

Report by the NSW State Coroner

**into deaths in custody/police
operations**

for the year 2016.

(Coroners Act 2009, Section 23)

NSW Office of the State Coroner
NSW Department of Attorney General and Justice
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into deaths in

custody/police operations

for the year 2016.

The Hon. Mark Speakman, MP
Attorney General and Minister for Justice
Level 31 Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

25th March 2016

Dear Attorney,

Section 37(1) of the *Coroners Act 2009* ('the Act') requires that I provide to you annually, a summary of all deaths in custody and deaths in a police operation that were reported to a coroner in the previous year. Inquests are mandatory in such cases but many of those which relate to deaths which occurred last year have not yet been finalised. I have also included a summary of those deaths which were reported in previous years but only finalised last year. As a result you will, if you wish be able to follow a particular death from its initial report to finalisation by looking at successive annual reports.

I attach a hard copy and an electronic copy of the 2016 report.

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

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

It is unclear whether deaths in Commonwealth detention facilities fall within this definition. In the submission I made to the review of the Coroners Act that is currently underway I suggested this should be clarified. As you would appreciate, deaths in prisons have for centuries been recognised as sensitive matters warranting independent scrutiny. Similarly, deaths occurring in the course of police operations which include shootings by police officers, shootings of police officers, suicides and other unnatural deaths, also attract public and media attention.

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

Yours faithfully,



Magistrate Michael Barnes
(NSW State Coroner)

2016 Summary in Brief

- 37 *Section 23* deaths were reported to the State Coroner in the calendar year 2016, a decrease of 4 deaths compared to the previous year, 2015.
- In 2016 the State Coroner and the Deputy State Coroners completed and made findings in 22 *Section 23* inquests.
- As at the 31st December 2016 there are 76 unfinalised *Section 23* matters compared to 65 at the same time in 2015.
- Just fewer than 50% of the deaths reported in 2016 were as a result of natural causes. Natural cause deaths continues to be the substantive cause of death recorded for those persons who die in custody or as a result of a police operation as opposed to non natural causes of death.
- 4 Aboriginal deaths were recorded in 2016, a decrease of 3 deaths compared to 2015. 1 of the 4 deaths occurred in custody and 3 as a result of police operation. 3 as a result of natural causes and 1 as a result of non natural causes.
- In 2016 there were 21 deaths as result of a Police Operation and 16 deaths in custody.
- 31 of the 37 overall deaths for 2016 were male.
- Of the 31 male deaths, 26 of the males were over the age of 30 years.
- 6 of the 37 overall deaths reported were female, 5 of the five female deaths were over 30 years of age.
- 5 of the 6 females died from non natural causes.

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 2016

His Honour Magistrate MICHAEL BARNES NSW State Coroner

- 1982- 1987:** Solicitor in private practice
- 1987 -1990:** Principal Solicitor, Aboriginal Legal Service
- 1990-1993:** Principal Legal Officer, Criminal Justice Commission
- 1993-1999:** Chief Officer, Complaints Section, Criminal Justice Commission
- 2000-2003:** Head, School of Justice Studies, Queensland University of Technology
- 2003-2013:** Queensland State Coroner
- 2013:** Appointed NSW Magistrate
- 2014:** Appointed NSW 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 part time President of Chief of Defence Force Commissions of Inquiry (Defence Force Inquests).
- 2008:** Appointed NSW Deputy State Coroner.

Her Honour Magistrate TERESA O’SULLIVAN

Deputy State Coroner

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

Her Honour Magistrate HARRIET GRAHAME

Deputy State Coroner

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

His Honour Magistrate Derek Lee

Deputy State Coroner

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

His Honour Magistrate Robert Stone

Deputy State Coroner

- 1977:** Admitted as a Solicitor of the Supreme Court of NSW
- 1977- 1979:** Solicitor at Messrs. Greaves Wannan & Williams of Sydney
- 1981:** Solicitor at Messrs. Conway McCallum & Co of Sydney
- 1982 -2012:** Solicitor and Partner of Mortimer Hendriks Griffin & Erratt that in 1992, became Messrs Commins Hendriks of Wagga Wagga
- 2012:** Appointed NSW Local Court Magistrate
- 2016:** Appointed NSW Deputy State Coroner

CONTENTS

Introduction by the New South Wales State Coroner	2
What is a death in custody?	2
Intensive corrections orders	3
What is a death as a result of or in the course of a police operation?	3
Why is it desirable to hold inquests into deaths of persons in custody or police operations?	4
NSW coronial protocol for deaths in custody/police operations	5
Responsibility of the Coroner	7
Role of the Inquest	9
Recommendations	9
Unavoidable delays	10
Overview of deaths in custody/police operations reported to the NSW State Coroner in 2016	11
Deaths in custody/police operations which occurred in 2016	11
Aboriginal deaths in custody/police operations which occurred in 2016	12
Circumstances of deaths which occurred in 2016	13
Summary of individual cases completed in 2016	14
Appendices	
Appendix 1: Summary of deaths in custody/police operations before the State Coroner in 2016 for which inquests are not yet completed.	238

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.

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

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

Intensive Correction Orders

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

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

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

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

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

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

- **any police operation calculated to apprehend a person(s)**
- **a police siege or a police shooting**
- **a high speed police motor vehicle pursuit**
- **an operation to contain or restrain persons**
- **an evacuation**
- **a traffic control/enforcement**
- **a road block**
- **execution of a writ/service of process**

- **any other circumstance considered applicable by the State Coroner or a Deputy State Coroner.**

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

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

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

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

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

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

The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty, and it is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion,

and satisfies the community that deaths in such places are properly investigated².

I also agree with Mr Waller that:

In the public mind, a death in custody differs from other deaths in a number of significant ways.

The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution.

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

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

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

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

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

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

²Kevin 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.

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.

Unavoidable delays in hearing cases

The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases is at times unavoidable and there are many various reasons for delay.

The view taken by the State Coroner is that deaths in custody/police operations must be fully and properly investigated. This will often involve a large number of witnesses being spoken to and statements being obtained.

It is settled coronial practice in New South Wales that the brief of evidence be as comprehensive as possible before an inquest is set down for determination. At that time a more accurate estimation can be made about the anticipated length of the case.

It has been found that an initially comprehensive investigation will lead to a substantial saving of court time in the conduct of the actual inquest.

In some cases there may be concurrent investigations taking place, for example by the New South Wales Police Service Internal Affairs Unit or the Internal Investigation Unit of the Department of Corrective Services.

The results of those investigations may have to be considered by the Coroner prior to the inquest as they could raise further matters for consideration and perhaps investigation.

AN OVERVIEW OF SECTION 23 DEATHS REPORTED TO THE NSW DURING 2016.

Table 1: Deaths in Custody/Police Operations, for the period to 2016.

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

Deaths in Custody / Police Operations

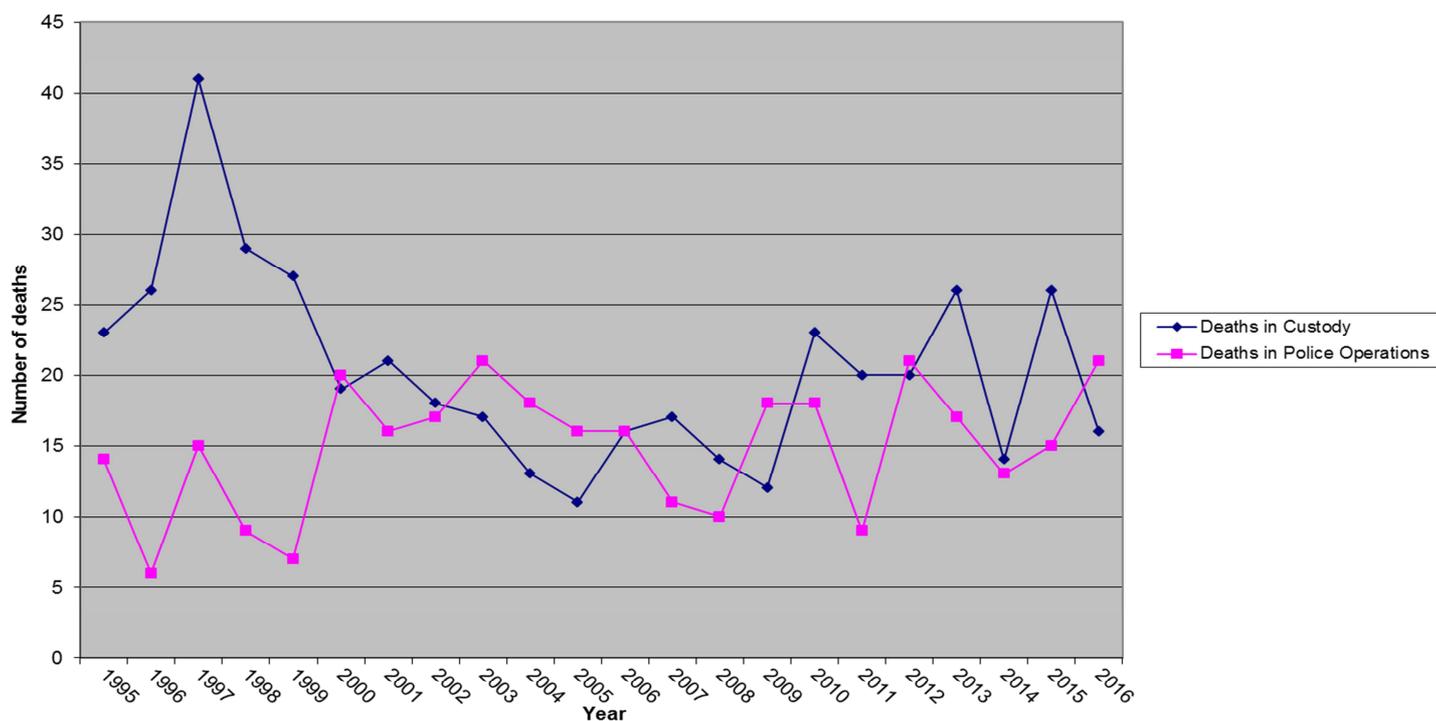
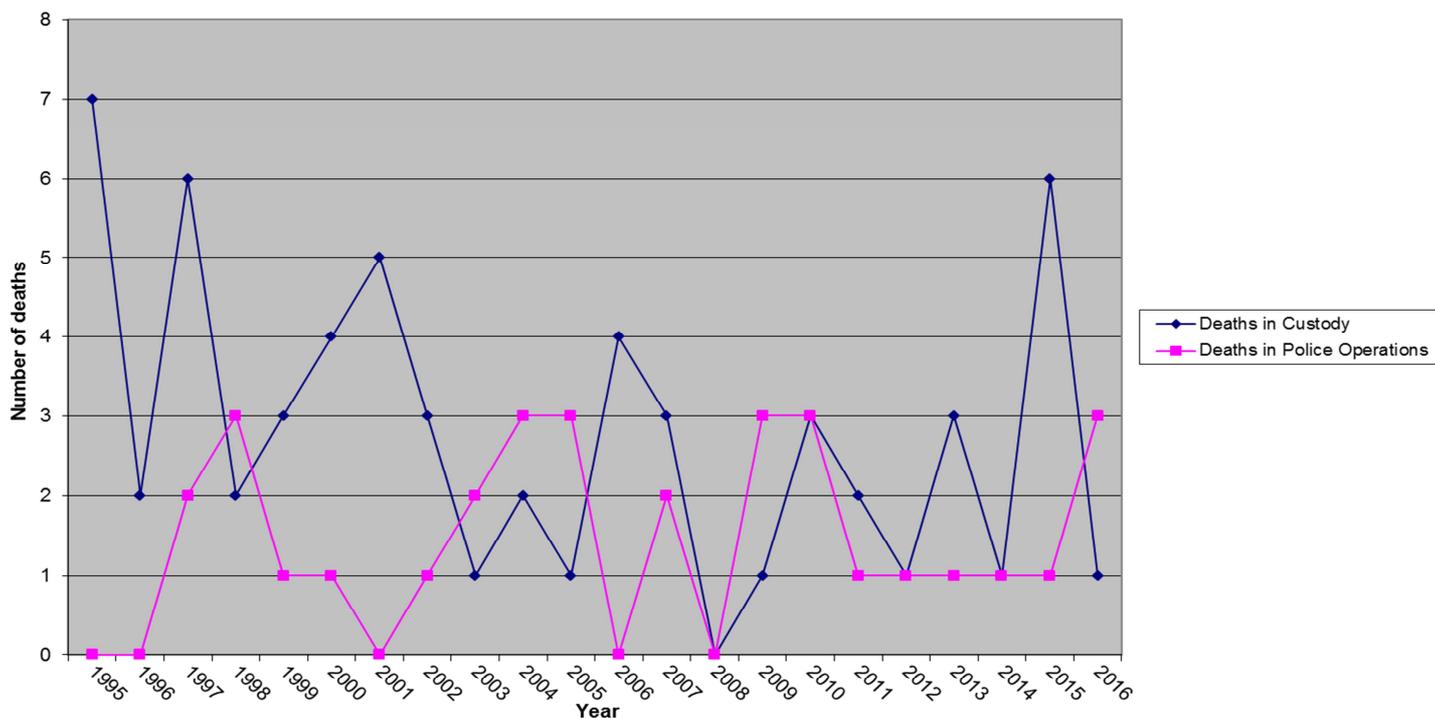


Table 2: Aboriginal deaths in custody/police operations 2016

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

Aboriginal Deaths in Custody / Police Operations



Circumstances of deaths of persons who died in Custody/Police Operations in 2016:

14 x Natural Causes

3 x Fall/Jump

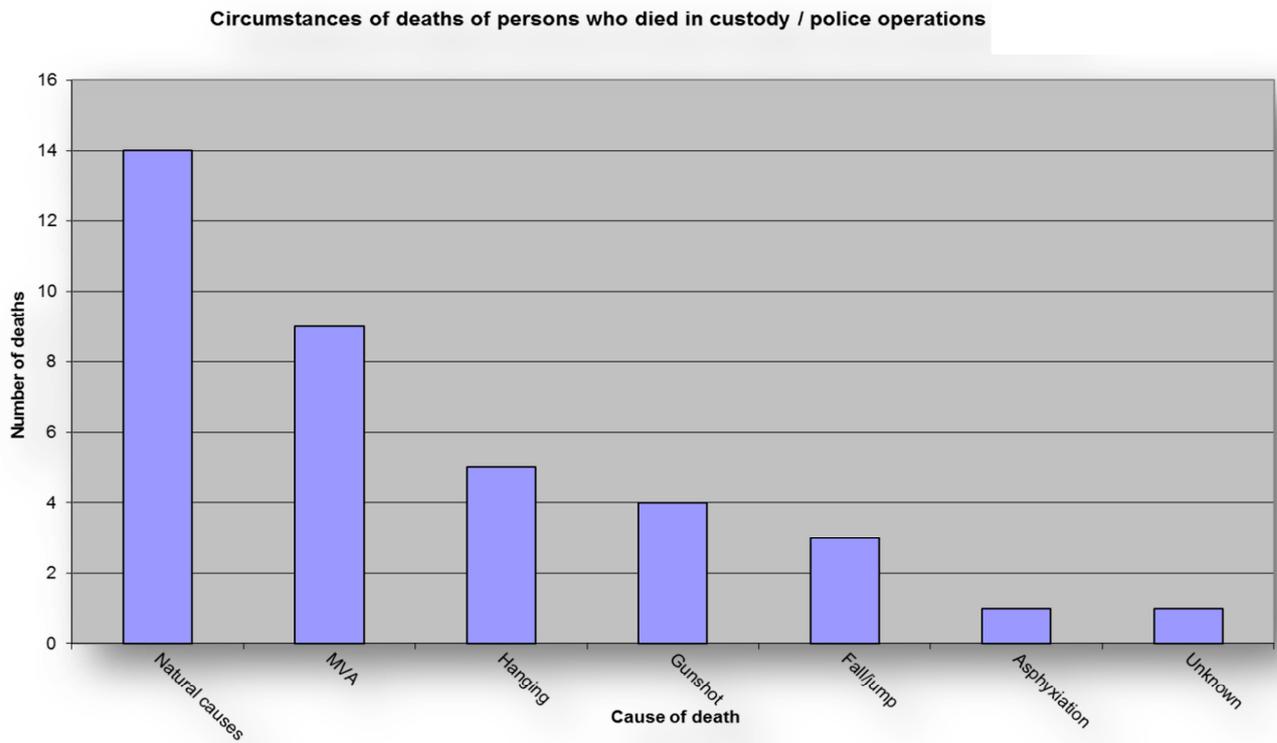
4 x Gunshot/Firearm

9 x Motor Vehicle Accident

1 x Unknown

5 x Hanging

1 x Asphyxiation



SECTION 23 INQUESTS UNDERTAKEN IN 2016

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 2016. 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 a pseudonym.***

	Case No	Year	Name	Coroner
1	71675	2012	David Rixon	DSC Dillon
2	20175	2013	MN	SC Barnes
3	203515	2013	Officer A	DSC Dillon
4	243783	2013	ST	DSC Dillon
5	267697	2013	RS	DSC Dillon
6	214164	2014	Idris Griffiths	DSC Lee
7	341985	2014	MM	DSC Barry
8	379966	2014	Ronald Wilson	DSC Stone
9	341842	2014	John McFerrier	DSC O'Sullivan
10	7720	2015	Tateolena Tauaifaga	Suspended
11	21976	2015	AA	DSC Lee
12	32915	2015	Sidney Bowtell	DSC Truscott
13	39150	2015	David Fleming	DSC Lee
14	44176	2015	Allen Burke	DSC Lee
15	109556	2015	Rodney Bates	DSC Grahame
16	112961	2015	Terry Riordan	DSC Barry
17	141687	2015	William MacDonald	DSC O'Sullivan
18	162071	2015	Narayana Simpson	DSC Lee
19	194931	2015	Peter Moffat	DSC Barry
20	269065	2015	Kevin Smith	DSC O'Sullivan
21	321206	2015	Barry Gooley	DSC Lee
22	363999	2015	JC	DSC O'Sullivan

1. 71675 of 2012

Inquest into the death of David Rixon. Finding handed down by Deputy State Coroner Dillon at Glebe on the 21 June 2016.

One of the reasons why we hold inquests when people die in police operations is so that the public can understand more about policing, and in some cases we are dealing with the deaths of people police are arresting, or something like that, but in other cases, sadly, it is the death of a police officer that this inquest investigates.

It is an interesting coincidence, I think, that in the week following the conviction of a man described as the most corrupt policeman in New South Wales history, Roger Rogerson, for murder, we are gathered here in this quiet Courthouse to remember the life and death of another police officer, a much more exemplary police officer, whom Mr Budd has described in extraordinary terms, very moving terms, as a fine human being, a fine man, and a police officer whom everyone respected.

In contrast with Rogerson, David Rixon exemplified the virtues of a true officer of the law, a true honest and good servant of the society he had sworn to serve and protect, and I am sure David's children and Fiona and his parents, Gwen and Ken, are very proud of him, and I hope that pride will at least help you deal with the heartbreak that you are feeling now. A Coroner's statutory duty is to find the facts concerning a sudden, unexpected, suspicious, violent or unnatural death, and sadly David Rixon's grossly premature death at the hands of Michael Jacobs was all of those things.

A sudden, unexpected, suspicious or violent death leaves a trail of psychological devastation behind it, and it is very clear to my observation, seeing you here today, that that devastation has been deeply felt, grossly felt, by David's wife Fiona and their children, and by David's parents. Ken is not here, but I cannot imagine that he is feeling very happy today. The families heartbreak must move us all, it has moved us all, I am sure. Any death of this nature has a huge ripple effect as well. Superintendent Budd has talked about that ripple effect, how even the crooks in Tamworth felt moved by what had happened, that a line had been crossed. This is something that just should not happen.

There are things that we can sort of live with. There are, of course, people who do bad things and there are police who try and stop them, or try and arrest them after what they have done, but killing a police officer really is something that is well beyond the pale.

David's workmates, his friends, his neighbours, felt it, but so too did the people of north-western New South Wales, especially people around this area, and the people of New South Wales, I can remember my own sense of shock when I learned of his death and the way he had been killed, and all members of the New South Wales Police Force must feel this deep down.

Although deaths of police officers in Australia, fortunately, in the line of duty are quite rare, we should never forget that the men and women of the police force are daily engaged in tasks in a job that is always challenging, sometimes very difficult. Personally I do not understand how they can daily go out and deal with all the domestic violence and drug taking and so on that they have to deal with, the car accidents, the mayhem and so forth, but sometimes it is very dangerous, and that risk is always there and you never know when it is around the corner.

Every police officer, and perhaps Jemma, a police officer herself, has a much more profound understanding of her job than she ever did before, but so do all the police, especially in this area, as Superintendent Budd has said. They do this job so that the rest of us can live in peace and safety and we owe them a very great deal for that commitment. As we have discussed, in New South Wales the Coroner's Court requires that an inquest be held when a person dies in the course of a police operation. We are not here to discuss Michael Jacobs' guilt, although that is obviously clear. We are here to focus on other aspects of this tragic event. Holding an inquest is one way our society demonstrates its respect for human lives, the lives of those who have died, but also for the lives of those who mourn.

Every single one of you is bearing a legacy from David: every single member of the family, every single member of his police family, is carrying a legacy from David. The mourning has had an effect, and has a great and profound effect, in increasing the determination of the police in this area especially, but no doubt in a wider sense throughout the state, to carry out their duty, their sworn duty to protect the rest of us. Ms Sullivan has eloquently outlined the terrible facts of this case and Detective Chief Inspector Olen I think gave us a deep insight into what happened on that terrible morning.

Although I will be repeating what has already been said, it is necessary, to summarise those facts and make some formal findings under the *Coroners Act* as to David's identity, the date and place of his death and the cause and manner and circumstances of his death.

What we know is that David, as a good police officer, had done some research, he had gathered intelligence both from the COPS system, but also from his colleagues.

He knew about Michael Jacobs: he knew Michael Jacobs was a habitual offender; he knew he was a possible drug dealer; he knew that Jacobs lived in a certain place; he knew Jacobs' vehicle; and when he saw that vehicle, he knew, or strongly suspected, that Jacobs had breached the law. Jacobs has a long history.

In exhibit 2, which has been tendered, I have some 30 pages of police records describing things that he has done. Reading between the lines, and you do not have to read very deeply between the lines, it also displays a portrait of a man who, for whatever reason, appears to have been a damaged human being who lived on the outskirts of society as an outsider, defiant of the law, defiant of social norms.

Back in 1997 he had even gone so far as to shoot police. On this particular morning, and it is not clear exactly when he got the gun that he had armed himself with, but on this particular morning he had armed himself, had a fight with his partner, and he was probably still under the effects of methyl amphetamine. A terrible combination.

It was David Rixon's misfortune to run into him when he was in a state of mind that was defiant, angry and, as it turned out, homicidal, and in possession of a .38 pistol. David Rixon followed him to his house. Jacobs tried to conceal himself from police, it appears, by driving his car way down into the garden area of the premises in which he lived. David followed from the road and approached the vehicle. He spoke to him. Obviously he was about to go through the process of imposing a random breath test on Jacobs.

It is not clear, but I suspect that he thought that Jacobs might be affected by drugs. If so, he was almost certainly correct and he spoke to Jacobs. Very shortly afterwards, for whatever reason, Jacobs fired on Senior Constable Rixon and Senior Constable Rixon had mortal wounds inflicted to his heart and lungs. Notwithstanding that, Senior Constable Rixon pulled out his pistol, fired four times, hit Jacobs and then, with astonishing presence of mind, got out his handcuffs and placed one of them on the wrist of Jacobs.

I will come back to that in a moment, because I want to speak about the virtues that David Rixon displayed on that particular morning. The police and ambulance were on the scene quickly. He was taken to the hospital, but he died.

He was beyond saving, tragically. Before coming to my formal findings under the *Coroners Act*, I want to dwell for a moment, and I think it is appropriate and important to do so, on David Rixon, the living human being, whose death has left the family and his friends so heartbroken.

As I have said when I started this morning, he exemplifies the virtues of a good police officer, and to me three things stand out conspicuously, and they were all on display in those few moments in which he was speaking to Jacobs.

First of all, he knew Michael Jacobs was a person who was a habitual law breaker. A good police officer knows his or her own patch. He knew that good police practice focuses on crime prevention. This means in some cases keeping an eye on certain people, and he was doing that. Secondly, when he approached Jacobs at the car window, or as Detective Chief Inspector Olen has surmised, when Jacobs was outside the car, he was cautious.

Of course, he was exercising the great power that our society entrusts to police, but what is, I think, one of the most interesting aspects of this very brief confrontation is that David acted with restraint and courtesy. He did not bully or provoke Jacobs.

His death was entirely unprovoked. Jacobs' act was entirely unprovoked. Thirdly, of course, and it is self-evident, he acted with astonishing courage and presence of mind and great determination to do his duty as a police officer.

Even though he was mortally wounded, he returned fire and he sought to restrain Jacobs. He must have known that if Jacobs could do this to him, he might repeat this extreme violence towards others. David Rixon died trying to protect the community from a very violent and desperate man, so it is a privilege for me, and for the coronial team, to be here not simply to outline the facts surrounding David's death, but to honour him and to come to understand him as a human being and as a police officer, limited as we may be in our understanding.

Like Superintendent Budd, I cannot imagine how members of the family feel. The loss is immense, it cannot be replaced, but what I do hope, and I am sure all of those who know about David hope, is that your pride in him and the good and happy memories of him will one day outweigh the sense of loss and heartbreak that you must all be feeling.

I am sure David would not want Jacobs to ruin your lives forever. I hope that David's would be the final victory, not that of Jacobs.

He was, as Superintendent Budd has described, a very good police officer, an honourable police officer, a dutiful and very courageous police officer, but he was also a fundamentally decent human being, and that is the great loss to our community, and that is really why we honour him, that he was such a good human being, and it is obvious when I look at the faces of his family.

One can see how much he is loved, how much he was admired, and how much his loss causes you to suffer, and I am so sorry that you have lost him in this way. Before I finally turn to my formal findings, I would like to commend the investigators.

I know this was a difficult task. It must be incredibly difficult for police officers to investigate the death of a colleague, and especially such an esteemed colleague. I thank Detective Chief Inspector Olen and his team for the investigation and for the assistance he has provided to the coronial team. It is much valued, and I thank you.

I thank you also, Superintendent Budd. Your words this morning were very, very moving, and I am sure all of those of us who listened to you speak were moved immensely, and you honoured David greatly, and that is to your credit as well, and all the police under your command.

Finally, may I thank Emma Sullivan and Alana McCarthy, who have worked so hard on this. I know that we have come right in at the end, after so much has been done before, but it is a privilege and an honour to participate in this inquest and we are grateful for that. My final thanks go, of course, to the family, who are here bringing David in some way to life, for me, at least, and I thank you for your attendance and for your pride in David, your care and I am sorry for your loss. I am lost for words, really, about that. Finally I turn to my formal findings under s 81 of the *Coroners Act*.

Formal Finding:

I FIND THAT DAVID RIXON DIED ON 2 MARCH 2012 AT TAMWORTH BASE HOSPITAL, TAMWORTH, NEW SOUTH WALES, DUE TO A GUNSHOT WOUND TO HIS CHEST INFLICTED UPON HIM BY MICHAEL ALLAN JACOBS AT PREMISES AT LORRAINE STREET, TAMWORTH.

2. 20175 of 2013

Inquest into the death of MN. Finding handed down by State Coroner Barnes at Glebe on the 14th March 2016.

The Coroners Act 2009 (the Act) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of MN.

Introduction

On 21 January 2013, MN was found by correctional officers dead in his cell at the Metropolitan Remand Reception Centre (MRRC). It was obvious that he had bled profusely from an incision in his wrist. He was 30 years of age.

Because MN died in custody an inquest into his death is mandatory. I am required by the Act to find various particulars in relation to the deceased and the circumstances of his death. In this case, because it was readily apparent the fatal injuries had been self-inflicted, the inquest has focused on whether correctional authorities and Justice Health practitioners adequately managed the risk of MN self-harming and appropriately treated his mental illness.

The evidence

Social History

MN was born in Sydney on 17 March 1982. He was the only son of RN and DN. He had two sisters. It is reported that he suffered developmental delay resulting in what was later diagnosed as mild retardation.

His parents separated when he was about five. It is reported he had conflictual relationships with his mother's subsequent partner. He left school at year six and was functionally illiterate. In 1999, he suffered a severe head trauma which apparently left him with an acquired brain injury.

Throughout his adult life MN was a poly-substance abuser.

At various times he used marijuana, heroin and various prescription drugs. At various times he was on a methadone treatment program and on occasions he suffered from drug and alcohol withdrawal and drug induced psychosis.

The evidence before the court contains assessments undertaken by psychiatrists and mental health practitioners between 2003 and the year of his death. Almost all refer to his mental retardation and acquired brain injury.

Some make reference to a personality disorder. There is inconsistency among the assessors as to whether he also suffered from a major mental illness. Some of those who reviewed MN considered he suffered from conduct disorder and poor judgement and impulsivity. Others diagnosed him as suffering from major depressive disorder, schizophrenia, organic psychosis, persistent auditory hallucinations and impulsivity.

There are also numerous reports of his expressing homicidal and suicidal ideation. There was a high level of agreement that MN lacked insight into his condition and had almost no ability to reality test any decision he might make. He was reported as having very limited self-control and emotional regulation – that is an inability to monitor decisions and actions.

It was generally accepted that MN provided a very challenging set of symptoms and disorders for those seeking to keep he and those around him safe. It seems likely that throughout his adult life MN was in almost constant mental health crisis. The first recorded self-harming attempt was recorded in 1999 when it was reported that he attempted to self-immolate and hang himself while in custody at Cobham Juvenile Detention Centre. There were to be other attempts or threats of suicide both when he was in custody and when he was in the community.

It seems he was never in gainful employment and spent the majority of his adult life in correctional custody. When he was in the community, he habitually abused illicit drugs and committed various criminal offences. He was not compliant with medication regimes and made irregular contact with mental health service providers.

Criminal justice history

MN first came to the attention of police when he was about 12 years old. Since then he was charged 80 times with a wide variety of offences including the use or threatened use of violence, larceny, breaking and entering, willful damage and the like.

MN first entered the adult correctional system in June 2000. Thereafter he was taken into custody on 15 separate admissions.

From his initial incarceration it became apparent that MN would be at risk of deliberate self-harm and a risk of harming others. As a result he was frequently housed in acute crisis management units.

In the period between his first incarceration as an adult in 2000 and his death in 2013, MN spent the majority of his life in custody. He engaged in acts of self-harm both when he was in custody and when he was in the community.

Final period of custody

On 26 November 2013, MN was taken into custody charged with three counts of "Break and enter a building with intention to injure". He was bail refused by police and appeared in court the following day where the magistrate directed he be taken for a mental health assessment pursuant to s33 of the *Mental Health (Forensic Provisions) Act 1990* (the Mental Health Act).

MN was assessed of being mentally ill within the terms of that Act and admitted as an involuntary patient to Cumberland Hospital. Over the next two weeks he received psychotropic medication and was monitored regularly. On 7 November he was assessed as no longer fulfilling the criteria for involuntary treatment and was in accordance with the Mental Health Act released back into the custody of police and again taken before the court.

The Magistrate before whom MN appeared apparently had concerns about his mental state and so directed he be further assessed pursuant to s33. That assessment also occurred at the Cumberland Hospital. The doctor who saw MN on that occasion concluded in his written assessment that the patient "*does not have a mental illness.*" I conclude that what he intended to convey was that MN was not at the time he was seen mentally ill or thought disordered within the terms of the Mental Health Act.

Accordingly, he was given back into police custody without further treatment and the next day MN was again brought before the court and remanded in custody.

On 9 November he was transferred to the Parklea Correctional Centre. On reception he underwent a physical and mental health assessment during which his drug withdrawal and mental illness symptoms were noted along with his extensive history of self-harming.

He was initially placed in a normal cell but on 18 November threats of self-harm caused him to be moved to a safe cell, placed on 24 hour observations and denied access to sharps or ligatures.

On 23 November MN actively participated in a RIT review and guaranteed his own safety. Accordingly his access to a hygiene pack with a disposable razor was reinstated but three days later, on 26 November he cut his left wrist and made an incision behind his left ear. He explained that he was acting in response to auditory hallucinations. He was placed back in a camera cell with nil sharps and 15 minute observations. The next day he was transferred to the MRRC.

On account of having previously had violent interactions with other prisoners at the MRRC, MN was placed on a Protection Non Association order (PRNA).

On 7 December 2012, MN was placed in the Mental Health Screening Unit (MHSU) so that his complex care needs could be assessed and a care plan devised. While he was in there a comprehensive mental health assessment was undertaken by a psychiatrist, Professor David Greenberg, who had been involved in treating MN during previous terms of imprisonment. Contrary to the assessment of the Cumberland Hospital medical officers, Professor Greenberg was firmly of the view that MN was acutely psychotic and mentally ill within the terms of the Mental Health Act.

By 7 January 2013, MN was assessed as no longer being at risk of self-harming. He purported to guarantee his safety and that of others. He was moved to M block but the same day again threatened self-harm. Accordingly he was moved back to a safe cell in Darcy 1. The next day, 8 January, he explained that he had been unsettled by being required to exercise with other prisoners in M block. It was agreed he would be housed in a single cell regular cell in Darcy 2 with limited contact with other prisoners until a bed became available in the mental health step down pods Hamden 17/18. He was to receive regular psychiatric reviews. He was allocated cell 77.

On 15 January, MN was reviewed by Dr Sarah Spencer, a Justice Health psychiatrist. She assessed his acute risk of suicide as low at that time. He told her he had no ideas of suicide or self-harm. He continued to report auditory hallucinations. She said he told her he was "*alright*" but keen to move from Darcy to Hamden pods. She said he was future focused, discussing his charges and not overly anxious about possible outcomes. They discussed some dissatisfaction MN had with his medications.

Dr Spencer agreed to trial him on other but these first required blood screening which she ordered.

She considered the plan to house him in a single cell in Darcy 2 pod until a place in the Hamden mental health step down pods 17/18 became available was appropriate.

Although Dr Spencer considered MN to be at low risk of immediately self-harming she recognized that his mental state was very changeable and she accordingly arranged to see him again in a week's time.

Nothing else of note is included in the brief or correctional records until the day of MN death. It is appropriate to note however, that conditions in Darcy 2 pod were taxing. The unit was very crowded and the cell next to that occupied by MN was being converted from a regular cell to a "safe cell". This undoubtedly generated a lot of loud and intrusive noise. During this period, MN was locked in his cell for most of the day.

Day of the death

Because MN was on a non-association order, he could only be let out of his cell when all others prisoners were in theirs. In effect this meant he could not expect to be out of his cell for more than an hour a day. In practice, this regime was not strictly adhered to and MN was let out of his cell for short periods during the day to get hot water for tea and to access the telephone etc. Further, he had contact with Justice Health nurses three times per day: twice for the dispensing of his prescribed medication and once for the administering of his opioid replacement therapy.

The area outside of his cell was under constant CCTV observation. Accordingly, his movements on the day of his death can be established with a fair degree of accuracy and the versions of witnesses can be cross referenced to this recorded vision.

Breakfasts were distributed to all prisoners in their cells soon after 8:00am. At 8:21 MN was released from his cell. He can be seen going off camera for a brief period before returning at 8:24 carrying a drinking cup. His door is left open and he moves around the area of his cell. During this period he received medication from a nurse. His cell was secured at 8:58 and the other prisoners in the block were then released.

At 10:17 MN was again released from his cell for a short period.

After his death, a number of prisoners variously reported that on the day of his death MN was expressing concern about remaining in Darcy 2 pod; was threatening self harm and/or was manhandled by the correctional officers. I accept that he was almost certainly expressing dissatisfaction with his custodial arrangements but I have also come to the view that those witnesses have exaggerated what occurred.

When interviewed on the day of MN's death, inmate Angus O'Casey said he heard the deceased tell a guard that he wished to kill himself. He said MN was in tears and said "*I don't want to be alive*" and "*I want to die*" Guards then "*threw MN into his cell.*"

When called to give evidence at the inquest, Mr. O'Casey said he had no memory of the incident as he suffered from an acquired brain injury.

Inmate Jay Hopgood said that he saw MN in tears asking for medication and asking for a light for his cigarette. Correctional officers forced him back into his cell – "*there was a bit of a scene.*"

Neither of those inmates knew MN. Noah Filimoehala, on the other hand, had known him for about 10 years and had socialised with him outside of prison. He said that on the day in question, he spoke to MN through the flap in his cell door and MN complained about the noise being created by the adjacent cell being renovated. He also said that MN asked him if he could get him some drugs, but Mr. Filimoehala told him there were none in the pod at that time. He said he gave MN some cigarettes.

Senior Correctional Officer Adrian White had contact with MN over a number of years at the MRRC. He knew him to be a very difficult prisoner to manage who was demanding of staff time. He also acknowledged that in his last period of incarceration in Darcy 2 pod, MN was kept in difficult circumstances for a lengthy period on account of the ongoing renovations and his non association order. He said that was difficult to alleviate on account of the shortage of single occupancy cells and the high occupancy rate of the pod. He was adamant that had MN threatened self-harm the RIT procedures would have been activated. He also denied that MN was agitated on the day in question and said that had he been distressed he would have referred him to a mental health nurse. In fact that is what occurred.

Registered Nurse Barbara Sullivan had on-going contact with MN through-out his last period of incarceration. She recalled that during the morning of 21 December she was asked by a senior correctional officer, who I accept was Mr. White, to see MN as he was agitated and "*playing up*".

Accordingly, she saw MN in a holding cell adjacent to the pod. She knew he had been assessed as suitable for transfer to Hamden pods 17/18 but she also knew that he could not be housed there on account of other inmates already there with whom he had a history of conflict.

She said MN told her he was anxious to get to Hamden. She understood why that would be so.

She asked him if he would be content with a move to Hamden pods 15/16 and he agreed. She told him she would pass on that request. Nurse Sullivan said MN did not appear distressed and he did not make any threats of self-harm or give her any reason to believe he was at risk of that. Otherwise she would have activated the RIT procedures as she had done previously in relation to this prisoner.

He went back to the pod and she went to her workstation and completed a Health Problem Notification form which was a mechanism to inform those responsible for prisoner intra-centre transfers that a prisoner had been assessed as suitable for transfer to a particular pod. She also completed an electronic referral to the same effect.

The CCTV recorded vision shows MN returning from that meeting. His body language suggests he is not happy about having to go back into his cell but there is no indication that he is distressed or resisting. Officers ushered him towards the cell, but no physical contact was required. This occurred at approximately 10:30am.

Throughout the next few hours various prisoners can be seen approaching the cell and talking through the door flap. At various time correctional officers also look through the flap and slide meals under the door. At 2:40 pm MN leaves his cell with a drinking cup in his hand. He returns about two minutes later and appears to speak with a correctional officer at his cell door for about a minute. He is then locked in his cell and does not leave thereafter.

The death is discovered

At 7:15pm a correctional officer and a nurse were conducting the evening medication round in Darcy 2 pod when they opened the door to cell 77 and found MN lying on the floor, next to his bunk, with his head towards the door, with a pool of blood beside him. One of them called a medical emergency and then both entered the cell to examine MN. They could find no signs of life. The cell was secured while awaiting the attendance of paramedics and a crime scene log was commenced.

Ambulance officers were on scene by 7:35pm. They confirmed that MN was deceased and that no resuscitation could be attempted.

Police were at the pod by 8:30pm and detectives from the Corrective Services investigation Unit (CSIU) took over the investigation.

It was immediately apparent that MN had lost a significant amount of blood from a wound to his right wrist. There were pools of blood in a number of discrete areas around the cell: on the bedding; near the shower and around the body.

Within a congealed pool of blood on the cell floor was found a dismantled, prison issued, disposable razor. The head had been broken open and the blade removed. The plastic handle had been melted and the blade attached to it, forming a makeshift knife. Numerous spent matches were in an ashtray nearby.

In each cell there is an intercom the occupant can activate to speak to correctional officers. It is referred to in jail parlance as the knock up button. If the call is not responded to by officers in the pod when the prisoner is housed, the call goes through to a central office that is manned continuously.

The knock up button was working when tested by a CSIU officer on the night of MN's death. There were no obvious blood smears on the button. The officers on duty in the pod at the relevant time said they had heard no activation of the intercom by the prisoner in cell 77 throughout the relevant period. Due to a malfunction in the relevant software, the intercom system was not able to be interrogated to ascertain whether activation was recorded from the cell at the relevant time.

The autopsy evidence

On the 22 January 2013, MN's father identified his body to police. The body then underwent an internal autopsy by an experienced forensic pathologist.

The examination found two small scratch abrasions on the right frontal area of the head. These were not of significance. The autopsy also found two incisions in the lateral aspect of the right wrist. That section of the wrist showed that one of those incisions penetrated the right radial blood vessel. No other trauma was found to the body and when it was subject to a whole body x-ray no abnormalities were discovered.

Toxicology testing showed the presence of methadone in the amount of 0.88 mg/L. Although that level is within the toxic range in view of the fact that MN was a long time user it is unlikely to have had adverse effects on him. The level found in his blood was consistent with his prescribed dose of 95mg daily.

Olanzapine was also found within a therapeutic range. MN had been prescribed both drugs while in prison.

The pathologist was of the opinion the incisions in MN wrist occurred at least a few hours before death. She cited exsanguination resulting from the incision to the radial vein as the primary cause of death.

Expert psychiatric opinion

All of the relevant information gathered during the course of the investigation was provided to Dr Tanveer Ahmed, an independent experienced consultant psychiatrist. Dr Ahmed provided the court with a report and gave evidence.

In his report, he wrote that MN could be diagnosed as suffering from a combination of paranoid schizophrenia exacerbated by underlying acquired brain injury, with a possibility of developmental delay. Having reviewed the Cumberland Hospital records for the period during which MN was last there, 27 October to 7 November 2012, Dr Ahmed expressed the view that the decision to discharge him was not unreasonable. He did however disagree with the assessment of Dr Kota that MN did not have a mental illness.

In oral evidence, Dr Ahmed acknowledged that by the end of his in-patient treatment at the Cumberland Hospital it was reasonable to assess MN as not being mentally ill within the terms of the Mental Health Act.

Dr Ahmed also agreed that further hospitalisation was unlikely to be of assistance to MN and in those circumstances it was not unreasonable to discharge him back into police custody to be taken before the court.

Having reviewed the Justice Mental Health Service records Dr Ahmed considered that the management plan instituted for MN on 5 January 2013 was appropriate. However, in his report he expressed the view that the assessment that MN was at low risk of suicide made following a RIT meeting on 8 January was not supported by the evidence. He pointed out that MN satisfied almost all of the factors contributing to risk of suicide in a correctional setting with few or none of the protective factors.

As a result he considered MN should have been assessed to be in the moderate to high risk range.

Dr Ahmed was of the view that the risk assessment tools used in the Mental Health Service are not the problem but they were inappropriately applied in this case.

When he gave oral evidence at the inquest, it was explained to Dr Ahmed that the assessment had been made by a forensic psychiatrist with many years' experience working in prison mental health and that her assessment was not meant to indicate that MN was not at a chronic heightened risk of suicide. Rather, the psychiatrist, Dr Spencer, had concluded that that MN was not at such acute or immediate risk that he could not be safely housed in a mental health step down pod. The acute crisis which had caused him to be removed to the Mental Health Screening Unit had been resolved.

In those circumstances, Dr Ahmed withdrew his criticism of the assessment and care planning for MN. He accepted that the medication given to MN was appropriate as was his regular psychiatric review.

Conclusions

MN had a difficult life. I accept his sister's account of MN as a boy succeeding at and enjoying football but that happiness was short-lived. I also accept his sister's account of the affection his parents and sisters had for MN which was reciprocated by him.

