him asking him if he would like to stay with her, obviously reaching out to him. He spoke again to Zoey at 4 minutes to 6. He told her that he was at The Gap.

Almost immediately she rang the police and of course then the police operation got underway. We have heard from three of the officers who attended, Senior Constable Timothy Jones and Probationary Constable Steven Reynolds went out to the Jacobs Ladder end of The Gap cliffs. Constable Elliott Merrett was also there and has given evidence. He started at the other end and worked his back towards Jacobs Ladder.

Senior Constable Jones and Probationary Constable Reynolds ran into the Chakerians. The Chakerians had observed XX lying on a rock shelf on the wrong side of the fence, the safety fence. They had not spoken to him but they had observed him, one might have thought, acting a little bit oddly, mumbling, lying, somewhere - well, very differing estimates of how close he was to the edge, but at that stage they did not disturb him. There was nothing to indicate that he was planning at that very moment to jump or to roll off or do anything terribly dangerous.

The police, however, had had the message from Ms T and were on their way looking for XX. They ran into the C'ss. Mr C, the elder led the police back down towards the rock shelf where he and his son Aaron had first seen XX.

The police ran down until they got to a certain distance away from XX and then slowed down so as not to spook him as Senior Constable Jones put it. Senior Constable Jones, who is obviously an experienced officer and of some maturity and sensitivity, got very close to XX on the other side of the fence. Probationary Constable Reynolds was with Senior Constable Jones at that time.

Senior Constable Jones only had time to ask XX to come away from the edge before XX raised his right arm, which was stabilising him on the edge as he lay partially over the edge and rolled off. Miraculously XX survived the fall at least for a short time but he was obviously very badly injured by the fall from such a height.

He suffered in the water, it seems, for a couple of minutes, maybe one or two minutes, before rolling over and either dying of his injuries or drowning, but certainly in that very short time he was in the water his life ended.

The pathology report indicates that it is most likely that XX died of the combined effects of the multiple injuries he suffered during the fall, or as a result of the fall and drowning, lying in the water and presumably unable to help himself very much. It is not clear whether he deliberately rolled over onto his face after he had been floating on his back but it may well be that he did do so because I think that the overwhelming weight of evidence suggests that he had decided to take his own life.

I have referred to the text messages. He had also sent an email with the lyrics of a Green Day song, which spoke to him and he, it seems even a few days before he took his own life, was contemplating the peace that ending his life would bring him. He had gone out to The Gap, I think anyone in Australia probably knows that The Gap is the most notorious, well publicised suicide spot in the country.

His history in 2012 of self harm is indicative of a growing sense that his life was becoming more and more difficult to maintain.

He was suffering from some mental illness. He was diagnosed with adjustment disorder and depression and the police, particularly Senior Constable Jones, who is a very experienced officer, both officers had the view that he had looked at them and then deliberately rolled off the edge.

The observations of Senior Constable Jones, who, as I say, is a very experienced officer, I think, are particularly pertinent here, which is not to say I discount Probationary Constable Reynolds views either, but Senior Constable Jones has seen more people in that kind of situation than the younger officer. In my view I think it is very clear that XX decided to take his own life.

There is nothing that I would consider can or should be criticised in the way the police operation was conducted. As I have already said, the standard operating procedures for the Rose Bay Area Command, Local Area Command, are, I think, excellent. They contain - although they are not for publication - they contain serious and excellent advice, I think, to the police, particularly the young police who serve at that area command.

They are obviously designed as best they can be designed to prevent the loss of life and if in this case a life was lost, that was due to no fault of the police service, the police force, or to any individual officer, and in fact quite the reverse, and I propose to write to the Commissioner and commend the officers who were involved and also to commend those who are running Rose Bay and have developed the standard operating procedures. I think many lives must have been saved by the police at Rose Bay and will continue to be, and we owe them as a community a great deal of gratitude for their work.

The tragedy here is that XX, who had so much to give in his life, obviously if his sisters are any indication of what he might be like in some directions, he would be a man of intelligence and empathy and compassion, and I am very, very sorry that you have lost your brother in these circumstances.

Formal Finding:

I FIND THAT XX DIED ON 7 FEBRUARY 2013 AT THE GAP, WATSON'S BAY, NEW SOUTH WALES AS A RESULT OF THE COMBINED EFFECTS OF MULTIPLE INJURIES INFLICTED WHEN HE FELL FROM HEIGHT AND DROWNING AND THAT HIS DEATH WAS SELF INFLICTED.