I offer the family my sincere condolences for their sad loss of their son/brother at such a young age.

From at least his teenage years, MN experienced difficulties as a result of intellectual and personality limitations. Congenital disabilities cumulated with an acquired brain injury, fluctuating mental illness and the long term effects of illicit drug use.

This constellation of cognitive, perceptual and attitudinal disorders generated very complex and challenging treatment needs. They also resulted in aberrant behavior that precipitated frequent interaction with the criminal justice system and numerous relatively short periods of imprisonment. When he was not in prison, MN lived an unstable and transient life punctuated by episodes of drug induced psychosis and chronic mental illness. He engaged in numerous instances of serious self-harming both in the community and when he was in custody.

Most mental health patients benefit from a continuity of care involving, among other things, the development of a therapeutic alliance between the patient and the clinicians. This would be of particular importance for a patient like MN who had very limited insight into his various conditions and who was prone to paranoid delusions.

MN symptoms included a high level of changeability; impulsivity; and unpredictable, aggressive outbursts.

His limited intellect and his thought disorders hindered his capacity to respond constructively to the stressors he encountered in the community and in custody. He struggled to cope by being demanding and manipulative and engaging in self-harming. These responses compounded the challenges to providing him with effective mental health care. Sadly and ironically, the behaviors precipitated by MN conglomeration of disorders made continuity of care almost impossible. His chronic elevated risk of self-harm or suicide never abated.

A meaningful understanding of how MN came to die in his cell in January 2013 would require a review of his treatment as an in-patient, in the community and in custody over many years. A detailed analysis of the treatment options and their impact on his psychosocial condition over that time would be necessary to explain how he came to be in Darcy 2 pod on the day of his death.

The short answer is that he could not cope by himself, his family was unable to help and the various government agencies he interacted with only gave short-term solutions. An understanding of why that was and how it could be remedied is beyond the scope of this inquest. Therefore, somewhat artificially, this inquiry has focused only on the last couple of weeks of MN's life.

I turn now to my conclusions in relation to the issues raised in relation to that period. MN was discharged from the Mental Health Screening Unit on 5 January at his request. He did not wish to remain in the MHSU and threatened to hang himself unless he was moved. On successive days he again made threats of self-harm and the RIT processes were appropriately activated. On 8 January he was assessed as no longer being at such risk of immediate self-harm as to necessitate his placement in a safe cell. Accordingly, he was moved to Darcy 2 Pod, to be accommodated in a single cell and to exercise alone on the understanding that he would be moved to Hamden 17/18 mental health step down pods when a bed became available and his non association requirements could be satisfied.

In the meantime, he would be regularly reviewed by the mental health staff in Darcy and he would continue to receive his prescribed medication.

I am satisfied that these assessments and the implementation of the plan were appropriate.

On 15 January, MN was reviewed by a Justice Health psychiatrist in accordance with the plan formulated when he was discharged from the MHSU. I accept the evidence indicating her assessment and treatment of MN condition was appropriate having regard to his history and presentation.

There was no persuasive evidence that she should have sought to have MN returned to the MHSU or housed in a "safe cell." His medication was also appropriate as was the psychiatrist's willingness to explore the utilization of other psychotropic drugs after appropriate blood screening had been undertaken. The autopsy results demonstrate the prescribed medication was administered.

Criticism by the court appointed expert of the assessment undertaken on this occasion was withdrawn when the expert was made aware of the Justice Health psychiatrist's qualifications and experience and the basis of her conclusions.

I conclude that because of his intellectual and psychiatric deficiencies; his propensity to abuse drugs and his personality disorders, MN was always at a heightened baseline risk of suicide – that is, he was always more at risk than a member of the general public and that applied whether he was in the community or in prison.

However, I also accept that a large section of the prison population is in a similar state. All of the prisoners with similar disabilities cannot be kept under constant observation. Rather, prison mental health services have to monitor and review at-risk prisoners regularly, ensure they are adequately medicated and respond to their changes in mental state as those become apparent.

I am satisfied this happened in relation to MN. His dying does not necessarily demonstrate a failure of Justice Health or Corrective Services policies or practice. He was seen three times per day by a nurse. When he exhibited signs of being at increased or greater risk of self-harm the RIT procedures were activated. I don't accept that he met that threshold on the day of his death – being restless, frustrated and manipulating staff was not an indicator of increased risk of self-harm, rather it was a usual state for MN.

He was frustrated and complaining – but he was often like that. His conditions were made worse by the length of his stay in the Darcy 2 pod and the renovation of the adjacent cell. It would have been preferable for him to have been placed elsewhere, but that was complicated by his non association status.

In hindsight, it would have been better had he not been given a disposable razor. However, I accept the policy provided he could have one if he did not meet the risk of self-harm threshold.

It was not explained why in other parts of the prison inmates were only given temporary access to razors in exchange for the prisoner's identification card. Nor can it be shown that had that system been in place in Darcy 2 pod it would have made any difference to the outcome for MN.

The evidence persuasively demonstrates that no one else entered MN cell after lock-down until he was found deceased and that only he could have caused the fatal injury to his wrist. I have given careful consideration to whether MN intended to take his own life when he caused the injury.

He had self-harmed previously in circumstances where he could have killed himself had he been so inclined.

I accept that on this occasion he did not seek to summon help as he had previously done – on the balance of probabilities the knock up button was not activated. Conversely, the self-inflicted wound was relatively slight – it was not done accidentally but he may well have mistakenly believed he would not die from the injury before the next cell inspection occurred. I am left uncertain as to MN intentions.

Formal Finding

The identity of the deceased

The person who died was MN.

Date of death

MN died on 21 January 2013.

Place of death

MN died at the Metropolitan Remand and Reception Centre, Silverwater, New South Wales.

Cause of death

The cause of his death was exsanguination due to an incision in the radial vein of his right wrist.

Manner of death

Although I conclude MN deliberately inflicted the fatal wound I am unable to ascertain whether he intended to cause his death.

3. 203515 of 2013

Inquest into the death of GM. Finding handed down by Deputy State Coroner Dillon at Glebe on the 18th December 2016.

Introduction

Officer A died on 3 July 2013. Her death was self-inflicted and came about while she was suffering a Major Depressive Illness and was also suffering symptoms of Post-Traumatic Stress Disorder. She left behind her a shocked and devastated family, her devoted husband, F, also a police officer, and their two young children. It was also very evident during the inquest that her death has had an enormous and very saddening effect on many of her friends and colleagues in the NSW Police Force.

Because she died while on duty, her death was considered to have taken place in the course of a 'police operation'. In such circumstances, the Coroners Act requires that an inquest be held by a senior coroner: s 23.

The deaths of police officers on duty always raise serious questions of public interest.

Police services are important public institutions and the protection of their officers from undue risk and harm is a major responsibility of senior police management and our society more generally. Officer A's case has raised questions concerning the way in which her illness was managed and whether improvements can or should be made to the police injury management system to reduce risk of self-harm by police officers suffering psychological injuries in future.

The role of the coroner and the function of an inquest

An inquest is not a trial but an independent judicial inquiry, a fact-finding exercise. Although difficult questions may be put to witnesses, and cross-examination may touch tender nerves, this is done not to prove or disprove a case but with the intention of testing the evidence so that the relevant facts can be determined.

This court does not adjudicate a contest between parties on questions of guilt or innocence, or rights and liabilities. If those issues arise, they may be decided in other jurisdictions.

The Coroners Act requires me to identify the person whose death is the subject of the inquest, the date and place of death and the immediate cause of death. None of these matters are controversial. I am also required to consider the 'manner' or circumstances of the death. It is this issue, and the questions related to it, on which this inquest has mainly focused.

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

Officer A

Inquests are not detached technical exercises merely concerned with technical or policy issues. They have at the heart of them sad human stories. Before proceeding to deal with the technical issues, I should start by outlining something of Officer A's history and personality, and how she was known by her husband and her friends.

Officer A was born in [year] and joined the NSW Police Force (NSWPF) after school. She graduated from the Police Academy and met F, also a police officer, while they were both stationed at a Sydney Police Station. They were married.

In [year], Officer A resigned from the NSWPF, and took up a job as an investigator with a private company. [REDACTED]

Officer A re-joined the NSWPF, and was stationed at a Sydney police station.

F also re-joined the NSWPF. It was in early 2007 that Officer A seems first to have sought treatment for psychological issues. In March 2007 she was diagnosed as suffering major depression, with acute anxiety, severe insomnia and panic attacks.

A significant contributing factor to this 2007 episode seems to have been the stress of commuting from [her place of duty to the family home], compounded by advice that she was unlikely to be transferred closer to home.

In common with most police officers, Officer A attended the scenes of some very disturbing incidents in the course of her police work. It was in about late 2009 that Officer A started having significant problems with sleeping. She was particularly affected by a number of fatalities.

Despite suffering the effects of her mental conditions, Officer A's motivation and determination to work were very striking and unusual aspects of her character. She was a strong-minded, hard-working, intelligent woman who was very determined to do her work as well as she possibly could, *even* at personal cost. Her husband F described a woman with 'a passion for policing', who would 'run towards danger when others *were* running away from it.' She saw policing as a noble vocation.

Before the illness that finally overcame her struck hard, Officer A was a highly regarded officer known for her energy, enthusiasm and sense of humour. It is important, when considering her death, to be reminded of how full of life she was before she became sick.

The issues

This inquest has considered the following issues:

- The nature of Officer A's mental condition;
- The cause of Officer A's mental condition;

The appropriateness of police management of Officer A's mental condition and return to work in the period preceding her death;

The appropriateness of medical treatment received by Officer A in the period preceding her death;

- The appropriateness of the review of Officer A by police medical officers on 2 July 2013 and of recommendations made following that review:

- The appropriateness of actions of police in reaching and carrying out a decision to transfer Officer A on or about 3 July 2013;
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Whether Officer A was involved in a relationship of an intimate nature with Officer B or Officer C or any other officer of the NSW Police Force. Whether any such relationship(s) adversely affected Officer A's mental condition or police management of her mental condition and return to work in the period preceding her death;

The appropriateness of actions by police to locate Officer A after she left [the police station at which she had a meeting with representatives of management] on the morning of 3 July 2013.

Before considering them, however, it is necessary to understand the factual background which is largely uncontroversial.

Background and summary of events

Officer A was an officer working in a police station. Her substantive position was in a unit at that station.

She attempted suicide at work by taking an overdose of prescription medication. Following this incident, she was placed on sick leave.

On 3 July 2013, she attended a meeting at the station at which a plan for her return to work was presented to her. It involved an immediate transfer to [another] police station in a Local Area Command that she did not wish to accept. She left the meeting in tears, apparently unhappy with the plan that senior management had developed for her. She drove to a hardware store, bought a rope, and then drove to a State Forest where she hanged herself. A welfare alert was raised and a search started for her.

Later in the day she was found by searching police. Unfortunately, she was beyond resuscitation.

Although the meeting at the station was the trigger for this calamity, what caused Officer A's death was a much more complex set of factors. To understand them, we need to look more closely at her history over the years leading up to July 2013.

Officer A's mental health history

As noted above, Officer A suffered depression in 2007 and was significantly traumatised by incidents that occurred in 2009 and 2010.

In 2010 she continued to consult with doctors and a psychologist and was prescribed anti-depressants. It was in 2010 also that Officer A commenced drinking quantities of wine at night in order to help her sleep.

In 2010 Officer A was promoted to Sergeant and took up a position in a unit at a police station, the unit was headed at the time by Officer B. As Manager he was directly responsible for three other staff in the unit. When Officer A joined the unit the position was vacant. The vacancy was became a source of tension for Officer A over time.

In 2010 Officer A was promoted to Sergeant and took up a position in a unit at a police Station.

The unit was headed at that time by Officer B as Manager, Officer A continued in the position in the unit during 2011. Although she carried a heavy workload it appears that Officer A coped reasonably well in her job during 2011, and had mostly good relationships with her co-workers.

Although she spoke of immense stress from her workload and from reading some of the distressing 'SITREPS' which some of her work *involved*, she does not appear to have reported any major psychological problems during 2011.

However, things changed for the worse in 2012. Although she had temporarily relieved Officer B as Manager during January 2011 without obvious or reported difficulties, when she did so again in January 2012 it was a stressful experience for her. This was in part because no-one filled Officer A's own job. It seems that she attempted to keep on top of both the Manager's job and her own simultaneously.

In the period following Officer B's return from leave at the end of January 2012, one of Officer A's co-workers observed that *'the unit dynamics had changed considerably'* and, in particular, that there was a notable degree of conflict between Officer A and Officer B.

Officer A was working extremely long hours in 2012, and took a number of periods of sick leave during the year. She was also drinking substantial quantities of alcohol at night, and having trouble sleeping. This all came to a head in 2012, when Officer A broke down and told her husband of current thoughts of traumatic incidents she had attended as a general duties police officer. In 2012 a P902 'Incident Notification Form' was submitted to the NSWPF by Officer A's husband, F. The purpose of that form was to inform the employer and workers compensation insurer of a workplace injury, and to set in train an investigation into the cause of the injury.

In the section which asked 'How did the incident or near miss occur?' F recorded:

Stressful work environment, at [REDACTED] office. PTSD from [REDACTED]

The pressure at work has caused the victim to re-live these incidents'. Subsequently, Officer A was certified by doctors as 'Unfit' for work, and remained off work for about two months. She returned to work in 2012.

In a report dated 2012 a psychiatrist commissioned by the police insurer Employers Mutual Ltd concluded that Officer A was suffering a *'Major Depressive Episode and Post Traumatic Stress Disorder* and that these psychiatric conditions were a result of her exposure to traumatic incidents at work as a police officer, most notably the fatalities in 2009 and in 2010.

It is apparent that after her return to work in 2012 Officer A was experiencing stress from the workload associated with her job, and working long hours. This led to several email exchanges between Officer A and Officer B in relation to her hours and various outstanding tasks that she was trying to manage. He ultimately insisted that she not work overtime without his permission.

Officer A's condition, however, continued to deteriorate culminating, on 23 November 2012, in a suicide attempt. She took a large quantity of tablets in the attempt. She was discovered, unconscious, in the locked office of one of her co-workers in the unit. She was admitted to hospital and remained under medical treatment or assessment until her discharge in 2012.

A P902 'Incident Notification Form' was not submitted by the employer in relation to this overdose. The incident was treated by the employer apparently on the advice of the insurer-- as a 'recurrence' of Officer A's earlier psychological injury. The basis of that advice and who gave it is unclear. This later became a very sore point with Officer A.

Officer A remained off work until 2013 when she returned on a graduated Return to Work plan. However, after a verbal disagreement with a supervisor that day, she again went on sick leave until 2013 when she again returned on another graduated Return to Work plan.

The incident in 2013 was viewed objectively, a minor one but it led to an intense reaction from Officer A symptomatic of her fragile state of mind. Her RTW plan had specified that she would work in the unit where she was given a task to do with firearms as her duty for the day.

At some point during the day, however, she left her desk in the unit and went around to her previous unit where she offered assistance to Sergeant P who was working temporarily in Officer A's position in that unit. Inspector M, who was the Unit Manager, asked what she was doing in the unit. He knew that she had been posted to another Unit and some of Officer A's history. Officer A reacted furiously, stormed out of the office, went home and later sent a message to Officer D who was managing the other Unit that she would not be coming in to work.

The 'Police Blue Ribbon Insurance Scheme', which applied to officers such as Officer A, provided for a period of up to 270 days (about nine months) during which she could remain off work, but on full pay, and without the need to resort to using recreation leave as sick leave.

During 2013, Officer A was seeing a psychiatrist and a psychologist for ongoing counselling and treatment. However, the effectiveness of this counselling and treatment was limited, largely, or at least in part, by Officer A's reluctance to engage with it.

Events of late June and early July 2013.

A number of events took place in late June and early July 2013 that appear to have had cumulatively adverse effects on Officer A.

On or about 24 June 2013, Officer A and her husband learned that her wage 'top up' period of 270 days had come to an end nine days earlier. Her salary was effectively going to reduce by 25 per cent. This came as a shock to Officer A and her husband F, as they had been told that they would be given about 30 days' notice of when the '270-day' full top up period would expire.

The failure to give Officer A proper notice of the expiry of the 270 day period was an oversight by NSWPF staff responsible for administering the Income Protection scheme, and an apology for this mistake was sent to Officer A by email.

This oversight, however, unfortunately coincided with the announcement of improvements to the benefits payable under the PBRI Scheme but for which she was ineligible.

A form letter announcing those improvements was received by Officer A at around this time exacerbated her distress and sense of grievance.

In late June 2013 Officer A's treating psychiatrist, Dr E, told Officer A that he may refer her to a different psychiatrist for treatment because of the lack of progress they were making. He felt that a working therapeutic relationship had not developed between them.

Another event that assumed significance for Officer A in late June 2013 was that *she* became aware of and concerned about some correspondence she believed had been sent to her treating psychiatrist by her NSWPF Injury Management Advisor.

Officer A by then had a poor relationship with the Injury Management Advisors and she became quite fixated on this issue, demanding that a copy of the correspondence be given to her.

That correspondence is discussed further below but the upshot was that on 1 July 2013 a heated telephone conversation between Officer A and her Injury Management Advisor, Ms. G in relation to her request for a copy of this correspondence took place. This conversation was very upsetting both for Officer A and Ms. G.

As a result of the acrimony between them, the difficulties in managing Officer A's return to work, and the tensions that had developed in the Office as a consequence a meeting involving Officer A's supervisor, the Regional Commander and various Injury Management staff was convened following the phone call.

It was decided to arrange for a Police Medical Officer and a Police Psychologist to assess Officer A's fitness for work. Apart from the fact that Officer A's volatility was stressful for others in the office, those managing her had become concerned that the pattern of behaviour that had culminated in her suicide attempt the previous November was repeating itself. They believed she may be at risk of self-harm.

Officer A and her husband F were informed of the proposed Police Medical Officer assessment that evening and it was agreed that Officer A would be driven to the assessment by her husband F who would support her.

On the morning of 2 July 2013, however Officer A told F that she did not want him to accompany her to the assessment. She drove herself to Sydney. When F informed Officer A's supervisors of this development, they made arrangements to drive F to Sydney so that he could provide support to his wife.

Officer A was assessed by the PMO and psychologist as fit for restricted duties. It was also recommended that she work at a different location for a period of three to six months, with a review after three months.

The Region Commander endorsed this recommendation and directed Officer A's supervisor, Chief Inspector J and another Chief Inspector to inform Officer A. He also directed that the change of work location take place immediately. The plan was that following the meeting she would be driven to another police station to commence her duties there.

On 3 July 2013, Officer A arrived for work at about 8am. It seems that one of the first things she did was to complete a P902 Incident Notification Form in relation to her overdose seven months earlier. In the section describing the nature of the injury, she wrote, *'Attempted suicide at workplace by taking an overdose due to the mismanagement of psychological injury by staff.'*

At around 8.40am, Officer A was spoken to by her supervisor, Chief Inspector J and by a representative of the Region Commander, Chief Inspector T.

Neither her husband F nor a support person, independent of the Regional Command and specifically chosen by her to accompany her to the meeting, was present.

In that meeting she was told of the recommendations of the PMO assessment and of the Region Commander's decision that she be transferred that same day to commence work at another police station.

She became upset at this news, and said she was 'going off sick'.

Although efforts were made by Officer A's supervisor to drive her home or to have her husband pick her up, Officer A insisted on driving herself. She left in her car sometime before 9.30am that morning.

Officer A's husband F was informed of the outcome of the meeting and that Officer A was expected to be driving home. However, Officer A did not go home, and at about 10.15am that morning she visited a Bunnings Hardware store where she bought a length of rope, and some other items. F became aware of this fact by checking bank records and by then attending and speaking to staff at the Bunnings store. He eventually spoke with Officer A by telephone. F's fears that she was considering self-harm were confirmed he immediately understood that she intended to take her own life. He desperately sought to dissuade her but had the devastating experience of being unable to do so.

In the meantime, police in the region at this time were attempting to locate Officer A by means of tracking her mobile telephone. These efforts were carried out promptly and effectively and Officer A's location was determined to be in a State Forest.

Tragically, however, when police located Officer A she was no longer alive. Toxicology testing later indicated that Officer A had also consumed a quantity of tranquiliser and anti-depressant drugs before hanging herself.

I now turn to consider the issues that Officer A's death has raised.

Officer A's mental condition

The medical and psychiatric evidence all demonstrates that Officer A was suffering from a Major Depressive Disorder with symptoms of Post-Traumatic Stress Disorder. Her history and all the medical and psychiatric evidence points to this diagnosis. There is no controversy about this issue.

The causes of Officer A's mental condition

Analysing the causes of Officer A's condition is a much more complicated exercise. During the inquest, one independent expert, psychiatrist Dr BB, suggested that the causes of Officer A's depression are open to speculation. On the other hand, another independent expert, psychiatrist Dr CC expressed the opinion that Officer A's depression was linked to her employment with the Police Force.

Both psychiatrists agreed that a number of matters may have contributed to the development and persistence of Officer A's mental condition.

Personality

A person's inherent personality traits are always a factor in their mental health. One of Officer A's personal attributes that made her a very capable officer was that she had a very high work ethic bordering on perfectionism. Officer A's work ethic and sense of professionalism seems to have been so intense that she gave work priority over many other issues, including her own health. Paradoxically, the intensity of her professionalism seems to have contributed to her illness. She was hard on herself and her judgments of others whom she perceived to be less professional in their attitudes could be harsh.

This may have undercut the support that she would otherwise have received. This very driven element of Officer A's personality was described by her treating psychiatrist, Dr E in his report of 20 January 2013, when he wrote:

'...Although not by nature harsh, Officer A seems to have grown that way towards herself and anyone or anything that reminds her of what she sees as her own unacceptable failings. Officer A does not view herself as legitimately injured-she views herself as weak. Officer A is much more concerned about her career than she is about her health..(and) her own survival. If Officer A makes another suicide attempt the next one will be driven by {1} a sense of shame at weakness and [2} anger at herself for having stupidly ruined her career...'

As a result of this very rigorous and exacting attitude, and her general personality, Officer A could be very a challenging and outspoken personality, unafraid to express her views bluntly to her superiors and others. This made her at times a difficult person to live with, work with, or supervise. While Officer A's inherent personality traits were important in this respect, some of these difficulties were created, or exacerbated, by workplace psychological injuries, by her management within the workplace and, more generally, police culture. More than one witness described Officer A as a perfectionist, and it appears that she held herself to impossibly high standards.

Dr E wrote in a report of 17 February 2013 that Officer A had a low tolerance for being sick, seeing doctors, taking sickies and had the idea that people rorted the system by pleading sick. In Dr E's view, which I endorse, this attitude does Officer A some credit.

Indeed, it was the notoriety of the 'rotting' of the workers' compensation system by some police officers that ultimately led to the changes in the system that disadvantaged Officer A.

Regrettably, however, Officer A applied these views just as, or even more, stringently to herself, viewing her own condition not as an illness but as a 'weakness' which she could deal with using willpower. As a consequence, she did not readily seek support from others, and was not comfortable discussing emotional or psychological problems. This adversely affected her ability to engage with those treating her.

Dr E considered whether Officer A had a personality disorder but ruled this out on the basis that she had been high-functioning and successful at work in the past. The independent psychiatrists agreed.

Dr E did, however, consider that a degree of 'personality decompensation' (i.e., regression of relatively normal personality function to a disordered state, under pressure of intervening psychiatric disorder and other stressors) had arisen, exacerbating Officer A's condition and her presentation.

Occupational effects

There is strong evidence that Officer A's depression was linked to her employment. In November 2012, Dr H, a local psychiatrist, concluded that Officer A's Major Depressive Episode and Post Traumatic Stress Disorder were a result of her exposure to traumatic events in the course of duty, and her claim in this respect was accepted by her employer.

What is more difficult to determine is whether the problems later (i.e. post August 2012) experienced at work by Officer A were a cause of her continuing depression or a consequence of it. Perhaps they were both. An analysis of the coincidence in timing between Officer A's depressive symptoms and events in the workplace is perhaps instructive:

The onset of Officer A's depression in February 2007 was at a time when she was suffering stress due to long hours commuting from work to home, and the demands of also trying to manage her children and household. Police work, especially for a person of Officer A's temperament, is inherently demanding. Adding several hours of travel to lengthy police shifts must have been exhausting. The risk of adverse health effects of long hours is well-known and can include depression.'

Officer A attempted to return to work in 2007 but on the very day she returned she became very upset and again went off sick when her supervisor refused to allow her to work without seeing a medical certificate.

She later returned to work following a transfer to a more convenient police station on compassionate grounds in 2007.

Officer A became depressed again in 2010 after witnessing traumatic events in the course of her duties.

Officer A relieved in Officer B's role, which she found stressful, during January 2012. Following an argument with him at work near the end of January 2012 she attended her GP with symptoms of depression.

In 2012 Officer A attended her GP with depression and reported 'pressure at work'. This appears to have coincided with stress about her workload and conflict relating to her desire that Ms. U continue to act in the role.

Officer A's attempted suicide occurred when she was trying unsuccessfully to return to work, was not coping and was involved in some conflict in the workplace.

The events that precipitated Officer A's suicide also involved conflict and problems in the workplace. It is difficult to conclude that any one or more of these work-associated incidents were the cause of Officer A's initial or ongoing depression. It seems more likely that these incidents were at times a contributor to that depression and at other times (and perhaps at the same time) an outward manifestation of it.

Other possible contributory factors

Dr CC thought that these injuries may also have played a role in the development of her depression. This is given further support by the evidence of at least one witness who said that Officer A often suffered from pain, associated with her injuries. Chronic pain is well-known to be associated with depression.

Officer A reportedly was drinking up to a bottle of wine a day from 2010. This was almost certainly an attempt on her part at self-medication.

Both experts agreed that this may have had an impact on Officer A's condition. Dr BB placed more emphasis on alcohol than Dr CC. In his opinion, Officer A experienced alcohol dependency, which is supported by some other assessments.

Although alcohol is believed to assist a person to sleep, it has a disturbing effect on the quality of that sleep.

Further, alcohol is a depressant agent in itself. It is not an anti-depressant medication. To what extent alcohol use affected Officer A's depression is difficult to say but it was not the primary cause of her depression. Rather, she overused alcohol in response to her condition.

Dr BB noted that there may have been a genetic component in Officer A's condition. Women are more likely to suffer from depression than men.

How management issues and her relationships with Officer Band Officer C may have affected her condition will be considered separately.

Management of Officer A's condition and return to work

It is in respect of the way Officer A was managed by the NSWPF, especially in relation to her suicide attempt in 2012 and her return to work in 2013, that her family expressed their gravest concerns and strongest criticisms. In summary, the systemic criticisms made by counsel for the family were as follows:

Police management failed Officer A in several respects related to staffing and workload issues, investigation of her suicide attempt, the management of her psychological injury or injuries, her return to work plans, and salary advice.

While the decision to have Officer A reviewed by a PMO was appropriate, the execution of the plan was not and was deficient in several ways. The medical care given to Officer A was deficient in a number of respects. In making the decision to move Officer A, and in carrying out that decision, Assistant Commissioner N failed to discharge his responsibilities to Officer A; and Officer B had an inappropriate relationship with Officer A that compromised his ability to manage her appropriately.

In answer, the NSWPF submitted that it acted carefully and with genuine respect for Officer A and her well-being, and with every intention of helping her recover. It also submitted that it acted appropriately both in what it decided to do and how it carried out those decisions. It says that Officer A's death was not predicted or predictable.

General management issues

(1) Workload

Counsel for the family argued that the unit was inadequately staffed and that the understaffing of the unit had contributed to Officer A's stress, thereby exacerbating her depression and PTSD. The NSWPF disputes this contention.

I am not in a position to resolve this issue. I do not doubt that Officer A's perception was that she was, at least at times, overwhelmed with work. But subjective perception may not coincide with a more objective institutional assessment. Much depends on the expectations of both the organisation and the individual. As far as I am able to tell, no one in her Command ever criticised Officer A for laziness, incompetence, lack of attention to detail, or indecisiveness. Nor is there any evidence before me that she was creating an unacceptable backlog or failing to meet KPI's (if there were any). She appears to have ruthlessly applied to herself a much higher standard than the organisation or her supervisors did.

Presumably the unit Manager and other middle managers were consulted about these sorts of issues. It may be that the support she was provided was indeed insufficient for her to maintain a high level of productivity in her own particular position and that she therefore took on work that would otherwise have been delegated. If so, she was effectively doing her own job and someone else's.

However, if she was therefore working much harder than *some* others in the office, it does not necessarily follow that the unit was understaffed. If police senior management had other staffing priorities and was prepared to accept a lower standard of productivity and output from the unit than Officer A was, that was a matter for them.

Concerning Officer A, the practical issue was more complex and psychological: how to stop her working so hard. In my view, it is likely that many of the staffing issues that exercised Officer A so much were a symptom of her condition rather than a significant cause of the decline in her condition.

Her perfectionism and other aspects of her mental condition, such as insomnia, led her to work long hours of unpaid overtime, regardless of strict directions and exhortations not to do so.

(ii) Failure to investigate suicide attempt appropriately

A second management issue that Officer A's family raised was the failure by anyone in management to initiate a formal P902 investigation into Officer A's suicide attempt. The general approach taken at the time was that, because Officer A had a pre-existing psychological injury, it was unnecessary to investigate this incident. On the day she died, Officer A filed a P902 report, alleging among other things, that her psychological injury resulting in the suicide attempt had been caused or exacerbated by the Injury Management Team.

In the period immediately following Officer A's attempted suicide there was discussion about the issue:

[A] Health and Safety Coordinator, Ms Y, believed that a P902 should have been filed, and she emailed Officer B on 4 December 2012 asking him to lodge a P902. Officer B said he would do so later that day. He then spoke with Inspector K who directed him to Ms L an Injury Management Adviser.

According to Officer B, Ms L advised that a P902 was not required as there was already an open injury file. Ms L gave evidence that she did not recall this conversation, but accepted it was possible it took place.

Officer B said that he accepted Ms L's advice because she was the 'expert' in injury management.

Ms Y said she also spoke with Inspector K about the matter, who told her she had been in touch with Ms G and the insurer to confirm the injury was being treated as a recurrence and a P902 need not be submitted.

Although Inspector K said she did not recall this conversation, she did not dispute it. Officer A raised the issue of the P902 not being submitted on a number of occasions:

On 3 May 2013 Officer A told the insurer she wanted to file a P902 and that the attempted suicide was as a result of poor injury management. Chief Inspector J spoke with Officer A on 8 May 2013, explaining the process and offering assistance including a discussion with the Region Commander. However, according to Chief Inspector J, Officer A told him that it was 'in the past' and that she did not wish to pursue the matter by submitting the P902.

It seems however, that Officer A was not genuinely satisfied with this situation. On 13 May 2013, she asked Chief Inspector J whether there was any investigation of the 23 November 2012 suicide attempt. According to Chief Inspector J, he spoke with Inspector K and Ms. G about the matter, and then told Officer A on 16 May 2013 that they were not aware of any such investigation.

The issue was still a live one on 23 May 2013, when Ms. G noted in an email that Officer A had expressed concern that there would be 'repercussions' if she submitted a P902. Some support for this view is perhaps given by the fact that Ms. G recorded in that same email that if a P902 was submitted, then she would immediately withdraw from Officer A's case. She apparently did not speak to Officer A about the issue however.

Chief Inspector J stated that he discussed the issue of an investigation with Officer A again on 29 May 2013, when she said that her previous discussion had resolved the issue, and she did not require further information.

However, this seems to be contradicted by the fact that on the morning of the death, Officer A submitted a P902 in relation to her 2012 attempted suicide, in which she alleged 'mismanagement of psychological injury' by staff attached to her region.

Ms. G believed that Officer A wanted to file a P902 in order to gain a further nine months of 'top up' pay. However, while this was probably one of Officer A's motivations, it appears that she was also concerned about whether there had been an investigation into the circumstances of her attempted suicide and whether the matter had been reported to Work Cover.

None of the witnesses could identify any disadvantage in submitting a P902. In oral evidence, it was acknowledged (by Ms. L, Inspector K and Assistant Commissioner V) that on reflection, the preferable course of action would have been to file a P902.

Clearly, those involved in Officer A's injury management (especially Ms. G) had good reason to resist a P902 being filed if it was going to allege that it was the actions of the Injury Management Team which caused or contributed to the suicide attempt. This was effectively acknowledged by Ms. G in her confidential email to Dr E on 3 June 2013, where she stated '*I would not submit a notification on her behalf, alleging myself, or her supervisor at the time, as the cause of her attempted suicide*'.

This comment demonstrates a clear conflict of interest in relation to Ms. G her stated reason for refusing to file a P902 being her concern that the P902 would allege that the suicide attempt was linked to mismanagement by Injury Management staff and others (including Ms. G herself).

A clearer conflict of interest is difficult to imagine, and it is surprising that Ms. G did not seem to accept this when she gave evidence in the inquest. This underlines the importance of there being a mandatory requirement for a P902 (or similar) notification in all cases of self-harm or self-harm attempts.

I doubt that the decision not to file a P902 was because of a conscious wish to avoid an investigation or was any part of an attempted 'cover-up', The Injury Management staff were well aware that Officer A or F could have themselves filed a P902 at any stage, so a 'cover-up' would have been futile.

It appears likely that Officer A was reluctant to do so because she didn't want to 'rock the boat' and was concerned about repercussions.

The relevant policy relating to the submission of a P902 (and other issues) was being revised at the time of Officer A's attempted suicide, including the *Guidelines for the Injury Management of all NSWPF Employees* and the *Injury Management Standard Operating Procedures* ('SOPs'). While the SOPS were not officially issued until June 2013, various Injury Management witnesses agreed that they were being applied 'in spirit' from late 2012.

The SOPs had the following effect: a new injury should be reported on form P902; a 'recurrence of injury' should be reported on a recurrence of injury form; if an 'incident' has caused a recurrence this should be reported as a new incident via a P902.

Neither the Guidelines nor a previous version of the SOPs made the distinction between a new injury and a recurrence.

The reference to this distinction suggests staff were aware of the new definitions at the time of Officer A's attempted suicide. And, in event (as already noted) the June 2013 SOPS were being applied in spirit from late 2012.

The SOPs state that a P902 form can be filed by any Police employee. It is required to be filed by the injured officer or his or her supervisor within 24 hours. The consequences of filing a P902 are that, first, the command, the insurer, injury management and the health and safety coordinator are all automatically notified of the injury; and, second, a P901 safety investigation is commenced, usually completed by the supervisor.

The P902 is also part of the injury reporting process that prompts the manager or commander to consider obligations to notify WorkCover pursuant to the *Work Health and Safety Act 2011*. Because a P902 was not submitted, no P901 safety investigation was commenced. As a result, no investigation was ever conducted into the circumstances of Officer A's attempted suicide until after her death.

It is extraordinary that no P902 form was filed, and that no investigation was ever conducted into Officer A's suicide attempt. As several witnesses agreed, a suicide attempt by an officer (especially where it occurs in the workplace) is clearly a most serious event. Short of an actual death, it is indeed difficult to envisage a more serious event. As several witnesses also agreed, one of the purposes of a P902 is to trigger an investigation, and an investigation into such a serious event would ordinarily be desirable (if not imperative).

In Officer A's case the very point of conducting an investigation would have been to find out why, despite being managed over a period of years for her pre-existing injury, she had taken such a drastic, life-threatening step at that time. What had been the trigger? What had changed in her situation? Had something gone wrong in her treatment? Had some significant feature of her illness been missed or misdiagnosed?

These questions needed to be investigated. Yet without further ado the pre-existing injury was presumed to be the root cause of her action. No one involved in Officer A's injury management satisfactorily explained why. Nor did anyone who gave evidence at the inquest take responsibility for this oversight. Nevertheless, virtually everyone who gave evidence on this topic conceded, at least with the benefit of hindsight, that an investigation should *have* been carried out. This was also conceded by the NSWPF.

The lodging of a P902 and the conduct of an investigation was not only desirable from the perspective of 'good staff management', but it might also (as more than one police witness agreed) have resulted in Officer A's suicide attempt being treated as a new injury.

If it had been so treated, then this would have meant that the 'clock' would have re-started, and Officer A would have had another nine-month period within which to return to work without suffering a pay 'drop down'.

No satisfactory explanation has been given for the failure to lodge a P902, and the failure to conduct an investigation into Officer A's suicide attempt.

While it is not necessary to single out any particular individual for criticism, this was a significant systems failure. Additionally, no notification was made to WorkCover until 7 June 2013, after Inspector K attended training on the subject and raised the issue with Superintendent W.

(iii) Officer A and the Injury Management Advisers

The management of Officer A's condition and return to work was complex. It is unusual for an officer to return to work after attempting suicide. Although neither Dr CC nor Dr 88 was critical of police management of Officer A's mental illness, there are some aspects of the process that were problematic.

The Injury Management Unit had a primary role in Officer A's return to work, being responsible for her case management with the goal of assisting her return to pre-injury duties. The electronic case management system ('OLJMS') notes show that staff spent considerable effort trying to manage Officer A's return to work. Ms. G, the Senior Injury Management Adviser ('SIMA') stated that Officer A's case took up more of her time than any other.

Officer A developed antagonism toward her initial RTWP because she was not happy with the way her return to work had been handled, ostensibly because Dr X 's report was not provided to her treating doctors but also because rapport between Officer A and Ms. L had been poor.

Because of this, and also because Officer A's case was becoming increasingly complex, in February 2013 Ms. G took over case management.

Ms. G met with Officer A and F in their home and discussed Officer A's plans to return to work in detail. At that time, Ms. G made enquiries with Dr E and drew up a proposed return to work plan.

However, following Officer A's abortive attempt to return to work on 15 March 2013, the relationship between Officer A and Ms. G began to deteriorate. Officer A blamed Ms. G for this failure and 'vented' her anger at her.

In my view, Officer A's criticism of Ms. G at that time was not justified. The nub of Officer A's complaint was apparently that Ms. G had not written into the return to work plan that Officer A was not to carry out any work in the unit. However, this was hardly a valid criticism. The return to work plan contemplated that Officer A would carry out particular work in a different section of the command office, (not the unit in which she had been working), which, by implication, meant that she was not expected to carry out work associated with that unit. (The question of the RTW plan is discussed in more detail below.)

Officer A's reaction when approached by Inspector M on 15 March 2013 (who politely asked if she should be in the unit) was very disproportionate to the significance of the issue. A proper response would have been for Officer A to have immediately complied with Inspector M's request, and left the unit to carry out her assigned duties as set out in the return to work plan. But her irrational response to Inspector M, and her complaint against Ms. G, is yet further symptoms of her illness, and of her fragility.

From May 2013 Officer A stopped responding to emails from Ms. G.

On 1 June 2013 and 3 June 2013 there was a frank email exchange between Dr E and Ms. G in which they described the difficulties they had had or were having with Officer A.

These communications were intended to be kept confidential between them. In Dr E's view this sort of exchange was an appropriate way of sharing experiences and it was necessary or desirable to do so as part of the attempts to manage Officer A effectively. He also felt he had a role in providing support to Ms. G.

Ms. G stated in her email of 3 June 2013 that Officer A left a suicide note which talked about an affair, and that the suicide attempt and the discovery of the affair were 'timely'.

In evidence Ms G accepted that her basis for speculating about the suicide note, which she had not seen, was not well founded, she also accepted that it was inappropriate to have provided information that could have been relevant to Officer A's treatment in a confidential way.

Ms G said in evidence that she no longer engages in such confidential communication with doctors and she has also advised other injury management staff to record all relevant information in OLIMS.

A further deterioration in the relationship occurred after Ms G sent Dr E an email on 18 June 2013 in which she stated, wrongly, that Officer A intended to change treatment providers. Officer A learned about some of the contents of this email from Dr E's receptionist and made repeated requests to see it.

Officer A contacted Ms G about this email on 1 July 2013. There was conflict in the evidence about the manner in which both Officer A and Ms G conducted themselves during this call. There is little doubt that Ms G was upset by the conversation (as was Officer A), and stated in evidence that she had broken down in tears when she had spoken with Inspector K afterwards. This event, when reported to Assistant Commissioner N, directly precipitated the decision to have Officer A assessed by the Police Medical Officer (PMO) and to consider moving Officer A from the command office.

Officer A was a forceful personality who held herself to high standards and expected others to do the same. Some staff said that they felt like they were 'walking on eggshells' around her after her attempted suicide. Some other staff also experienced conflict with Officer A, notably Inspector M on 15 March 2013 and Chief Inspector I on 17 June 2013. It is highly probable that Officer A's forceful personality and the effects of her mental condition contributed markedly to the breakdown in relationships with Ms L and Ms G.

Given the deterioration in the relationship with Officer A, it might have been appropriate for Ms G to have considered allocating another Injury Management Advisor (IMA) to take over Officer A's case.

Ms G said that she did not do this because she believed there was no-one more experienced than herself who could manage the case and because in any event, Officer A was gradually returning to work and relevant information could be obtained from the doctors.

Given the history of conflict with (the previous IMA) and with several other staff, it seems unlikely that such a change would have led to a sustained improvement in Officer A's management.

The email by Ms G to Dr Eon 3 June 2013 raises a number of issues of concern. Firstly, the confidential nature of this email exchange seems to have led to Ms G feeling free to inform Dr E of matters that (if the email had not been confidential or if it had been recorded on OLIMS) she would likely not have raised, or not raised in that way.

In particular, Ms G offered her own opinion questioning the diagnosis of PTSD. She also saw fit to raise her belief in there being some connection between Officer A's suicide attempt and an 'affair' which was referred to in a suicide note.

This suggestion of a suicide note making reference to an affair was, as is now known, completely untrue. The source of this rumour about the contents of the suicide note remains unclear. However, the falsity of this suggestion underlines the danger associated with 'confidential' exchanges of this kind which may have the potential in some cases to adversely affect an officer's treatment.

As a result of this experience, Ms G has revised the injury management practices which apply in the command office. Communications with treating practitioners can no longer be treated as confidential. (Presumably this does not exclude formal case conferences and the like.)

(iv) The Return to Work plan

It was argued by counsel for the family that either Officer A's Return to Work (RTW) March 2013 should have specified that she was not permitted to perform the duties of her substantive position, or there should have been no issue with her assisting Sergeant P with the work.

It was also submitted that Officer A should either have been treated like a 'normal' officer, and been permitted to assist Sergeant P, who was standing in for her in the unit, or have been placed in a 'special' category identified in the RTW plan.

Inspector M gave evidence that had he had access to the RTW plan, he would have worded it differently to make it more precise.

This may be so. But he made that concession with hindsight and during a cross-examination in which it was being implied that his conduct had in some fashion contributed to Officer A's downward spiral.

When considered objectively, the RTW plan set out, in positive form, a series of goals, parameters and activities that were intended to assist Officer A's recovery. It did not expressly prohibit her from visiting or working in the unit. It specified that her duties were in another unit.

It would have been unreasonable, in my view, for the plan to have specified all the duties that Officer A was *not* permitted to carry out. Taken to a logical extreme, they could have included everything from the duties of the Commissioner to those of the security guards at the Police Academy. In any event, a list of prohibitions, short or long, might be counter-productive. A plan that is intended to give an officer returning to work a positive program to look forward to might be implicitly undermined by a list of prohibitions and warnings, especially if they are designed primarily to protect management from potential criticism of this nature, rather than to help the injured officer.

In my view, Officer A's plan implied that the unit was not regarded by senior police management and the injury management staff as a suitable work environment for her. The fact that she had been highly stressed while working in the unit, and had attempted suicide in one of its offices, was a solid foundation for such a view. Whatever else may be said about those managing Officer A at this time, there appears to be no doubt that they had her best interests and her welfare at heart when they made their various decisions.

An officer on a RTW plan is, almost by definition, still at risk and is, therefore, in a 'special category'. His or her risk must be carefully considered by supervisors and managed. Had Officer A been allowed, despite the RTW, to work part-time in the unit and had a relapse or made another suicide attempt, any criticism of the supervisors for failing to prevent her from returning to a toxic environment would have been abundantly justified.

For welfare reasons, it made sense to direct Officer A not to spend time in another unit away from her other duties. Her reaction- again, symptomatic of her fragile condition - was highly disproportionate to the objective significance of Inspector M's intervention which, in my view, was reasonable in the circumstances.

From a general management perspective, it also appears to have been reasonable. If an officer has duties in a particular unit, it is reasonable for management to expect the officer to carry out those duties, not others that he or she would prefer to carry out at the time. I accept, of course, that police officers assist one another in their general duties but would not expect that officers in specialist units are free to wander about lending a hand in other units without supervision or direction. That would make management impossible. Nevertheless, whether it was spelled out in the RTW plan or otherwise, in hindsight it may have been prudent for those managing Officer A to explain why she was being moved and why they did not wish her to work in the unit at that time.

{v) Compartmentalisation of Officer A's care

The 'compartmentalisation' of different aspects of Officer A's care within the police force was criticised by counsel for the family as 'having deleteriously affected the capacity of individuals to discharge their responsibilities for Officer A's care, particularly upon and after her return to work in 2013.

There may be some force in this argument, although perhaps not as much as counsel suggests. Indeed, one of her strongest criticisms of Ms. G and Dr E was that they conferred and exchanged views about managing and treating Officer A and the difficulties they were having. The 'silos', as Ms. Lawson put it, were not quite as impermeable and separate as the argument implied.

Ironically, a formal example of the capacity of the injury management system to allow cross-referencing by the various involved parties is the conference on 2 July at which the decision was made to move her from the Regional office to Charlestown.

There is, however, a degree of compartmentalisation in the system. This is a necessary consequence of the confidentiality of therapeutic relationships between patients and their treating clinicians. Without that protection for patients, psychologically injured police officers could not be treated appropriately or adequately.

(vi) Salary advice

The NSWPF has conceded that Officer A did not receive timely advice about the reduction in her salary.

There is no doubt that this was a very important issue for her and the administrative error caused her considerable distress. As has been noted above this exacerbated her condition.

Whether intimate relationships contributed to Officer A's death one of the many unfortunate aspects of this case is that while Officer A was suffering from her condition, she had a brief affair with Officer C.

There is some evidence in the form of email messages and the like that raises a suspicion that she may also have had an intimate relationship with Officer B and possibly with Officer D. Ordinarily, these private matters would be irrelevant in a coronial investigation like this. As I stated during the hearing, this is not a court of morals. The issue became relevant, however, because of the possibility that these relationships may have contributed directly or indirectly to Officer A's death. It is also relevant because there may have been a conflict or conflicts of interest that affected the ways in which Officer A's psychological injuries were managed.

Both B and D were Officer A's direct supervisors, although Officer D was only for a few hours. Officer C was neither her direct supervisor nor was he in a direct line of command over her. Officer A and Officer C had met as junior police officers working at a Sydney Police Station many years before and had remained friends.

Officer B

During the investigation of Officer A's death, a large quantity of material consisting of emails, text messages and 'chat' messages between Officer B and Officer A was discovered. Given the nature of this case and the issues to be resolved, it is neither necessary nor, in my view, appropriate to outline more than a few details of these communications.

In summary, from about April until December 2011 Officer A and Officer B exchanged a large volume of email, instant chat and text messages. Officer A also communicated with Officer B via her second phone in 2012. The content of these messages is not known. Over time these messages became increasingly sexually suggestive. Each person initiated a thread of these messages at various times although Officer A was more often the initiating party. While some messages might be characterised as office 'banter', it is apparent that many were much more intimate.

Officer B gave evidence that he was aware that Officer A found these messages gratifying that she was attracted to him and that she was interested in having a physical relationship.

Physical contact occurred between them on 21 June 2011 (although Officer B claims that he was 'groped' without his consent on this occasion).

There is no direct evidence that physical contact occurred at any other time. After this event, Officer B continued to exchange suggestive messages with Officer A.

The sexual content appears to have ceased after Officer A relieved in his position in January 2012 and following an argument about her conduct at work on 31 January 2012.

In his evidence and the submissions made on his behalf, Officer B sought to convey the impression that he had not reciprocated Officer A's feelings or behaviours in any significant way. He claimed that on some occasions he had been engaging in ordinary office 'banter' or, on other occasions, to have been humouring her as some form of misguided management technique.

I find this evidence implausible. When read together, the messages of various types strongly suggest that, for a period, Officer A and Officer B had a mutually flirtatious relationship. Whether Officer B felt as attracted to Officer A as she apparently was to him is not to the point, his response was to encourage and stimulate the dalliance, not to dampen it down. His evidence that he had been affronted by Officer A's behaviour but had exercised his discretion not to report it did not ring true.

I accept that a person who has been 'groped' in the workplace by a colleague may not report it. There are many reasons why he or she may make this decision, not least, if the victim likes that person and is willing to forgive him or her, the embarrassment that it might cause the offending colleague or both parties. But Officer B's communications with Officer A afterwards were hardly discouraging of further advances and were, in that context, both flirtatious and inconsistent with his evidence at the inquest. Indeed, it does Officer B little credit that he accepts very little responsibility for the situation and entirely blames Officer A who, conveniently for him, cannot answer.

Whether there was a physical relationship between Officer A and Officer B is not clear. It is unnecessary for me to make any positive finding about that.

What is clear, however, because of the potential or actual conflict of interest that inevitably 'arose as a result, is that the type of relationship that developed between them was inappropriate for a supervisor and a subordinate colleague working in the same unit in the same organisation.

At some point around December 2011 or January 2012. The records indicate that the flirtatious relationship was abandoned by Officer B. Why he did so and the reason why he chose to do so at that time, he has not been explained.

In any event, Officer B appears to have realised that the way he had been communicating with Officer A was inappropriate from a managerial and professional point of view. As a man who valued his wife and marriage, he may also have had moral qualms about conducting himself in such a way. Certainly, it seemed apparent during the inquest that he cares very much about his wife and family and is remorseful for his conduct.

The effect, especially the long-term effect, on Officer A of Officer B distancing himself from her is difficult to gauge. Although some of the messages she sent him suggest that she accepted the new situation quite stoically, it would be hard for anyone to continue to work happily or enthusiastically in such circumstances. It is evident from her messages to him that Officer A felt rejected and disappointed by Officer B. In the circumstances she probably felt professionally isolated as a result.

Inspector Officer D

A series of suggestive and flirtatious email messages that had passed between Officer A and Officer D over a period of 19 days in August 2011 was discovered by the investigators late in the investigation. In many respects they were similar to messages exchanged between Officer A and Officer B during 2011. At the time Officer D had no formal supervisory responsibilities in respect of Officer A but he was superior to her in rank and working in the same building. He later supervised her and acted as her welfare officer for a period from December 2012.

What prompted the exchange of emails, which were full of double entendre and sexual innuendo, is not known. Officer D was too ill to attend the inquest. There is, however, no evidence that it led to a physical affair between the two officers.

Nor is there any evidence that this short period of inappropriate messaging adversely affected Officer A's mental state.

The relevance of this exchange is threefold: first, it lends support to Officer B's claims that there was a general nature of ribald or risqué 'banter' in the office at the time.

Second, if that is correct, the inference that might otherwise be available that B and Officer A were having an affair at that time cannot be drawn with any confidence.

Third, if there was a general culture of such sexualised 'banter' in the command office at the time, it ought to be a concern to senior police management. Of course, the investigators in this case did not conduct an audit of all emails, text messages and 'chat' passing between officers and civilian staff in the office at the time.

So how common this kind of 'banter' was at the time (or is now) is impossible to say. But the numerous scandals that have beset the Australian Defence Force over the years should be a warning to police forces of the dangers of allowing professional standards to be set by the lowest common denominators in a unit. As Lieutenant-General David Morrison, then Chief of Army, stated during the Army's 'Jedi Council' scandal, 'The standard you walk past, is the standard you accept. That goes for all of us, but especially those, who by their rank in have a leadership role.

Dr E, Officer A's psychiatrist at the time of her death, proffered the opinion that office affairs are much more common among police officers than in the general population. If that is so, it may need a psychological anthropologist' to explain this phenomenon and its effects on police officers.

Whatever the explanation, if affairs result in poor workplace cultures, that in turn undermines professional relationships, corrodes discipline and morale in a hierarchical organisation. This can lead not only to loss of mutual respect between supervisors and subordinates but, as the ADFs scandals have shown, to conflicts of interest, abuse of position and authority, and even to criminal offences, including sexual assaults.

Officer B's difficulty in asserting his managerial authority and properly taking responsibility in respect of Officer A from January or February 2012 is probably attributable in large part to his failure to keep his relationship with Officer A entirely on a professional level.

Officer C

It seems more than a coincidence that after the apparent breakdown of her relationship (whatever it was) with Officer B, Officer A had a brief affair with Officer C, who was an old friend. After a small number of meetings, Officer A terminated the relationship. There appears to have been no acrimony about this on either part.

Although it may have been another symptom of her deep unhappiness, the brief affair does not appear to have caused any great distress to Officer A at the time. It is much more difficult to discern to what extent it played on her mind over the following months. Officer C was not only Officer A's old friend but he was a friend of F's too. The complexities of such a relationship, as well as feelings of anxiety and guilt, must have affected Officer A.

Officer C was strongly criticised by counsel for the family. She contended that the relationship had created a potential conflict of interest and, in any event, because he was a senior officer was improper and not in accordance with the values espoused by the NSW Police Force as an organisation. Officer C was not Officer A's supervisor, nor was he in a position directly to influence how she was being managed or would be managed.

In this sense, there was no conflict of interest that could arise. There is no evidence or even suggestion that he misused his position to cut across lines of command to benefit or disadvantage Officer A.

The Coroners Court is not a military 'honour court' or a disciplinary tribunal because they fall outside the scope of this inquest, it is, in my view, inappropriate for me to comment further on the personal and moral issues that the relationship between Officer A and Officer C raises.

Medical and psychological treatment

Her medical records show that Officer A was treated in 2007 for adjustment disorder, anxiety and depression. She had rejoined the Police Force but been posted to a Sydney police station while her husband F was posted to a regional police station.

She was apparently informed that there was little likelihood of a posting to her husband's area. Interestingly, at this time she was willing to engage with and receive treatment from her GP, Dr Z and a psychologist Ms. AA.

This inquest, however, has largely concentrated on the medical and psychological care she received following her suicide attempt in November 2012. Counsel for the family argued strongly that this care was deficient in several respects. In particular, she was critical of Dr E, who was Officer A's treating psychiatrist, Dr Q, her treating psychologist, the Police Medical Officer, Dr R, who reviewed her on 2 July, and Ms. S, the psychologist who reviewed her on 2 July.

In relation to Dr E, the main criticisms made were that he had been slow to recognise that he was not making progress in engaging Officer A, that he had been 'somewhat arrogant' in presuming that no one else could treat her, and that he had divulged aspects of his care of Officer A to Ms. G in an inappropriate manner.

Dr E explained that the exchange with Ms. G had been similar to those he might have with a junior member of a clinical treating team. He said that treating patients with mental health issues could be difficult and that psychiatrists were trained to support members of the treating team.

He said that he had been trying to provide Ms. G with support by letting her know he understood how she was feeling and allowing her to vent her feelings. His comments had been made strictly confidentially to Ms. G to assist both of them sort out their feelings and to obviate them distorting the relationship with Officer A.

In the exchange, both of them vented feelings about the problems they had been experiencing in seeking to treat or manage concerning Officer A. Provided that such discussions do not contaminate or prejudice the treatment of the patient, this approach seems appropriate and reasonable.

Indeed this criticism of Dr E seems somewhat inconsistent with the argument that there should not be 'silos' of care for injured police officers. While there are ethical limits on what can be disclosed by a clinician about a patient's confidences, it is obviously appropriate for those involved in a rehabilitation or return to work program to discuss the mutual issues concerning patients with a view to solving any problems that may arise in the course of the program.

In contrast with her attitude in 2007 when she engaged with her therapists, in 2012 Officer A seems to have been determined to resist their attempts to engage with her.

She expressed contempt for weakness in others and seems to have been determined to show no weakness in herself to anyone. Why her attitude towards herself had by 2012 become so remorseless is impossible to say. But a clue may be found in tensions within police culture between those who (notoriously) seek to 'rot' the workers' compensation system and those who have too much professional pride to do so. She was very much of the 'proud' school.

Dr E was not slow to recognise that he was making little headway with Officer A. But he also recognised the primary impediment to progress was that Officer A did not appear to want to engage in the process. She did not want to undergo therapy. She wanted to get back to her full duties without further ado. In my view, it was not arrogance that led Dr E to keep trying with Officer A, it was the sense that she was unlikely to engage with anyone involved in her return to work program.

That was demonstrably the case- she did not engage with him, with Dr Q or with Ms. G, Dr E was unable to think of anyone to whom he could refer Officer A and, in any event, if he did so, that person would have had to start all over again.

It seems highly unlikely that Officer A would have been content to do that.

Dr Q first saw Officer A on 5 December 2012. He did not feel he established a good rapport and perceived a number of 'red flags', including her disappointment at having survived her suicide attempt, her strong motivation to return to work and her resistance to being helped. He felt there could be aspects of her condition that were beyond the range of his speciality, including possible personality problems. As a result he referred Officer A to Dr E and asked him to see her sooner rather than later. Dr E saw Officer A on three further occasions in 2013, when he began to introduce strategies for coping with stress, and for developing resilience.

Dr Q finally saw Officer A on 24 June 2013. At that appointment Dr Q reported that Officer A had variable mood, and that she had also made a veiled threat that if it doesn't all work out she will do it again (attempt suicide). However, he did not assess her as at particular risk of suicide.

At that appointment, Officer A was talking about enrolling in a PTSD clinic at Westmead Hospital and had booked a future appointment. This indicated a reasonably positive outlook on Officer A's part, suggesting that she could see a better future ahead of her.

Dr Q's assessment and approach was reasonable, appropriate to Officer A's best interests.

Dr E described Officer A as a uniquely difficult patient for him and said that his impression was that others found her to be difficult also. Ms. G gave evidence that she spent more time on Officer A's case than on any other. Ms. G took over the case from Ms. L because she felt that Officer A's case was so complex it needed her experience as Senior Injury Management Adviser to manage it. There can be little doubt that all those charged with treating and managing Officer A's condition and return to work program did their best to help her and to find solutions to the problems.

Both the independent experts who reviewed the case, Dr's BB and CC, considered that the care and treatment the clinicians provided Officer A were appropriate and reasonable. I agree with that assessment.

Review by Police Medical Officers on 2 July 2013

The review by the Police Medical Officer, Dr R, and Ms. S is a classic demonstration of the unpredictability of suicide. But it was also a flawed process. In particular, Dr R came to a view, which he expressed to Officer N and others managing Officer A that her suicide attempt may not have been genuine. And he did so without specialist qualifications in psychiatry and without conferring with Dr E or Dr Q who had a much better understanding of Officer A's history and complex psychology than he did. His impression came from her 'matter of fact' demeanour when giving her account of the suicide attempt and his doubts were also reinforced by what he called a lack of 'corroboration'.

This was a curious state of affairs. Dr R knew that Officer A had been referred by people who were much more familiar with her and her history than he was. He also knew or should have known that she had been referred for assessment due to concerns they held that she was at risk because she was repeating behaviours that had preceded her suicide attempt in November 2012.

He agreed in his evidence that it is better to err on the side of caution before expressing the kinds of view that cast doubt on the previously accepted understanding.

But he did not adequately explain why he had not applied the precautionary principle of assuming, until proven otherwise, that the November incident had been a genuine attempt or why, if his doubts about the genuineness of the attempt were strong, he did not consult Dr E or Dr Q or both for their views. His justification for not doing so, namely that Officer A was not being returned to full duties, was both lame and irrelevant. On all the evidence available both then and now, Officer A's suicide attempt was genuine. His impression about that was wrong and it led him to underestimate the risk.

While his assessment at the time he saw Officer A was that she was then unlikely to harm herself, and this may have been accurate at that moment, because he discounted the November attempt, the advice he gave to Officer N implied that Officer A's risk level was lower than it actually was.

It is well known that a previous suicide attempt is a significant risk factor and, in the circumstances, it should not have been under-rated. The consequence was that Dr R's advice to the Region commander was considerably more reassuring than it ought to have been.

This is not to suggest that Dr R caused or was responsible for Officer A's death. Her decision appears to have been relatively spontaneous, and made at or shortly after the meeting on the morning of 3 July. But Dr R's assessment of Officer A was flawed and contributed to the failure of a process intended to protect Officer A.

Ms. S, on the other hand, thought that Officer A's attempt had been genuine and she proceeded on that assumption. She applied the MMPI tests, a rigorous, but not infallible, personality test. It indicated that Officer A was truthful in claiming to be reasonably positive in her outlook. She also interviewed Officer A at some length. This supported the test results. Ms. S's view was that Officer A, at the time of the assessment had no current suicidal ideation or plans and had 'turned a corner'. Her overall impression was that Officer A's outlook was positive.

Significantly, during the interview, Ms. S asked Officer A what she would do if she was required to move from her current location for work at which point Officer A had tears in her eyes and said, 'I just wouldn't go to work - I'd go off sick'. Ms. S said Officer A appeared to be genuine when she said this. Ms. S did not explore this response further other than to discuss with Officer A who would be an appropriate person to whom she could raise her concerns about moving locations.

In this context, Ms. S asked about her then supervisor, Officer J, and Officer A said something like, 'He's all right'. Officer A's comment to Ms. S about what she would do if she was relocated did not of itself indicate any intention to self-harm. The independent experts were divided about the appropriate response. Dr CC thought that the comments should have been explored further, whereas Dr BB was not critical of Ms. S and noted that the comment could be viewed in a positive way (as being counter-indicative of suicidality).

These views are not mutually exclusive and are probably both right

One of the acknowledged problems of risk-assessment is that suicide is virtually impossible to predict accurately even for patients assessed as being in the 'high-risk' category in psychiatric units according to standard risk assessment tests and by way of clinical examination. Only a small proportion of patients assessed as being in the high-risk category commit suicide. And some patients assessed as being in the low-risk category do commit suicide.

Clinical assessments of this nature are essentially slices in time. Of course, they are coloured by a patient's history but they have very limited value as predictors of suicide. Some suicides are impulsive acts. In other cases, the suicide may be planned but the victim conceals his or her intentions from family members and clinicians. On 2 July 2013, at the time that she saw Dr R and Ms. S, it may have been true that Officer A was not ruminating about or planning her suicide.

I make no criticism, express or implied of Ms. S, who appears to have conducted a careful and thorough assessment. Nevertheless, in hindsight, it would have been better for Ms. S to have advised the Region Commander, Officer N, or those advising him, of Officer A's remark about going off sick if she were moved.

This would have given the region a chance to prepare an appropriate response, such as advising F, seeking his presence and help in letting Officer A down as gently as possible or providing her with some other effective means of support.

The meeting on 3 July 2013

In my view, Officer N's decision to move Officer A out of the Northern Region office was reasonable and considered. Objectively assessed, the plan to move her temporarily to another police station was both pragmatic and compassionate.

Relationships between Officers A and a number of people in the office was poor. Some people in the office felt that they were 'walking on eggshells' because of her volatility. As Dr E put it, the situation had become 'untenable'.

For the good of everyone, this needed to be addressed by the Region Commander.

Although Officer A was unable to recognise it, the environment was toxic for her and for others. Moving to another police station, away from people, including 'bosses', whom she did not like, would have provided her with a new start, doing real and meaningful work with a supportive team. The move was not planned as a permanent one but as a circuit breaker to be reviewed in three months' time.

The immediate execution of the plan, however, although well-intentioned, was not well thought through. It was entirely predictable, and indeed was predicted by Officer A, that she would be resistant to any proposal to move her out of the (the police station in which she was working]. It was almost inevitable that she would feel slighted, isolated and alienated if the decision to move her was taken. That she would react angrily and emotionally was a racing certainty. It was therefore imperative that she go to the meeting feeling that she had someone on her side, someone whom she could trust to understand her point of view and to put it to police management.

Although she had nominated Officer J as a person to whom she could talk if the question of a transfer or move was raised, to appoint him as one of the two representatives of the Region Commander was a mistake. The intention, of course, was to demonstrate that management cared about her and was trying to help her recover.

And, to be fair, this was no mere demonstration; the concern for her was genuine. But Officer J could not simultaneously act as her support person and one of the delegates of the Region Commander without a conflict of interest arising.

Had F been invited to be present at the meeting and to support Officer A it is possible that she would not have felt so bereft or have taken such a drastic course. A decision had been taken by the group managing Officer A, however, that he would be her domestic support person and that someone else in this case Officer J would be called in as her support person for the meeting.

Although I believe both senior officers behaved compassionately and kindly towards Officer A, they could not sugar what for her was a very bitter pill. As far as she was concerned that morning, she was being expelled from the group to which she wanted desperately to belong. Hence she needed someone to whom she could turn in the crisis and who would be an advocate for her. But that morning she clearly felt she had no one. Even Officer J, in whom she had previously expressed some confidence, appeared to be against her.

An obvious lesson to be learned from this terrible experience is that in such delicate situations conflicts of interest, real or perceived, must be avoided, and that support persons must be exactly that.

The search for Officer A

No criticism can be made of the efforts by police to find Officer A. Indeed, it appears to me that officer F has exercised his detective skills in consummate fashion in working out Officer A's movements and intentions. Sadly, those skills and the police ability to triangulate Officer A's telephone calls were not enough to save her.

Lessons learned

Several lessons can be learned from this case: First, attempted suicides or acts of self-harm or attempted self-harm by police officers should *always* be investigated. They should *never* be presumed to be a recurrence of a pre-existing injury. If an officer has a pre-existing psychological injury that is being managed one of the primary questions for investigation is whether or not the incident or attempt is a fresh injury or a recurrence.

Second, even if the attempt flows from a pre-existing injury, investigation of the circumstances should prompt an immediate reassessment of the case including the diagnosis, treatment and ongoing management of the officer.

Third, assessments by PMOs and police psychologists of officers suffering psychological injuries should ordinarily include, when reasonably practicable, consultation with the officers' treating clinicians to ensure that the PMO and psychologist (a) obtain a full understanding of the officers' histories; (b) undertake risk assessments on a fully informed basis; and (c) provide advice to commanders and injury managers that is based on the best available information.

In cases such as this where the reason for the assessment is that supervisors or commanders are concerned for the officer's safety from self-harm, consultation with the treating clinicians should be considered a priority for the purposes of assessment.

Fourth, where treating clinicians have difficulties engaging officers suffering psychological injuries in appropriate treatment programs, consideration ought to be given to holding regular case conferences with relevant staff including supervisors, to assess progress, identify problems and to investigate possible solutions. Such a process might also include engaging with spouses, welfare officers and support persons, as the case may be.

Fifth, conflicts of interest arose in Officer A's case in at least three ways: Officer B's overly familiar relationship with Officer A gave rise to a potential conflict in managing the unit; Ms. G was conflicted in relation to the P902 report concerning Officer A's suicide attempt; and Officer J was placed in the invidious position of being both the messenger with the bad news and the support person at the meeting on 3 July.

Although there is a Conflict of Interest policy that is meant to guide the actions of police officers, there appears to be a surprisingly widespread ignorance both of the rules but, more significantly, of the underlying principles and rationale for the rules within the organisation. If this case is any indicator, even some senior officers do not appear to be able to recognise even obvious examples of potential or actual conflict of interest. This is not to criticise individuals - if my impression is correct, it is an indication of a flaw in the culture of the organisation. If that is the case, the implications for the management of the Police Force are profound.

Sixth, at present, when a P901 investigation is carried out, it is frequently and perhaps usually carried out by the officer's supervisor. In some cases, however such as this one, there is potential for conflict of interest to arise.

An officer's supervisor(s) may have contributed directly or indirectly to causing the injury.

At least in relation to serious injuries, especially psychological injuries, consideration ought to be given to obviating that risk by having the investigation carried out by a more independent officer, such as an officer from another specialist unit or command.

Seventh, in meetings (and other situations) in which an injured officer might want or require support because his or her interests are at stake, a support person who is independent of the supervisor or commander making the relevant decisions, and who is specifically nominated by the officer, and who is willing to act in the role, ought to be made available at those meetings if reasonably practicable. This would be protective both for the officer concerned and the commander.

The Police Force is a close knit community. Many of its members are young. The job is at times stressful, exciting, challenging and even dangerous. Police officers rely heavily on those with whom they work and form close relationships as a result. They work shifts. They see and do things that few others in the community understand or ever observe.

They understand one another's experiences and therefore many police officers marry or partner with other officers. But, as I have observed above, affairs can be deleterious to the organisation. In my view, the Police Force may need to consider its own culture to ensure that officers are not placed in positions of conflict, are not psychologically harmed and that professional relationships are properly maintained for the good of the organisation and the community more generally.

Eighth, there does not appear to be a satisfactory rationale in the Critical Incident Guidelines for distinguishing between the use of service weapons to attempt or commit suicide and other lethal methods. If the intention is the same and the outcome is the same, the means seem to be a detail rather than an essential element.

Ninth, the income protection schemes for NSW police officers operate in different ways and may, in some respects, be unfair or disadvantageous to certain groups of officers. F has suggested a recommendation under the Coroners Act that the scheme be reviewed by an independent person. While income protection issues were a concern of Officer A's, the inquest did not explore the scheme in detail.

The NSWPF submitted that because the Police Blue Ribbon Insurance Scheme is not owned by it but by the insurers it is not in a position to review the terms of the agreement. In my view, the Police Association is much better placed than a coroner both to understand the scheme and to consider how it should be reviewed.

A number of other suggestions for recommendations to the Minister for Police and Commissioner were circulated by Counsel Assisting and counsel for the family.

I have considered them all as well as the responses by the NSWPF. The recommendations I propose to make are based on the lessons I have referred to above.

Conclusions

Officer A's death was sad. She was only 43 and should have been in the prime of her life. She left behind two beautiful children and a devoted husband who are grief-stricken not only by what happened to Officer A but by how her life fell apart.

The sense of loss is compounded by a sense that perhaps there might have been a different outcome. The great English writer Samuel Johnson, thinking about grief and loss wrote:

But for [grief] there is no remedy provided by nature; it is often occasioned by accidents irreparable, and dwells upon objects that have lost or changed their existence; it requires what it cannot hope, that the laws of the universe should be repealed; that the dead should return, or the past should be recalled.

This seems to capture precisely the feelings of so many who knew Officer A and who have participated in this inquest all of whom wish in their hearts that 'the laws of the universe should be repealed' and that Officer A would return.

Officer A was afflicted with a mental condition that cannot be attributed to a single causative factor. Indeed it would be surprising if things were that simple. Her Major Depression (with elements of PTSD) resulted from a combination of factors.

First of all, she was a person who was more prone to the condition than others, by reason of her personality, her perfectionism, and her inability to engage help from others. Secondly, she worked in an occupation which exposed her to events that would be traumatic and depressing to even the hardest individuals. And thirdly, she ended up in a workplace where there was always work to be done, and constant pressure (partly self-imposed) to complete it in a timely manner.

At the same time, Officer A was trying her best to manage (with her husband) the demands of raising young children.

On top of all this there is evidence that Officer A was, during 2011 and 2012, engaging in some type of intimate relationship with at least two other officers - and was perhaps experiencing stress and guilt associated with this.

However, it is also likely that Officer A's mental condition was in large part brought about and exacerbated by her employment with the NSW Police Force.

This conclusion is supported in particular by the opinions of Officer A's treating practitioners, in particular Dr E, who somewhat presciently said in his report of 20 January 2013 that- *'Officer A is much more concerned about her career than she is about her health. Officer A is more concerned about her career than she is ~~about~~ her own survival'*.

F movingly described how much Officer A loved policing and how important being a police officer, a fully-functioning officer, was to her. She was difficult to manage partly because of her personality but also because she refused to behave like an invalid or disabled person.

He also described how she preferred to run towards danger when others were running from it. She was very strong in some ways but also very vulnerable.

Although, in my view, there is no such thing as 'closure' after such a tragedy, F and his children may take some comfort from the fact that their concerns have been listened to and some lessons have been learned from Officer A's life and death that may help reduce the risk of harm for other police officers.

Finally, I hope that he and his children will accept the sincere and respectful condolences that the coronial team and I offer them.

Formal Finding

I find that Officer A died on duty as a police officer on 3 July 2013 as a result of external neck compression due to self-inflicted hanging in the (State Forest), New South Wales while suffering from a work-related Major Depressive Disorder and Post-Traumatic Stress Disorder.

Recommendations s82 Coroners Act 2009

1. That the Commissioner revise relevant policies and procedures, including the Injury Management Standard Operating Procedures, to require that any known act that has been identified as an act of suicide or attempted suicide by an officer of the NSW Police Force is (i) reported to the Region Commander or equivalent officer within 24 hours of the incident coming to notice;

(ii) that that officer then ensures that a P902 report form is submitted as soon as practicable; and (iii) that the incident is then subject to a safety investigation in accordance with the procedures encapsulated in the P901/P902 process.
2. That the P901/P902 process in respect of Suicides and attempted suicides should include investigation not only of the incident itself but also, if the injured officer has suffered from a pre-existing injury, should result in an urgent reassessment of the case including diagnosis, treatment and ongoing management of the injured officer.
3. That, in relation to attempted suicides and other serious psychological injuries, consideration is given to obviating the risk of conflict of interest by having the investigation carried out by an independent officer, such as an officer from another specialist unit or command, rather than by the injured officer's supervisor.
4. That assessments by Police Medical Officers and police psychologists of officers suffering psychological injuries should ordinarily include, when reasonably practicable, consultation with the officers' treating clinicians to ensure that the PMO and psychologist (a) obtain a full understanding of the officers' histories; (b) undertake risk assessments on a fully informed basis; and (c) provide advice to commanders and injury managers that is based on the best available information. In cases where the reason for the assessment is that supervisors or commanders are concerned for the officer's safety from self-harm, consultation with the treating clinicians should be considered a priority for the purposes of assessment.

5. That where Injury Management Advisers or treating clinicians have difficulties engaging officers suffering psychological injuries in appropriate treatment programs, consideration be given to holding regular case conferences with relevant staff including supervisors, I MAs, and clinicians to assess progress, identify problems and to investigate possible solutions. Such a process might also include engaging with spouses, partners, welfare officers, support persons and others as the case may be.
6. That urgent consideration is given by the NSW Police Force both to amending the Conflict of Interests Policy (see next recommendation) and to ensuring that all senior officers are educated in the fundamental principles concerning conflicts of interest and in recognising and resolving potential conflicts.
7. That the NSW Police Force 'Procedures for Managing Conflicts of Interest' be amended so as to add the words "or other ongoing intimate" after the word "domestic" on pages 12 and 24 and add the words "or other persons in an ongoing intimate relationship" after the word "spouses" on page 24.
8. That the Commissioner take steps to provide further training and instruction regarding the operation of the 'Procedures for Managing Conflicts of Interest' (in the amended form as suggested above) so as to raise awareness of the requirement to identify, and manage, the potential conflict of interest which may arise where a domestic or other intimate relationship exists between two police officers.
9. That in decision-making meetings in which an injured officer might want or require support because his or her interests are at stake, a support person who is independent of the supervisor or commander making the relevant decisions, and who is specifically nominated by the officer and who is willing to act in the role, ought to be made available at those meetings if reasonably practicable.
10. That consideration is given to amending the Critical Incident Guidelines to remove the distinction between incidents in which officers use their service weapons to attempt or commit suicide and those in which other lethal methods are used on the basis that the implement is a means to a common end.

4 & 5 243783 & 267697 of 2013

Inquest into the death of ST and RS. Findings handed down by Deputy State Coroner Dillon at Glebe.

Introduction

These are joint inquests into the deaths of ST and RS, a married couple with a small child. Unfortunately, for reasons that are not clear, in the early hours of 10 August 2013, Mr S lost his temper and killed Ms T by strangling her.

About a month later, while remanded in custody awaiting trial on a charge of murdering Ms T, Mr S committed suicide.

Inquests are mandatory in homicide cases and also when a death occurs in custody: s 23 Coroners Act 2009. As the two deaths are closely related, the inquests are being dealt with together.

The coroner's functions and the nature of the inquest

An inquest is an independent judicial inquiry by coroner. When a person dies violently or unnaturally, the Coroners Act requires that it be reported to a coroner. If the death is a suspected homicide, and a person is not tried for the killing, an inquest will be held. Both the bereaved family and the wider community have a profound interest in learning how the death came about and how it was investigated. This public inquest is a demonstration of the value placed on human lives- the lives of those who have died but also of those who mourn for the dead--by our society and institutions.

Deaths in custody raise different considerations. When a person to whom the state owes a particular duty of care dies in the custody of the state, questions can and should be asked. Loss of liberty is the greatest punishment that our society can impose on a member of this community or visitors to it.

Courts are only permitted to deprive a person of their liberty if they are proven to have committed serious criminal offences or if they are suspected of having committed serious offences and the safety and welfare of the community is reasonably considered to be in jeopardy if they remain free.

The corollary of this extraordinary state power to detain people in custody is the responsibility to care for and protect prisoners. If, for whatever reasons, the system intended to protect prisoners fails to do so, s 23 of the Coroners Act 2009 requires that an inquest be held.

At an inquest, a coroner is obliged to make findings, if possible, as to the identity of the person who has died, the date and place of death, the cause of death and the manner or circumstances of death. In this case, it is the manner and circumstances of these deaths that raise the difficult questions. If it appears necessary or desirable to do so, a coroner may also make recommendations to relevant persons or organisations.

The death of Ms T

ST was a 30 year old woman. RS was a 38 year old man.

They were married in June or July 2007 at Patala Village, Punjab India, where Mr S and his family lived. Ms T had grown up in a nearby village. The marriage was arranged in traditional Indian fashion by Mr S's uncle, the head of the family. By all accounts both parties were happy with the marriage. On 6 December 2008, Ms T and Mr S arrived in Australia from India through Kingsford Smith Airport, Mascot on Student Visas. On 22 March 2011, Ms T gave birth in Australia to a child named MS, the first and only child of the couple.

On 29 June 2012, Ms T lodged an application for Permanent Residency under the Regional Sponsored Migration Scheme with Mr S and MS listed as dependents on the application. The sponsor was Golden Scissors Hair Dressing Australia Pty Ltd. In October 2012, Ms T returned to India with MS. Due to work commitments of both Ms T and Mr S, Ms T left MS in the care of Mr S's family in India so that she could return to Australia and continue work without the need to arrange care for the child while she and Mr S worked.

In December 2012, Ms T made arrangements to be sponsored and work for Breeze Hair and Beauty Salon, Ingleburn. Temporary Sponsored Work Visas were applied for by Ms T and Mr S and were granted on 07 January 2013. The visas were valid through to 07 January 2017.

On 16 January 2013 the Department of Immigration received notification via Migration Agent, Mr Nishant Malik, that the application for permanent residency had been withdrawn.

On 11 February 2013 Mr S was offered employment as a subcontractor, cleaning McDonald's family restaurant at Gregory Hills. The manager of SBS Maintenance Service, Wisam Sadik, was aware that Ms T would help Mr S to clean the store.

In March 2013, Ms T and Mr S moved into a unit at 18/4 Dotterel Place, Ingleburn. The unit was shared accommodation with Ms T and Mr S occupying one room; Matreet Kaur, Parmjeet Mr S and their child Harsiman Mr S occupying a second room and CS, the nephew of Ms T and Mr S, who occupied the final room.

On 20 March 2013, Mr Nishant Malik advised the Department of Immigration that he had ceased representing Ms T in the application for permanent residency.

During April 2013, Wisam Sadik spoke with Ms T about cleaning the McDonalds Restaurant at Narellan. Ms T agreed to clean the Narellan store with Mr S. The normal routine involved Ms T and Mr S cleaning the Narellan store after closing at 11:00pm on week days and 12:00am on weekends. They would then attend the Gregory Hills store between 2:00am and 2:30am to clean.

On 12 April 2013, Golden Scissors Hair Dressing advised that they had withdrawn sponsorship of Ms T. On 4 June 2013, the Department of Immigration received information that Ms T had paid a salon owner \$25,000 for sponsorship. It was unable to substantiate or verify which sponsor was alleged to have been paid. The Department was also told that Ms T was undertaking other work on a casual basis.

On the morning of Friday 9 August Ms. T attended her workplace at Breeze Hair and Beauty. Whilst at work Ms. T asked her employer if she could obtain a price for flights to and from India.

She explained that Mr. S's mother was ill and that he was planning on returning to India to visit his sick mother. Ms. T was upset by this as she did not want to be left alone and be apart from Mr. S. She did not want to travel with Mr. S as she was saving money so M could return to Australia to live with them. Ms. T also spoke with Wisam Sadik who approved leave for Mr. S. Throughout the remainder of the day, Ms. T appeared in good spirits.

At about 6:00pm on Friday 9 August 2013, Ms. T finished work at Breeze Hair and Beauty and was picked up by Mr. S. They returned to their residence and later that evening went to bed. Mr. S was unable to sleep due to working long hours and feeling confused.

He woke Ms. T and told her he wanted to go to work early and start cleaning. This made Ms. T angry as she wanted to remain in bed and go in to work later that morning. Nevertheless, she accompanied Mr S to McDonalds Gregory Hills. They arrived at the restaurant about 12.21 am on Saturday 10 August 2013. At the time there were three employees working: the Manager Gabriella Zavaglia as well as Sean Byers and Kelsea Heinjus.

At 1:08am on Saturday 10 August 2013 Mr. S was captured on CCTV footage entering the rear female staff toilet cubicle with Ms. T following close behind. Once in the cubicle, Mr. S locked the toilet indicator bolt door lock He immediately grabbed Ms. T around the neck with his right hand, squeezing her throat and neck Ms. T said "Why are you doing this? What are you doing this for? Let me go, let me go".

Mr. S did not reply and continued to squeeze Ms. T's neck He held Ms. T's throat for several minutes until he felt her stop breathing. He then placed her on the ground face up. Ms. T started to shake her head and convulse. He placed his right foot across her neck and throat using his body weight to push down. He held his foot on her throat for about two or three minutes until she stopped moving. Then he removed his jacket and tied it around his own neck, attempting to strangle himself.

At about 1:55am Ms. Zavaglia asked Mr. Byers to look for the cleaners. He heard noises behind the locked toilet door and alerted Ms. Zavaglia. She manipulated the lock to open the door. She found Ms. T lying on her left side. Mr. S was in a seated position with his legs over her body.

He had a maroon jacket tied around his neck which he was twisting in a further attempt to strangle himself. Ms. Zavaglia screamed for help. A number of customers assisted with CPR and contacted "000".

Police arrived at 2:09am and continued CPR. Ms. T was found to be breathing and was placed in the recovery position. An ambulance arrived shortly afterwards. Mr. S was escorted from the restaurant and was placed under arrest. He was seen to by paramedics before being conveyed to Liverpool Hospital for treatment where he remained under police guard.

At 2:25am Ms. T's body was removed from the toilet cubicle and conveyed to Campbelltown Hospital where she was pronounced life extinct at 3:31am.

As a result of the investigation, RS was charged with the murder of ST. He was transferred to Silverwater Correctional Centre on and housed in Cell 585 within the Mental Health Screening Unit (MHSU) under the care of a psychiatrist.

Up to this time, it seems that to all outward appearances that Ms. T and Mr. S had had a loving relationship. There is no known history of violence by him towards her.

Nor is there any evidence of bad blood between Mr. S and Ms. T. Why he acted in such an extreme manner is therefore a mystery. There is nothing known to the investigators that might have predicted this terrible event. Clearly a person like Mr. S does not act like that without a great deal of underlying pressure having built up. The only thing known to have caused tension in the relationship was having to leave MS in India. It is reasonable to assume that the impermanency of their immigration status was another stressor on both Mr. S and Ms. T and their relationship. The long hours of work, the constant night shifts, the crowded accommodation and the sheer drudgery of cleaning work also probably added to whatever psychological load Mr. S felt he was bearing. And there had been an argument earlier during the night.

For all of that, there is no clear explanation for Mr. S's behaviour that morning.

There is no evidence of pre-meditation. It appears that, for whatever reasons, Mr. S simply "snapped", completely losing his temper with Ms. T.

The death of Mr S

At about 09:45pm on Tuesday 3 September 2013, Correctional Officers were conducting head checks in Pod 20 at the MHSU.

Whilst attempting to communicate with Mr. S, Correctional Officers looked through the small window on the cell door and saw Mr. S's feet in the doorway of the bathroom. He did not respond to any verbal direction so Correctional Officers opened the cell door. They found Mr. S hanging by his neck from a handrail in the adjacent bathroom. A piece of material, later identified as part of a pillow slip, had been secured to the top disability hand railing in the bathroom and the other end around his neck Mr. S was in a seated position on the floor below the hanging point.

The material was cut by Correctional Officers before placing Mr. S in the recovery position. His face was pale, his lips were blue and he was cold to touch. Justice Health Staff attended a short time later. No signs of life were found. NSW Ambulance and Police were notified and a crime scene was established. There was no indication that the death was suspicious in nature.

Issues

The main question concerning the death of Ms. T is why Mr. S killed her.

The main issues surrounding the death of RS are to do with the risk assessment, his classification for a one-out cell placement and why he was placed in a disabled cell.

Risk assessment

Directly after the murder of his wife, Mr. S was found trying to harm himself with the intent of taking his own life.

In custody, however, during subsequent placement interviews, he denied suicidal ideation and thoughts of self-harm. He guaranteed his own safety and denied thoughts of harming others. It appears that his classification was changed to one-out cell placement on the basis that his assurances seemed plausible and truthful.

It is possible that Mr. S was giving a truthful account at the time he was asked whether he was thinking of suicide and self-harm. He may, however, have been concealing his real thinking and intentions. It is also possible that he made the decision and formed the plan to take his own life relatively spontaneously despite having previously decided against such action and guaranteed his own safety.

Suicide risk assessment is an inherently very difficult task. In a report presented to the Coroners Court concerning suicide risk in psychiatric units, an independent psychiatric consultant, Dr Christopher Ryan described the problems of suicide risk assessment:

The first and most important thing to understand is that it is not possible to usefully categorise patients, who are admitted to a psychiatric unit into those at relatively higher and those at relatively lower likelihood of future suicide. In reality all psychiatric inpatients are at a very greatly elevated likelihood of dying by suicide. Although it is possible to use some features of such patients' presentations, especially a past history of suicide attempt and a diagnosis of major depression to categorise patients into those at a statistically higher risk of suicide than those who do not exhibit such features, the degree to which these features increase the suicide rate of this "high-risk" group is so small as to be of no utility in guiding management decisions.

The idea that it is not possible to usefully identify psychiatric inpatients at a particularly high risk of suicide strikes most people as counterintuitive, at least at first blush. However, it is possible to confidently make this statement because it is based on a number of large studies that have examined possible risk factors in large numbers of people who have been psychiatric inpatients, some of whom have gone on to suicide.

Based on the evidence of these large studies my colleagues and I have spent a number of years campaigning against the sort of checkbox risk assessment tools that Ms GC has found so confounding when reviewing her husband's medical records. We have argued simply that, since it is literally impossible to usefully assign psychiatric inpatients into groups who are at meaningfully (as opposed to statistically) high or low risk, it makes no sense whatever to compel staff to make check-box assertions about a patient's "suicide risk".