.

Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed as at 31 December 2013.

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	1107/10	20/03/10	Canberra	23	Police Op
2	1108/10	20/03/10	Canberra	33	Police Op
3	1109/10	20/03/10	Canberra	29	Police Op
4	1110/10	20/03/10	Canberra	3m	Police Op
5	962/11	29/04/11	Orange	31	In Custody
6	1074/11	15/05/11	Berkshire Park	23	In Custody
7	2305/11	26/09/11	Silverwater	38	In Custody
8	65200/12	27/02/12	Liverpool	44	In Custody
9	71675/12	02/03/12	Tamworth	40	Police Op
10	83234/12	14/03/12	West Ryde	33	Police Op
11	94483/12	25/03/12	Parramatta	34	Police Op
12	100399/12	29/03/12	Randwick	51	In Custody
13	102820/12	30/03/12	Malabar	31	In Custody
14	189678/12	16/06/12	Emu Plains	22	In Custody
15	192526/12	19/06/12	Randwick	27	In Custody
16	259122/12	18/08/12	Malabar	40	In Custody
17	247660/12	08/08/12	Cessnock	60	In Custody
18	273783/12	01/09/12	Silverwater	49	In Custody
19	302011/12	27/09/12	Blackalls Park	29	Police Op
20	314507/12	10/10/12	Camperdown	48	Police Op
21	32345/12	17/10/12	Tweed Heads	42	Police Op
22	349869/12	08/11/12	Wollongong	34	Police Op
23	366920/12	23/11/12	Redfern	46	Police Op
24	379032/12	05/12/12	Silverwater	40	In Custody
25	379965/12	06/12/12	Windsor	45	Police Op
26	1220/13	01/01/13	Malabar	65	In Custody
27	2130/13	03/01/13	Rankin Park	40	Police Op
28	8375/13	10/01/13	Ermington	28	Police Op
29	18658/13	19/01/13	Randwick	39	In Custody
30	20175/13	21/01/13	Silverwater	30	In Custody
31	31630/13	01/02/13	Randwick	45	In Custody
32	52657/13	18/02/13	Muswellbrook	16	Police Op
33	59259/13	24/02/13	Penrith	41	In Custody
34	77634/13	13/03/13	Malabar	75	In Custody
35	98426/13	31/03/13	Silverwater	42	In Custody
36	98427/13	31/03/13	Silverwater	55	In Custody
37	114526/13	14/04/13	Cessnock	32	In Custody

No	File No.	Date of Death	Place of Death	Age	Circumstances
38	123760/13	20/04/13	Villawood	33	Police Op
39	134128/13	30/04/13	Malabar	72	In Custody
40	153360/13	17/05/13	Randwick	19	In Custody
41	155396/13	19/05/13	Malabar	15	Police Op
42	159048/13	22/05/13	Randwick	42	In Custody
43	162787/13	24/05/13	Junee	49	In Custody
44	177495/13	08/06/13	Malabar	37	In Custody
45	189899/13	20/06/13	Villawood	26	In Custody
46	200685/13	01/07/13	Liverpool	21	Police Op
47	203515/13	03/07/13	Nerong	43	Police Op
48	222036/13	20/07/13	Marrickville	36	Police Op
49	224346/13	22/07/13	Westmead	51	In Custody
50	240615/13	07/08/13	Silverwater	75	In Custody
51	246399/13	13/08/13	Kogarah	18	Police Op
52	258164/13	25/08/13	Sydney	46	Poice Op
53	265085/13	30/08/13	Goulburn	34	In Custody
54	265110/13	31/08/13	Malabar	86	In Custody
55	267697/13	03/09/13	Silverwater	38	In Custody
56	275420/13	11/09/13	Randwick	73	In Custody
57	286184/13	20/09/13	Coffs Harbour	37	Police Op
58	304282/13	09/10/13	Liverpool	14	Police Op
59	316085/13	18/10/13	Malabar	64	In Custody
60	331891/13	31/10/13	St Leonards	49	Police Op
61	354840/13	24/11/13	Westmead	33	In Custody
62	359900/13	27/11/13	Sydney	69	Police Op
63	365275/13	03/12/13	Malabar	60	In Custody
64	387501/13	23/12/13	Moree	23	Police Op
65	388077/13	27/12/13	Watsons Bay	58	Police Op
66	389043/13	28/12/13	Randwick	21	Police Op