All that can be meaningfully said about the likelihood of future suicide regarding a person who has been admitted to a psychiatric unit is that he or she is at a very high relative risk of future of suicide during that admission compared to the population risk of suicide, but, notwithstanding this, he or she is at very low absolute risk of suicide, since only around one in 700 admissions end in suicide.

Compounding this problem is the fact that the forms that were devised by New South Wales Health for the mandatory documentation of a "risk assessment" are poorly designed. As a result of the poor design it is not at all clear what staff members are affirming when they check the various boxes associated with the various statements on the forms.

For example ... it is not at all clear what a "significant past history of risk" actually means- arguably the phrase is without meaning, certainly it is ambiguous. Patients do not have a past history of "risk "per se; at best they may have a past history of one or more events that might impact on their future risk, though as I have noted above, this is only true in a strictly statistical sense, and then only with very a limited number of events. (Incidentally the offending phrase on the form also provides no indication of what is meant by "significant" in this context).

Similar observations apply in respect of persons in the custody of Corrective Services.

Nevertheless, Mr S was known to have attempted to take his own life immediately have killing Ms T. That was an act that went beyond mere suicidal ideation. In the immediate context, it was a very significant matter. He almost certainly acted out of remorse and shame when he made the attempt on his own life. This was probably an additional risk factor to be taken into account because he had not been able at the time he killed Ms T, to extinguish his sense of shame and remorse by extinguishing his own life.

At my request, Justice Health provided a research paper on the question of whether persons who have committed domestic violence homicides are at greater risk of suicide than others in custody. (The full paper is annexed to this decision as Appendix 1.) A very helpful literature review was conducted by Associate Professor Kimberlie Dean, a consultant forensic psychiatrist and chair of Forensic Mental Health in the School of Psychiatry at the University of New South Wales and consultant with justice Health. Professor Dean's review reveals that "these events are rare and there has been limited research devoted to understanding their occurrence."

The phenomenon of homicide-suicide is, fortunately, rare but it is common enough to warrant close study. One of the obvious practical problems, however, in conducting such research is that the principal witnesses are no longer alive to be reviewed and assessed by relevant health professionals. Studies and research must, therefore, be conducted indirectly and, to some extent, speculatively.

The studies show, among other things, that not only is the killing of a domestic partner the most common form of homicide, it is also, unsurprisingly, the most prevalent form of homicide-suicide. Men are the most usual perpetrators of homicides followed by their own suicides. In contrast with this case, some studies show that previous physical abuse tends to be prevalent in homicide-suicide cases.

A number of theories have been developed to explain homicide-suicide. Social stress and strain that results from a person being unable to achieve desired positive goals combined with occurrence of negative stimuli is thought by some to be a plausible explanation. This seems a common sense analysis of some cases and is apposite here. Other theorists are more interested in the direction of the violence than its origins.

One researcher surmised that a homicide-suicide results from the perpetrator feeling an inability to live *with* or *without* the victim of the homicide. Homicide-suicide psychology may be viewed as including both outward and inward attribution of blame. The victim is blamed then the perpetrator blames him for the crime. This fits the picture we have in this inquest. Various other theories have also been formulated but they are of less immediate relevance to our understanding of this case.

Because of the scarcity of general research into homicide-suicide, and because of the general unpredictability of suicide, it is not possible to draw any significant conclusions as to whether persons in custody on domestic violence homicide charges ought be assessed as being at higher risk than other remand prisoners *simply on that basis*. Indeed, as for other prisoners, it seems that in a case such as this risk assessment must be undertaken on an individual basis. In such an assessment Mr. S's attempted suicide following the killing, while not predictive of suicide, would be taken as an indicator that the prisoner is at higher risk of suicide than people in the general population.

Placement in a disabled cell

A review of the occupancy and disabled cell locations was undertaken as part of the investigation into the death of RS. There are three pods within the MHSU, Pod 19, Pod 20 and Pod 21. Only one cell, which has extra support railings, per pod, is classified as a 'disabled cell'. In Pod 19 it is cell 561, Pod 20 it is cell 585 and Pod 20 it is cell 590. Pod 19 contains a total of thirteen cells including the disability cell (561), Pod contains a total of twelve cells including the disability cell (585) and Pod 21 contains a total of twelve cells including the disability cell (590).

A review of the housing history of the MHSU and specifically cell 585 indicates that all cells were occupied at the time of Mr. S's transfer into the MHSU. On the housing list it indicated that Mr. S was transferred on 30 August 2013 at 22:43 hours with an end date/time of 03 September 2013 at 21:45 hours, after his death.

According to this report it shows a second inmate was in cell 585 at the time Mr. S was housed in there. Further investigation into this indicates an inmate, Mr. Lord, was moved out of cell 585 to another block on 5 February 2013 at 16:20 hours. This discrepancy appears to be human error in transferring on the computer system. At the time of his death Mr. S was housed one out in Cell 585.

The reasons that Mr. S was placed in the disability cell were that he had been classified as suitable for "normal cell placement" (i.e., one-out) and that the disability cell was the only available cell. He was not placed on suicide watch and therefore was not placed in a "protection" cell. Such cells are designed to have eliminated all hanging points.

It is well-known, and indeed was stated by Associate Professor Dean, that placement in a one-out cell is a suicide risk factor. A prisoner alone in a cell is more capable of taking undetected steps to end his or her own life than a person with a cellmate. But placement in a two-out situation is not always protective and can bring small but real risk of even greater harm as well. On occasions, homicide-suicides have occurred in prison cells. I have dealt with a case in which a prisoner who was assessed as a suicide risk killed his own cellmate before committing suicide. That event was impossible to predict but demonstrates that there are no perfect solutions to suicide risk.

Once the assessment was made that Mr. S was not at immediate risk, the cell placement was reasonable in the circumstances.

CCTV footage

During the course of the investigation it was determined that there was no CCTV camera installed in cell 585 but it was determined that there are CCTV cameras located throughout Pod 20. Upon request for recordings of the CCTV footage from Pod 20 for 3 September 2013, the Systems Security Manager reported that the computer hard disk drives, which recorded all the video footage, had failed, and as such, there was no CCTV footage available.

It is unclear why the hard disk drives failed but it is a matter of considerable concern not only that they failed but that the failure went undetected, it appears, until the request for footage was requested. That poses a significant safety and security issue for inmates and staff and steps should be taken to rectify this problem.

Conclusions

There are few more severe forms of interpersonal violence than homicide-murder cases.

They shock and horrify the immediate family and friends of the people who have died, who frequently suffer enormous and irreparable emotional trauma as a result. They also send a ripple effect of alarm and incomprehension throughout the communities in which they take place.

It is difficult to imagine the feelings of members of the T and S families.

I hope, however, that they will accept the sincere and respectful condolences of the coronial team and all the staff of the Coroners Court. Our thoughts and sympathy are especially for M who will now grow up in the bosom of a loving family but without parents.

Formal Findings

I find that ST died about 2:30pm on 10 August 2013 at McDonalds Family Restaurant, Gregory Hills, New South Wales as a result of blunt force trauma to the neck inflicted by her husband, RS.

I find that RS took his own life by way of hanging on Tuesday 03 September 2013 in cell 585 at the Metropolitan Remand and Reception Centre Silverwater, New South Wales.

Recommendations s 82 Coroners Act

I make the following recommendations to the Minister for Corrective Services and Minister for Health:

- 1. A review of the Mental Health Screening Unit is conducted to identify and, if reasonably practicable, remove hanging points and any other identifiable hazards to both staff and inmates.**

- 2. An audit is carried out all CCTV equipment within the Mental Health Screening Unit area and a system of daily back-up of CCTV footage be installed.**

Research statement

Prepared by:

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May 2016

This review is focused on providing a brief overview statement on the peer-reviewed and other literature relevant to a number of specific issues raised by the Coroner in the inquest into the death of Mr RS.

The epidemiology of homicide-suicide

A small proportion of homicide perpetrators commit suicide following the homicide, a phenomenon labelled 'homicide-suicide' or H-S. These events are rare and there has been limited research devoted to understanding their occurrence. When they do occur the perpetrators are most commonly male and their victims are most commonly their female partners or ex-partners, sometimes also their children. There is a literature focused on the extent to which H-S cases resemble homicide-only cases or suicide-only cases. In a published systematic and quantitative review of 49 studies, the authors concluded that H-S appears epidemiologically closer to homicide than to suicide in regions with high homicide rates such as the US, while the opposite may be true for regions without high homicide rates (Large, Smith, & Nielssen, 2009). H-S cases in this systematic review were defined as those where the homicide perpetrator committed suicide prior to conviction while some individual studies require the suicide to have occurred in close temporal proximity to the homicide; most suicides in H-S cases are known to occur within 24 hours of the homicide. In a recent Australian study of H-S, homicide-only and suicide-only cases, the characteristics of the H-S cases were found to more closely resemble the suicide-only cases than the homicide-only cases (McPhedran et al., 2015). For example, both the H-S and suicide-only cases were more likely to share a history of mental ill health and to have had alcohol use problems. All three groups were likely to have a history of past suicide attempts.

Other acts of co-occurring aggression to self and others

Homicide-suicide or H-S events may be usefully considered as at the extreme or lethal end of a continuum of aggression which is directed both towards others and towards the self (Hillbrand, 2001), a continuum which would include attempted H-S events (attempted homicide followed by suicide and homicide followed by attempted suicide). The lethal intent to commit an act of H-S may be present in such cases but factors potentially outside the individual's control may have intervened to limit the seriousness of at least one of the outcomes. The extent to which such attempted H-S events occur and to what extent they differ in character from completed H-S events is not well understood. One Dutch study examined a sample of men who had attempted or completed an act of intimate partner homicide and found that those who also demonstrated suicidal behaviour were more likely to be: unemployed, motivated by a fear of abandonment rather than narcissistic injury, depressed, and to have previously expressed suicidal threats (Liem & Roberts, 2009). The risk of subsequent completed suicide following an attempted H-S is also not well studied. One study of mortality among 176 homicide offenders in Sweden reported 13% died by suicide, a rate which contributed significantly to the three-fold increase in mortality for this group (Lindqvist, Leifman, & Eriksson, 2007).

Given the overlap in risk factors for aggression aimed at the self and at others, it is perhaps not surprising that such behaviour can co occur (O'Donnell, House, & Waterman, 2015). Although approaches to the assessment and management of suicide and violence are often considered separately, they share an important overall goal of reducing the level of identified risk factors for aggression (Hillbrand, 2001). Some have extended this argument to suggest that those individuals presenting to mental health clinicians with a history of violence should be considered a potential risk of self harm and vice versa, and it is to some extent on this basis that structure professional risk assessment tools such as the START (Short Term Assessment of Risk and Treatability), which considered multiple potential risk outcomes, have been developed (Webster, Nicholls, Martin, Desmarais, & Brink, 2006). In practice however, particularly in settings over which the clinician has limited control such as prison, this approach can present difficulties. The decision to place an individual with risks of aggression in a single cell represents an example of such a difficulty. It is clear that further research is needed to guide policy and practice in this area.

Role of single cell occupation in terms of risk of in-prison suicide

Single cell occupation is an established risk factor for completed suicide in prison settings. In a published systematic review of 34 prison suicide studies, the following risk factors were highlighted as the most important factors consistently found to be associated with suicide-occupation of a single cell, recent suicidal ideation.

A history of attempted suicide, and having a psychiatric diagnosis or history of alcohol use problems (Fazel, Cartwright, Norman Nott, & Hawton, 2008). Occupation of a single cell was associated with odds of suicide 9.1 times higher (95% confidence interval 6.1 13.5) than for prisoners not occupying a single cell.

The authors of the review comment, however, on the likelihood that single cell occupation as a risk factor for prison suicide is influenced by the presence of mental illness since those with active mental illness are more likely to be placed in a single cell when disturbed behaviour and/or aggression directed towards others is demonstrated. In such circumstances, mental health clinicians and prison officers face a difficult situation where there is a need to balance risk of suicide with other risks including risk of harm to others. It is also clear that while single cell occupation is associated with suicide in prison, such an event is uncommon and the vast majority of individuals placed in single cells do not attempt or complete suicide. This highlights the difficulty in applying findings derived from study groups, particularly when defined by an uncommon event or characteristic, to an individual case.

Role of assessments of suicidal ideation/assurances of safety in terms of suicide risk

The literature regarding the association between expressing thoughts/ideas/plans of self harm or suicide and the occurrence of subsequent completed suicide is conflicting. Similarly, statements 'guaranteeing safety' or denying suicidal ideation in the context of a recent suicide attempt and the extent to which they can justifiably reassure mental health clinicians about suicide risk is unclear. It is true that the ability of clinicians to make accurate predictions about the risk of an individual attempting suicide at some point in the future is very difficult indeed and is often further complicated by limitations placed on clinicians to alter the status of important risk factors in individual cases.

In the systematic review of prison studies mentioned earlier, recent suicidal ideation was identified as an important risk factor for prison suicide, with odds of suicide being 15.2 times greater (95% confidence interval 8.5 27.2) among those reporting thoughts of suicide compared to those without such ideas (Fazel et al., 2008).

The risk of completed suicide among individuals with a history of suicidal behaviour but recent denial of suicidal ideation in the prison setting has not been established.

In the context of mental health settings, for those patients with a history of suicidal behaviour who go on to die by suicide, denial of suicidal ideation prior to the completed suicide is not uncommonly documented (Busch, Fawcett, & Jacobs, 2003).

Overall, mental health clinicians working with those who present a risk of aggression, to themselves and/or others, must assess the significance of denial of suicidal ideation in the context of the circumstances and characteristics of the individual.

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6. 214164 of 2014

Inquest into the death of Idris Griffiths finding handed down by Deputy State Coroner Lee at Glebe on the 29th April 2016.

Introduction

Mr Idris Kevin Griffiths was born in 1934. At the time of his death he was serving a custodial sentence at Long Bay Correctional Centre.

As Mr Griffith was in lawful custody at the time of his death an inquest is required to be held pursuant to sections 23 and 27 of the Act. Section 81(1) of the *Coroners Act 2009* requires that when an inquest is held the coroner must record his or her findings as to various aspects of the death. These are the findings of an inquest into Mr Griffiths' death.

The role of a Coroner and purpose of this inquest

The role of a Coroner, as set out in s 81 of the *Coroners 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.

Pursuant to s 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

Mr. Griffith's personal history

Unfortunately, very little is known about Mr Griffiths' personal history other than he was born in 1934 and that he had six children. His wife passed away about 5 years before he was last sentenced. The brief of evidence did not contain any statements from any member of Mr Griffith's family.

However in an email to the police officer-in-charge, Detective Senior Constable Melissa Martens, one of Mr Griffiths' daughters, Linda Friedland, expressed her thanks that family members were permitted to visit Mr Griffiths at Prince of Wales Hospital.

No member of Mr Griffiths' family was present at the inquest.

Mr. Griffith's custodial history

On 3 September 2010 Mr Griffiths was sentenced at the Sydney District Court in relation to two offences of supplying a large commercial quantity of a prohibited drug.

For one of the offences Mr Griffiths received a 9 year sentence of imprisonment backdated to commence on 25 September 2008 and expire on 24 September 2017, with a five year non-parole period expiring on 24 September 2014.

For the other offence, Mr Griffiths received a partially cumulative 8 year sentence of imprisonment from 25 September 2010 to 24 September 2018 with a 4 year non-parole period expiring on 24 September 2014. This last date was Mr Griffiths' earliest possible release date to parole.

At the time of entering custody in 2008 Mr Griffiths was 74 years old. He was initially kept at the Dawn de Loas Correctional Centre at the Silverwater Correctional Complex and later permanently transferred to the Aged Care and Rehabilitation Unit at Long Bay Hospital.

Mr. Griffiths' medical history

When Mr Griffiths entered custody in 2008 he had a number of serious health conditions. He had previously undergone coronary bypass surgery, he had a history of hypertension and stomach ulcers, and was positive for Hepatitis C with associated liver conditions such as jaundice.

In 2010 it was found that Mr Griffiths had an enlarged spleen and his liver function test results were poor. By 2012, Mr Griffiths was under the care of a hepatologist although on many occasions he declined treatment for his Hepatitis C. By 2013 he had developed cirrhosis of the liver and end stage liver disease.

In mid to late 2014 it was recognised that Mr Griffiths' poor liver health made him prone to encephalopathy which in turn caused confusion and increased his risk of falls. By this time Mr Griffiths had also developed an unsteady gait and was prone to Parkinson's disease-like symptoms, such as involuntary shaking.

The events of July 2014

At about 9:35am on 14 July 2014 a correctional officer went to Mr Griffiths' cell to rouse him for breakfast. Mr Griffiths was found lying on the floor with a small amount of blood around his head. Justice Health nurses attended a short time later and Mr Griffiths was taken to the emergency department at Prince of Wales Hospital at about 10:55am.

Mr Griffiths was found to have a laceration to the back of his head from the fall. But further examination did not reveal any intracranial pathology. Mr Griffiths was later transferred to a secure bed within the hospital.

Over the course of the next few days, Mr Griffiths' condition deteriorated. He developed pneumonia and a viral infection, became hypothermic, and was found to have an abnormally low heart rate.

On 17 July 2014 it appears that, following consultation with his treating physicians, Mr Griffiths signed a no cardiopulmonary resuscitation (CPR) order.

Mr Griffiths' family were notified of his condition and arrangements were made for them to visit him on 18 and 19 July 2014 as his condition was dire and not improving. Following a discussion between the physicians and Mr Griffiths' daughters it was decided that only palliative care would be provided to Mr Griffiths. Late on the evening of 18 July 2014 a chaplain at the hospital, at the request of Mr Griffiths' family, attended his room to perform the last rites.

At about 7:10am on 19 July 2014 Mr Griffiths was noted to be deeply unconscious. By the early afternoon Mr Griffiths was unresponsive to verbal or tactile stimuli and had no heart sounds or pulse. He was declared deceased at 2:10pm.

What caused Mr. Griffith's death?

On 21 July 2014 his Honour Deputy State Coroner MacMahon issued a coronial certificate recording Mr Griffith's cause of death to be pneumonia. Multi-organ failure in the form of liver failure (due to chronic Hepatitis C infection) and congestive cardiac failure (due to ischaemic heart disease) were listed as antecedent causes.

Are there any other issues to investigate?

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility.

I have examined Mr Griffiths' Justice Health records. They reveal that in 2013 it was recognised that Mr Griffiths' poor health made his incarceration at Dawn de Loas correctional centre inappropriate due to the environmental risks associated with the fast-paced routine of that particular centre. It had already been identified that Mr Griffiths required assistance from other inmates with his daily living activities. Accordingly, Mr Griffiths' was reclassified and transferred to the Aged Care and Rehabilitation Unit at Long Bay Hospital.

Justice Health also identified that, due to his end stage liver disease and unsteady gait, Mr Griffiths was prone to falls. It was noticed that most of his falls occurred whilst Mr Griffiths was attempting to get out of bed and so pressure alarms were placed in his bed. He was also given training on how to safely transfer in and out of his bed. Unfortunately, Mr Griffiths had a tendency to remove the alarms which increased his risk of falls.

In an attempt to improve the conditioning in his arm and leg muscles, so as to reduce the risk of falls, Mr Griffiths was provided with regular physiotherapy sessions. He was also given appropriate a walking frame to help with his mobility and stability.

Conclusion

Having considered all of the available evidence I reach the conclusion that Mr Griffiths' death is not suspicious and that he died as a consequence of a natural cause process.

I also conclude that Mr Griffiths received health care of an appropriate standard whilst in custody. The physical complications associated with his poor health were identified by both Justice Health and Corrective Services, and appropriate measures were put in place to assist Mr Griffiths and to reduce the risk of injury.

I also conclude that the circumstances in which Mr Griffith was found on the morning of 14 July 2014 was a result of his poor health making him susceptible to falls, particularly when leaving his bed. There is no evidence to suggest any third party involvement in this incident. There is also no evidence to suggest that any action or inaction by either Corrective Services or Justice Health contributed to Mr Griffiths' death in any way. Given Mr Griffiths' long-standing health issues, which were appropriately managed whilst he was in custody, and his rapid deterioration whilst in hospital it does not appear that anything could have reasonably been done to prevent Mr Griffiths' death.

On behalf of the coronial team I would like to offer my sincere and respectful condolences to Mr Griffiths' family.

Formal Finding:

Identity

The person who died was Idris Kevin Griffiths.

Date of death

Mr Griffiths died on 19 July 2014.

Place of death

Mr Griffiths died at Prince of Wales Hospital, Randwick, New South Wales.

Cause of death

The cause of death was pneumonia, with multi-organ failure in the form of liver failure (due to chronic Hepatitis C infection) and congestive cardiac failure (due to ischaemic heart disease) as an antecedent cause.

Manner of death

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

7. 341985 of 2014

Inquest into the death of MM. Finding handed down by Deputy State Coroner Barry at Glebe on the 24th August 2016.

Non Publication Order: A non- publication order was made pursuant to section 75 of the Coroners Act 2009 in relation to the identity of the deceased.

The role of the Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

- (a) the identity of the deceased
- (b) the date and place of the person's death
- (c) the physical or medical cause of death; and
- (d) the manner of death, in other words, the circumstances surrounding the death.

The identity of the deceased, the date and place and the cause of death are uncontentionous.

This primary focus of this inquest is the manner of Mr. MM's death and the police response to the 000 call made by Ms. C.

In addition, Mr. MM's death occurred in the course of a police operation and the holding of an inquest is mandatory, pursuant to ss.23 and 27 of the Act.

Introduction:

On the morning of 19 November 2014, MM spoke with police at Macksville police station about some personal property that was still at his ex de- facto's (Ms. C) premises and about some "stolen" property that was also at those premises.

Police attended those premises and retrieved some of MM's personal property. After returning to Macksville police station, police returned the property to MM and advised him that they were not proposing to charge Ms. C about any stolen items or fraud concerning a disputed amount of money. MM became very angry and left. At about 3pm that afternoon, police received a telephone call from Ms. C stating that she had been advised that MM was heading to her property with a gun.

Police attended the property and observed MM seated on a chair outside the house. He had a rifle on his lap. After a short period of negotiation he raised the firearm and pulled the trigger which failed to fire. He again raised the firearm a short time later and put the rifle to his right temple and pulled the trigger.

Background

MM was 63 years of age when he died. He was described as a fit and powerful man who was hard working.

MM was reported by a previous employer as one of the best workers he had ever seen. He was described as a man who had an incapacity for idleness and "down time", being "on the go" from first light until dusk.

He had four adult children and he had been in a relationship with Ms. C in the Bowraville area. This relationship commenced in 2009 and continued for about two years. MM had moved into her property for a short time and had completed some work on her property.

The relationship had broken down after about two years. MM left the property and moved to Burleigh Heads in Queensland to be with one of his sons. He left behind a number of personal items and equipment at Ms. C's property. Ms. C described the relationship as "quite dysfunctional."

MM suffered from a number of health problems. In 2011 he was diagnosed with prostate cancer, although a biopsy had revealed it was of comparatively low concern. However, In October 2014, blood tests revealed some concerns and M M's GP referred him to a urologist.

He was due to attend hospital for further investigation on 28 November 2014.

In March 2014, MM suffered an eye injury and had a metal fragment removed from his eye on 12 March 2014. Following this he complained of visual disturbance in his right eye and headaches, although medical investigation was unable to identify the cause. His eyesight failed to improve, and he attended the Emergency Department at Gold Coast University Hospital where he was reported to be "tearful"

MM had a substantial criminal history including a firearms offence, being a prohibited person in possession of a firearm, in 2008. He had also served some time in custody for drug offences.

There had been no convictions recorded since 2008, although he had been arrested in July 2014 in Queensland on an outstanding warrant. He was released on bail to report weekly to police at Robina in Queensland and his daughter-in-law had provided \$10,000 surety. It would appear that this matter was still outstanding at the time of his death.

MM's family was invited to attend the inquest but were unable to do so.

The Autopsy and Cause of Death:

An Autopsy was conducted by Dr B Beer on 21 November 2014. The direct Cause of Death was a single gunshot wound to the head.

Events Prior to MM's Death:

On 24 September 2014 Ms. C contacted local police and stated that MM had again commenced contacting her. She was given advice about an AVO, which she declined.

She told police that she believed MM had been attending her home and removing property when she was not present and also damaging some of her property.

Ms. C was referred to the 'Staying Home Leaving Violence' organisation and spoke with Shelley Baker. Although Ms. C stated that MM had never been violent towards her during the course of their relationship, she was fearful of some of his criminal connections.

Ms. Baker considered Ms. C to be at high risk given her isolation and arranged to visit her property on 20 November for a safety audit.

On 28 October at about 11pm, MM attended Ms. C's property unannounced. He brought groceries and roses for Ms. C's birthday a few days later. Ms. C refused to admit him and locked herself in the pantry and called the police. Senior Constable Kennedy arrived at the property about one hour later, by which time MM had left.

Significantly, Ms. C informed police that MM had access to an unregistered firearm, although she had last seen it 2 years previously when she asked him to remove it.

She again was asked to consider an AVO, but a few days later she told police she did not want an application made.

October 31 was Ms. C's birthday. MM sent her an email wishing her a happy birthday and tried several times to contact her by telephone. There were two more emails the next day. In one email MM stated:

"I am writing this with great sadness and tears... I wanted to spend the rest of my life with you. If no correspondence is forthcoming than (sic) I will have to cease trying and leave it in the lap of the gods.

In November 2014, MM contacted Macksville police and spoke with Detectives Stuart and Welsh. He told them about some stolen property which he said was located on Ms. C's property. He also complained about money he had lent Ms. C for dental work and wanted police to charge Ms. C with obtaining money by deception.

On Monday 17th November MM hired a car in Queensland and drove to Macksville. On route he contacted Detective Stuart regarding the stolen property. He attended the police station that afternoon and spoke again about the stolen property and the loan. He wanted a search warrant to be executed on Ms. C's property. This was declined.

He also mentioned some x-rays belonging to him which were still at Ms. C's property. These x-rays showed the state of his prostate from a couple of years earlier and he wanted to show them to his current doctor so that changes could be observed.

MM attended the police station on 18th November and showed Detective Welsh some photographs of the stolen property he claimed was on Ms. C's property.

Detective Welsh discovered that the property had been stolen from a Department of Primary Industries site near Lismore in 2011. It was then decided to approach Ms. C and ask her about these items.

The events of 19th November 2014

On Wednesday 19th November MM attended Macksville police station early. He was advised that police would be visiting Ms. C later that day.

Detective Welsh and Detective Stuart attended Ms. C's property at about 11am. Ms. C allowed them to search the property and they were able to locate MM's x-rays. In addition they located some of the stolen property, but Ms. C stated that those items in fact had been brought onto her property by MM.

At 12.43pm, MM sent an email to Ms. C:

"I'm in town give me a call hope your (sic) having a good day there's many more to come."

Detective Stuart came to the view that this email amounted to intimidation. Ms. C was concerned about the content of the email and spoke with Detective Stuart who told Ms. C that he would contact the Domestic Violence Unit and also advised Ms. C that police would be initiating an AVO.

When the Detectives returned to Macksville police station, MM was waiting outside. His x-rays were returned to him and Detective Stuart advised MM that there would be no action taken against Ms. C, either for the stolen property or the alleged fraud in relation to the loan.

On hearing that information, MM's attitude changed and he became very angry. He said to Detective Stuart:

"Ah, yeah, the women always get away with things."

Detective Stuart told MM to cut his losses and to "move on." In his statement, Detective Stuart said that MM was very angry. Detective Stuart said that he had never seen him like that in all the times he had spoken with him.

It was Detective Stuart's impression at that stage that MM would be returning to Queensland, having retrieved his x-rays.

After leaving the police station, at about 1.20pm, MM contacted RS, who was a neighbour of Ms. C and for whom MM had worked in the past. That call was not connected. MM drove to RS's property and was invited inside by RS. He observed that MM had a firearm and believed this to be the only time he had ever seen MM with a firearm. He said in his statement:

"MM was not the least bit threatening and I was not alarmed to see him with a weapon. I have had a weapon all my life and I knew MM grew up in Orbost Victoria and had a rural background."

RS inferred from the conversation with MM that he was planning to do some hunting, as he was speaking of dingoes.

MM advised RS that he was planning to arrange the removal of some of his property from Ms. C's place. In addition, he told RS that he had been diagnosed with prostate cancer about two years ago and that at a recent medical consultation he had been advised that he only had about 18 months to 2 years to live.

After MM left the property RS contacted Ms. C to warn her that MM was in the area and had a gun. Ms. C immediately contacted OOO. In that call Ms. C told the operator:

"MM is on his way here to this property. He has a gun..... I'm leaving now I'm leaving My neighbour has just telephoned me. There is a history of domestic violence. He's on his way here and he's got a gun."

In that call, Ms. C also referred to "Jessie", and was heard to tell Jessie to "come here" and to "get in". At the time, the 000 operator believed that Ms. C was referring to a child. In fact Jessie was Ms. C's dog. Ms. C was obviously distressed and terminated the call.

The Police Response

Following the 000 call, police broadcast an "all resources" message at 3.04pm. That message was broadcast verbally on VKG. The VKG recording is as follows:

"Very distressed female inft saying she was just contacted by RS from North Arm Rd Bowraville saying her ex partner, MM 63 old is enroute to AA armed with a gun. POI in a car NFD. Inft declined to speak any further, getting into a car with chile (sic) to leave AA ASAP and terminated call Check OTW"

Detective Stuart was told of the broadcast by Sergeant Maxwell who said to him:

"There's a job just come over the radio and I think you need to hear about it....there's a job just come over that he's trying to get a firearm and he's going back to"

Detective Stuart recognised the address. Three pairs of police officers responded to the broadcast.

Senior Constables Hickson and Black from Nambucca Heads had further to travel and arrived after MM's death. Sergeant Maxwell and Senior Constable English from Macksville police station arrived about 40 minutes after the broadcast and a few minutes before Detectives Stuart and Welsh.

Sergeant Maxwell and Senior Constable English located MM's car parked out of sight of the house. Detective Stuart placed the keys to MM's car in his pocket. All four officers put on ballistic vests.

At that point a plan was discussed whereby Sergeant Maxwell and Senior Constable English would proceed by foot across a creek and then go up the hill to the south to come down the back of the house.

Because of their concerns for the safety of Ms. C, Detectives Stuart and Welsh decided to drive further to get as close as they could to the gate that leads immediately onto the property. They parked about three or four metres from this gate and exited the vehicle.

Detective Stuart removed his pistol from its holster and started to walk to the gate. Detective Walsh followed behind to Detective Stuart's left.

As Detective Stuart was about to open the gate he heard the words:

"Dave, I'm up here."

Detectives Stuart and Welsh observed MM sitting on a chair on top of a hill about 75 metres away. That position gave MM a vantage point from which to observe the gate through a gap in the trees. MM had no shirt on and a firearm was across his lap. The following exchange took place.

Detective Stuart:

"What are you doing mate? Don't be stupid. What are you doing?"

MM:

"Dave, I've had enough. I'm going to end it all."

Detective Stuart:

"M, don't be fuckin' stupid. Throw the gun down mate. Get the gun away from you mate."

Detective Stuart yelled out to Sergeant Maxwell and Senior Constable English:

"He's got a gun. He's got a fuckin' gun"

Detective Stuart then yelled to MM:

"M just throw the gun. Get it away from you mate"

He asked MM what type of gun he had and MM replied that he had a .22. Detective Stuart repeated to MM to drop the gun and to get away from the gun. MM replied:

"No no"

At that point MM put the gun to the right side of his head near his temple and initially it appeared that the gun failed to fire. MM then pulled the firearm down and in so doing pointed it at both detectives.

Detective Stuart stated that he was *"within seconds of letting rounds go at him because I thought I'm in the middle of nowhere here. He's pointed a gun at us."*

Detective Welsh had his firearm out in the cover position and when MM swung the firearm at the police after the miss -fire Detective Welsh took cover behind the police vehicle. He saw Detective Stuart backing back.

As MM brought the gun down it dropped further toward the ground. Detective Stuart believed at that point the threat had ceased somewhat. MM was seen to fiddle with the gun and then the gun came straight back up and he discharged it point blank to his head.

A search was conducted and Ms. C was located about 25 minutes later hiding in some lantana about one kilometre from the house.

Neither detective in responding to this incident classified it as a high risk incident.

The NSW Police Handbook provides guidance to first responders in high risk situations. Both officers had completed the mandatory training in Responding to High Risk Incidents.

The only criterion that may have been met in this incident at the time Detectives Stuart and Welsh responded was the "reasonable grounds to believe that the suspect may cause injury or death."

At the time of responding it was believed that Ms. C had left the property. Neither Detective believed at that time that MM would cause self- harm.

Both officers were very familiar with MM. Detective Welsh told the court that he had never heard MM express an intent to harm anyone or to self-harm. Detective Welsh did not believe that MM was capable of harming anyone.

In addition, Detective Welsh had seen the inside of MM's car that day and had not seen a firearm. When he was responding to the police callout he was unclear about the information concerning MM's possession of a firearm. Whilst there was a risk that MM may have had a gun, Detective Welsh could not determine where he would have obtained a gun from.

Similarly, Detective Stuart did not believe that MM did in fact have a firearm-he had not personally heard the VKG message. From his dealings with MM, he had no reason to believe he would act dangerously and at that stage he had no concerns about MM or Ms. C. Detective Stuart told the court that approaching the house he did not think it was a high risk incident as there was no credible evidence provided to categorize it as such.

Once MM was sighted with a firearm that position changed and it became a high risk incident. At that point police needed to negotiate, which is what Detective Stuart attempted to do. At all times police welfare is paramount as well the preservation of life in the community. Both officers were wearing vests and had their firearms drawn. Detective Stuart had the best rapport with MM and it was appropriate that he try to contain the situation and engage in negotiation.

Little turns on this assessment. Given the remoteness of the location and the suddenness of the escalation of the threat it was clear that nothing could have been done differently.

Conclusion

Policing is a difficult and often dangerous job. There is no doubt that on 19 November 2014, police were placed in an extremely dangerous position. They were on a remote rural property. MM had the tactical advantage and the police were not to know if MM was intending to harm them.

It is purely speculative what MM's intentions were on that day. In hindsight, it would seem that MM was of the belief that his health was deteriorating and he may have believed he had a poor prognosis.

In addition, he was clearly upset about the relationship breakdown and he also had the added stress of a further criminal prosecution.

In this dynamic and dangerous situation, the police not only acted appropriately but bravely. They exercised experienced and well-judged restraint in their dealings with MM on that day. A copy of this decision is to be forwarded to the Local Area Commander.

Formal Finding

I find that MM died on 19th November 2014 at 69 Maddrake Chase, Girralong, NSW as a result of a gunshot wound to the head which was self-inflicted with the intention of ending life.

8. 379966 of 2014

Inquest into the death of Ronald Terrence Wilson. Finding handed down by Deputy State Coroner Stone at Newcastle on the 9th December 2016

Introduction

Section 81(1) of the *Coroners Act* 2009 (the Act) requires that when an inquest is held the Coroner must record his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Ronald Terrence Wilson.

The role of a coroner and purpose of this inquest

The role of a Coroner, as set out in section 81 of the *Coroners Act*, is to make findings as to:

- (A) The identity of the deceased;
- (B) The date and place of the person's death;
- (C) The physical or medical cause of death; and
- (D) The manner of death, in other words, the circumstances surrounding the death.

As Mr Wilson was in lawful custody at the time of his death an inquest is required to be held pursuant to sections 23 and 27 of the act.

Pursuant to section 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

Mr Wilson's personal history

Mr Wilson was born in Nundah, Queensland on 27 October 1946. He was the eldest child of his parents. He had two sisters Marjorie and Helen. His father left home when the deceased was quite young and he was raised by his mother and stepfather on a cane farm in Queensland until he left home at about the age of 15.

Mr Wilson moved to Sydney and lived with his natural father in Caringbah with his father dying in about 1990.

He married Doris at age 19 following her becoming pregnant with their first child Margaret on 1 October 1966. They subsequently had two other children Robert on 20 January 1969 and Ronald on 22nd of April 1972. Another child Susan is attributed to the deceased however no record of the deceased being her father was located on the births deaths and marriages registrar.

Mr Wilson left Doris when Robert was three years old in about 1972 and consequently none of these children had any contact or relationship with the deceased until much later in his life.

He attained a heavy vehicle drivers licence in 1974 and commenced driving buses. In 1992 and 2000 he attained further heavy vehicle licences.

Mr Wilson met Maryanne Wilson in 1981 whilst driving buses between Hurstville and Miranda. They had a relationship on an off before marrying in 1988. They lived together in Gympie until 2003.

They separated and lived apart for seven years and divorced in 2010 however, remained in contact and stayed friends.

The deceased was employed as a bus driver by Trans Dev between 29 December 1993 and 14 August 2011.

While married to Maryanne, the deceased met Maria Marek when they were neighbours. After separating from Maryanne the deceased lived with Joseph Marek, Maria's son in about four different residences over numerous years.

Maria had a brief intermittent relationship with the deceased sometime after he separated from Maryanne.

The deceased was known to be a reformed smoker and a drinker. He was also known to gamble and had credit card debts. It is believed that he utilised his superannuation to pay his debts and legal fees following him being charged with the offences for which he was in custody.

Mr Wilson's custodial history

The deceased was first known to New South Wales Police in August 1965 for the offence of trespassing. Between this time and 1971 he was prosecuted for vagrancy, stealing, driving with PCA and negligent driving. He was then not known to New South Wales Police until his arrest in 2011.

Mr Wilson was arrested on 11 August 2011 and charged with 12 counts of sexual intercourse with a person with a cognitive impairment. Initially he was received into custody at the Metropolitan Remand and Reception Centre on 24 November 2012 where he spent some time on remand. He was convicted of two counts of aggravated sexual assault of a person with a cognitive impairment and one count of aggravated sexual assault of a person with a cognitive impairment at the Campbelltown District Court on 19 April 2013.

He was sentenced to a maximum term of six years imprisonment with a non-parole period of four years. Mr Wilson's earliest possible release date to parole was 9 October 2016. After sentencing, Mr Wilson was approved for placement to Bathurst Correctional Centre and then transferred to Cessnock Correctional Centre.

Mr Wilson was classified "minimum security" and remained at the Cessnock Correctional Centre until his death. An inspection of the New South Wales Correctional Service case management file indicates that Mr Wilson was not subject to any disciplinary action or misconduct charges.

Further the notes indicate there were no adverse comments about his behaviour and he had good work reports being described as "self-motivated, compliant, consistently polite and proactive in working in industries at the centre".

Mr Wilson's medical history

When Mr Wilson first went into custody he was identified with non-insulin dependent diabetes and hypertension. He had ECG examinations and X-rays with findings that were considered normal. The deceased also attended endocrinologists appointments while in custody.

In October 2014 Mr Wilson sustained an infection to his right leg which was swollen. He expressed to his ex-wife Maryanne that his treatment was taking a long time and his leg wasn't getting better. He was given antibiotics and his leg swelling resolved. He was examined for deep vein thrombosis and no DVT was found.

The events of 26 and 27 December 2014

Mr Wilson was locked in his cell as per normal routine at about 3:45 PM on Friday, 26 December 2014.

Senior Correctional Officer Kirkman in his statement indicated that he spoke to the deceased on three occasions on 26 December and the deceased appeared to be in normal health. The deceased did not complain of any unusual feelings and when last observed by the Officer he was sitting up in his bed and was responsive towards the officer. He was on all musters, obtained a meat pack and drink. He was not checked overnight, which is normal for inmates of this classification and in this location.

On 27 December 2014 at about 6.34 AM Correctional Officer Scott Wilson was conducting what is known as "let go" (the process of unlocking prisoner's cell doors) when he opened cell number 1326 housing the deceased. When he opened the cell he observed Mr Wilson lying face down on the floor motionless next to his bed. He engaged the deceased with verbal questioning from the doorway of the cell to attempt to gain a response. Not receiving a response he then entered the cell and knelt down next to the inmate and firmly shook the area between his shoulder blades to get a response.

He again received no response. He then checked his pulse on his neck to which there was no pulse. He then radioed for Assistant Superintendent Gallen to attend the cell immediately.

By this stage correctional officer Rootes also came to the cell and radioed for a medical response from Justice Health and other staff.

At about 6:37AM Justice Health nurses Abbot and Erets attended and commenced resuscitation. They pronounced the deceased life extinct a minute later. New South Wales Ambulance officers attended at 7:02AM and concurred with the nursing staff that Mr Wilson was deceased.

At about 7:10AM police officers attended from Cessnock police. They undertook their own investigation and found no suspicious circumstances. Mr Wilson had a normal cell placement as per his health problem notification form and was in a cell on his own. The inmate intercom was tested and found to be operational. The intercom had not been used by the deceased in the previous three days.

What caused Mr Wilson's death?

Dr Jane Vuletic senior staff specialist in forensic pathology performed an autopsy on 30 December 2014. In her report the Doctor concluded that the direct cause of death was ischaemic heart disease. She also concluded that Mr Wilson had atherosclerotic coronary vascular disease, hypertension and diabetes that were all significant conditions that contributed to his death.

Dr Vuletic also commented in the report that "the degree of atherosclerosis was such that the risk of sudden death was high; the mechanism of death likely to have been a fatal cardiac rhythm disturbance secondary to acute myocardial ischaemia. The heart also showed features of chronic hypertension."(Page 3 of the Report).

Are there any other issues to investigate?

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State.

Even when a person in custody dies of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility.

Only one issue appears to have been identified and that was under the Correctional Services operations procedural manual it states:

"Section 13.2.2 (a). Check for signs of life and commence resuscitating immediately"

While the initial correctional service officers did not commence resuscitation immediately the Justice Health nurses were on the scene within a couple of minutes and did attempt resuscitation. Further he was identified as being cold, and rigor mortis and lividity had set in. In those circumstances on balance it was highly unlikely that any immediate steps at resuscitation would have been successful.

Conclusion

I am satisfied on the available evidence that Mr Wilson's death is not suspicious and that he died as a consequence of a natural cause process.

I am also satisfied that Mr Wilson received health care of an appropriate standard whilst in custody. There is no evidence to suggest that any action or inaction by either Corrective Services or Justice Health contributed to Mr Wilson's death in any way. There was nothing that could have reasonably been done to prevent Mr Wilson's death. Given the opinion of Or Vuletic that there was a high risk of sudden death, it is highly likely that the outcome would have been the same even if Mr Wilson had not been in custody.

I do not intend to make any adverse comment or recommendation in relation to what I consider to be a technical breach of the operations manual.

Formal Finding

I find that Ronald Terrence Wilson died between the 26th and 27th of December 2014 at Cessnock Correctional Centre, Alunga Avenue Cessnock NSW. The cause of death was ischaemic heart disease.

The underlying conditions of atherosclerotic coronary vascular disease, hypertension and diabetes were all significant conditions which contributed to his death. Mr Wilson died of natural causes while serving a custodial sentence.

9. 341842 of 2014

Inquest into the death of John McFerrier. Finding handed down by Deputy State Coroner O'Sullivan at Glebe on the 14th July 2016.

The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of John McFerrier.

Introduction:

Mr John McFerrier was born on 13 April 1963 in Zimbabwe. At the time of his death he was in the custody of the Department of Immigration at the Villawood Immigration Detention Centre, Villawood.

As Mr McFerrier was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act 2009.

The Inquest:

The role of a Coroner, as set out in s 81 of the Coroners 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.

Pursuant to s 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

The Evidence:**Background:**

Mr McFerrier was born in Zimbabwe and immigrated to Australia in 2008. The International Health and Medical Services (IHMS) Progress Notes mention that Mr McFerrier was very close to his family and that they were a good source of support for him.

His sister, Marlien, lives in the United Kingdom and she is his next of kin. His only relative in Australia was an uncle in Perth. He was particularly close to his mother who died in 2008.

He was very affected by not being able to attend her funeral. She was only 17 years old when she became pregnant with him and they had a very close relationship. He describes them as being more like close friends than mother and son. Mr McFerrier was a gay man and had some difficulties coming out. He reported to Mental Health staff at Villawood detention Centre that he felt stigmatised in Blaxland, the unit in which he was held, because of his sexuality.

The IHMS Mental Health Progress Notes mention his feelings that “other blokes don’t engage with him. He feels that he is not welcome here.” The Progress Notes also state that he described himself as a very emotional man with a low tolerance for stress and that he dealt with stress by withdrawing. He loved cooking and enjoyed writing.

He reported that he believed that the reason he gained so much weight was due to “institute lifestyle”. He also reported not wanting to go back to Zimbabwe as he had little support there and held fears that he would be imprisoned or killed if he returned.

Custodial History:

In August, 2008 Mr McFerrier was convicted for drug trafficking offences and was sentenced to seven years imprisonment with a non-parole period of four years which commenced on 27 August 2008.

Upon his release from custody, Mr McFerrier’s visa was cancelled and he was sent to Perth Immigration Centre on 26 August 2012.

He was transferred to the Villawood Detention Centre on the 12th February, 2013 where arrangements were being made for his deportation to Zimbabwe. He was in immigration detention at the time of his death.

Medical history:

John McFerrier was morbidly obese weighing approximately 200kgs, however reportedly lost 60kgs prior to his death. Mr McFerrier suffered from a variety of health issues due to his weight and suffered from many ailments including skin sores, and ulcers.

Immediately prior to his death, Mr McFerrier had been housed at Villawood Detention Centre however, during his incarceration in immigration custody, his health was managed by International Health and Medical Services (IHMS).

In the days leading up to his death, Mr McFerrier was bedridden and immobile due to his back pain. He suffered from sleep apnoea and was taking antidepressants. Medical notes made by IHMS indicate that in the days leading up to his death, nursing staff observed his mental state to be declining due to poor health and back injury. The IHMS notes indicate that Mr McFerrier was seen by nursing staff on an almost daily basis and he was receiving daily medication for a range of medical conditions. He was also receiving support from mental health staff.

Liverpool Hospital Admission:

On the 14th November, 2014 Mr McFerrier complained of breathing difficulties. An ambulance was called and he was subsequently transferred to Liverpool Hospital Intensive Care Unit (ICU). He was constantly monitored and treated for severe septic poisoning, however his health continued to deteriorate.

The Fatal Incident:

Mr McFerrier was being constantly monitored in the Intensive Care Unit at Liverpool Hospital. Despite receiving multi organ support and antibiotic escalation, he suffered a cardiac arrest at about 12:44pm on the 17th November, 2014. The hospital staff commenced cardiopulmonary resuscitation at 12:44pm and the patient was shocked at 12:46pm.

Cardiopulmonary resuscitation was continued however all attempts to revive Mr McFerrier failed. He was pronounced life extinct at 12:55 on 17 November 2014.

As Mr McFerrier was in lawful custody at the time of his death, it is a mandatory requirement of the Coroners Act 2009 that his death be reported and an inquest held. Police were notified of his death and they attended Liverpool Hospital.

Care and Treatment:

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes, an inquest is required to independently assess whether the State has discharged its responsibility.

A thorough investigation was conducted into the death and all relevant medical and custodial records were obtained and form part of the coronial brief. These records indicate that Mr McFerrier's care and treatment was appropriate. Mr McFerrier's death is not suspicious and he died of natural causes.

Medical Record Review

A medical record review was conducted by Rebecca Irvine, Senior Staff Specialist Forensic Pathologist, Department of Forensic Medicine. She was of the view that the cause of death was:

**(a) Sepsis with multi-organ failure
Pneumonia (multi-drug resistant Staphylococcus)**

Complications of morbid obesity.

Formal Finding

The identity of the deceased

The deceased person was John McFerrier.

Date of death

John McFerrier died on 17 November 2014.

Place of death

John McFerrier died at Liverpool Hospital, Liverpool.

Cause of death

The medical cause of the death was sepsis with multi-organ failure; pneumonia (multi-drug resistant Staphylococcus) was an antecedent cause. Complications of morbid obesity were a significant condition contributing to his death.

Manner of death

John McFerrier died of natural causes whilst he was in immigration detention.

10. 7720 of 2015

Inquest into the death of Tateolena Tauaifaga. Suspended.

There being a person charged with an indictable offence in relation to the death of Tateolena TAUAIFAGA, the Inquest is suspended in accordance with *Section 78 of the Coroners Act 2009*.

11. 21976 of 2015

Inquest into the death of AA finding handed down by Deputy State Coroner Lee at Glebe on the 14th November 2016.

1. Pursuant to sections 75(1) & (2) (b) of the *Coroners Act 2009*, publication of any matter that identifies AA in relation to these proceedings is prohibited.
2. Pursuant to section 74(1) (b) of the *Coroners Act 2009*, the statement of Senior Sergeant Peter Davis dated 12 October 2016 (including all attachments) is not be published.
3. Pursuant to s 65(4) of the *Coroners Act 2009*, the statement of Senior Sergeant Peter Davis dated 12 October 2016 is not to be supplied in response to a request under s 65.
4. Pursuant to section 74(1)(b) of the *Coroners Act 2009*, the last two paragraphs on page 7 of Annexure E to the statement of Lisa Odgers dated 27 September 2016 is not to be published.
5. Pursuant to section 74(1)(b) of the *Coroners Act 2009*, annexures A, D, E and F to the statement of Brendan Forde dated 27 September 2016 are not be published.
6. Pursuant to s 65(4) of the *Coroners Act 2009*, the material the subject of orders 4 and 5 above is not to be supplied in response to a request under s 65.

Introduction

Mr AA was 43 years old at the time of his death. In his 43 years he had experienced extreme tragedy and hardship, both in his homeland in the Middle East and also in his adopted country of Australia. Despite these adversities, Mr AA was also shown kindness, friendship and generosity from people who were complete strangers to him. With the help of these people, who would later become his close friends, and through his own resilience, Mr AA later established a life for himself that was largely free of the adversity that he had previously experienced.

Sadly, Mr AA died on 22 January 2015, after intentionally taking his own life, in the most tragic of circumstances.

Why was an inquest held?

When a person's death is reported to a Coroner there is an obligation on the Coroner to make findings in order to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances in which that person died.

In AA's case the answers to most of these questions could easily be answered from the material which formed the brief of evidence submitted by the investigating police to the Coroner's Court. The only question which will be considered in detail in these findings is the manner of AA's death.

However, because police officers were called to the scene where AA's fatal injuries were inflicted, and because they were present when this occurred, AA is considered to have died in the course of a police operation. This means that, under section 23(c) of the *Coroners Act 2009* (the Act), an inquest into AA's death must be held.

The inquest examined issues surrounding the lead up to the fatal incident on 19 January 2015 and the appropriateness of the actions taken by police officers and others involved in the incident. These issues will be explored in greater detail below.

AA's life

Before going on to provide a factual summary of the 19 January 2015 incident, and the relevant events both before and after it, it is appropriate to briefly acknowledge AA's life.

AA was born in Basra, in southern Iraq, in 1971. Following the death of his father in the 1980s, AA, his mother and brother moved to Iran and later Syria as a result of the Iran-Iraq conflict. AA's mother later took her own life, leaving AA and his brother on their own. They eventually went to live with their uncle in Baalbek, in northern Lebanon. Following the end of the Gulf War it is believed that AA's brother joined a local militia before he later disappeared and was presumed to have died.

AA attended university in Beirut before eventually finding work as a journalist for local newspapers. He later married and had a son, I. Due to his job as a journalist AA encountered pressure from a militant political group which sought to use the newspaper as a means to further its own ends. AA was resistant to such pressure and this resistance would later prove to be catastrophic. AA's wife and young son were killed when a bomb was detonated in their home whilst AA was away.

Seeking to leave behind the tragedies that had plagued him AA travelled to Australia sometime in 2001 seeking to gain entry by unlawful means. He was taken into immigration detention and transferred to Woomera Detention Centre. In May 2002 AA was released from detention on a temporary protection visa and he made his way to Melbourne. He later discovered that a friend, Osama, who had been with him in detention at Woomera was now housed at Villawood Detention Centre. AA travelled to meet Osama and it was during a meeting at Villawood that Osama introduced him to Michelle McDonald. Ms McDonald had previously taken an interest, and become involved, in supporting refugees and persons seeking asylum who were housed in detention centres. Osama asked Ms McDonald if she could help AA who, at that time, was without accommodation or any financial means.

Ms McDonald generously agreed and brought AA to her home in Sydney's northern beaches. It was there that AA met Ms McDonald's then partner, Gavin Fry. The fortuitous meeting at Villawood would produce a friendship between AA, Ms McDonald and Mr Fry for the years to come.

Over time AA gradually developed a life for himself in Australia, working a number of different jobs whilst enjoying the vibrancy of living in Sydney's inner city suburbs where there was a strong cultural presence.

AA kept in semi-regular contact with Ms McDonald and Mr Fry and they continued to support AA with their friendship and kindness. AA's last job was as a truck driver for an ice works company making deliveries to all parts of Sydney.

Following a workplace injury whilst at this job, AA was unable to work again. Due to the limitations that unemployment placed on his financial situation, AA was forced to move from his home in Campsie. Over the following years, AA lived in different areas including Katoomba, Gymea, Newcastle, Oberon and, eventually, Singleton. Sadly, his forced relocation meant that he lost contact with Ms McDonald and Mr Fry. AA's inability to work and his life in remote areas only added to this social isolation.

Much of AA's frustration at not being able to return to work stemmed from his work ethic. AA was known to be hard-working, with a strength and energy for the difficult tasks that his jobs demanded of him. In his lighter moments, Ms McDonald described AA as being funny and engaging, with remarkable mimicry skills and a zest for life, especially before his injury. AA also never forgot the kindness that Ms McDonald had originally shown him, repaying that kindness by helping her when bushfires threatened her home and by looking after her following an operation.

What happened as a result of AA's workplace injury?

On 23 January 2007 AA was at work when he slipped and fell from the back of a truck and onto the road, fracturing his wrist in the process. He subsequently lodged a claim for compensation. The claim was handled by QBE Workers Compensation (NSW) Limited (QBE). The inability to work frustrated AA and had an adverse effect on his mental well-being. As part of his claim AA received both medical treatment for the injury itself, and also psychiatric counselling. AA also received weekly entitlement benefits and was paid a permanent impairment settlement amount in April 2010.

Over time, the frustration at being unable to work, AA's isolated existence, and the demands that were made of him to attend medical assessments as a routine part of the compensation claim manifested themselves in anger and rash behaviour on AA's part.

In October 2008 and January 2010 AA made threats towards QBE staff members and also a solicitor who had been working with AA in relation to his compensation claim. These incidents were reported to the police but, following discussions with the people involved, were not taken any further.

AA's claim was eventually transferred to the QBE office in Newcastle. One of the case managers there, Patrick Walker, took over the day-to-day management of AA's claim in March 2012.

What happened on 12 November 2012?

On 12 November 2012 AA went to the QBE Newcastle office for an unscheduled meeting with Mr Walker to discuss his compensation entitlements. Peter Bell, another QBE employee, was also present at the meeting. The meeting was unremarkable until at some point AA told Mr Walker and Mr Bell, "I have petrol and I want to kill myself". AA reached into a backpack that he had brought with him to the meeting and withdrew a plastic drink bottle which contained some type of liquid.

Mr Bell asked AA if the liquid was petrol and AA confirmed that it was. Mr Bell asked AA if he could smell the liquid in order to see for himself. AA allowed him to do so and, after smelling the contents of the bottle, Mr Bell recognised the smell of petrol. Mr Bell placed the bottle on the ground away from AA. It appears that the meeting continued without further incident.

After the meeting ended AA asked for the bottle back but Mr Bell refused to return it and instead left the meeting room in order to secure it in another part of the office. AA did not appear to be troubled by the bottle not being returned because when Mr Bell re-joined the meeting, AA shook their hands, thanked them and left.

Immediately after the meeting Mr Walker and Mr Bell told Lisa Odgers, the portfolio manager of the Newcastle office, about the incident. Mr Walker also told AA's treating psychiatrist at the time, Dr Samir Benjamin, about the incident. Ms Odgers in turn notified Brendan Forde, the State Manager of QBE, via email and also notified QBE security staff in the Newcastle office. The security staff suggested to Ms Odgers that she should call the police and so Ms Odgers did so. She called Newcastle police station and passed on the details she had been given about the incident.

What happened leading up to 19 January 2015?

Mr Walker called AA on 5 November 2014 in order to discuss an upcoming appointment that AA had with a doctor regarding his injury.

AA expressed some unhappiness at being referred for another assessment but eventually agreed to attend. Mr Walker called AA back on 11 November 2014 in order to advise him that the appointment, which had been scheduled for the following day, needed to be changed to a different day due to the doctor being unavailable.

On 14 November 2014, the day after the scheduled appointment, AA called Mr Walker back. During the call AA indicated that he was frustrated about the brevity of the appointment and about having to attend in the first place. AA also asked for a referral to a psychiatrist. Mr Walker explained that a referral from AA's treating doctor was required before a psychiatrist could be engaged.

In December AA received two letters from QBE dated 15 December 2014 and 16 December 2014. At this time AA was receiving entitlement benefits that were paid fortnightly by direct deposit into his nominated account. The letters explained that there would be a change in the usual schedule of AA's payments due to the upcoming Christmas and New Year period.

Effectively the only change was that instead of receiving a fortnightly payment on 29 December 2014, AA would be paid his fortnightly entitlement 8 days earlier on 21 December 2014. This change in payment schedule was routine practice for QBE, and was applied to all persons receiving entitlement payments, due to reduced staff levels over the Christmas period. However, it is unclear why two letters in the same terms were sent to AA, when only one was required.

What happened on 19 January 2015?

Sometime before 10:30am on 19 January 2015 AA parked his car on Throsby Street, Wickham about 900 metres from the QBE Newcastle office located on level 4 at 28 Honeysuckle Drive, Newcastle.

AA secured the car's steering wheel with a lock and locked the car. He walked to the office building, entering at 10:34am. AA caught a lift from the entry lobby to level 4 where the QBE reception area is located.

The reception area is typically staffed however on this day, due to a staff meeting at the time, the area was unattended. Typically, members of the public do not visit the reception area with walk-in enquiries.

The reception area is located to the right of the elevators as one exits the elevators and consists of a front counter and a waiting area with armchairs. The front counter itself has two glass panels, from the counter to the ceiling, with a gap in the centre through which people can speak and papers can be passed through. There is also call button to alert staff if the counter is unattended. A large window is located to the right of the counter area, with a glass door located to the left of the counter for staff to enter and exit.

AA walked into the reception area carrying a backpack and some papers in his hand. He was wearing jeans, a long-sleeved collared shirt and a baseball cap. At 10:35am AA placed his backpack on one of the armchairs and removed a 1.25 litre plastic drink bottle from the backpack. For the next 9 minutes AA is seen on CCTV footage to be pacing around the reception area, standing and looking out the window, and at times talking to himself. At 10:44am AA placed the papers in his hand on the front counter.

At 10:57am two QBE staff members, Candice Taylor and Nikki Lopez, walked out of the door next to the counter on their way to the elevator. Ms Taylor saw AA looking out the window and saw the plastic bottle in his right hand which she noticed was half-full of a yellow-coloured liquid. Ms Taylor initially thought that the liquid was alcohol. She asked AA if he needed any assistance and when AA did not answer, Ms Taylor repeated the question. AA half-turned in Ms Taylor's direction and mumbled the word "trick" which Ms Taylor assumed to be a reference to Patrick Walker. She walked back into the office area and told Mr Walker, who was at his desk in the office area behind the counter, what had just occurred. Mr Walker looked through the counter area and immediately recognised AA from their earlier meeting in November 2012.

Mr Walker told Mr Bell, who was also in the office area behind the counter, that AA was in the reception area and asked him to speak with AA.

Ms Taylor explained that, as Mr Bell was previously employed as a police officer, he was often asked to speak with persons at the front counter if there is a concern for staff safety.

Mr Bell and Mr Walker both walked to the front counter area at 11:01am but remained behind the glass partition. They saw that AA was still looking out the window.

As they approached, AA raised the bottle next to his shoulder and poured the liquid inside the bottle around his shirt collar and onto his clothing. Analysis would later reveal that the liquid was mineral turpentine.

Seeing this, Mr Bell told Mr Walker to call the police immediately. Records from the police incident despatch log indicate that this call was received at about 11:02am. Mr Bell approached AA, saying, "Come on mate. Let's talk about this". AA initially did not reply and instead raised his left hand, showing Mr Bell that he was holding a cigarette lighter.

For the next 8 minutes Mr Bell attempted to engage AA in some general conversation in order to distract him from using the lighter. Mr Bell repeatedly told AA that he would like to talk with him but that he (AA) needed to first put the lighter down. AA was unresponsive to Mr Bell's requests. At some point AA said, "I only have two regrets in my life. That is my mother and father meeting and having me, and me coming to Australia from Iraq in 2001". Mr Bell continued trying to engage AA in other general conversation, again in order to distract him. During this time, another QBE staff member, Matt Angelov, entered the counter area and asked AA if he could do anything to help. Mr Angelov saw that AA was crying and heard AA say, "I have no future".

After Mr Bell's call was entered on the police despatch system it was acknowledged at 11:04AM by Leading Senior Constable (LSC) Benjamin Kelly and Constable Aaron Hudson. At the time, both police officers were performing general duties in the Newcastle area in a police vehicle with call sign NCC-19. LSC Kelly and Constable Hudson proceeded to the QBE office building, arriving at 11:07am.

Mr Bell kept trying to engage AA in conversation, however AA would either only nod or stand in silence looking out the window. By also looking out the window Mr Bell saw vehicle NCC-19 approaching the building. He wrote the words "Cops downstairs" on a piece of paper and showed it to Mr Angelov. He also whispered to Mr Angelov, "Can you go around and stop them at the elevators".

Meanwhile, LSC Kelly and Constable Hudson had already arrived at the scene. As he exited his vehicle LSC Kelly grabbed a fire blanket that was kept within the vehicle as part of equipment used in bush fire situations. LSC Kelly and Constable Hudson entered the building and made their way to the elevators in order to reach level 4.

Upon reaching level 4 at 11:09am, LSC Kelly stepped out the elevator and immediately smelled a strong odour of what he described as some type of accelerant. He saw that AA was standing to his right in front of the window about 10 metres away.

LSC saw that AA had something in his right hand and that his left arm was held out in front of him. LSC Kelly called out to AA by saying, "Hey mate". According to Mr Angelov, he heard one of the police officers say something similar to, "Are you OK?" followed by the words, "Put the lighter down".

As the police officers walked towards the reception area, AA moved his left hand towards his right arm and struck the lighter. This ignited the mineral turpentine on AA's clothing, producing flames on AA's left arm which, almost immediately, engulfed his entire body. AA initially stood in one place waving his left arm around, then turned in the direction of the police officers and ran towards them, yelling as he did so. Constable Hudson used his radio to call for further assistance, indicating that AA had set himself alight.

LSC Kelly initially stepped backwards, unfolding the fire blanket as did so, concerned that AA would run at himself and Constable Hudson and set them alight. However as AA ran towards him LSC Kelly moved forward, yelling at AA to drop to the ground. LSC Kelly threw the blanket over AA and pushed him to the ground, using the blanket to suppress the flames. LSC Kelly called out to Mr Bell for a fire extinguisher. As he attempted to smother the flames surrounding AA's body, LSC Kelly yelled at AA to roll around on the ground, hoping that this would help to put out the flames.

Within seconds Mr Bell obtained a fire extinguisher which he directed at AA and extinguished the remaining flames. Another QBE staff member, Allan Mitchell, obtained another fire extinguisher and used it to combat flames which had spread to the carpet in the reception area.

The conflagration which engulfed AA burnt almost the entirety of his clothing, leaving his skin extremely blistered. Although AA was still conscious, he was unable to speak. LSC Kelly spread the fire blanket flat on the ground and instructed AA to roll on to it.

Then, with the assistance of two QBE staff members, the police officers carried AA down the fire escape stairs in the makeshift stretcher made from the fire blanket.

Once they reached the building's car park ambulance personnel, who had arrived at the scene by this time, they took over AA's care.

AA was taken by ambulance to John Hunter Hospital and later airlifted to Royal North Shore Hospital in Sydney for treatment of 65% total body surface area full thickness burns. AA's condition was considered to be extremely grave. Despite advanced life support measures AA later died at hospital on 22 January 2015.

What was the cause of AA's death?

Dr Kendall Bailey, forensic pathologist, performed the post-mortem examination on 23 January 2015 at the Department of Forensic Medicine in Glebe. She found that AA had suffered significant loss of skin and subcutaneous tissue from his upper limbs. Dr Bailey ultimately concluded that AA died from complications of thermal injuries, noting that such injuries cause dysfunction in regulation of blood pressure, heart rate, and body temperature, as well as decreased blood oxygen levels and increased risk of infection.

Was the response to the incident on 12 November 2012 appropriate?

There is no evidence to suggest that the QBE staff did not appropriately deal with the incident on 12 November 2012. It is clear that after Mr Bell confirmed that the bottle that AA produced did in fact contain some type of accelerant, it was removed and not returned to AA. Further, it appears that Mr Bell and Mr Walker sat with AA for 30 minutes to discuss his claim and then they called AA's general practitioner, Dr Khalil, to notify him of the incident and AA's emotional state. Pre-approval was also given by QBE for any treatment that Dr Khalil felt was required. This seems to have resulted in a referral by Dr Khalil to Dr Samir Benjamin, a consultant psychiatrist.

Following the meeting, QBE staff attempted to call AA a number of times to check on his welfare, but the calls were not answered. Ms Odgers also reported the incident to the local police.

However, there is no police record of this call having been made, although there is a contemporaneous note made by Ms Odgers.

It is not known why this is the case. However, it seems by the time the matter had been reported to the police any possible risk of self-harm, or harm to another person, had subsided. All accounts indicate that by the time of the report AA had returned to his usual functioning and appropriate follow-up steps had been put in place by QBE staff. As no further action was required, this may explain why no police record was made of the report.

In any event, there is no evidence to suggest that any further action should have been taken by either QBE staff or by the police. Given that this incident occurred a little over 2 years prior to the fatal incident, it also cannot be said that any action or inaction taken by QBE staff or the police contributed to AA's death.

What prompted AA to go to the QBE office on 19 January 2015?

The evidence suggests that the two letters AA received from QBE in December 2014 motivated AA to attend the QBE office. It was these same two letters that AA placed on the counter in the reception area on 19 January 2015.

Mr Fry was well aware that changes to the frequency of AA's entitlement payments troubled AA and caused him concern. Mr Fry explained that, because of AA's financial situation, even a small change in the frequency of payments made it difficult for AA to manage his budget. Although Mr Fry had in the past tried to help AA plan for such periods by setting aside some money in advance of them, AA still found these periods challenging.

As already mentioned above, the change in the timing of AA's entitlement payments was routine practice for QBE and not in any way unusual. It was a practice applied to all entitlement recipients. AA did not suffer any financial disadvantage as a result of this practice. Financial statements confirm that AA received the payment that he was entitled to, the only difference being that it was paid 8 days earlier (on 21 December 2014). However this earlier payment meant that AA's next payment would not be for another 22 days (on 12 January 2015). Given AA's difficulties with budgeting that Mr Fry described, it seems clear that this extended period between payments would have caused AA concern and prompted him to act by going to the QBE office on 19 January 2014.

The fact that AA had also in November 2014 expressed his dissatisfaction with his ongoing medical assessment requirements probable also played a part in AA's decision to act.

Was the response by QBE staff to the 19 January 2015 incident appropriate?

According to the CCTV footage, AA was in the reception area for approximately 23 minutes before he had any interaction with QBE staff. As explained already, the counter of the reception area is normally staffed but was not on this particular day due to a staff meeting. In any event there was a call button which AA could have used to alert a staff member of his presence. However, AA did not use this button and the CCTV footage indicates that AA was not demonstrating any signs of urgency, or any frustration that his presence in the reception area had not been acknowledged. Apart from the times when he was talking to himself, the footage suggests that AA was waiting calmly in the reception area, often looking out the window. There is no evidence to suggest that the delay in attending to AA influenced his later actions.

There is also no evidence to suggest that any interaction with the QBE staff prompted AA to pour the mineral turpentine on his clothing. The CCTV footage clearly shows that this occurred as Mr Bell and Mr Walker walked into the counter area. Neither Mr Bell nor Mr Walker had any opportunity to speak with AA before this occurred.

Having seen what AA had done, a call was immediately placed to the police. There is no suggestion of any delay in responding to the situation, or any suggestion that there should have been any other response. For approximately the next 8 minutes Mr Bell sought to direct AA's attention away from the prospect of causing himself, or anyone else, harm. The evidence establishes that AA was largely non-responsive to Mr Bell's attempts to engage him. Again it does not appear from the CCTV footage that AA was visibly disturbed by Mr Bell's attempts, nor by the presence of Mr Angelov and his offer of assistance. I can find no evidence that the actions of Mr Bell and Mr Angelov were not an appropriate response to the confronting situation which they faced. Instead, they should be commended for dealing with an extremely difficult situation in a calm and compassionate manner.

Was the response by the attending police officers to the 19 January 2015 incident appropriate?

It should be noted at the outset that there is no suggestion on the available evidence that the actions of the attending police officers on 19 January 2015 was anything other than appropriate.

However, one of the primary reasons why an inquest must be held when there is a death in the course of, or arising from, a police operation is so that an independent investigation can be conducted into the circumstances of the death and the actions of the police involved.

The involvement of the police in AA's case raises two issues. Firstly, did any action by the police in the reception area contribute to AA's death? Secondly, did the absence of a fire extinguisher in the vehicle NCC-19, and therefore the inability of LSC Kelly and Constable Hudson to use one, contribute to AA's death?

Did any action or inaction by the police officers contribute to AA's death?

The first issue arises primarily due to the evidence of Mr Bell. In his statement Mr Bell says that he asked Mr Angelov to stop the arriving police at the elevators. Mr Bell did not specify whether he was referring to stopping the police from entering the elevator on the ground floor lobby, or whether he was referring to stopping the police once they exited the elevator on level 4. However, given the close proximity of the elevators on level 4 to the reception area, it seems that Mr Bell was referring to stopping the police from entering the elevator in the lobby. It appears that Mr Bell's made this request because he was concerned that the sudden arrival of the police might trigger an adverse, unwanted response from AA.

However, there is an inconsistency in Mr Angelov's evidence regarding this issue. In his statement Mr Angelov said that Mr Bell told him that the police were downstairs and to make sure that they were able to access the building. As neither Mr Bell nor Mr Angelov gave oral evidence at inquest, it is not possible to resolve this inconsistency. However, resolution is unnecessary because the evidence given by Detective Senior Constable (DSC) Darren Evans, the officer-in-charge of the investigation, during the inquest was that LSC Kelly and Constable Kelly would not have acted any differently even if Mr Bell had made his request and it had been passed onto them. DSC Evans explained that this is because LSC Kelly and Constable Kelly were confronted with an imminent threat of harm, not only to AA but also to other persons in the building.

This then leads to consideration of whether the subsequent actions taken by LSC Kelly and Constable Hudson were appropriate. It seems clear that the arrival of the police officers on level 4 prompted AA to act by striking the lighter and igniting his right arm. This is because by the time this occurred AA had been in the reception area for approximately 34 minutes.

It had also been approximately 8 minutes since he had poured the mineral turpentine on his clothing. Given this amount of time, during which AA had demonstrated no other steps towards self-harming behaviour, the fact that he acted within seconds of the arrival of the police would not appear to be mere coincidence. Furthermore, it seems likely that AA was aware of the imminent arrival of the police officers. Mr Bell could clearly see the approaching police vehicle from his view out of the reception window. It is very likely that AA also had the same view.

Despite the arrival of the police prompting AA to act, there is no evidence to suggest that they could have done anything to prevent AA from doing so. The CCTV footage shows that a mere 13 seconds elapsed from the time the police officers exited the elevator to the time that AA ignited his arm. There was no opportunity for anything other than a very brief moment of interaction between LSC Kelly and AA. I acknowledge that there is a discrepancy in the evidence regarding what LSC Kelly actually said to AA. However, given the brevity of the interaction and the absence of any response from AA, it does not appear that what was actually said by LSC Kelly prompted AA to act.

So far as the response by LSC Kelly and Constable Hudson are concerned, the inquest received evidence in the form of a statement from Senior Sergeant Peter Davis. [REDACTED]

There is no evidence to suggest that LSC Kelly and Constable Hudson should have been acting in accordance with any standard operating procedure on 19 January 2015. The situation that they were confronted with was unusual and required initiative and swift thinking. It is clear that both police officers demonstrated these attributes in dealing with the situation. They, like the QBE staff members, are to be commended for doing so. Once AA had ignited his arm, LSC Kelly acted appropriately and bravely by moving towards AA in order to more quickly use the fire blanket to combat the flames around AA's body. LSC Kelly gave appropriate directions to AA for him to get on the ground and called for the QBE staff to assist by obtaining a fire extinguisher.

Why was there no fire extinguisher in police vehicle NCC-19?

This leads to the second issue concerning the absence of a fire extinguisher in police vehicle NCC-19. The vehicle was a Ford Ranger dual cab utility that was regularly used by general duties officers from Newcastle police station. At the time of the vehicle's original fit out on 8 October 2013, a fire extinguisher was located in the vehicle. Although sometimes fire extinguishers in police vehicles were mounted to a bracket in the front passenger foot well, on occasions the extinguishers were stored loosely in the rear seat foot well area in order to avoid obstructing the front seat passenger.

LSC Kelly said that he only briefly looked for a fire extinguisher in the vehicle before grabbing the fire blanket. According to inspection records for NCC-19 between November 2014 and February 2015 it appears that the fire extinguisher was last recorded as being present on 30 November 2014. An inspection record for 7 December 2014 notes that it was to be replaced, which suggests that it was no longer present by this date. On 18 January 2015 the word "nil" was recorded in the inspection entry. All of this suggests that there was no fire extinguisher within NCC-19 on 19 January 2015. The reason for this is unknown.

Notwithstanding, there is no evidence that the absence of a fire extinguisher contributed to AA's death in any way. LSC Kelly had equipped himself with the fire blanket and was conscious of the fact that there would be fire extinguishers available within the building. The CCTV footage establishes that within 10 seconds of ignition LSC Kelly was using the fire blanket to suppress the flames whilst AA was on the ground, and that within 21 seconds of ignition Mr Bell had obtained a fire extinguisher and began discharging it on the remaining flames on AA's body.

There is no evidence to suggest that earlier use of the fire extinguisher would have prevented AA's death or that the absence of a fire extinguisher in vehicle NCC-19 contributed to it in any way.

What was the manner of AA's death?

It is clear that AA brought the bottle containing mineral turpentine and a cigarette lighter with him to the QBE office. What AA's exact intentions were up until the point of ignition will remain unknown. AA himself may not have known what he was planning to do. There is the possibility that he may have brought the items, and poured the mineral turpentine on himself, as a way to draw attention to his perceived grievance with the change in his entitlement payment schedule or his dissatisfaction with having to frequently attend medical appointments. This is because the evidence establishes that AA parked his car in the closest non-metered parking area to the QBE office. He also locked his car and secured it with a steering wheel lock. These factors suggest that AA wanted to avoid being given a parking ticket and that he intended to return to his car at some stage.

Furthermore, Mr Fry visited AA's unit in Singleton the day after AA's funeral in order to gather some of his personal belongings. Mr Fry had visited the unit before and on this occasion found it to be tidy, organised and well kept. As someone who was familiar with the various homes where AA lived, Mr Fry expressed the opinion that there was nothing to suggest that AA was not planning to return to the unit.

The incident on 12 November 2012 is the only evidence of any time that AA had previously expressed any intention of harming himself. None of the medical records indicate that AA had previously expressed any suicidal ideation. Indeed, the most recent record in about February 2013, prior to AA's death, indicates that he had denied any thought of self-harm.

However, there is other evidence indicating that AA deliberately ignited his arm and that his intention in doing so was to end his own life. I consider the evidence to be sufficiently cogent and persuasive to allow such a conclusion to be made for the following reasons:

Firstly, even allowing for the discrepancy (already referred to above) regarding which hand AA used, the evidence of both Mr Bell and LSC Kelly is that AA deliberately moved the lighter to his arm and ignited it.

Secondly, this was done with knowledge of AA's own deliberate act in pouring the mineral turpentine on himself.

Thirdly, the presence of both the lighter and the mineral turpentine were preparatory acts taken by AA.

Fourthly, AA had been diagnosed as suffering from adjustment disorder with depressed mood in February 2013. Given AA's increasing social isolation and his growing dissatisfaction with aspects of his claim in November 2014 it appears that his mental well-being was in sharp decline.

Finally, AA's unsolicited comments to Mr Bell and Mr Angelov indicated feelings of regret about his own life and existence and, by inference, an intention to act on such feelings.

Having considered all of the above, I conclude that AA's death was deliberately self-inflicted.

Should any recommendations be made?

Section 82 of the Act allows a coroner to make recommendations in relation to any matter connected with a person's death. The words of section 82 say that such recommendations may be made if the coroner considers them to be necessary or desirable. Issues of public health and safety can be, and often are, the subject of recommendations.

Given that I have found that the actions of the QBE staff and the police officers were entirely appropriate, and that there is no evidence that any action or inaction taken by them contributed to AA's death, it is neither necessary nor desirable for any recommendations to be made.

Formal Finding

Identity

The person who died was AA.

Date of death

AA died on 22 January 2015.

Place of death

AA died at Royal North Shore Hospital, St Leonards NSW 2065.

Cause of death

The cause of AA's death was complications of thermal injuries.

Manner of death

AA died as a consequence of actions taken by him with the intention of ending his life when he deliberately set himself alight.

Epilogue

AA's early life, and the last moments of it, was filled with tragedies and hardships that most people fortunately do not experience. However, during the years between these periods AA found kindness, generosity and friendship in the most unlikely of places. AA was also shown kindness in death with his funeral rites performed by stranger whose only connection to AA was that he came from the same hometown as him. Despite AA living a mostly solitary life during his time in Australia it is clear that he made a lasting connection with the lives of others. To those people, I would like to extend my condolences on behalf of the Coroner's Court.

12. 32915 of 2015

Inquest into the death of Sidney Bowtell. Finding handed down by Deputy State Coroner Truscott at Glebe

This inquest into the death of Sidney Bowtell is conducted pursuant to section 27(1)(b) and s23 (d)(ii) of the Coroners Act 2009. Mr Bowtell was born in Queensland on the 6 January 1971.

He was the son of John and Deborah BOWTELL. Sidney BOWTELL had a brother, Simon BOWTELL, and a half-sister, Kimberly ROSS. Simon attended this Inquest. At the time of his death, Mr Bowtell was a prisoner in the custody of the NSW Department of Corrective Services. He was accommodated in the Long Bay Hospital Ward Medical Subacute Unit.

I have received a brief of evidence and a report by the Department of Corrective Services into relating to their investigation into Mr Bowtell's death.

On the 20 July 1989 Sidney BOWTELL was convicted and sentenced to life imprisonment for a sexual assault and murder in Wollongong, New South Wales. On appeal, this sentence was reduced to 21 years with a non-parole period of 15 years. The non-parole period was to end on the 24 September 2003 however in 2001 he escaped and whilst at large for 2 days he committed further serious offences.

Upon appeal to the Court of Criminal Appeal Mr Bowtell received a further sentence of 11 years imprisonment, with a non-parole period of 6 years commencing on 25 September 2006. He also received a 2 year fixed term commencing 25/9/2012.

He was eligible to be considered for release to parole on 25 September 2014 with a balance of 3 years of his sentence remaining. In December 2014 the Parole board declined to grant parole indicating that a further consideration of parole would be given in July 2015.

In February 2012 Mr Bowtell was treated for a lesion on his right upper forearm. The biopsy indicated basal cell carcinoma.

It was completely removed without complications. In April 2012 a biopsy of a lump on his neck revealed he had a nerve sheath tumour.

Further biopsies showed metastatic melanoma, primary site unknown. He also had papillary thyroid carcinoma. In March 2013 Mr Bowtell was diagnosed with a lesion in his lung. He was given a life expectancy prognosis of three to six months. In December 2013 he had a CT scan of his brain, which showed haemorrhaging. He had a craniotomy and resection of his brain. Post procedure complications such as infection and meningitis attributed to further deterioration. In June 2014 another CT scan indicated ongoing disease progression, increasing metastases and new brain metastases. By the end of November 2014 Mr Bowtell was often confused, receiving palliative care and required assistance with basic care•

On the 14 January 2015 Mr. Bowtell was granted parole pursuant to the provisions of section 160 of the Crimes (Administration of Sentences) Act 1999. Section 160 of the Crimes (Administration of Sentences) Act provides for early parole to be granted where an inmate is dying or because there are exceptional extenuating circumstances. The Corrective Services Sentence Administration Branch supported the issuing of a parole order for the deceased on the basis of what they referred to as a "rapid decline in health, with his life expectancy now only a matter of weeks".

In support of this diagnosis, the Corrective Services Administration Branch refers to the 7 January 2015 letter of Ms. Julie BABINEAU, Chief Executive of the Justice and Forensic Mental Health Network, and the letter of Dr Georgia SAYER, Palliative Care Registrar at Prince of Wales Hospital. Dr SAYER states "he has progressive metastatic melanoma with multiple brain metastases. He is having no further active treatment, with comfort measures only. The palliative care team have been reviewing him in the MediSurg Unit at Long Bay Jail and he is now deteriorating clinically with signs of raised intracranial pressure, and his prognosis is now very limited, perhaps only weeks."

Mr. Bowtell was released on parole on 14 January 2015. He was admitted into the Sacred Heart Hospice at St Vincent's Hospital Darlinghurst. Mr. Bowtell's family visited him, his father travelling from Western Australia.

Mr. Bowtell's health was such that he was able to leave the hospice and attend local cafes and though he was able to walk a few steps he was conveyed by wheel chair.

On the 19 January 2015, a nurse at the Sacred Heart Hospice contacted the Long Bay Parole Unit to verify release conditions and permission to leave the unit regarding the deceased. On the 20 January 2015, the deceased was again absent from the hospice. He was apparently noticed by the media who then made inquiries about the terms of Mr. Holman's liberty with Ms. Holman, the manager of the Hospice.

The Community Corrections Officer Libby Leafe spoke with Ms. Holman on the 20 January 2015 and according to Ms. Leafe's file note Ms. Holman stated that the deceased was mobile, could walk short distances, was attending art class, and had been out in the local area in a wheel chair with family members. Prognosis was discussed, and Ms. Holman stated that the facility never provides a definitive prognosis on any patient and confirmed that often patients who enter palliative care improve initially before a further decline in their health occurs.

Mr. Bowtell's parole was revoked on the 20 January 2015. The reason cited on the revocation of parole order is a breach of condition 4 of the parole order, which states: "This order may be revoked should the grounds on which this order is made no longer exist."

Mr. Bowtell's return to prison would have been very difficult and disappointing for him and his family but it is not a role of this Inquest to inquire into the revocation of parole. Suffice to say that the offences for which Mr. Bowtell was on parole were extremely serious and the course of his illness did not involve the rapid deterioration as was apparently anticipated. There is no suggestion that either Mr. Bowtell or his family behaved inappropriately or in breach of the Parole Order.

Mr. Bowtell was again accommodated at the Long Bay Hospital's Medical Subacute Unit.

His care was palliative. Mr. Bowtell was subject to a "No CPR order". This order was put in place during a period when he was admitted to the Prince of Wales Hospital between the 28 October 2014 and the 26 November 2014. Dr Spasojevic formalised this on the Justice Health file on the 27 November 2014 following a discussion with Mr. Bowtell during which he agreed and consented to such an Order remaining.

I have read the progress/clinical notes on record and it is clear that over the ensuing days Mr. Bowtell received the appropriate care and treatment and pain management. He was treated with dignity and care. Mr. Bowtell's brother Simon was able to visit as was a friend.

At about 8:00 p.m. on Monday the 2 February 2015, Justice Health nurse Brian Owens was performing medication rounds in the company of First Class Correctional Officer Derek Gomez and Probationary Correctional Officer Joshua Hamade. About 8:05 p.m. Officer Gomez and Nurse Owens entered Mr. Bowtell's cell and observed that he was breathing in sporadic amounts of four breaths per minute. He was pale and unresponsive to verbal commands.

Officer Gomez contacted Senior Correctional Officer Gay Taylor and informed her of Mr. Bowtell's deteriorating condition. About 8:10p.m. Officers Taylor and Gomez and Nurses Prasai and Owens entered Mr. Bowtell's cell. Nurse Owens detected nil respiration or heartbeat, and he pronounced Mr. BOWTELL life extinct at 8:10 pm. Following Mr. Bowtell's death the Department of Corrective Services, in accordance with protocols conducted the appropriate investigations relevant to the death of a person in custody and that report is an exhibit in these proceedings. There are no issues which require further inquiry or any recommendation.

Formal Finding:

Sidney Justin Bowtell died on 2 February 2015 in the Medical Subacute Ward, Long Bay Hospital of natural causes, namely metastatic malignant melanoma.

13. 39150 of 2015

Inquest into the death of David Fleming. Finding handed down by Deputy State Coroner Lee at Glebe on the 8th March 2016

Introduction

Section 81(1) of the *Coroners Act 2009* requires that when an inquest is held the coroner must record his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Mr David Fleming.

The role of a Coroner and purpose of this inquest

The role of a Coroner, as set out in section 81 of the *Coroners 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.

As Mr Fleming was in lawful custody at the time of his death an inquest is required to be held pursuant to sections 23 and 27 of the Act.

Pursuant to section 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

Mr. Fleming's personal history

Mr Fleming was born in 1953. Little is known about his early years other than he lost contact with his sister, Narelle Milligan, in the early 1980s. During the same period of time he sustained an injury to his leg which required it to be amputated above the knee.

Mr Fleming met his eventual wife, Maureen McConville, in Cairns in 1985.

At the time, Mr Fleming was exploring the possibility of receiving an improved prosthesis in the hope of returning to work as a long distance truck driver.

After several months he moved to Melbourne where he worked for a company moving containers on the wharves.

Ms McConville later joined him in Melbourne where they lived for about 18 months before eventually returning to Queensland. They married in Nambour in 1988.

Over the next several years, Mr Fleming moved to a number of different areas – New Zealand, Tasmania, Darwin, and South Australia – before returning to Victoria and settling in the town of Willatook, near Warrnambool.

Ms McConville presently resides in New Zealand and was not present at the inquest. She was informed of these proceedings via email communication with the police officer in charge.

Mr. Fleming's custodial history

Mr Fleming was arrested on 18 January 2005 and extradited to New South Wales on a charge of murder. He entered Corrective Services NSW custody a day later. At the time, Mr Fleming was confined to a wheelchair and suffering from medical difficulties relating to his heart, back and respiratory system for which he was taking medication.

Mr Fleming was initially kept on remand until being convicted of murder and then sentenced on 29 June 2007 to a sentence of 21 years (commencing on 18 January 2005) with a non-parole period of 16 years. Mr Fleming's earliest possible release date to parole was 17 January 2021.

Whilst on remand Mr Fleming was initially kept at the Metropolitan Remand and Reception Centre (MRRC) in Sydney. Due to his mobility impairment Mr Fleming was later transferred to Junee Correctional Centre in December 2007. However Parklea Correctional Centre was later identified as being more suitable accommodation for Mr Fleming and he was transferred there in November 2011.

Due to accommodation changes at Parklea, Mr Fleming was returned to Junee in February 2013 where he remained until he was transferred to Long Bay Hospital in October 2014.

Mr. Fleming's medical history

Mr Fleming had numerous serious medical issues that required ongoing care and treatment. He suffered from recurring back pain, osteoarthritis, migraines, sleep apnoea and asthma. These ailments were complicated by Mr Fleming's obesity and lack of mobility. In 2012 Mr Fleming underwent an operation for a perforated gastric ulcer.

He was referred to a cardiologist for chest pain in 2014. In the same year he was treated for bronchitis and was later found to be coughing up blood. A subsequent CT scan detected laryngeal squamous cell carcinoma (cancer of the larynx). Although several dates were planned for surgical intervention, Mr Fleming did not agree to the surgery proceeding.

On 7 October 2014, Mr Fleming was transferred from Junee to the medical subacute ward at Long Bay Hospital. In late 2014 Mr Fleming initially opted for radiation therapy but later decided to have a laryngectomy (surgical removal of the larynx) in December. Several weeks after surgery Mr Fleming refused further treatment causing the wound site to become open. On 12 January 2015 he signed an advanced care directive not to be resuscitated together with a no cardiopulmonary resuscitation (CPR) order.

Mr Fleming subsequently developed post-operative complications due to his refusal to eat and resist nasogastric feeding. He also refused to adequately maintain appropriate care in relation to a tracheostomy (surgical insertion of a tube in the windpipe to assist breathing).

On 31 January 2015 Mr Fleming was admitted to Prince of Wales Hospital due to difficulty breathing. He later discharged himself against medical advice.

The events of 5 and 6 February 2015

On the afternoon of 5 February 2015 Mr Fleming was in the yard area of the subacute ward. He asked a correctional officer if he could return to his cell. At about 3:30pm an officer saw Mr Fleming cleaning his throat with a medical device. At 6:30pm Mr Fleming was given his medication. Approximately two hours later an officer performed a welfare check and did not observe anything adverse.

At 10:30pm a final head check was performed and Mr Fleming was seen to be going to the bathroom.

At some unknown time later, an officer saw the light in Mr Fleming's cell turn off.

At about 6:30am on 6 February 2015, a correctional officer went to Mr Fleming's cell and saw him sitting on the floor facing the wall. It was not unusual for Mr Fleming to be seen sitting in this position. After being unable to rouse Mr Fleming, the officer notified Justice Health staff.

Two nurses attended a short time later. They examined Mr Fleming and found that he had nil vital signs and no pulse.

In accordance with the advanced care directive and no CPR order signed by Mr Fleming, there was no attempt at resuscitation. Mr Fleming was pronounced deceased at 6:30am.

Police subsequently attended at about 7:15am, examined Mr Fleming's cell and found no suspicious circumstances. The police investigation found that the alert system available in Mr Fleming's cell was functional and that no alarm was raised between when Mr Fleming was last observed at about 10:30pm on 5 February 2015 and when he was found the following morning.

What caused Mr. Fleming's death?

Dr Kendall Bailey, forensic pathologist, performed an autopsy on 9 February 2015. In her report Dr Bailey noted that there were multiple findings in keeping with Mr Fleming's documented medical history, including a large inflamed tracheostomy site.

Dr Bailey concluded that the cause of death was pulmonary thromboembolus noting that there was a large saddle thromboembolus obstructing the vasculature to the left lung. Dr Bailey also concluded that Mr Fleming's amputation, ischaemic heart disease and emphysema were all significant conditions that contributed to his death.

Are there any other issues to investigate?

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility.

Records obtained from Corrective Services NSW indicate that Mr Fleming lodged a number of complaints in his dealings with Statewide Disability Services and the Corrective Services Support Line. Mr Fleming and Ms McConville also lodged complaints with the Anti-Discrimination Board, the Human Rights and Equal Opportunity Commission, the NSW Ombudsman, and the Independent Commission Against Corruption.

For the most part, the complaints related to inadequate facilities being available in custody to accommodate Mr Fleming's mobility impairment. It appears that some of Mr Fleming's complaints were initially justified, being a product of his remand classification and corresponding security requirements.

However, these issues appear to have been later resolved after Mr Fleming's sentencing, reclassification, and special placement consideration which resulted in his transfer to Junee. Furthermore, Mr Fleming's mobility issues were addressed with appropriate modifications to his cell, wheelchair, and shower facilities.

In any event there is no evidence available to me to indicate that any of these factors contributed to Mr Fleming's death in any way. Regrettably the evidence establishes that Mr Fleming often refused alternatives that were offered to him to address his mobility issues and medical conditions, and was highly resistant to medical treatment.

Conclusion

I am satisfied that the available evidence reveals that Mr Fleming's death is not suspicious and that he died as a consequence of a natural cause process. Regrettably, it appears that Mr Fleming's reluctance to accept medical treatment and to adequately care for himself following surgery adversely affected the longstanding medical conditions that he had been suffering from.

I am also satisfied that despite the difficulties mentioned above, Mr Fleming received health care of an appropriate standard whilst in custody. There is no evidence to suggest that any action or inaction by either Corrective Services or Justice Health contributed to Mr Fleming's death in any way. There was nothing that could have reasonably been done to prevent Mr Fleming's death. Given the combined effects of Mr Fleming's medical conditions, his resistance to treatment, and his reluctance to personally maintain adequate care of himself, it is highly likely that the outcome would have been the same even if Mr Fleming had not been in custody.

Formal Finding

I find that David Fleming died on 5 or 6 February 2015 at Long Bay Correctional Complex at Malabar, NSW. The cause of death was pulmonary thromboembolus. His above knee amputation, ischaemic heart disease, and emphysema were all significant conditions which contributed to his death. Mr Fleming died of natural causes whilst serving a custodial sentence.

14. 44176 of 2015

Inquest into the death of Allen Burke. Finding handed down by Deputy State Coroner Lee at Glebe on the 8th March 2016.

Introduction

Section 81(1) of the *Coroners Act 2009* requires that when an inquest is held the coroner must record his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Mr Allen Burke, an Aboriginal man aged 50 years old at the time of his death.

The role of a Coroner and purpose of this inquest

The role of a Coroner, as set out in section 81 of the *Coroners 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.

As Mr Burke was in lawful custody at the time of his death an inquest is required to be held pursuant to sections 23 and 27 of the Act.

Pursuant to section 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

Mr. Burke's personal history

Unfortunately little is known about Mr Burke's personal history other than he was born in Kurri Kurri in 1964 and that he had four children.

Investigating police spoke to Joshua Burke, Mr Burke's son, who said that he did not wish to make a statement. Mr Burke's son did not respond to several requests from police to provide some information about his father's background and family history.

No member of Mr Burke's family was present at the inquest.

Mr. Burke's custodial history

On 3 December 2013 Mr Burke was sentenced in relation to a number of sexual assault and assault offences. He received a 15 year sentence commencing on 4 May 2012 and expiring on 3 May 2027 with a non-parole period of 11 years and 3 months. Mr Burke's earliest possible release date to parole was 3 August 2023.

Mr Burke was initially kept on remand at the Metropolitan Reception and Remand Centre and was later transferred to correctional centres on the South Coast, Parklea, Long Bay and finally Goulburn, where he was housed at the time of his death. Mr Burke's medical history

Mr Burke suffered from asthma since childhood. He was also a heavy smoker. One of his fellow inmates described Mr Burke as the heaviest smoker he had ever seen. He required ongoing treatment for his asthma which included oral corticosteroids, nebulisers, inhalers and antibiotics. Mr Burke also had arthritis in his knees and had cataract surgery in 2014 whilst in custody. Apart from his asthma and arthritis, Mr Burke was not known to have any other chronic health conditions.

Records obtained from Corrective Services NSW indicate that during a routine intake assessment in June 2008 Mr Burke told an officer from Probation and Parole (as the service was then known) that he was experiencing some unconfirmed heart trouble, along with being an asthmatic. Mr Burke was not in custody at the time. His comment was recorded but there was no indication that Mr Burke was receiving any medical treatment or taking any medication for this reported condition when the comment was made.

It appears that the information was later transferred to an electronic record kept by Corrective Services so that on 23 June 2009 a disability alert was created by Statewide Disability Services on behalf of Mr Burke. Enquiries made by the police officer in charge of the investigation revealed that the alert expired on 9 February 2014 and was rendered inactive (some 12 months before Mr Burke's death).

There is no reference to a heart condition contained within any of Mr Burke's other Corrective Services records.

More importantly, there is no record of any complaint being made of a heart, or heart-related, condition in any of Mr Burke's Corrective Services records which date back to 1979.

The events of 11 February 2015

On Wednesday 11 February 2015 Mr Burke was inside his cell within the Multi Purpose Unit (MPU) at Goulburn Correctional Centre. Although Mr Burke was housed in a two out cell he was the only occupant. At about 5:28am he activated his cell call button. A correctional officer, Mark Cohen, answered and Mr Burke told him that he had a headache and was vomiting. Officer Cohen asked Mr Burke if he had any known medical conditions. Mr Burke answered no. Officer Cohen asked if Mr Burke could wait for the Justice Health nurses to arrive later that morning and Mr Burke answered that he could.

About ten minutes later Officer Cohen tried to call Mr Burke back using the cell call system to check on his welfare. The call system was not working so Officer Cohen asked another officer, Jeff Edwards, to attend Mr Burke's cell to check on him.

At about 5:55am Officer Edwards and three other correctional officers went to Mr Burke's cell. Mr Burke was sitting on his bed. He told the officers that he had a headache and felt sick. Officer Edwards told Mr Burke that he was not permitted to give Mr Burke any medication and asked him if he could wait for the Justice Health staff to attend later when they started duty. Mr Burke said that he could and asked for his cell light to be turned off. Officer Edwards obliged, reported the matter to his Area Manager, and informed the Justice Health clinic staff of Mr Burke's complaint. The clinic staff indicated that they would check on Mr Burke in the morning.

Correctional Officer Derek Haine performed a head check at about 8:30am. He spoke to Mr Burke who told him that he had been vomiting during the night and that he had a sore throat. Officer Burke asked if there was anything else and Mr Burke told him that he had a headache. Officer Haine told Mr Burke that he would call the clinic and advise them of Mr Burke's complaint.

Officer Haine subsequently contacted the clinic. One of the clinic staff advised that Mr Burke would be seen by one of the nurses attending the MPU that morning. A short time later Officer Haine heard noises that sounded like vomiting coming from Mr Burke's cell.

At about 10:00am whilst Nurse Melanie Ross was distributing medication within the MPU, Mr Burke approached her and told Ms Ross that he had had a sore throat for two days but it was feeling worse. Mr Burke also said that he had been vomiting overnight and into the morning, and that he had a severe headache.

Ms Ross checked Mr Burke's blood pressure and found it to be normal for Mr Burke. Ms Ross noted that Mr Burke was not in any respiratory distress and that he denied having any chest or abdominal pain.

Ms Ross told Mr Burke to use the cell call button if he felt worse and that she would return after distributing medication to other inmates. Ms Ross gave Mr Burke a new Ventolin inhaler and some medication (metoclopramide) to treat nausea and vomiting, along with Mr Burke's usual medication.

Correctional Officer Christopher Greenwood was present and helping Justice Health staff with medication distribution when Mr Burke spoke to Ms Ross. Officer Greenwood recalls Mr Burke mentioning that he had been vomiting and that he had a sore throat.

One of Mr Burke's fellow inmates, Darin Wheeldon, said that when he went to collect his medication he saw Mr Burke crouched down near a door speaking to Ms Ross. Mr Wheeldon says that he saw Mr Burke indicate something with his hand to his chest and that he heard Mr Burke say something similar to, "It is just uncomfortable and causing a bit of pain". Mr Wheeldon said that Ms Ross replied with words similar to, "I have not got any equipment here. I will come back and see you after I finish here".

Mr Wheeldon returned to his cell and had a conversation with Mr Burke who by that time had also returned to his cell. Mr Wheeldon saw that Mr Burke looked pale and appeared to be in pain. Mr Wheeldon said that he asked Mr Burke if he was OK. Mr Burke said that he was not and that he had been up all night unable to sleep. When Mr Wheeldon asked what was wrong, Mr Burke replied that he had pains in his chest. Mr Wheeldon offered to notify a correctional officer but Mr Burke said, "Don't do that. I don't want to overplay it as they will move me to a safety cell and I want to be able to smoke".

Mr Wheeldon suggested that Mr Burke should tell someone about his pain but Mr Burke said, "No, it's OK, I can't stand the safety cell", and then changed the subject.

Between about 10:00am and 11:00am correctional officers saw Mr Burke coming and going from his cell and speaking with other inmates. At around 11:00am Mr Burke presented for lunch muster. It is not known whether Mr Burke collected his lunch tray and ate his lunch, or whether he collected it and gave it to another inmate. After lunch, Mr Burke was secured back in his cell.

At about 11:00am Ms Ross returned to the clinic and notified the on-call doctor, Dr Haddrick (as there was no doctor on-site), of Mr Burke's complaints. Dr Haddrick ordered that penicillin be given to Mr Burke.

At about 12:40pm Ms Ross returned to Mr Burke's cell, with Officer Haine, to give Mr Burke the penicillin and check on his welfare. Ms Ross saw Mr Burke lying on his bed with his arms behind his head. Officer Haine opened the cell door and Ms Ross noticed that Mr Burke was not breathing. She immediately began CPR and told the Officer Haine to alert the clinic that there was a medical emergency.

At about 12:46pm another nurse arrived with a defibrillator which was used on a number of occasions without effect. During the resuscitation attempts the nurses gave Mr Burke three doses of adrenalin. About ten minutes later ambulance officers arrived and took over the efforts to resuscitate Mr Burke. Unfortunately they were unable to revive him and Mr Burke was declared deceased at 1:10pm.

What caused Mr. Burke's death?

Professor Johan Duflou, forensic pathologist, performed an autopsy on 13 February 2015. In his report Professor Duflou identified that Mr Burke had severe atherosclerosis of his left anterior descending coronary artery and right coronary artery. Professor Duflou also observed that Mr Burke had changes to his lungs that were typical of heavy smoking.

Professor Duflou concluded that the cause of death was acute myocardial infarction due to coronary atherosclerosis.

Are there any other issues to investigate?

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility.

In his statement, Mr Wheeldon suggests that Mr Burke complained of experiencing chest pain to Ms Ross. If this was the case it would raise cause for concern given that Mr Burke died about three hours after the alleged complaint.

However, I find that the alleged complaint is improbable for a number of reasons. Firstly, Ms Ross in her statement said that she specifically asked Mr Burke if was experiencing any chest pain, which he denied. Secondly, Ms Ross was the only person to make a contemporaneous note of her interaction with Mr Burke.

The note contains no reference to Mr Burke complaining of chest pain. Thirdly, Officer Greenwood makes no mention of hearing any such complaint made by Mr Burke. Fourthly, the evidence gathered from Officers Haine, Cohen and Edwards is that each of them asked Mr Burke how he was feeling and no mention of chest pain was made in any of those three exchanges. Finally, Mr Wheeldon said that Mr Burke told him not to tell anybody about his chest pain because he (Mr Burke) did not want to go to the safety cell. If this was the case, then it is difficult to understand why Mr Burke would make the complaint himself, only a short time before telling Mr Wheeldon about his reluctance to go to the safety cell.

I am also satisfied that the disability alert created in 2009 was not a factor in Mr Burke's death. The information provided in 2008 was vague and unsupported by any medical evidence. Further, in the approximate seven years that elapsed since the comment was made, there is no other evidence consistent with it. In any event the alert had expired by the time of Mr Burke's death and was inactive. There is no evidence to suggest that failure to notice the alert contributed to Mr Burke's death in any way.

Conclusion

I am satisfied that the evidence reveals that Mr Burke's death is not suspicious and that he died as a consequence of a natural cause process.

I am also satisfied that Mr Burke received health care of an appropriate standard whilst in custody. There is no evidence to suggest that any action or inaction by either Corrective Services or Justice Health contributed to Mr Burke's death in any way. It does not appear that anything could have reasonably been done to prevent Mr Burke's death.

Formal Finding

I find that Allen Burke died on 11 February 2015 at Goulburn Correctional Centre at Goulburn, NSW. The cause of death was acute myocardial infarction due to coronary atherosclerosis. Mr Burke died of natural causes whilst serving a custodial sentence.

15. 109556 of 2015

Inquest into the death of Rodney Bates. Finding handed down by Deputy State Coroner Grahame at Glebe.

REASONS FOR DECISION

This inquest concerns the death of Rodney James Bates

Introduction

Rodney was born on 28 June 1959. He was one of five children born to Kevin and Leah Bates. He grew up in the Rydalmere area and completed his schooling at Macquarie Boys High School.

Unfortunately, Rodney developed substance abuse issues and as a result became involved in the criminal justice system at an early age.

Rodney was serving a custodial sentence at the Cessnock Correctional Centre at the time of his death. He had been sentenced at the Blacktown Local Court for a number of offences in October 2014. His earliest possible release date was 30 December 2015.

Recent case notes from the Department of Correctives Services file describe Rodney as “extremely polite and well mannered.” He was considering pursuing an educational program and was focussed positively on his release. Unfortunately Rodney died on 13 April 2015. He was only 55 years of age.

The role of the Coroner and scope of the inquest

An inquest is intended to be an independent examination of all the available evidence in relation to the circumstances of a person’s death. The Coroner is to make findings as to the identity of the nominated person and in relation to the date and place of death. The Coroner is also to address any issues concerning the manner and cause of the person’s death.

Where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner. When a person is detained in custody the State is responsible for his or her safety and medical treatment.

Given that inmates are not free to seek out and obtain the medical treatment of their choice, it is especially important that the care they receive is of an appropriate standard.

Even where the death appears to have been naturally caused, it is essential that any medical treatment provided is reviewed independently and its quality carefully assessed.

It should also be noted that a coroner has the power to make recommendations connected with a death in an attempt to increase public health or safety, if it appears necessary or desirable on the evidence as it emerges.

The Evidence

The inquest heard oral evidence from Detective Senior Constable Melissa Martens of the Corrective Services Investigation Unit. A significant amount of documentary evidence was tendered including medical records, an expert report, departmental files, photographs and witness statements.

Shortly after the inquest commenced on 21 July 2016, Ms Jacqueline Conroy entered the court and directly advised the inquest that there were, to her knowledge, serious problems in the care Rodney Bates had received in custody. She stated that she was Rodney's former partner and that she was prepared to make a statement outlining her concerns. At that time she stated that she had possession of medical records that would shed light on the matter. The inquest was adjourned for further investigations. A statement was subsequently taken from Ms Conroy and further evidence was received on 12 September 2016.

Rodney's custodial and medical history

Rodney had been known to the criminal justice system since he was 16 years of age and had spent a number of significant periods in custody. He had been convicted of a range of offences including dishonesty offences, drug matters, driving matters and matters involving violence.

A review of the records reveals that Rodney had been substance dependant for many years. At the time of his death he was on a methadone program. He reportedly suffered migraines and had been treated for skin cancers.

Rodney had undergone a skin graft related to a large squamous cell carcinoma which had been removed from his face.

This procedure resulted in tattooed skin from his forearm being grafted onto his face and also left noticeable scarring. Ms Conroy told the inquest that Rodney felt “hurt and disgusted” by the tattoo on his face.

He had apparently been advised that the unmarked skin on his hip or bottom was not “strong enough” to be placed on his face. Ms Conroy believed the decision was “something about the movement needed to open his mouth and move his jaw. It was also something to do with the veins and blood vessels”.

Rodney had recently been treated for a broken right shoulder.

Most significantly, Rodney had suffered a number of episodes of loss of consciousness. The first record of such an event appears to be in 2009.

Justice Health records indicate that Rodney had several episodes of loss of consciousness from November 2014, however the reason for these episodes was undetermined. Some records indicate that Rodney was at times non-compliant with medical appointments, but this appears to have no relevance to his death.

Fall in December 2014

Records indicate that on 21 December 2014, whilst in custody, Rodney slipped and fell in a bathroom. While Rodney’s brother later heard a rumour that Rodney had been assaulted there is no evidence to support this.

Rodney was admitted to the Intensive Care Unit at Nepean Hospital under the care of Dr Al-Khawaja, neurosurgeon.

CT scans and MRI imaging showed the presence of cerebral contusions as well as a small subdural haematoma and skull fracture.

As a result of this episode Rodney was seen by a neurologist, Dr Ip to investigate the possibility of seizure activity. It was Dr Ip's opinion that there was no firm evidence of epilepsy. Rodney's electroencephalograms appeared normal.

The doctor was of the view that the episodes may have been secondary to a cardiac event and recommended that there be cardiac follow up. There was also the possibility that methadone may have been involved.

Further MRI scans showed continued evidence of brain injury and it was decided that Rodney should be followed up by both the Brain Injury Unit at Westmead and the Neurological Clinic at Nepean. A cardiac review was also suggested.

Fall in February 2015

It appears that during January 2015, Rodney was still not feeling well. A Health Problem Notification Form (HPNF) was completed on 1 January 2015. Rodney had complained of headaches and of feeling light headed, unwell and drowsy at times. He indicated that he sometimes felt "confused, drowsy or unconscious". It was confirmed that he should be placed in a "two out" cell. This was extended on 13 February 2015.

In February 2015 Rodney suffered another episode of loss of consciousness and fell again. This is said to have happened while he was eating his breakfast. In this instance it was reported by other inmates that Rodney had some jerky movements but no full seizure was found to have occurred. He was seen by the Westmead Brain Injury Unit and while the previous brain injury was noted, no other neurological conditions or concerns were identified. He was discharged with a plan for follow-up by the Neurological Department at Nepean Hospital. There was no suggestion that anticonvulsant medication was indicated or prescribed.

Events leading up to his death in April 2015

On the afternoon of 2 April 2015 Rodney was in the yard area of number 2 wing at Cessnock Correctional Centre.

He appeared to suffer a seizure of some kind and fell backwards onto the concrete, striking the back of his head heavily as he landed on the ground.

One inmate who saw Rodney just before he fell said Rodney “went very stiff as if he had a heart attack”. There is no CCTV footage available of this incident.

Inmates in the immediate vicinity came to his aid and quickly placed Rodney in the recovery position. Corrective Service Officers were notified and they arranged for Justice Health nursing staff to attend and assist, while an ambulance was called. Rodney was taken directly to John Hunter Hospital.

Unfortunately, on route to the Hospital Rodney suffered another seizure. Upon arrival at the Hospital he was immediately taken to the theatre for emergency brain surgery. After surgery he was admitted to the Intensive Care Unit. He was in an induced coma and needed respiratory support.

The following day Rodney underwent further surgery in an attempt to ease the pressure on his brain. Brain scans conducted between 3 and 7 April 2015 showed no improvement. On 7 April 2015 sedation was ceased but Rodney did not regain consciousness.

After consultation with Rodney’s family, respiratory support was removed on 13 April 2015. Rodney continued to deteriorate and was pronounced dead at 3.55 that day. Rodney’s sisters Vicki and Lyn and brothers Craig and Steve were present on the ward.

The autopsy

An autopsy was conducted by Dr Leah Clifton at the Department of Forensic medicine, Newcastle on 15 April 2015. Dr Clifton was of the view that Rodney died from the effects of a blunt force injury to the head. There were significant head injuries including a skull fracture, multiple acute contusions and lacerations to the brain surface, bleeding on the surface of the brain and within the cranial cavity and significant swelling. She described the pattern of injury as consistent with a fall backwards from a standing height.

She noted that there was evidence of recent surgical intervention and saw that there were healed contusions of the surface of the brain which were consistent with the history given of a closed head injury in 2014. She noted he had other significant medical issues including liver cirrhosis, chronic hepatitis B and C, and valvular heart disease. However, these did not cause his death.

Independent review of Rodney's medical treatment

The Coroner obtained an expert medical review of Rodney's records from an independent consultant neurologist, Dr Dudley O'Sullivan. Dr O'Sullivan had full access to Rodney's medical records.

Dr O'Sullivan was of the view that Rodney had received appropriate treatment in relation to the head injuries he suffered in December 2014 and February 2015. Immediate arrangements were made for his hospitalisation. Once in Hospital he was treated by appropriate specialists and the necessary investigations were carried out.

Dr O'Sullivan also considered whether Rodney's ongoing treatment on release from Hospital was adequate. In particular he considered whether Rodney's history indicated that anticonvulsant medication should have been commenced. Dr O'Sullivan was not critical of the decision to withhold anticonvulsant medication. He states "the neurologist obviously felt there was some evidence to suggest that he may have had some form of syncopal episodes rather than a true epileptic fit. There could be a case for him to be placed on anticonvulsant medication but of course the neurologist obviously would have considered that possibility".

Dr O'Sullivan noted that there can be significant complications in patients prescribed both methadone and anticonvulsants. He also noted that the response in patients on methadone to anticonvulsant treatment "is poor and they will often have recurrent seizures despite medication".

Once Rodney had been admitted to John Hunter Hospital on 2 April 2015 it appears that his very significant injuries were not survivable, notwithstanding the emergency treatment he received.

Ms Conroy's concerns

Ms Conroy initially claimed that she had significant concerns in relation to Rodney's care. She said that he had not received appropriate care whilst in custody and that she had documents to prove it.

On 10 August 2016, Ms Conroy attended Blacktown Police Station to make a statement about her concerns.

She did not have any documents from Westmead Hospital or further information to provide concerning the medical issues which led to Rodney's death. Nevertheless, Detective Senior Constable Melissa Martens obtained the Westmead Hospital medical records in relation to Mr Bates. I have had an opportunity to review those records and am of the view that they do not shed further light on the circumstances surrounding Rodney's death.

Ms Conroy was called to give evidence on 12 September 2016. She did not raise concerns about Rodney's treatment at the time of his fall or in relation to any known conditions which Justice Health had ignored, as she had originally suggested. I am now satisfied that further investigation of her initial claim of medical neglect is unwarranted.

Conclusion

The cause of Rodney's episodes of loss of consciousness was still unknown and under investigation at the time of his death. It was not a clearly diagnosed case of epilepsy. It was unpredictable and long standing. Dr Ip had reviewed Rodney's medical history and did not prescribe an anticonvulsant medication. This may have been at least partly influenced by Rodney's ongoing methadone treatment. In any event, it was, according to an expert review conducted by Dr O'Sullivan, a clinical decision properly available to Dr Ip in all the circumstances of the case.

There is nothing to suggest that Justice Health or Corrective Services provided less than appropriate care to Rodney. He was placed in a cell with another prisoner. He was provided timely emergency admission to Hospital when required and appears to have been provided adequate follow-up. I note that his family have not raised any particular concerns in relation to the treatment of these episodes of loss of consciousness or in relation to the treatment he received after his fall in April 2015.

Tragically, Rodney died as a result of injuries he sustained in a fall. The exact cause of the underlying episodes of loss of consciousness remains unknown.

The evidence does not disclose the need for any recommendation in this matter.

Formal Finding

Identity of the deceased

The identity of the deceased is Rodney James Bates.

Date of death

Rodney Bates died on 13 April 2015.

Place of death

Rodney Bates died at the John Hunter Hospital, Rankin Park, NSW.

Cause of death

Rodney Bates died from a traumatic brain injury caused by blunt force to the head.

Manner of death

Rodney Bates died as a result of a fall. It is likely the fall was caused by a sudden loss of consciousness.

16. 112961 of 2015

Inquest into the death of Terry Riordan. Finding handed down by Deputy State Coroner Barry at Glebe on the 30th September 2016.

The role of the 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.

This primary focus of this inquest is the manner of Terry's death and the care and treatment Terry received from health professionals prior to his death, and the response of the NSW Police Force in relation to a 'concern for welfare' call following a telephone call from Terry's mother on the evening of 14 April 2015.

BACKGROUND

Terry Riordan was 45 years old when he died. He was found deceased on the morning of 15 April 2015 at his home in Ballina.

He had a long history of mental health issues and medical problems and for some period before his death his health had been deteriorating. He suffered from seizures in the three years prior to his death and there had been periods of admission into psychiatric facilities for depression.

Terry was known to be an abuser of prescription medication and was often seen to be under the influence of drugs.

In January 2014, Terry was the victim of a serious home invasion in which he sustained a blow to the head from an axe. Following that event his mental health deteriorated further. In addition, he lost weight and became paranoid.

In November 2014, Terry was charged with assault occasioning actual bodily harm against his partner and at the time of his death he was required to report daily to police as a condition of bail. He was due to attend court for sentencing in relation to that matter on 23 April 2015, and had expressed concerns to a number of people about the possibility of a gaol sentence.

Terry had two brothers, Michael who is two years older and John who is nine years younger. He was close to his mother and his brothers and was Michael's best friend.

As a young man, Terry attended Ballina High School and was a talented football player. At age 18 years he became a player with the South Sydney Juniors football Team. Sadly, his promising career was ended by an assault which resulted in a skull fracture, leading to the onset of depression.

A child, Jack, was born to Terry and his then partner in the late 1990s. Terry later commenced a relationship with Michelle McLennan. Michelle had a younger daughter, Tiarna, from a previous relationship. Terry and Michelle had two children together: Tyler in 2002 and Misty in 2008. Their relationship lasted about 16 years but was plagued by domestic violence abuse by both partners.

Terry's mother, Mrs Edge, gave a statement to the court. She described Terry as a good and loving father. She further described Terry's close bond with his brothers and his kindness to his family and to people he hardly knew. Mrs Edge described Terry as having a "heart of gold".

Following his death, Mrs Edge stated that she had been approached by a number of people who attested to Terry's kindness. These were people who were often homeless and told her how Terry had offered them a bed in his house and food until they were able to re – establish themselves.

After the assault in January 2014, Mrs Edge stated that Terry never really recovered and his life changed. Terry's mother and family are left with an overwhelming sense of loss and sadness.

Autopsy and Cause of Death

As to cause of death, the Court had the benefit of the: Autopsy report by Dr Rexson Tse and Professor Tim Lyons dated 20 May 2015 and a supplementary report by Dr Rexson Tse and Professor Tim Lyons dated 22 June 2015; and Report of toxicologist Professor Alison Jones dated 3 June 2016.

Autopsy report of Dr Rexson Tse

Dr Tse opines that the direct cause of Terry's death was "mixed drug toxicity". He noted that the toxicology screening showed a range of prescription medication including: amitriptyline (a tri-cyclic anti-depressant – 1.2mg/L); citalopram; opioids; and benzodiazepines.

Whilst Dr Tse commented that the mechanism of death would be the individual and synergistic effect of the drugs on the central nervous system, he considered that the relative contribution of each drug to the death could not be determined with "absolute confidence" by autopsy. Dr Tse stated that a forensic toxicologist ought to be consulted to interpret the specific toxicological results.

Dr Tse otherwise noted that there were no natural disease processes recognised during the autopsy. He also observed no marks or injuries such as to indicate any third party involvement.

Toxicology Report of Professor Alison Jones

Professor Jones interpreted the results of the toxicology post-mortem blood screening as follows: amitriptyline (1.2mg) and nortriptyline (0.62mg) as in the "toxic and potentially fatal ranges"; citalopram (0.11mg/L) as in the therapeutic range; diazepam (0.41mg/L) and nordiazepam (0.34mg/L) as in the therapeutic range; oxycodone (0.21mg/L) and oxymorphone (0.006mg/L) as representing "therapeutic or supratherapeutic blood concentrations (i.e. dosing just above the top of the normal therapeutic range) but not fatal concentrations"; temazepam (0.02mg/L) as representing subtherapeutic levels (being a metabolite of the diazepam ingested); and methadone (0.62mg/L) as in the "potentially fatal range".

The presence of THC (0.004 mg/L) and THCA (0.036mg/L) was also noted, with the concentration suggesting the recreational use of cannabis by Terry.

Professor Jones opined that Terry's death "occurred due predominantly to a combination of overdose of amitriptyline and methadone". In her view, it was the combination of the two drugs, namely amitriptyline in the toxic and potentially fatal range, and methadone, being in the potentially fatal range, that would have caused profound respiratory depression and coma.

More specifically, Professor Jones stated: *"In the case of amitriptyline, cardiac arrhythmias are an additional potential cause of death and the risk of this is exacerbated by hypoxia due to any respiratory depression. In my view, either the overdose of methadone alone, or the overdose of amitriptyline alone in Mr Riordan could potentially have caused death.*

In combination, they were much more likely to cause death than either drug alone." Professor Jones also noted that the presence of diazepam and oxycodone in therapeutic doses would be expected to have contributed to Terry's respiratory depression and coma, "but in isolation would not have caused death at these doses".

Similarly, while citalopram at a therapeutic dose might have contributed to the risk of death after the amitriptyline overdose, "it would not have caused death in its own right" given the particular concentration. Professor Jones opined that the timing of the overdose of amitriptyline and methadone is difficult to assess given the time of ingestion is unknown. However, the presence of active metabolites of a number of the drugs indicated that Terry was "alive for at least a few hours after ingestion of the overdose", such that his liver could metabolise the drugs.

Additionally, Professor Jones commented that the "snoring" reported by police attending Terry's unit on the evening of 14 April 2015 "probably represented" his obstructed and laboured breathing after the overdose, although she could not exclude it as a simple snore. Ultimately, Professor Jones concluded that the most likely time of death was "sometime in the early hours of the morning of 15 April 2015".

Based on the uncontested and clear expert reports of Dr Rexon Tse and Professor Alison Jones, there would seem no doubt that Terry died from multiple drug toxicity, and that the death was predominantly due to a combined overdose from amitriptyline and methadone (although either drug alone could have been responsible for Terry's death). The methadone was illegally obtained by Terry without prescription.

The circumstances in which it may have been obtained were explored during the inquest, following numerous investigations by the officer in charge. Ultimately, however, that matter could not be elucidated, given the label on the bottle had been tampered with.

The amitriptyline was prescribed to Terry by his GP, Dr Hartmann on a regular basis during the period 2014 to 2015, the last was on 13 April 2015 during his final consultation with that doctor. The prescription (of 50 tablets), together with a prescription for other medication (namely Oxycontin (28 tablets) and diazepam (50 tablets)) was dispensed by a pharmacy in Ballina that same day.

MANNER OF DEATH

In his oral evidence, Detective Senior Sergeant O'Reilly, believed that Terry self-ingested the medications on which he had overdosed and there were no suspicious matters surrounding the death.

The evidence of Dr Tse was that there were no marks or injuries such as to indicate any third party involvement in the death and similarly, the evidence of Senior Constable Gary Kennedy of the Lismore Crime Scene, (Forensic Services), who inspected Terry's unit closely, photographing each room in detail, formed the view that "there were no indications of suspicious or unusual circumstances or trauma" in relation to Terry's death.

Did Terry intend to take his own life?

Suicide may not be presumed – it must be proven by evidence. Further, it is generally accepted that before making such a finding, (*Briginshaw v Briginshaw (1938) 60 CLR 336*) standard of clear, cogent and exact proof of evidence ought to be applied.

There are undoubtedly some references in Terry's medical records to him having had periods of suicidal ideation – for example: Dr Hartmann, in his statement, states that Terry talked about suicide many times.

In a record dated 9 March 2015, Terry told the Mental Health Assessment Line that he had attempted suicide in November 2014 by crashing his car and that no one knew of the attempt; he also reported ongoing suicidal ideation.

A note dated 28 March 2015 (from Lismore ACS) records the following:

“The client reported regular suicidal ideation. “If I could wake up dead tomorrow ...”, with some recent vague planning including cutting wrists and shooting self. Denied access to firearms but reported “I could find them if I want to.” Has been resisting so far from acting on these thoughts, however is concerned that it’s becoming more difficult. Currently ambivalent intent. Client reported that risk is likely to escalate if sent to jail. “If sent to jail I would try to kill myself ...”.

That record also refers to an attempted suicide in 1984 by “jumping”;

Additionally, in February 2015, Terry’s cousin Wayne recalled Terry stating that he felt like driving his car into a tree as he did not want to go to gaol. Mr Les Coulstock who gave evidence at the inquest said that he saw Terry the night before he died, and that Terry “had had enough” of what was going on in life, and wanted to end it. Some doubt may attend Mr Coulstock’s recollection of events, given that he and Terry had evidently had an argument in the weeks prior to Terry’s death; Mr Coulstock’s statement was some 10 months after the event (being obtained in February 2016); and certain details that he gave evidence about did not accord with other objective evidence.

There is considerable evidence to suggest that it was not Terry’s intention to take his life as at 14 April 2015. One or two days prior to his death, Terry visited Shanen Craig in the same unit complex as his own; on this occasion, she described him as “drinking spirits straight from the bottle” and “eating his Oxycontin like skittles”. She also stated:

“Terry was really worried about going to gaol. I don’t know what for but he didn’t want to go to gaol. Terry told me he had a plan to take pills, ring the ambulance to say he was going to kill himself and get taken to the Richmond Clinic so he wouldn’t go to gaol.” In response, Ms Craig told him that he was mad and could not be sure he would survive, to which he responded – “I’ve done it before. I know what I’m doing”.

There is no doubt, as the evidence reveals, that Terry was becoming increasingly forgetful and was “chaotic” in relation to managing his medication. It is conceivable that he may have forgotten that he had previously ingested amounts of amitriptyline and methadone. Notably, Terry’s brother Michael had seen Terry during the day of 14 April 2015 and found him “off his gut on medication”, with others such as Dylan Mott and Phillip Flood observing him behaving strangely also. In such circumstances, Terry’s capacity to recall what medication he had previously ingested would likely have been significantly compromised.

There was other medication found in Terry's unit that he could have taken to attempt to ensure a fatal overdose – for example, a further blister pack of endep (amitriptyline) with only five tablets missing.

Mrs Edge gave evidence that Terry had never expressed any thoughts of suicide and that she did not believe that he had intentionally overdosed on medication.

No suicide note was left and on 30 March and 6 and 8 April 2015 when the AT service called Terry to check on his welfare, he reported no suicidal ideation or thoughts of self-harm.

In Dr Hartmann's statement he said that during the consultation on 13 April 2015 (being Terry's last contact with any medical or mental health service), he did not express any suicidal ideation (although it is noted that Dr Hartman referred him to the Ballina Mental Health Team on that date, the referral noting that Terry "*feels he is not coping with his current situation*").

Dr Wilson opined in her Report dated 7 June 2016:

"I suggest that in the hours and days before his death Mr Riordan was highly distressed and looking for relief from his emotional pain and that as a result, he took a large amount of amitriptyline as well as methadone. This lead to increasing side-effects, which could have included confusion, hallucinations, respiratory depression and resulted in his death.

On the material available, I am not satisfied that there is sufficient evidence to be reasonably satisfied that Terry intended to take his own life.

Care & Treatment Provided By Richmond Clarence Network Acute Care Services (RCNACS)

On 9 March 2015, Mrs Edge contacted the Mental Health Assessment Line to raise concerns about Terry; he was then triaged by a specialist over the phone; there was further follow up with Mrs Edge that evening.

On 12 March 2015, Terry was booked for a mental health assessment but Mrs Edge telephoned to change the date to 16 March 2015.

On 16 March 2015, Terry was seen by clinical nurse specialist RN Vaughan Beek for a mental health assessment; his complex personal and medical history was noted; the initial management plan included contacting Terry's GP (Dr Hartmann) and a review by Dr Rose (psychiatric registrar) at Lismore Community Mental Health Service; at this time, Terry was a client under the care of the Assessment Team;

On 18 March 2015, RN Beek spoke with Dr Hartmann to advise him of Terry's contact with Mental Health Services and of the planned review by Dr Rose (on 19 March 2015).

On 19 March 2015, Dr Rose, psychiatric registrar, reviewed Terry for approximately 40 minutes. Terry attended that appointment with his mother. Prior to the meeting, Dr Rose reviewed Terry's notes from his earlier contact with the Mental Health Assessment Line team. Dr Rose stated in oral evidence that Terry told her about his medication regime, and that he was "nodding off" periodically. He requested medication to help him sleep, though she was concerned that he was already taking too much sedating medication. She believed that the addition of a sedative, given the level of sedation that she observed would be potentially dangerous.

Dr Rose questioned Terry about any thoughts of suicidal ideation or self – harm. He denied any such thoughts. She determined that Terry was not "mentally ill" within the meaning of the *Mental Health Act*. A voluntary admission was proposed in order to review his medication and for diagnostic purposes.

Terry declined this suggestion and became "agitated". She was able to "de-escalate" the situation, but despite her best efforts and on raising again the suggestion of voluntary admission, Terry again became agitated and the interview concluded.

In her oral evidence, Dr Rose confirmed her impression that Terry had developed oxycontin and valium dependence with secondary effects of anxiety and panic attacks. Her treatment plan was as follows: Voluntary inpatient care for diagnostic clarification and medication review. No change to his medication regime until there was a clear picture of longitudinal mental state - due to his level of sedation she was concerned about providing anything that could sedate him further. A safety plan was created with Mrs Riordan which she agreed to.

Mrs Riordan was to contact emergency services if she became concerned for Terry's safety.

Terry was to continue interactions with the pain clinic. A recommendation was made for the engagement of a psychologist to support Terry to deal with numerous psychosocial stressors and to encourage him to consider a medication review via a referral through Terry's GP. A note "Please contact GP with concerns of prescription medication dependence and the possible usefulness of same", was left as a request for an AT staff member to make contact with the GP to discuss Terry's prescription medication. On 24 March 2015, RN Burns telephoned Dr Hartmann who confirmed he would see Terry regularly and accepted the transfer of care following discharge from the ACS. On 29 March 2015, RN Martin Gallagher contacted Terry, (who was not keen to talk), and reported that he hadn't slept for seven days. A note records: "*Little point in pushing this man @ present – try again tomorrow*";

On 30 March 2015, RN Beek telephoned Terry. Terry was apparently having a better day and denied suicidal ideation or thoughts of self-harm. On 3 April 2015, RN Burns attempted to contact Terry on his mobile twice and both calls were unanswered. On 6 April 2015 – RN Burns spoke with Terry who was at home resting; he had no thoughts of self-harm or suicidal ideation but did not think the Cipramil Dr Hartmann had prescribed was helping. On 8 April 2015 – RN Burns telephoned Terry to follow up. Terry denied thoughts of self-harm or suicidal ideation, although his mood continued to be up and down.

He was happy to be discharged from the service at that stage. He said he had the phone numbers for the Mental Health Assessment Line and Lifeline and would contact them as required. On 13 April 2015, Dr Hartmann wrote a referral to the Ballina Mental Health Team (which was faxed to the Lismore ACS that day) stating: "*Thank you for getting involved in the care of Terry Riordan with a long history of mood and social problems. He feels he is not coping with his current situation.*"

Later that day, around 2.30pm, Terry's case was discussed at an ACS team review meeting.

The notes recorded that the plan was for Dr Rose to liaise with Terry's GP (Dr Hartmann) but that he was not to be accepted for care by the Assessment Team at that time. It is evident from the documented contact and attempted contact with Terry between 9 March 2015 and 13 April 2015, that numerous attempts were made by RCNACS to provide Terry with mental health support and to ensure that when he was discharged from the service.

Terry's care was then to be assumed by his GP. In her oral evidence, Dr Rose presented as a careful and considered witness.

She was evidently concerned about Terry's welfare and wanted him to be admitted to hospital in an attempt to assist with issues relating to his medication and also for diagnostic purposes – he was not amenable to this course. Dr Rose's clinical notes are detailed and clear (extending over four pages), and set out her observations and impression of Terry, as well as a proposed treatment plan.

The notes also record her willingness to further assist if required. The only matter arising with respect to the care provided by RCNACS was the basis upon which a determination was made at an informal ACS Team review meeting on 13 April 2015 for the Assessment Team to defer accepting the care of Terry in response to Dr Hartmann's referral of the same date, given a note in the 'mental health acute care book' on that date which stated: *"Dr Rose will liaise with GP. Not for ACS. On board for p/c Dr Rose 1/7."*

Registered Nurse Coleman, who attended the meeting on that date, stated that there was discussion about the referral at the clinical team meeting. She noted that from the referral, there was no indication that Terry was "acutely unwell or at imminent risk". She also noted that Terry had been discharged from the ACS after a period of care from 9 March to 8 April 2015. The clinical team accordingly made the decision that it was "unlikely" that Terry required further input from the ACS at that time. RN Coleman further stated:

"This decision was based on recent contact with Mr Riordan that indicated he had ongoing engagement with his GP, expressed a plan to organise a Mental Health Plan through his GP to see a psychologist, had not expressed suicidal ideation and was aware of how to access services as required." RN Coleman also referred to Terry's interview with Dr Rose on 19 March 2016, at which time Terry had declined inpatient admission.

At the meeting, it was also proposed that Dr Rose would contact Dr Hartmann to liaise with him.

Dr Rose gave evidence at the inquest and did not recall attending this meeting on 13 April 2015 because of other clinical commitments. However, she was later contacted by a colleague who asked her to speak with Dr Hartmann to clarify the referral.

On 14 April 2015 Dr Rose was unable to do so due to her workload (and a note was entered in Terry's medical records confirming this). On 15 April 2015, however, Dr Rose attempted to contact Dr Hartmann, but he was unavailable (as stated on his automated voicemail system).

In circumstances where (as stated by RN Coleman) there was no clear urgency or crisis apparent from Dr Hartmann's referral (which was faxed to the ACS, in contrast to the patient presenting at the hospital with the referral) -,and against the background of Terry's somewhat limited engagement with the service during March, coupled with the plan for Dr Rose to make contact with Dr Hartmann to clarify the basis of the referral, the decision to defer accepting Terry into care on 13 April 2015 and to follow up with Dr Hartmann appears both reasonable and appropriate.

THE RESPONSE OF NSW POLICE

'Concern for welfare call'

An issue explored at the inquest was the response of officers from the NSW Police Force to Mrs Edge's "concern for welfare" call on the evening of 14 April 2015.

Sometime in the evening on 14 April 2015 – Senior Constable Danielle Ford reviewed the automated bail reporting system (ABRS) and noted that Terry had not yet reported to Ballina Police station, which was "unusual" as he would generally report in the morning; she telephoned Michael Riordan (Terry's brother) to explain her concern about him reporting; Michael said he would notify his brother.

Prior to 9.12pm, Mrs Edge telephoned Ballina Police Station and spoke with Constable Fiona Ozols stating that she was concerned that her son had not reported for bail and requesting police to check on him; she said that she told Constable Ozols that Terry had had a bad day, had been to the doctor and his medication was being changed and conveyed information which formed the basis of the CAD message recorded as: *Terry Riordan resides at location, inft is the mother of POI, POIs brother has attended location trying to raise POI, without success, however can hear someone inside unit. POI resides at location by himself. POI has been a bit depressed lately, inft concerned for POIs welfare."*

The message was created at 9.12pm and given a priority '3' by Senior Constable Ford.

The only source of the information for the job was Constable Ozols, who conveyed the information to Senior Constable Ford, likely in the form of a note (given Mrs Edge's phone number was recorded in the CAD informant details). Constable Ozols gave evidence that she had requested that Senior Constable Ford put the job onto CAD to ensure she did not forget it.

At around 9.13pm VKG (police radio) broadcast the concern for welfare job;

Between 10.53 and 10.57 pm – Senior Constable David Matheson and Constable Ozols attended Terry's unit (12/5-9 Norton Street). They walked up the stairs to the unit and knocked on the front screen door. There was no response to the knocking, nor to the call "Terry". Senior Constable Matheson then walked to the glass sliding door (that opened into the dining kitchen area) which was open. He called out again – "Terry it's the police". The officers could hear someone snoring. The officers then walked in through the glass door to the hallway, remaining there for around 30 seconds.

During this time, consistent breathing and snoring was heard. Senior Sergeant Matheson told Constable Ozols: "He is breathing. We are not going to wake him up".

Later, Senior Constable Ford was advised by one of the attending officers that Terry was asleep at home; she confirmed with her supervisor, Sergeant Craig Norton that "no formal action [was] required" regarding Terry's failure to report.

At 3.31am, Senior Constable Matheson entered the following "action text" into CAD:

"POI ASLEEP IN HIS BED, POLICE COULD HEAR THE POI SNORING".

At 5.06am, Sergeant Craig Norton verified the CAD message relating to the concern for welfare job, considering the action taken by responding police to be appropriate.

At some time prior to completing her shift at 6.00am, Senior Constable Ford entered the following into the ABRS system:

"FTA [Fail to attend] – POI observed by police during CFW check to be asleep in his unit, POI has recently changed medications".

At 8.45am, Mrs Edge called '000' to raise the alarm about finding her son apparently deceased.

At 8.51am, Paramedics from the NSW Ambulance Service attended the scene, finding Terry “*deceased on examination*”.

During the hearing, there was a factual issue about the content of Mrs Edge’s telephone call with Constable Ozols, which formed the basis of the CAD message created by Senior Constable Ford at 9.12pm.

Ultimately however, there is no need to resolve the precise terms of the conversation, there being no doubt on the basis of the CAD narrative that Mrs Edge conveyed that she was concerned about the welfare of her son Terry, and requested that police check on him.

There was tension in the evidence as to the nature of the ‘job’ Constable Ozols and Senior Constable Matheson understood they were attending relative to the contemporaneous documentation relating to Mrs Edge’s ‘concern for welfare’ call.

It was the clear position of both officers that they were never attending a ‘concern for welfare’ job, but rather checking on Terry because of his breach of bail. Constable Ozols gave evidence that she believed she was assisting Terry to report with bail, while for his part Senior Constable Matheson understood that he was attending the premises at Norton Street to see if Terry was there and to speak with him in relation to failing to report.

Additionally, both officers gave evidence that they never saw the ‘concern for welfare’ CAD job created by Senior Constable Ford until after Terry’s death, nor heard the broadcast of the ‘concern for welfare’ job by VKG some- time around 9.13pm. In oral evidence, Sergeant Norton stated that he had heard the VKG broadcast of the job and knew that a Ballina car crew was attending – he thought the nature of the job was “following up on bail conditions”.

Consistent with the officers’ stated understanding of the job, after attending, Senior Constable Matheson also consulted Sergeant Norton in relation to taking no action for Terry’s breach of bail and an entry confirming this was entered onto the ABRS system by Senior Constable Ford.

In contrast, the CAD job created by Senior Constable Ford at 9.12pm on 14 April 2015 (based on her “interpretation” of information given to her by Constable Ozols from the conversation with Mrs Edge) made no reference to checking on Terry for breach of bail and was put as a ‘concern for welfare’ job.

Little turns on this discrepancy. Both officers attending the premises were concerned not to wake Terry, being fearful of a possible violent confrontation.

Senior Constable Matheson knew Terry to be into drugs, and that he could be violent.

He was also aware of warnings on the system relating to Terry (which included a mental health warning, an 'approach with caution' warning and also reference to Terry having a 'level of resistance' (striking and kicking [at police])). Finally, he was also aware that Terry was a victim of a violent home invasion in 2014.

Constable Ozols was also familiar with Terry, having known him during her three years of service at Ballina Police Station. She had seen him sometimes appearing dishevelled and drug affected (slurring his words). Notably, she was also involved in the investigation of the home invasion incident in January 2014.

Constable Ozols gave evidence that she was concerned that it was "*extremely likely*" they would be injured if Terry awoke, while Senior Constable Matheson told the Court he believed there would be a violent confrontation.

Indeed, Mrs Edge told the Court that since the serious assault and home invasion in January 2014 (about which both officers were aware), Terry had become paranoid and was sleeping with weapons. It is also noted that Michael Riordan, Terry's brother, was apparently reluctant to go into Terry's unit on the evening of 14 April when he went upstairs to remind him about reporting for bail, due to personal violence incidents.

I find the decision not to wake Terry was justified, given the time of night, and the officers' knowledge of Terry and the recent home invasion.

In the circumstances, it follows that even if (contrary to their evidence) Constable Ozols and Senior Constable Matheson believed they were attending a concern for welfare, they would have been unlikely to have woken Terry and checked on his physical well-being.

Moreover, even assuming the officers were attending a concern for welfare check on Terry at this time, the evidence is that Terry was alive and breathing (both Constable Ozols and Senior Constable Matheson hearing his "regular snoring" or rhythmic breathing). As noted above, the officers would clearly have been concerned not to wake Terry, for reasons that appear justified.

Both Senior Constable Matheson and Constable Ozols conceded that absent sighting Terry, they could not be sure that the snoring/breathing they heard was in fact him.

Both officers assumed that it was Terry who was snoring. This assumption was based on the knowledge that Terry lived alone. It was also believed that Terry was unlikely to have absconded and it was therefore unlikely that someone else was asleep in his room.

In addition Constable Ozols was concerned about the power police had to enter Terry's unit, there being no intention to arrest Terry.

Senior Constable Matheson stated that they entered the unit "*in good faith*".

Section 9 of the *Law Enforcement and Responsibilities Act 2002* confers on police the power to enter premises in emergencies if the police officer believes on reasonable grounds that...

(1)(b) a person has suffered significant physical injury or there is imminent danger of significant physical injury to a person and it is necessary to enter premises immediately to prevent further significant physical injury or significant injury to a person.

Attending officers believed they were attending neither an emergency nor a concern for welfare check. Even if they had been of that belief, on hearing the snoring, they were justified in leaving the premises. Their evidence is clear; they attended in order to assist Terry with his bail obligations and any continued presence, when a decision had already been made not to affect an arrest, would have been unlawful.

The decision to take no action concerning the breach of bail

As set out in Detective O'Reilly's statement and confirmed in his oral evidence, in dealing with a breach of bail, officers are trained to take into account four key matters, based on the facts as known to them – namely: The relative seriousness or triviality of the failure; The personal attributes and circumstances of the person such as cognitive, mental or physical impairment; whether the person has a reasonable excuse for the failure; and Whether an alternative action to arrest is appropriate in the circumstances.

Officers then have six options to deal with an identified breach of bail – namely: 1) take no action; 2) issue a warning to the person; 3) issue a notice to the person requiring the person to appear before an authorised justice;

4) issue a court attendance notice; 5) arrest the person without warrant and take the person as soon as practicable before a court or authorised justice; or 6) apply to an authorised justice for a warrant to arrest the person.

The training module relating to the new bail legislation underscored that the action police choose in dealing with a breach of bail should be relevant to what bail is there to mitigate and is connected to the notion of “unacceptable risk”. An emphasis was placed on the fact that: “Arrest is not the only option when you detect someone breaching their bail”. Moreover, a failure to comply with the conditions of bail does not constitute an offence.

Records confirm that both Senior Constable Matheson and Constable Ozols had completed the on-line training modules relating to the new approach to bail (including breach of bail).

It was the evidence of both Constable Ozols and Senior Constable Matheson that there was never any intention to arrest Terry for his failure to report for bail, having regard to the following matters:

Terry was known to be forgetful in reporting for bail, sometimes attending four times a day;
The victim of Terry’s alleged offence was incarcerated;

Terry’s prior reporting history was “relatively good”;

Terry’s residence was known to police and it was not believed he was a flight risk (Constable Ozols’ evidence was that she did not believe he would leave town given his family ties to the area).

It was known that Terry had drug and alcohol issues (Terry would often appear dishevelled and at times drug affected, slurring his words) and that he was medicated (Senior Constable Matheson gave evidence that Terry would sometimes refer to this when reporting for bail).

I find the decision of the officers to take no action in response to the breach of bail to be appropriate in the circumstances.

Terry’s failure to report was discussed by Senior Constable Matheson with Sergeant Craig Norton, the shift supervisor at Ballina Police station on the evening of 14 April 2015. Sergeant Norton understood that the officers had entered Terry’s unit, seen him asleep and heard him snoring. In oral evidence, Sergeant Norton told the Court that he had formed the impression from what he was told that the officers had sighted Terry.

He now understood they did not do so, but nonetheless considered their actions to be appropriate. Sergeant Norton also understood that the officers had decided not to wake Terry given the late hour, possibility of intoxication and potential for unnecessary conflict.

Determining to take no action was a course with which Sergeant Norton agreed given that Terry was still in Ballina and there was no indication he would fail to appear for court. Sergeant Norton was also aware of Terry's background, which included the issue of previous warnings arising from his attending late or on incorrect days. Sergeant Norton believed this was a result of his drug and alcohol abuse. Additionally, in oral evidence, Sergeant Norton stated that taking Terry into custody "may have caused more issues".

The priority given to the job relating to Terry

Four officers were working on the evening shift at Ballina Police Station from 6pm to 6.30am – namely, Senior Constable Danielle Ford (on station duties), Sergeant Craig Norton (as the supervisor), and Senior Constable David Matheson and Constable Ozols as the response crew (in Alstonville 18).

Concerns were expressed by the representative of Terry's family to the effect that whilst the "job" concerning Terry was entered into CAD around 9.12pm, the officers did not attend Norton Street until 10.53pm (approximately 1 hour and 40 minutes later).

Terry's residence is located some 150 metres from the Ballina Police Station. The job was given a priority 3 categorisation by Senior Constable Ford, which both Constable Ozols and Senior Constable Matheson thought was appropriate.

Constable Ozols gave evidence that at the time of the entry concerning Terry, she was involved in a serious matter involving the preparation and service of a Provisional Apprehended Domestic Violence Order in which the defendant was threatening to kill the victim. After completing that task, police attended Terry's residence. This was a question of police prioritising jobs and resources and I do not find that police responded inappropriately in the circumstances.

CARE & TREATMENT PROVIDED BY DR MARTIN HARTMANN

Dr Hartmann, a medical practitioner for the last 25 years, provided a statement to police dated 20 July 2015. He had been Terry's treating GP for 17 years (since 1998).

During that time, Dr Hartman stated that Terry had battled depression and substance abuse issues and had talked of suicide many times, although he was not aware of any attempts at suicide.

Dr Hartman described Terry's substances of choice as alcohol and THC and believed Terry to be "very compliant" with medications prescribed.

A "permanent feature" of Terry's life as noted by Dr Hartmann was "violence" – he was regularly in conflicts with people involving physical violence. In the weeks prior to his death, Dr Hartmann stated that: "Terry was going through a particularly difficult patch with violence and depression in association with his wife".

The last occasion Dr Hartmann saw Terry on 13 April 2015, he stated:

"He was lucid and rational and showed no signs of intoxication. He was upset about the situations he was facing with regards to his wife (in gaol) and children (in foster care). Terry did not express any suicidal ideas to me though. I prescribed Endep 100 mg nocte as well as his regular Oxycontin 40 mg (28)."

Report of Dr Hester Wilson (07/06/2016)

Dr Hester Wilson prepared a report for the purposes of the inquest, and also gave evidence. Dr Wilson is a general practitioner with 26 years of clinical experience, including in general practice, mental health and addiction medicine working in both primary and specialist settings. Dr Wilson has a Masters in Mental Health, and a speciality in the practice of addiction medicine.

At the outset, Dr Wilson noted in her report the challenging nature of Terry's presentation, stating:

"Mr Riordan's history of complex multi-morbidity on a background of significant social, financial, family and interpersonal impairment. He was noted to suffer a number of mental health issues including: depression, anxiety, panic attacks, bipolar disorder, personality disorder, antisocial traits, psychotic symptoms, recurrent suicidal ideation, threats of self-harm, and three past suicide attempts."

He had a significant drug and alcohol history including methamphetamine use, amphetamine use, cannabis use, prescribed opioid dependency, prescribed benzodiazepine dependency and hazardous alcohol use ...”.

In addition, Terry had a number of physical issues including chronic back pain, shoulder pain, jaw pain and migraines.

Notwithstanding the complexity of Terry’s health conditions, Dr Wilson’s report raised a number of concerns in relation to Dr Hartmann’s treatment of Terry, primarily being as follows:

The adequacy of Dr Hartmann’s consultation notes, which Dr Wilson considered to demonstrate little evidence of comprehensive assessment, diagnosis and treatment planning, or the documenting of objective treatment outcomes;

A potential failure to consider that Terry might have been at risk from multiple psychoactive and sedative medications;

A potential failure to take particular steps (such as contacting the PBS prescription shopping hotline, registering Terry with the NSW Pharmaceutical Unit as a dependent person, or complying with s. 28 of the *Poisons and Therapeutic Goods Act 1966*) when prescribing medication to him;

An apparent failure to record any suicide risk assessments that may have been undertaken;
The apparent lack of referral of Terry to specialist teams (such as a specialist pain team or the local drug and alcohol team) to case manage his needs;

The circumstances in which some prescriptions were prescribed to Terry, including the authorization of some scripts via telephone, and

The basis for prescribing Terry: multiple anti-depressants concurrently in March 2015 (that is, Citalopram, Amitriptyline and Doxepin); and two benzodiazepine medications (Oxazepam and Diazepam) and also the long-term use of that medication;

A number of measures could have been taken by Dr Hartman to address Terry’s complex medical presentation including:

Consulting a psychiatrist for a review of Terry's medication (given that he was evidently having difficulty finding an effective anti-depressant, prescribing them concurrently and also engaging in 'off' label prescribing); notably, Medicare includes an item number for such consultations;

Referral to a drug and alcohol service - although it must be appreciated that Terry may have been unlikely to engage with such a service, it is not apparent that Dr Hartmann ever considered this option or offered it to Terry;

Referral to a pain specialist to deal with Terry's many ongoing physical issues causing apparently chronic pain issues, requiring medication; and Preparing a detailed mental health care plan for Terry that included referral to a psychologist for psychological support.

Dr Hartman's referral of Terry to the Ballina Mental Health Team on 13 April 2015, the basis for him doing so falls short on adequate explanation. The evidence of both Dr Andrea Rose (psychiatric registrar) and also Dr Wilson, however, was that the referral contained little useful information and gave little description of the assessment or indication as to Terry's current state of risk.

Poor prescribing practices

Dr Hartmann's approach to prescribing medication for Terry appears to have been ill-considered, and was not apparently informed by current guidelines as to prescribing of drugs of dependence, particularly with respect to benzodiazepine and opioid medication (as noted in Dr Wilson's report).

Dr Hartmann particularly seems to have failed to consider that Terry might have been at risk from the concurrent prescribing of multiple psychoactive and sedative medications. Specifically, Dr Wilson noted that:

It was unclear why multiple anti-depressants were prescribed concurrently in March 2015 (that is, citalopram, amitriptyline and doxepin). The prescribing of multiple medication increases the risk of side effects and the prescription of multiple anti-depressants is best done with specialist psychiatric advice;

It was also unclear why two benzodiazepine medications (oxazepam and diazepam) were prescribed concurrently or used on a long-term basis.

Dr Wilson noted that there are few clinical reasons to continue benzodiazepines long term or to use them concurrently as the risks outweigh the benefits and there is an increasing move towards use of these medications for short-term use only.

On 27 January 2015, Dr Hartmann also apparently failed to consider that Terry's presentation relating to difficulties with his memory may have been caused by the medications prescribed.

Concerns also arise in that Terry's clinical records from 2009 refer to a conversation a health worker had with Dr Hartman (on 28 July 2009) in which Dr Hartmann apparently states that he "knows Terry well", and that he is a "known poly drug abuser, benzo's, cocaine, ETOH ...". The note raises the prospect that notwithstanding Dr Hartmann's awareness that Terry was an abuser of benzodiazepine medication, he continued to prescribe these medications to him from 2009.

The basis for Dr Hartmann's prescribing of various medications is difficult to determine, given the deficient nature of his medical records, as detailed below.

Inadequate medical records

As set out in Dr Wilson's report, she considered Dr Hartmann's notes to be "inadequate", and that they did not meet the guidelines for good clinical practice.

In this regard, two guidelines were tendered into evidence, and specify the following in relation to medical records: 'Good Medical Practice: A code of Conduct for Doctors in Australia' (2009): *"Maintaining clear and accurate medical records is essential for the continuing good care of patients.*

Good medical practice involves: 8.4.1 Keeping accurate, up-to-date and legible records that report relevant details of clinical history, clinical findings, investigations, and information given to patients, medication and other management." RACGP – Standards for general practices (4th ed) Standard 1.7 refers to the content of patient health records, and notes:

"Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes".

A reference to “indicators” notes that patient health records should also record (relevantly) the following, where clinically significant: date of consultation, patient reason for consultation, relevant clinical findings, diagnosis, recommended management plan, “any medicines prescribed for the patient (including name, strength, directions for use/dose frequency, number of repeats and date medicine started/ceased/changed)”, any referral to other health care providers or health services, and any special advice or other instructions.

Moreover, Part 4, r. 7 of the *Health Practitioner Regulation (New South Wales) Regulation 2010* also requires that practitioners keep records relating to each patient in accordance with Schedule 2. Schedule 2, clauses 1 and 2 relevantly include the following requirements: *Information to be included in record A record must include the following: any information known to the medical practitioner who provides the medical treatment or other medical services to the patient that is relevant to the patient’s diagnosis or treatment (for example, information concerning the patient’s medical history, the results of any physical examination of the patient, information obtained concerning the patient’s mental state, the results of any tests performed on the patient and information concerning allergies or other factors that may require special consideration when treating the patient), particulars of any clinical opinion reached by the medical practitioner, any plan of treatment for the patient, particulars of any medication prescribed for the patient.*

The record must include notes as to information or advice given to the patient in relation to any medical treatment proposed by the medical practitioner who is treating the patient.

A record must include the following particulars of any medical treatment (including any medical or surgical procedure) that is given to or performed on the patient by the medical practitioner who is treating the patient:

- *the date of the treatment,*
- *the nature of the treatment,*
- *the name of any person who gave or performed the treatment,*
- *the type of anaesthetic, if any, given to the patient,*
- *the tissues, if any, sent to pathology,*
- *the results or findings made in relation to the treatment.”*

2 General requirements as to content

In general, the level of detail contained in a record must be appropriate to the patient’s case and to the medical practice concerned.

A record must include sufficient information concerning the patient's case to allow another medical practitioner to continue management of the patient's case.

All entries in the record must be accurate statements of fact or statements of clinical judgment.

...”.

On any view, Dr Hartmann's medical records of his consultations with Terry fail to comply with the foregoing requirements.

Dr Hartmann was Terry's doctor from August 1998 until his death in April 2015 – some 17 years. During this period, his notes indicate that Terry attended his clinic on over 130 occasions. However, the total sum of Dr Hartmann's clinical notes is eight handwritten pages. Some entries are comprised only of a date and a [“] (ditto) marking.

Further, it is apparent that the notes omit certain very significant information. For example, in the last few months of Terry's life;

On 10 March 2015, Terry was referred for a CT scan to exclude frontal lobe damage – neither the fact of referral, nor the results are noted in the records;

On 30 March 2015, zyprexa (10mg), an anti-psychotic medication, was prescribed – the notes do not indicate why it was prescribed;

On 13 April 2015, Dr Hartmann referred Terry to the Ballina Mental Health Team – neither the fact of referral, nor a copy of the referral is contained in the notes or records;

On 13 April 2015, Dr Hartman prescribed oxycontin– 28 tablets, endep (amitriptyline) - 50 tablets, two repeats and diazepam – 50 tablets; only the endep was noted in his clinical notes.

Additionally, Dr Hartmann's statement also refers to Terry talking of suicide many times – however his notes contain two entries only in this regard in 1998 (to “death thoughts”) and in 2005 (“suicidally depressed 1/12 ago”). A patient expressing suicidal ideation is a clearly significant matter that ought to have been noted on each such occasion in Dr Hartmann's clinical notes.

As Dr Wilson stated, while there may in fact have been very good reasons for the clinical decisions made, that is not apparent from the notes. There is no evidence that treatment plans or objective treatment outcomes were documented, discussed or acted on with Terry, a process that would have allowed for some assessment as to the efficacy of the approach, and change of treatment as needed.

The records also largely fail to set out information relevant to Terry's clinical history or the particulars of medication prescribed (other than the name and on some occasions the dose). I find that Dr Hartmann's notes are grossly inadequate and for this reason and for the criticisms raised by Dr Wilson, I will refer Dr Hartman to the HCCC for investigation.

CONCLUSION

Information from Terry's family and other witnesses in the days before Terry's death paint a picture of what Dr Wilson describes as a "deeply unwell man, with very poor emotional regulation; cycles of intoxication and withdrawal." He was becoming "increasingly confused" and according to Dr Wilson was probably "looking for relief from his emotional pain" The tragedy of this matter is that although Terry's mother and family rallied around him, they were not able to prevent his death. Mrs Edge was determined to seek assistance for Terry, contacting mental health services and accompanying him to appointments with his GP. Mrs Edge stated that after the assault in January 2014, she "slowly watched him die."

A number of professionals were involved in the care of Terry. The evidence reveals that staff at RCNACS managed Terry's case in a professional, appropriate and commendable manner. Dr Rose and the health professionals from RCNACS were careful and thorough in their treatment of Terry and demonstrated concern for Terry within the constraints of the *Mental Health Act* and Terry's own reluctance to fully engage with what was being suggested.

The police were aware of Terry's difficulties and apart from their failure to actually sight Terry on the night of 14 April 2015, their response revealed attempts to assist this man who at times was chaotic, potentially dangerous and troubled by mental illness. Senior Constable Ford, concerned about Terry's failure to report on bail, spoke with Terry's brother Michael with a view to having Terry attend the station so he could be processed and thus avoid any anxiety. The decision to take no action on Terry's breach of bail was also a response to Terry's particular circumstances and personal attributes and demonstrated a degree of concern and compassion by the attending police at Terry's residence.

FORMAL FINDING

I find that Terry Riordan died on 14 or 15 April 2015 at unit 12 5 – 9 Norton Street Ballina from multi drug toxicity as a result of ingesting methadone and amitriptyline. I am unable to make a finding that the drugs ingested by Terry Riordan were with the intention of ending his life.

17. 141687 of 2015

Inquest into the death of William MacDonald. Finding handed down by Deputy State Coroner O’Sullivan at Glebe on the 9th June 2016.

The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of William MacDonald.

Introduction:

Mr William MacDonald was born on 17 June 1924 in the United Kingdom. At the time of his death he was serving a custodial sentence at the Long Bay Correctional Centre. At 90 years of age, he was the oldest inmate in NSW.

As Mr MacDonald was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act.

The Inquest:

The role of a Coroner, as set out in s 81 of the Coroners Act, is to make findings as to:

- (a) the identity of the deceased;
- (b) the date and place of the person’s death;
- (c) the physical or medical cause of death; and
- (d) the manner of death, in other words, the circumstances surrounding the death.

Pursuant to s 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

The Evidence:

Background:

Mr MacDonald was born in Liverpool, England.

He had discipline issues at school and in his mid to late teens was being treated by a psychiatrist who certified him as an erratic schizophrenic.

He was conscripted into the British Army at the age of 18 and it appears he served during World War 2. At the termination of the war, he received an honourable discharge with exemplary conduct.

In 1948, Mr MacDonald immigrated to Canada but soon found himself in dire circumstances and his family had to forward money so as he could return to England.

Upon returning to England, he started to display erratic behaviour. He was admitted as a voluntary patient to the Crichton Mental Home in Scotland, however, his mother arranged for him to be returned home from Crichton shortly after admission.

Mr MacDonald migrated to Australia and arrived in Brisbane in 1954. He worked numerous jobs before finding himself in Adelaide. On 18 April 1955 he was charged with 'indecent assault on a male person' and 2 counts of gross indecency. He received a two-year good behaviour bond with orders he submit himself to treatment. He did not comply with these orders and left Adelaide immediately.

After leaving Adelaide, Mr MacDonald spent time in Ballarat, and Perth. He changed his name to Alan Edward Brennan before travelling onto Hobart and later to New Zealand in 1959.

He returned to Australia and in 1961 and gained employment with the Postmaster- General's Department in Sydney. Mr MacDonald's behaviour was noticed to be odd and he was examined by a doctor who reported, *"There is little doubt that Mr Brennan (as he was then known) is an unusual personality, best described as schizoid."*

Not much is known of Mr MacDonald's family. As at 1963, his father was deceased, however records mention that his mother and a brother were alive at that time. Their names are not revealed in the brief.

To date, Police have been unable to locate any next of kin or known relatives of Mr MacDonald.

Mr MacDonald has never disclosed a next of kin or emergency contact to Police or Corrective Services. He continually stated to authorities he had no living relatives. Enquiries with the United Kingdom Consulate have proved fruitless.

Custodial History:

On 24 September 1963 Mr MacDonald was sentenced at the NSW Supreme Court in relation to four charges of murder.

The matter was sensational at the time, and Mr MacDonald gained notoriety as *'the Sydney mutilator'*, due to his modus operandi of removing the genitals of his male victims.

Mr MacDonald received a sentence of penal servitude for life. He was initially held at Long Bay Gaol, before being committed to Callan Park Mental Hospital by the then Minister for Health. He was certified medically and legally insane.

In 1964, Mr MacDonald was transferred to Morisset Hospital where he was diagnosed and treated for depression and schizophrenia.

In 1976 Mr MacDonald was admitted into the prison system proper, his schizophrenic and depressive illnesses considered to be in remission.

On 30 December 2004, Mr MacDonald was admitted to the Old Long Bay Hospital due to increasing age and associated health problems.

On 8 August 2007, Mr MacDonald was transferred to a section of the Metropolitan Special Programs Centre set aside for older inmates.

On 2 July 2008, Mr MacDonald was transferred to the new Long Bay Hospital's Medical Sub Acute Unit and then later transferred to the Aged Care Rehabilitation Unit (ACRU) on 5 January 2009.

Medical history:

Soon after entering custody, Mr MacDonald was certified as 'Mentally III' under section 27 of the Mental Health Act 1958 as it was then.

He was transferred to an appropriate secure facility where he received treatment for his illnesses. It was only when his illnesses were considered to be in remission that he was admitted into the general prison system.

On 30 December 2004, Mr MacDonald was admitted to the Old Long Bay Hospital due to increasing age and associated health problems.

On 8 August 2007, Mr MacDonald was transferred to a section of the Metropolitan Special Programs Centre set aside for older inmates. He was 85 years old and suffering from clots in his legs, cellulitis, peptic ulcer, hernias, decreased mobility, declining memory and dementia.

On 2 July 2008, Mr MacDonald was transferred to the new Long Bay Hospital's Medical Sub Acute Unit. He was later transferred to the Aged Care Rehabilitation Unit (ACRU) on 5 January 2009.

Whilst in the ACRU, the medical records reveal Mr Macdonald was regularly assessed by the nursing staff and the Clinical Director of Aged Care. Mr MacDonald suffered leg pain, hernias and occasional episodes of diarrhoea, however he was self-caring, and relatively mobile around his ward. All of his conditions were consistent with advancing age.

The Fatal Incident:

On the evening of 11 May 2015, Mr MacDonald complained of severe abdominal pain. He had nausea and was vomiting. He was transferred from Long Bay to the Prince of Wales Hospital that evening, where he was diagnosed with a gastrointestinal obstruction due to an incarcerated section of bowel in an inguinal hernia.

A surgical consultation occurred that night between specialists at the Hospital. It was considered Mr MacDonald's condition was not survivable and he was deemed not for operative management.

Mr MacDonald's resuscitation plan was marked 'No CPR' because CPR was only likely to result in negligible clinical benefit. A palliative care plan was initiated.

Mr MacDonald's condition did not improve and he died the next morning. He was pronounced dead on 12 May 2015 at 0814am.

End of Life Care:

Mr MacDonald had previously discussed “end of life care’ with his regular doctor, Dr Sim. He indicated end of life care to include full resuscitation and intubation. This conversation occurred in 2014.

NSW Health has guidelines and policies regarding resuscitation. The NSW Health Guideline ‘End of Life Care and Decision-Making Guidelines’ provides that:

A primary goal of medical care is preservation of life, however when life cannot be preserved, the task is to provide comfort and dignity to the dying person, and to support others in doing so.

It goes on:

Appropriate end-of-life care should intend to provide the best possible treatment for an individual at that time. It recognises that if the goals of care shift to primarily accommodate comfort and dignity, then withholding or withdrawal of life-sustaining medical interventions may be permissible in the best interests of the dying patient.

The applicable NSW Health Policy Directive is PD 2014_030 “Using Resuscitation Plans in End of Life Decisions.” This Directive provides that one of the rationales for withholding resuscitation is:

2.2.3 Where the Attending Medical Officer judges that resuscitation offers no benefit or where the benefits are small and overwhelmed by the burden to the patient.

- *Given that judgments about the benefits or otherwise of a therapy ultimately reflect the values, beliefs and hopes/goals of the patient, any decision to withhold resuscitation on clinical grounds alone must be carefully considered, properly justified and documented*

- *Focussing on patient comfort also entails withholding life-sustaining measures sometimes considered to be of negligible benefit (for example, where the ability to restore spontaneous rhythm or circulation with CPR is highly unlikely)*

- *A medical practitioner does not need to obtain agreement from the patient or family to withhold interventions considered to be of negligible benefit,*

but it is still good clinical practice to discuss why these are not being offered in the context of broader end of life goals of care conversation. This includes scenarios that may present at an Emergency Department. If consent is not sought, the reasons why should be documented in the patient record. It is also the case that engaging patients in such discussion does not obligate the treating team to provide treatments that they believe are considered to be of negligible benefit.

Mr MacDonald's Resuscitation Plan was made in consultation with Drs Sim, Muhlmann, Kaplin and authorised by the Attending Medical Officer, Dr Ann-Marie Cheshire. The medical records indicate that "*The patient's condition is such that CPR is likely to result in negligible clinical benefit.*"

The decision to withhold CPR from Mr MacDonald was appropriate in the circumstances and complied with the NSW Health Guidelines and applicable Policy Directive.

Care and Treatment:

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State.

Even when a person in custody dies of apparent natural causes, an inquest is required to independently assess whether the State has discharged its responsibility.

The Corrective Services records indicate that Mr MacDonald's care and treatment was appropriate.

Mr MacDonald's death is not suspicious and he died of natural causes.

Autopsy Report

On 13 May 2015, Dr Kendall Bailey conducted an autopsy upon Mr MacDonald. Dr Bailey issued a report recording Mr MacDonald's cause of death as complications of gastrointestinal obstruction. An incarcerated inguinal hernia was listed as an antecedent cause.

Formal Finding

The identity of the deceased

The deceased person was William MacDonald.

Date of death

Mr MacDonald died on 12 May 2015.

Place of death

Mr MacDonald died at Prince of Wales Hospital, Randwick, New South Wales.

Cause of death

The cause of death was complications arising from a gastrointestinal obstruction. An incarcerated inguinal hernia was an antecedent cause.

Manner of death

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

18. 162071 of 2015

Inquest into the death of Narayana Simpson. Finding handed down by Deputy State Coroner Lee at Tweed Heads on the 23 May 2016.

Introduction

In the early hours of the morning on 1 June 2015 a car containing two young men crashed into a telegraph pole along Tumbulgum Road, a residential street in Murwillumbah NSW. Sadly the driver of the car, Mr Narayana Simpson, died from injuries that he sustained in the collision. A short time earlier police officers, who were responding to a triple 0 call, had driven to a location where Narayana had been and saw his car leaving.

Due to the involvement of the police the incident was declared a Critical Incident under NSW Police guidelines. As Narayana had driven away from the police car, there was a question whether there had actually been a police pursuit before the collision. This inquest has examined this question, and also the questions of whether the Critical Incident Guidelines were subsequently followed, as well as the general circumstances surrounding Narayana's death.

The role of a Coroner and purpose of this inquest

Section 81(1) of the *Coroners Act 2009* (the Act) requires that when an inquest is held the coroner must record his or her findings as to various aspects of the death. These are the findings of an inquest into Narayana's death.

The role of a Coroner, as set out in section 81 of the Act, is to make findings as to:

- the identity of the person who died;
- 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.

Section 82 of the Act allows a Coroner to make recommendations concerning any public health or safety issues arising out of the death in question.

Narayan's death, when and where he died and the cause of his death are all matters which were not in dispute. The primary issue which the inquest has examined is whether the conduct of the police was compliant with any relevant policies including, if appropriate, the NSW Police Force Safe Driving Policy (to the extent that it had any application) and the Critical Incident Guidelines. Examination of this question has required consideration of a number of specific issues within this broader issue.

The life of Narayana Simpson

Before considering the questions that the inquest examined, it is fitting to briefly say something about the young man who tragically lost his life. Narayana was born on 31 January 1987. He was the eldest child of Simone Dewhirst and had five younger siblings. His father died when Narayana was only two years old.

After obtaining his School Certificate from Murwillumbah High School in 2003, Narayana was continuously employed in a variety of different jobs. He attained many certificates of achievement, most of them in the building industry. He had a talent for, and interest in, music and the arts. His mother describes him as an extremely loyal and dependable person who was always there when someone was in need.

No doubt this was one of the many reasons why he was loved by all his family and friends. They all miss him greatly, especially his grandparents as Narayana was their first grandson. The death of a young man with his life ahead of him is always heartbreaking. It is distressing to know that Narayana's family have lost a grandson, son and brother in such tragic circumstances.

What happened before the collision?

On the evening of 31 May 2015 Narayana made arrangements to meet up with Mr Leigh Wilson, one of his best friends. The two men meet up in the Murwillumbah CBD at about 7:00pm and had some drinks. From about 7:00pm to about 9:00pm Narayana and Mr Wilson were drinking beers, from a carton that Narayana had brought, in a car park.

After walking around town for a short while, they returned to the car park, behind the Commonwealth Bank and near the Murwillumbah Hotel, where Narayana had parked his car, a white Holden Commodore sedan.

At about 11:30pm Ms Jennifer Allfree, the manager of the Murwillumbah Hotel, went to bed in one of the hotel's rooms. A short time later she heard the sound of male voices but could not hear what was being said.

About five to ten minutes later she got up and went to the back veranda that overlooks the neighbouring Commonwealth Bank car park and the alley between the bank and the hotel. She saw Narayana and Mr Wilson standing in the alley.

Mr Wilson was having an argument with, and shouting at, three hotel residents. Narayana was not taking part in the argument. Ms Allfree asked Mr Wilson to stop but he ignored her. She walked down to the alley and again repeatedly asked Mr Wilson to stop shouting, telling him to leave the hotel otherwise she would have to call the police. Mr Wilson ignored Ms Allfree's requests. Narayana intervened and also asked Mr Wilson to leave, but Mr Wilson also ignored him.

Ms Allfree told Mr Wilson again that she was going to police and used her mobile phone to ring triple 0 at 11:59pm. Ms Allfree asked for the police to attend and began walking back upstairs. By the time she reached the veranda, Narayana and Mr Wilson had moved to Narayana's car which was parked in the car park. Ms Allfree saw them get in the car, with Narayana in the driver's seat and Mr Wilson in the front passenger seat. Narayana drove out of the car park onto the lane way leading to Tumbulgum Road heading east towards Murwillumbah Civic Centre. As she saw the car leave the car park, Ms Allfree rang triple 0 back at 12:06am to tell the operator that the car had left and to cancel the request for police.

By the time they left the car park Mr Wilson estimates that there were not even 6 beers left from the carton of 30 that Narayana had brought. Mr Wilson said that he and Narayana had been drinking in equal amounts. After leaving the car park Narayana was intending to go home to get something to eat.

At around midnight Senior Constable Stuart Gordon and Senior Constable Dean Wilson were out on patrol in a police 4WD with the designation "Murwillumbah 18". They had just completed a patrol up to Lions Lookout and were returning to Murwillumbah police station. They received a call over police radio in relation to the disturbance at the Murwillumbah Hotel that Ms Allfree had reported.

After driving down the hill the police officers turned on to Murwillumbah Street heading towards the river. Murwillumbah Street becomes Wharf Street and at the left hand bend past the row of shops it becomes Tumbulgum Road.

Shortly after the left hand bend there is an unnamed laneway on the left side of the road leading to the council car park, and the car park behind the hotel. This second car park is where Narayana had parked his car.

As the police vehicle turned into the laneway, the officers saw Narayana's car, which had left the car park and was near a public pool located at a bend in the laneway. Senior Constable Gordon estimated that Narayana's car was about 30 to 40 metres away. Upon seeing Narayana's car, Senior Constable Wilson asked Senior Constable Gordon if a white car was associated with the radio call that they were responding to. Senior Constable Gordon said that it was and Senior Constable Wilson formed the suspicion that Narayana's car was involved with the radio call.

Both Narayana and Mr Wilson saw the police car. According to Mr Wilson, Narayana said words to the effect of, "Fuck. We're going to get into trouble. I'm on a bond". Apart from these words Mr Wilson said that there was not much of a conversation between himself and Narayana about the police. Mr Wilson explained in evidence that he was concerned they were going to be pulled over because he knew the tyres on Narayana's car were bald and possibly not roadworthy. Mr Wilson also explained that he had a personal concern about being pulled over because he was on bail at the time.

Narayana drove out of the laneway onto Tumbulgum Road heading east. The police vehicle followed. Mr Wilson said that he did not know whether the police had seen Narayana's car. However he said that Narayana drove "hastily" from the car park, that "we kind of took off there pretty, you know, quick but it wasn't an excessive speed", and that Narayana "probably would have been over the speed but I'm not too sure". Mr Wilson did not think that Narayana had his seatbelt on. Senior Constable Wilson estimates that both his car and Narayana's car were travelling at about 30 or 40 kilometres per hour at this time.

Senior Constable Wilson turned on the high beams of the police vehicle in an attempt to illuminate the licence plate on Narayana's car. This also caused spotlights, which were mounted on the bull bar of the vehicle, to turn on as well. The high beam and spotlight remained on for a couple of seconds before being turned off.

From the laneway exit point, Tumbulgum Road continues in a gentle right hand bend before leading to a sharper left-right chicane. As Narayana's car rounded the right-hand bend just past the library and council buildings, and in front of a youth hostel, it accelerated harshly, fishtailing as it did so.

Senior Constable Gordon described the car as taking "off like a rocket" and "it just gunned it".

Senior Constable Gordon only saw the car's tail lights on and never saw its brake lights come on. When he saw the manner of Narayana's driving Senior Constable Wilson said, "Nah". Senior Constable Gordon understood this to mean that he (that is, Senior Constable Wilson) was not going to pursue Narayana's car. Senior Constable Gordon asked if Senior Constable Wilson saw the licence plate number. Senior Constable Wilson said that he had not.

Senior Constable Wilson later explained in a recorded interview that he decided not to pursue the car because the radio call had mentioned an intoxicated person leading him to believe that the driver might be intoxicated, and that the driver was not showing good driving skills by his manner of driving. Senior Constable Gordon later explained in his recorded interview that he agreed with this decision based on the speed that Narayana's car was travelling and the fact that he knew it was headed towards a chicane further ahead on Tumbulgum Road. He said that "it wasn't worth chasing it or pursuing the car".

After leaving the police vehicle behind, Narayana drove through the chicane towards the intersection with Old Ferry Road. As the car travelled through the bend, Mr Wilson described the driving as "it was a little bit fast there" and "we were hitting the brakes a little harder, you know and taking the corner a little bit, you know, a bit more acceleration out of it, you know".

The police officers continued driving along Tumbulgum Road. Senior Constable Gordon said that they continued to drive in the same manner as they had before they saw Narayana's car, although they may have accelerated "a little bit" but "nothing urgently".

Both Senior Constables said in evidence that they were probably travelling slightly above the speed limit which was 40 kilometres per hour. By this point, they could no longer see Narayana's car as it had entered the chicane. Senior Constable Wilson estimates that Narayana's car was travelling between 60 to 70 kilometres per hour as it approached the chicane.

Senior Constable Gordon checked a data terminal within the police vehicle to see if there was any licence plate number associated with the radio call and found that there was none. The police officers continued driving along Tumbulgum Road and through the chicane. Just past a left-hand intersection with Old Ferry Road, Tumbulgum Road straightens as it leads towards Mayal Creek. The speed limit at this point changes from 40 to 50 kilometres per hour.

As the police officers left the chicane they saw that Narayana's car had collided with a telegraph pole and had come to rest on the grass verge on the left side of the road.

At this point the police officers were about 150 to 200 metres away from Narayana's car. Senior Constable Gordon said that he did not hear the collision.

What happened after the collision?

The police vehicle pulled up and stopped near Narayana's car. Senior Constable Wilson left the car but returned moments later to turn on the vehicle's warning lights. Senior Constable Wilson explained that he did this in order to warn other cars that may have been approaching from the chicane about the collision. However, in evidence he was unable to recall whether he turned the lights on before or after checking on Narayana. Senior Constable Gordon said that he did not turn on the warning lights on the police vehicle but believes that Senior Constable Wilson may have done so when he returned to the car after checking on Narayana.

Senior Constable Gordon remained in the car and called an ambulance, advising that there were people trapped inside a car. A Computer Aided Despatch (CAD) log recorded that this call was made at 12:09am. After leaving the police car Senior Constable Wilson ran over to Narayana's car. He saw that Narayana was slumped forward in his seat, with his upper body partially out of the car and his head bleeding. Senior Constable Wilson felt for a pulse and found none.

At this point his attention was distracted by an altercation between Mr Wilson and a resident of Tumbulgum Road, Mr David Andrew, who had been woken by the sound of the collision and went outside to investigate. Mr Andrew, believing that his partner's car had been damaged in the collision, armed himself and engaged in a heated argument with Mr Wilson.

Senior Constable Gordon intervened and attempted to calm both men down. When Senior Constable Wilson returned his attention back to Narayana, he tried to move Narayana out of the car in order to place him in the recovery position to ensure that his airway was clear. As he moved Narayana he did not believe that Narayana was wearing a seatbelt. Senior Constable Wilson was only able to move Narayana partway out of the car; his legs remained in the driver's foot well. Both Senior Constable Wilson and Senior Constable Gordon checked on Narayana and found that he was already visibly deceased.

Mr Wilson was shouting and being verbally abusive towards the police officers. Senior Constable Gordon attempted to calm him down and move him away from the scene.

At some point Senior Constable Gordon asked Mr Wilson who the driver of the car was. When Mr Wilson told him Narayana's name, Senior Constable Gordon recognised it from some previous dealing he had had with Narayana.

An ambulance and other police officers arrived at the scene a short time later. Paramedics examined Narayana and confirmed that he had died.

Sergeant Warwick Rhodes was one of the first police officers to arrive on the scene. He informed Senior Constables Gordon and Wilson that he needed to call his superior in order to determine whether the incident would be declared a critical incident. After several minutes Sergeant Rhodes advised the Senior Constables that the matter had indeed been declared a critical incident. Sergeant Rhodes instructed the two officers to write some notes in their notebook and then he subjected each officer to a breath test.

What caused Narayana's death?

Dr Rexson Tse, forensic pathologist, performed an autopsy on 2 June 2015 at Newcastle. In his subsequent report Dr Tse concluded that Narayana had died from multiple injuries, particularly to the head and chest that were consistent with the high impact nature of the collision.

Did the actions of any police officer at the collision site contribute to Narayana's death?

This issue only arises because of what Mr Andrew, and his partner Ms Amanda Darby, said in their statements to police. Ms Darby said that when Senior Constable Wilson attempted to pull Narayana from the car Mr Wilson said words to the effect of, "You've broken his neck. You shouldn't have moved him like that. You've killed him." Mr Andrew said that Mr Wilson yelled, "You've killed him. You've snapped his neck". In his recorded interview Senior Constable Wilson also said that Mr Wilson was saying words to the effect of, "You know, you, you're pulling [my] mate out. You fucking break his, you'll break his back". Senior Constable Wilson clarified in evidence that when he was referring to Mr Wilson using the word "back" it was possible that he instead meant to say "neck".

There is no dispute that Senior Constable Wilson attempted to move Narayana from the car. In evidence Senior Constable Wilson explained that he did so by grabbing hold of Narayana under the armpits and was attempting to move him from out of the car and on to the ground. In both his recorded interview and in evidence Senior Constable Wilson explained that his reason for doing this was because he saw that Narayana's neck was "at a kink" and believed that his airway might therefore be compromised. Senior Constable Wilson went on to explain that he was trying to move Narayana out of the car so as to place him in the recovery position.

It should be noted that in his recorded interview Mr Wilson did not himself say that he said the words that Ms Darby, Mr Andrew and Senior Constable Wilson attribute to him. However in evidence he did not deny that he said them. I have no doubt that Mr Wilson was obviously concerned for Narayana's welfare. This fact, combined with Mr Wilson's intoxication and the immediate after effects of being involved in a sudden violent collision, adequately explains Mr Wilson's words and actions.

In his recorded interview two days after the incident Mr Wilson later explained that he was not accusing Senior Constable Wilson of having any involvement in Narayana's death and that he believed that Senior Constable Wilson's intention was to help Narayana. In evidence during the inquest Mr Wilson went further and explained that he was not aware at the time that Senior Constable Wilson was attempting to ensure that Narayana's airway was not compromised and said that he did not blame either of the police officers for Narayana's death.

The autopsy examination revealed that Narayana did not suffer a neck fracture. Dr Tse's opinion was that Narayana's injuries were such that "death would have been rapid and inevitable". There is no suggestion from the evidence of any of the neighbouring residents that Senior Constable Wilson acted inappropriately. Indeed, one of the witnesses who gave evidence at the inquest, Mr Charlie Parratt, said that Narayana had not been moved much at all from the original position where Senior Constable Wilson found him. Given these factors, and the change in Mr Wilson's stance after the incident, both in his recorded interview and in evidence, I conclude that the actions of Senior Constable Wilson at the collision site did not contribute to the death of Narayana in any way. I also conclude that Senior Constable Wilson acted appropriately and with due care and concern for Narayana.

Why was the incident declared a Critical Incident?

The NSW Police Force Critical Incident Guidelines (the Guidelines) apply to the investigation of all deaths or serious injuries which have occurred as a result of an interaction with police. The Guidelines provide for how such incidents are to be investigated and managed. At the time of Narayana's death the August 2012 Critical Incident Guidelines were in force.

Page 9 of the Guidelines defines what a critical incident is. A critical incident can arise from a police vehicle pursuit or from a collision involving a NSW Police Force vehicle. A critical incident can also arise from a police operation.

This of course raises the questions of whether there was a police pursuit, and whether there was a police operation.

Was there a police pursuit?

Part 6 of the NSW Police Force Safe Driving Policy (SDP) deals primarily with police pursuits and sets out guidelines for pursuits, what vehicles can be used, what the responsibilities of police officers involved in pursuits are, and when pursuits will be terminated. Part 6 of the SDP also defines what a pursuit is. That definition states:

PURSUIT: A pursuit commences at the time you decide to pursue a vehicle that has ignored a direction to stop.

An attempt by a police officer in a motor vehicle to stop and apprehend the occupant(s) of a moving vehicle when the driver of the other vehicle is attempting to avoid apprehension or appears to be ignoring police attempts to stop them.

A pursuit is deemed to continue if you FOLLOW the offending vehicle or continue to attempt to remain in contact with the offending vehicle, whether or not your police vehicle is displaying warning lights or sounding a siren.

Both Senior Constables Wilson and Gordon acknowledged that activating the warning lights and/or siren of a police vehicle amounted to a direction by police to another vehicle to stop. This of course raises the question: did the police officers activate the warning lights and/or siren of their vehicle at any time before the collision?

Both police officers maintain that they did not turn on the siren of the police vehicle. Statements were taken from people who lived in the vicinity of the collision site. Some of these people were awake when the collision happened; others were asleep. All of them recall hearing the loud sound of the collision but none remember hearing any police siren before the collision itself. Two of these witnesses, Augustus Firestone and Barbara Carroll, gave evidence at the inquest. Both said that ordinarily they can hear the sound of siren if a police vehicle is travelling with its siren on along Tumbulgum Road. However, both Mr Firestone and Ms Carroll confirmed that they did not hear any siren on this night.

The only person who claims that the police officers turned on the siren of their vehicle is Mr Wilson. In his recorded interview with police on 2 June 2015, Mr Wilson said that he heard the siren and saw the warning lights of the vehicle come on at a point near the intersection of Old Ferry Road and Tumbulgum Road. He repeated this in evidence during the inquest. Mr Wilson explained that when the siren and lights came on that Narayana “gunned it”. By this Mr Wilson explained that Narayana had the car in low gear and “gave it full throttle”. When Narayana changed gears Mr Wilson explained he recalled hearing the car “revving” and that it slid out and lost traction.

Senior Constable Wilson explained in evidence that he followed Narayana’s car with the intention to make some enquiries with the car’s occupants.

He further explained that his usual procedure when stopping a vehicle is to obtain the licence plate number, check for any warnings associated with the vehicle, find a suitable location to stop the vehicle, activate the siren and warning lights of the police vehicle, and park the police vehicle in such a way as to provide a corridor of safety against approaching traffic.

In maintaining that he did not activate the siren or warning lights of the police vehicle at any time prior to the collision (and only the warning lights after the collision) Senior Constable Wilson relied on the fact that he did not consider the area around the intersection between Old Ferry and Tumbulgum Roads to be a suitable place to stop a vehicle. This is because, he explained, there is nowhere for a vehicle to pull over.

The relevant section of Tumbulgum Road is a single lane road in each direction. Double unbroken centre lines divide the road. Having seen a video drive through of the location, it is clear to me that up to the intersection with Old Ferry Road, there is no safe location, either within or just beyond the chicane, for a vehicle to pull over. To do so would be to completely block approaching traffic due to the narrowness of the road width and a bend in it.

But beyond the intersection with Old Ferry Road, Tumbulgum Road widens whilst remaining a single lane road in each direction. There would be ample space for a vehicle to pull over to the kerb without blocking approaching traffic. The possibility therefore remains open that the police siren and warning lights could have been activated at around the intersection of Old Ferry and Tumbulgum Road in anticipation of pulling Narayana's car over further along Tumbulgum Road where it straightens out and widens.

However, I do not find that this occurred. This is because the only way in which I could find that this occurred would be to accept Mr Wilson's evidence. But I find his evidence problematic for a number of reasons.

Firstly, his evidence is contrary to the evidence of at least eight other witnesses who all say that they did not hear the sound of any siren before the collision. Secondly Mr Wilson said in his recorded interview that he did not look backwards in the direction of the police vehicle. However in evidence he said that he did look back and saw that the police vehicle was about 50 metres from Narayana's car.

This evidence itself was also inconsistent with Mr Wilson's later evidence when he said that he heard the siren for long enough without having to turn back to see the warning lights. Due to the absence of this reference in his recorded interview Mr Wilson agreed with Counsel Assisting that his memory of this issue could be a reconstruction. Thirdly, Mr Wilson said in both his recorded interview and in evidence that the warning lights were not turned on immediately after the collision. Later in evidence he said that the warning lights and sirens were turned on about 10 to 12 minutes after the collision.

Again this is contrary to every other police and civilian witness including Ms Darby and Mr Andrew, who were the first witnesses on the scene. Ms Darby said that the warning lights were initially off as she came out of her house, but she saw them turn on moments later. Fourthly, Mr Wilson was intoxicated on the night, having consumed almost half a carton containing 30 full-strength beers. Fifthly, Mr Wilson agreed in evidence that there were gaps in his memory. When told about the fact that none of the neighbouring residents had heard any siren Mr Wilson agreed that he could be mistaken about hearing the siren.

Finally, Mr Wilson said that he knew the warning lights had been turned on because he saw the inside of Narayana's car illuminated. However, the evidence established that the high beams and spot lights on the police vehicle could have done this.

Of course none of this is meant to denigrate Mr Wilson in any way. I must simply assess the reliability of his evidence in the same way as for any other witness when factual issues in dispute need to be resolved. I assessed Senior Constable Wilson's evidence in the same way. Although I found aspects of his evidence vague and somewhat confusing (such as how the warning devices on the police vehicle are operated, and exactly where the police vehicle was positioned when he lost sight of Narayana's car), I did not have any concerns about the reliability of his evidence as it was entirely consistent with the evidence of the independent witnesses.

I therefore conclude that the siren and warning lights of the police vehicle were not activated at any time before the collision. Therefore neither Senior Constable Gordon nor Senior Constable Wilson gave Narayana (or Mr Wilson) a direction to stop. As a result I also conclude that there was no pursuit. This is because the definition of pursuit is conditional upon there first having been a direction issued by a police officer to a person to stop their vehicle; and then that person then ignoring such a direction.

I have also considered whether the use of the high beam (and spotlights) on the police vehicle amounted to a direction to stop. Although Mr Wilson said that he did not see any high beam I do not find his recollection reliable for the reasons already referred to above. I therefore conclude that the high beam on the police vehicle was activated but I do not consider this to amount to a direction to stop.

As both Senior Constables explained, the purpose of activating the high beam was not to convey a signal to Narayana to stop his car. Instead it was done for the sole purpose of illuminating the licence plate so that it was visible. Mr Wilson says that he did not see the high beam come on so it is questionable whether Narayana was even aware that it was on. If this is the case I do not think it could be said that Narayana understood that the high beam meant that he should stop. It appears that from simply seeing the police car Narayana assumed that the police officers wanted him to stop. Given the evidence of Senior Constable Wilson this assumption was, of course, correct. However, this does not equate to an actual direction to stop.

I find that there no police action, other than the mere presence of the police vehicle and it following Narayan's car as it left the laneway, caused Narayana to drove off at speed in the manner that he did. It is clear that even without there having been an actual direction to be stop, Narayana believed that one would be given. This is because he had heard and seen Ms Allfree call the police. The evidence establishes that Narayana was concerned about being on a bond and having potentially breached it because of what happened in the car park. There is also evidence from Narayana's mother that he had not previously had a positive experience in past interactions with police. Of course it is not necessary, nor is it the purpose of the inquest, for me to make any finding about these past interactions. It is sufficient to simply note that they probably contributed to Narayana's belief at the time, and why he acted in the way that he did.

Taking all of the above into account I reach the conclusion that there was no pursuit by the police vehicle. I therefore also reach the conclusion that the SDP did not apply to the actions of Senior Constables Gordon and Wilson

What type of Critical Incident was it?

Although I have found that there was no pursuit, an incident can also be declared a critical incident if it arises "from a collision involving a NSW police force vehicle". It is arguable whether the collision "involved" a NSW Police Force vehicle.

Although Narayana's car obviously did not collide with the vehicle that Senior Constables Wilson and Gordon were in, there is no doubt that Narayana drove from the car park at speed (and collided with the telegraph pole a short time later) because he saw or was aware of the police vehicle. In this sense, because the presence of the police vehicle prompted Narayana's actions, resulting in the collision, it could be argued that the police vehicle was therefore "involved".

Even though I think there is some ambiguity about the question of involvement in this sense I conclude that the incident was appropriately deemed to be a critical incident because it arises "from a NSW Police Force operation". Pages 11 and 12 of the Guidelines set out a number of potential scenarios which could be classified as police operations. In the present case I think the fact that the police were called to the initial disturbance at the hotel involving Narayana, that they attended, that their presence caused Narayana to leave the scene at speed, and that the speed was a factor in the subsequent collision is sufficient for the incident to have arisen from a police operation.

Within the broad category of critical incidents, there are two sub-categories: Level 1 and Level 2 critical incidents. Page 11 of the Guidelines defines a death or serious injury to a person arising from a NSW Police Force operation to be a Level 2 critical incident. The incident involving Narayana was therefore a Level 2 critical incident.

Did the police comply with the Critical Incident Guidelines?

The Guidelines set out a number of procedures to follow when an incident has been declared a critical incident. Some of these procedures relate to police officers who are deemed to be "directly involved officers". The Guidelines define this term to mean "any officer who by words, actions or decisions in the opinion of the SCII [Senior Critical Incident Investigator], contributed to the critical incident under investigation". There was no dispute at the inquest that both Senior Constables Gordon and Wilson were directly involved officers. However, only some of the Guidelines' procedures are applicable to Narayana's case and relevant to this inquest. I will examine each of the relevant procedures in turn below.

Were Senior Constables Gordon and Wilson separated following the incident?

Page 24 of the Guidelines provides that one of the responsibilities of a Duty Officer who attends the scene of a critical incident is to "keep any officer [believed] to be [a] directly involved officer...

separated and ensure the evidence of these people is not cross contaminated". Page 29 of the Guidelines provides that the Senior Critical Incident Investigator (SCII) should "keep directly involved officers...separated and ensure the evidence is not cross contaminated". Both of these responsibilities are repeated in checklists attached to the Guidelines.

There is no dispute that Senior Constables Gordon and Wilson were appropriately separated at the scene, shortly after the collision. There is also no dispute that once they had been taken to Murwillumbah police station that they were placed in separate rooms. The only issue that arises is the how the Senior Constables were taken to the police station.

This appears to have occurred shortly after 1:46am when Inspector Brendon Cullen, the Crime Manager, arrived on the scene. Inspector Cullen took both of the directly involved officers to the police station in the same vehicle. This was obviously contrary to the Guidelines in the sense that the directly involved officers were not separated for the duration of the journey.

It appears that the reason this occurred is because of the lack of available police vehicles. Detective Sergeant Dave Mackie, the officer-in-charge of the investigation, gave evidence that he did not know whether there was any other police vehicle available to take Senior Constables Wilson and Gordon to the police station. However, Detective Sergeant Mackie only arrived at the scene at about 4:25am. By this time, although no precise time is specified in the evidence, it appears that both of the Senior Constables had already left the scene. Inspector Cameron Lindsay, who was the SCII, said in evidence that there was only one police vehicle available to take the Senior Constables from the scene. Unfortunately Inspector Cullen did not make a statement nor did he give evidence at the inquest, despite a subpoena being issued for his attendance, due to medical reasons. Therefore the precise reasoning behind Inspector Cullen's decision to transport the two directly involved officers together is not known.

Both Detective Sergeant Mackie and Inspector Lindsay were asked in evidence whether they were concerned about the Guidelines not being followed with respect to the transportation of the two directly involved officers. Detective Sergeant Mackie said that it would have been "best practice" to keep the officers separated. However both he and Inspector Lindsay did not express any concern that this had not taken place.

They both reasoned that there would be no opportunity for any cross contamination of evidence as both directly involved police officers were in the immediate presence of an Inspector of police whilst they were in the car.

It should be noted that there is no suggestion that Senior Constables Wilson and Gordon spoke about the incident in the car. They both gave evidence denying that this had occurred. There is no basis to doubt their evidence. When asked if there was any conversation at all on the way to the police station, Senior Constable Gordon said that Inspector Cullen only asked if he and Senior Constable Wilson were OK.

The drive from the collision site to the police station took only 2 minutes on Senior Constable Gordon's evidence. This means that the opportunity for any potential cross contamination of evidence was very limited. However, it also means that arranging for a second police vehicle to attend the scene so that the directly involved officers could be transported separately would not presumably have been a difficult task. Although Inspector Lindsay, who only arrived at the scene at 4:30am, said that no other police vehicle was available, compliance with the Guidelines indicates that efforts should have been made to call for a second vehicle. If a second vehicle was not immediately available, the transportation of the directly involved officers should have been delayed until one was available. To do so would have eliminated any possibility for cross contamination of evidence, as well as any suggestion that it could have occurred.

With due respect to Detective Sergeant Mackie and Inspector Lindsay I do not consider the mere presence of Inspector Cullen to be a sufficient safeguard against the possibility of cross contamination of evidence. The Guidelines do not put this forth as a possible option and instead identify actual physical separation of directly involved officers as the only way to avoid potential cross contamination. If the presence of an Inspector (or other more senior police officer) would be sufficient, then there would be no need, in this case, for Senior Constables Wilson and Gordon to be separated at the scene or at the police station. They could have simply remained together, in the presence of Inspector Cullen, the entire time.

Should both alcohol and drug testing have been performed?

At 1:30am Sergeant Warwick Rhodes submitted both Senior Constables Gordon and Wilson to an alcohol breath test. The test was negative. At no stage were either of the Senior Constables asked to take part in any drug testing.

It should again be noted that there is no suggestion, based on the evidence, that this should have occurred or that either of the Senior Constables was under the effect of any drug.

Under the Guidelines, the NSW Police Drug and Alcohol Policy requiring mandatory testing of directly involved officers applies to critical incidents where the death or serious injury of a person arises from a police pursuit or from a collision involving a NSW Police vehicle. The Policy does not apply in circumstances where the death or serious injury of a person arises from a NSW Police Force Operation (unless the person who died was being detained by police).

Section 211A (2A) of the *Police Act 1990* stipulates that any police officer directly involved in a mandatory testing incident must undergo both alcohol and drug testing. Section 211A (7) defines a mandatory testing incident to be, relevantly for the purposes of this inquest, where a person is killed or seriously injured “in circumstances involving a police aircraft, motor vehicle or vessel”.

I have already discussed above that it is arguable whether the police vehicle that Senior Constables Gordon and Wilson were in was involved in the collision. It seems to me that the same argument could apply to the requirement for mandatory drug and alcohol testing both under the Guidelines and pursuant to section 211A of the *Police Act*.

One question which the inquest examined was the timing of precisely when the incident was declared a critical incident. This seems to have occurred at about 1:00am. As mentioned above, the alcohol testing occurred at about 1:30am. This implies that by this time a decision had been made that the incident was not a mandatory testing incident, and nor was it a police pursuit or a matter where a death had occurred arising from a collision involving a police vehicle.

Inspector Lindsay’s initial evidence was that consideration was given at an early stage to the possibility that there had been a pursuit. This initially made it seem difficult to understand how the issue about whether there had been a pursuit or not could have been resolved in the brief 30 minute window from the time the incident was declared a critical incident to the time when the alcohol testing occurred. However, as Inspector Lindsay later explained, the possibility of whether there had been a pursuit or not was being continuously evaluated during the course of the night.

Inspector Lindsay explained that evidence collected from the independent witnesses at the scene all pointed towards the fact that no pursuit had occurred and therefore mandatory drug testing was not required. Inspector Lindsay also explained that if the available evidence indicated that a pursuit had in fact occurred, then mandatory drug testing would be organised. He said that in this event there would be no need to refer the matter back to the Region Commander for re-classification of the type of critical incident it was.

Of course this does not address the issue of whether the collision involved the police vehicle or whether section 211A of the Police Act applied. Counsel Assisting submitted that the use of the word “involving” in both the Guidelines and the Police Act is sufficiently ambiguous so as to leave the matter open to interpretation without the need for any recommendation to be made. Counsel for the NSW Police Commissioner submitted that there is no ambiguity but also that no recommendation should be made.

The use of the word “involving” can cover a broad range of scenarios. If the drafters of the Guidelines had intended to limit “involving” to only those situations where a police vehicle had actually collided with another vehicle then it seems to me that the words “collision with a NSW Police Force vehicle” would have been used rather than “collision involving a NSW Police Force vehicle”. Use of the word “involving” appears to cover an even broader range of scenarios because it relates to “circumstances” and is not limited to only collisions.

Whilst I am of the view that the use of the word “involving” is ambiguous and without precise definition, I do not think this is a matter where any recommendation is necessary, for several reasons. Firstly, there is no suggestion that drug testing should have occurred. Secondly, there is no evidence to suggest that there was a pursuit. Thirdly, Inspector Lindsay’s evidence is that continuous consideration was given to the possible need for drug testing and that if it was deemed necessary at any stage then it would have occurred.

Why was there a delay in interviewing Senior Constables Gordon and Wilson?

As the Senior Constables were deemed to be directly involved officers they were directed to take part in departmental interviews in accordance with clause 8(1) of the *Police Regulation 2008* (since repealed) and page 32 of the Guidelines. Senior Constable Gordon was interviewed on 3 June 2015 and Senior Constable Wilson was reviewed on 10 June 2015, two and nine days respectively from the day of the incident. Inspector Lindsay and Detective Sergeant Mackie conducted the interviews.

The timing of the interviews raises concern because it is commonly accepted that it is best to interview witnesses to an event as close as possible to when the event occurred due to the likelihood of human memory fading over time. The passage of time also allows for the possibility that witnesses may hear or see something, or speak about the incident with other witnesses (whether deliberately or accidentally) thereby contaminating their evidence.

Inspector Lindsay explained that the reason for the delay was that the interviews only took place when the Senior Constables were next on duty. In Senior Constable Wilson's case, he was permitted to take leave for a short period of time following the collision due to welfare considerations.

The Guidelines do not specify any precise timeframe in which departmental interviews with directly involved officers ought to take place. However, the Guidelines do provide for consideration to be given to such directly involved officers. Page 18 of the Guidelines states that "when a NSW police officer is exposed to a critical incident, the welfare and psychological care of the officer is crucial". On page 19 the Guidelines go on to state:

"It is important that the investigation of the incident proceed as quickly as possible after the incident has occurred. However the emotional state and fatigue of the directly involved officer/s must be taken into consideration during the course of the investigation.

If emotional or fatigue issues exist, it may be appropriate, in some instances, to stand the officer down (upon completion of mandatory tests), until the officer is in a healthy state to continue to assist with the investigation. In the event that an officer is stood down, they are to be directed not to discuss the incident with any other directly involved officer or witness."

On the one hand it is important to preserve the integrity of evidence and interview witnesses when events are fresh in their mind. On the other hand it is equally important to ensure that the welfare and emotional well-being of directly involved officers is managed appropriately. It is a difficult balancing act with obvious competing interests.

I conclude that the time taken to interview Senior Constable Gordon, and especially Senior Constable Wilson, did not adversely affect the investigation into Narayana's death in any way. There is nothing to suggest that the Senior Constables discussed their evidence with anyone or that their memories were compromised by the delay between incident and interview. Indeed, their evidence was entirely consistent with one another. In some situations this can suggest the possibility of collusion.

However, in this case, because their evidence is also consistent with that of all the independent witnesses, there can be no such suggestion.

Does the collision raise any general public safety issues?

Ms Barbara Carroll, one of the residents of Tumbulgum Road, told police that to her knowledge there had been 5 or 6 collisions along Tumbulgum Road in the past 26 years.

She said that one of the collisions resulted in a car ending up only metres from her house. Ms Carroll also said that she frequently heard cars speeding along Tumbulgum Road and that it was her belief that cars were racing each other and using Tumbulgum Road as an alternate exit out of town in order to avoid police patrols. Another resident, Ms Donna Swift, said that she was also aware of past car accidents and expressed the view that cars had a tendency to speed after Tumbulgum Road straightens out from the chicane. Ms Carroll suggested that traffic guard rails ought to be erected along Tumbulgum Road. She explained in evidence that she had raised the matter with the local council and whilst they were “interested”, no action had been taken.

There is no doubt that excessive speed was a factor in the collision involving Narayana’s car. Alcohol intoxication was also a contributing factor. However there is no suggestion that any particular feature of the road itself contributed to the collision. A police crash investigator who examined the scene and tyre marks left on the road concluded that because Narayana drove around the right hand bend, before the intersection with Old Ferry Road at excessive speed, this caused him to lose control of his car. The car rotated in a clockwise direction until Narayana over corrected the steering, causing the car to rotate in an anti-clockwise direction and collide with the telegraph pole. During each rotation the tyres of Narayana’s car left yaw marks on the road which indicated that the car was sliding sideways.

It is also clear that Narayana only took the route that he did and was only driving at speed because of the presence of the police vehicle. There is obviously no suggestion that he was racing another vehicle. For these reasons I do not consider the issues raised by Ms Carroll and Ms Swift to be sufficiently connected to Narayana’s death to allow any recommendation to be made.

In addition, the question of traffic safety along Tumbulgum was insufficiently canvassed at the inquest. The reference to past traffic incidents only arose from the anecdotal evidence of Ms Carroll and Ms Swift.

Whilst there is no reason to doubt the accuracy of their statements, both being long-standing residents on Tumbulgum Road, appropriate consideration of the issues that they raise would require statistical analysis of past traffic incidents and identification of common contributing factors. Finally, the suggestion by Ms Carroll to erect guard rails seems problematic from a practical point of view given the number of residential driveways along Tumbulgum Road. Proper consideration of this issue would require an appropriate feasibility study. For all these reasons I do not consider it either desirable or necessary to make any recommendations about this issue.

Should any recommendations be made?

Section 82 of the Act allows a coroner to make any recommendations that a coroner considers is necessary or desirable in relation to any matter connected with the death that the inquest is concerned with. Issues of public health and safety can be, and often are, the subject of recommendations.

In this case, for the reasons already set out above, I do not consider it necessary or desirable to make any recommendation.

Formal Finding:

Identity

The person who died was Narayana Simpson.

Date of death

Narayana died on 1 June 2015.

Place of death

Narayana died at Murwillumbah NSW 2484.

Cause of death

The cause of Narayana's death was multiple injuries that he sustained from a motor vehicle collision.

Manner of death

The collision occurred when Narayan's vehicle impacted with a telegraph pole on Tumbulgum Road during the course of a NSW police operation.

19. 194931 of 2015

Inquest into the death of Peter Moffatt. Finding handed down by Deputy State Coroner Barry at Glebe.

This inquest concerns the death of Peter Moffatt, Mr. Moffatt was a 52 year old man who was an inmate at the Long Bay Correctional Complex. It is evidence from the documentation provided by Corrective Services, New South Wales and Justice Health, New South Wales, that Mr. Moffatt was appropriately monitored and cared for whilst in custody. On several occasions he was transferred to hospital for treatment and conferencing with various specialists.

In addition, he was reviewed by a number of services, including drug and alcohol, palliative care, infectious diseases, oncology and psychology and mental health teams. I am satisfied there are no issues relating to the care and treatment of Mr. Moffatt whilst he was in custody and I make the following formal findings.

Formal Finding:

I FIND THAT PETER GARY MOFFATT DIED ON 2 JULY 2015 AT LONG BAY HOSPITAL, MALABAR, AND THE CAUSE OF DEATH WAS HEPATOCELLULAR CARCINOMA. THE MANNER OF DEATH WAS NATURAL CAUSES.

20. 269065 of 2015

Inquest into the death of Kevin Smith. Finding handed down by Deputy State Coroner O'Sullivan at Glebe on the 15th July 2016.

The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Kevin Smith.

Introduction:

Kevin John SMITH was born on 6 November 1948. At the time of his death he was in the custody of the Department of Corrective Services at Long Bay Gaol.

As Mr SMITH was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act 2009.

The Inquest:

The role of a Coroner, as set out in s 81 of the Coroners Act, is to make findings as to:

- (a) the identity of the deceased;
- (b) the date and place of the person's death;
- (c) the physical or medical cause of death; and
- (d) the manner of death, in other words, the circumstances surrounding the death.

Pursuant to s 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

The Evidence:

Background:

The deceased, Kevin John SMITH was aged 66 (DOB 6/11/1948) at the time of his death. Very little is known of his personal history apart from his criminal background. Not long before his death he requested that his brother, Noel, be notified of his illness and be listed as his next of kin.

Mr SMITH had been known to the criminal justice system since 1962, when he was fifteen years old. He held a lengthy criminal record, consisting of property offences, traffic offences and offences involving significant violence against his family and wife, Catherine SMITH.

In 1997 his relationship with Catherine ended. The marriage had been marred by significant domestic violence. In January 2000 Mr SMITH took his son Duncan and his son's girlfriend hostage at gun point in an attempt to force them reveal the location of his wife Catherine. After holding both for two days Mr SMITH was able to make contact with Catherine and they were released.

A meeting was arranged by Mr SMITH with Catherine under the pretext of conducting a property settlement. Prior to the meeting taking place Mr SMITH was located by police and arrested in possession of various weapons and restraint equipment.

He was subsequently charged and convicted of detaining for advantage and other related offences. He served a six year term of imprisonment for those offences. During this sentence he escaped from gaol. He was recaptured four days after he escaped and served the full sentence until he was released in May, 2006.

In June, 2006 Kevin SMITH was residing at a hostel at the Fairlight Centre, Sydney. His wife, Catherine SMITH, attended the residence and attempted to shoot Mr SMITH. She was unsuccessful and was disarmed by bystanders in the process. She was charged with shoot with intent to murder. At her trial in May 2008, Ms SMITH gave evidence about her history violence at the hands of Kevin, thereby raising self-defence; she was acquitted.

Custodial History:

As a result of the evidence given by Catherine SMITH at her criminal trial, Kevin SMITH was arrested and charged. In February 2010 he was charged with historic domestic violence offences, sexual assault and the attempted murder of Catherine.

The complainant for each of the 25 counts was his wife, Catherine. The offences spanned a period of nearly 20 years. On 14 July, 2011 he was convicted of these offences and was sentenced to an aggregate sentence of 17 years imprisonment commencing on the 4 February 2010.

His sentence would have been expired on 3 February 2027. The earliest date he could have been released on parole was 3 February 2020. Mr Smith lodged an all grounds appeal that he later abandoned.

From the time of his arrest on the 4 February 2010 aged 62, to his death on the 11 September 2015, Kevin SMITH remained in the custody of the Department of Corrective Services.

Medical history:

Kevin SMITH was to be housed at the South Coast Correctional Centre however, due to his poor health he was never transferred there. His condition was monitored from within the Long Bay Correctional Centre through the Special Programs Centre or alternatively Long Bay Hospital.

The reception screening that was conducted when Mr SMITH first came into custody identified that he suffered from depression, was at risk of self-harm and suffered from post-traumatic stress syndrome.

During his time in custody he was diagnosed with myelofibrosis with leukaemic transformation, emphysema, anaemia and was known to have a congenital absent left kidney, and other ailments. He was described as being in poor health and was known to be a smoker. During his incarceration he was treated by medical staff for these conditions.

On 15 August 2015 Kevin SMITH was admitted to Prince of Wales Hospital with chest pains associated with a diagnosis of myelofibrosis. At this time he was advised by medical staff he only had a matter of weeks or months left to live. He was released from hospital on 25 August and returned to Long Bay Gaol. On the 9 September he was transferred to palliative care within the Long Bay Hospital.

The Fatal Incident:

On 9 September 2015, Mr SMITH was transferred from the Metropolitan Special Programs Centre to Long Bay Hospital. In the two days leading up to his death his condition was observed to deteriorate rapidly. On 10 September 2015 an authorisation was made to keep his cell door open due to his condition. As he did not have any contact with his children, or with Catherine SMITH, he was given permission to speak to his brother, Noel SMITH, via telephone.

At about 6am on the morning of 11 September 2015, Mr SMITH was observed to be confused when awake and appeared jaundice with increased pallor. He was monitored at hourly intervals. He was given morphine and a no resuscitation order was completed and agreed to by Noel SMITH.

At 12:50pm on 11 September 2015, Correctional Services staff walked past Mr SMITH'S open door and observed that he was not breathing. Nursing staff attended and he was pronounced life extinct. A time log was commenced and the room was secured. Due to Kevin SMITH'S death occurring while he was in custody, police attended and an investigation was conducted. No suspicious circumstances were detected.

Care and Treatment:

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes, an inquest is required to independently assess whether the State has discharged its responsibility.

A thorough investigation was conducted into the death and all relevant medical and custodial records were obtained and form part of the coronial brief. These records indicate that Mr SMITH'S care and treatment was appropriate. Mr SMITH'S death is not suspicious and he died of natural causes.

Medical Record Review

A medical record review was conducted by Istvan Szentmariay, Staff Specialist Forensic Pathologist, Department of Forensic Medicine. He was of the view that the cause of death was myelofibrosis with leukaemic transformation.

Formal Finding:**The identity of the deceased**

The deceased person was Kevin Smith.

Date of death

He died on 11 September 2015.

Place of death

He died at Long Bay Hospital, Long Bay Gaol, Malabar, NSW.

Cause of death

The medical cause of the death was myelofibrosis with leukaemic transformation.

Manner of death

Kevin Smith died of natural causes whilst he was in serving a prison sentence at Long Bay Gaol.

21. 321206 of 2015

Inquest into the death of Barry Gooley. Finding handed down by Deputy State Coroner Lee at Glebe on the 16th August 2016.

Introduction

Barry Bruce Gooley was 70 years old at the time of his death. He was convicted in 2009 of a number of criminal offences and sentenced to a custodial sentence. At the time of his death on 31 October 2015 he was still serving that sentence.

Why does an inquest have to be held?

When a death is reported to a Coroner there is obligation on the Coroner to make findings about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances in which a person died.

Sections 23 and 27 of the *Coroners Act 2009* (the Act) provide that if a person dies whilst in lawful custody then an inquest must be held.

When an inquest is held section 81(1) of the Act requires that the findings of the Coroner are recorded in writing. These are the findings of an inquest into the death of Barry Gooley.

Mr. Gooley's personal history

Mr Gooley was born on 22 February 1945 in Marrickville, NSW and had 3 sisters. He lived for a time in NSW before later moving to South Australia.

Mr Gooley met his wife, Susan, in 1973 and they married 3 months later. They had 4 children together, 2 sons and 2 daughters. Mr Gooley and his wife initially lived in Renown Park before later moving to Salisbury, north of Adelaide.

Mr Gooley joined the South Australian Fire Service in about 1974 and remained with the Service for 19 years. Mr Gooley and his wife also ran an aquarium from their home for about 8 years. Mr Gooley used to periodically return to NSW to visit his father who lived in Orange.

After leaving the Fire Service, Mr Gooley's health deteriorated. He developed high blood pressure, type II diabetes, chronic obstructive pulmonary disease, and suffered a number of strokes.

Mr. Gooley's custodial history

Between 2005 and 2008 NSW police investigated a number of allegations made against Mr Gooley involving historical sexual assault offences. In 2008 Mr Gooley was extradited from South Australia to NSW and charged. Mr Gooley pleaded not guilty to the allegations but following a trial he was found guilty by a jury and later convicted.

On 24 July 2009 in the Sydney District Court Mr Gooley was sentenced in relation to a total of 9 offences. He received an overall term of 12 years imprisonment dating from 10 April 2008 to 9 April 2020, with a non-parole period of 7 years dating from 10 April 2008 and expiring on 9 April 2015.

Mr Gooley was initially kept at the Metropolitan Remand and Reception Centre (MRCC). In October 2009, Mr Gooley was transferred to Junee Correctional Centre. Due to his declining health, Mr Gooley was later transferred to Long Bay Correctional Centre Hospital in April 2015. On 22 October 2015 Mr Gooley was transferred to the Prince of Wales Hospital Secure Unit where he remained until his death.

On 19 March 2015 the State Parole Authority (SPA) authorised and directed that Mr Gooley be released on parole not earlier than 9 April 2015 and no later than 14 May 2015. However, on 7 May 2015 the SPA revoked this order due to the fact that satisfactory accommodation arrangements and post-release plans for Mr Gooley had not been made. These arrangements were required due to the nature of the offences that Mr Gooley had been convicted of.

On 6 August the SPA indicated that it had considered Mr Gooley's case and stood his matter over to 29 October 2015.

This was to enable a supplementary Community Corrections report could be prepared addressing the issue of Mr Gooley's post-release accommodation and plans, including an aged care assessment. Given Mr Gooley's dire health condition by 29 October 2015, it appears that no further determination was made by the SPA at this time.

Mr. Gooley's medical history

On 4 April 2015, Mr Gooley was taken to the Metropolitan Special Purpose Centre (MSPC) suffering from elevated blood pressure and oedema in the legs. His condition improved but Mr Gooley returned to the MSPC a week later suffering from shortness of breath. Mr Gooley was subsequently transferred to Prince of Wales Hospital where further investigations were conducted. On 13 April 2015 Mr Gooley was diagnosed with metastatic small cell carcinoma of the left lung, with pulmonary and hepatic metastases. Mr Gooley's care was transferred to the oncology department and he underwent six cycles of chemotherapy, which finished in August 2015.

In the months following April 2015 Mr Gooley's health continued to worsen. He developed paraneoplastic syndrome as a consequence of his cancer, Cushing's syndrome (a metabolic disorder), and a fungal infection of the lung. As a result of these conditions Mr Gooley had several admissions to Long Bay Hospital and continued to be treated for his other comorbidities, namely hypertension, chronic obstructive pulmonary disease, and insulin-dependent type II diabetes.

Mr Gooley also developed an unsteady gait and suffered a number of falls, especially between 15 September 2015 and 15 October 2015. Justice Health arranged for Mr Gooley to undergo physiotherapy assessments in an attempt to manage his mobility issues and reduce his risk of further falls.

During an admission to Prince of Wales Hospital emergency department following a fall, Mr Gooley had a CAT scan of his head which showed changes in his brain, consistent with metastatic tumour or possibly metastatic fungal infection. Mr Gooley was later re-admitted to Prince of Wales Hospital on 22 October 2015 and was noted to be confused and inattentive.

Unfortunately Mr Gooley's condition continued to deteriorate, his confusion worsened, his level of consciousness diminished, and he was noted to be a state of delirium. It was thought that this was a response to Mr Gooley's probable cerebral metastases.

On 28 October 2015 a not for resuscitation order was implemented and most treatment was ceased a day later. A welfare officer informed Mrs Gooley of her husband's condition. On 30 October 2015 Mr Gooley was put on an end of life pathway and treated with sedation and pain relief only. Mr Gooley gradually slipped into a coma. At about 10:10am on 31 October 2015 nursing staff observed that Mr Gooley's breathing was shallow. Ten minutes later at 10:20am Mr Gooley stopped breathing and was found to have no pulse and to be unresponsive.

What was the cause of Mr. Gooley's death?

Given Mr Gooley's well documented medical history whilst in custody, particularly during the last few weeks of his life, an autopsy was not performed. Instead a forensic pathologist, Dr Ansford, reviewed Mr Gooley's medical records and provided an opinion that the cause of Mr Gooley's death was small cell carcinoma in the left lung (with metastases). Chronic obstructive pulmonary disease and type II diabetes mellitus were identified by Dr Ansford as being significant conditions contributing to Mr Gooley's death.

Conclusion

When a person is detained in lawful custody, the State bears the responsibility for ensuring that that person receives all necessary and adequate care and treatment. Even when a person held in custody dies of apparent natural causes an inquest is mandatory. This is so that an independent assessment can be conducted to ensure that the State has discharged its responsibility appropriately.

It is clear from Mr Gooley's medical history that he was suffering from a number of serious health conditions at the time he began serving his custodial sentence at the age of 64. Regrettably, these conditions contributed to a poor quality of life in Mr Gooley's later years and following the detection of the metastatic carcinoma in April 2015, Mr Gooley's overall poor health rapidly worsened.

Having examined the records held by both Corrective Services NSW and Justice Health, I cannot identify any evidence to suggest that Mr Gooley was not afforded appropriate treatment and care for his various health concerns whilst in custody. There is no evidence to suggest that any action, or inaction, by Corrective Services NSW or Justice Health contributed to Mr Gooley's death in any way. His death was the result of a natural cause process. There are no suspicious circumstances.

Formal Finding:

Identity

The person who died was Barry Gooley.

Date of death

Mr Gooley died on 31 October 2015.

Place of death

Mr Gooley died at Prince of Wales Hospital, Randwick NSW 2031 whilst in lawful custody, serving a custodial sentence.

Cause of death

The cause of Mr Gooley's death was metastatic small cell carcinoma of the left lung, with chronic obstructive pulmonary disease and type II diabetes mellitus being significant conditions contributing to his death.

Manner of death

Mr Gooley died of natural causes.

22. 363999 of 2015

Inquest into the death of JC. Finding handed down by Deputy State Coroner O’Sullivan at Glebe on the 17th November 2016.

The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of JC.

Introduction:

This is an inquest into the death of JC. On 10 December 2015 JC contacted 000 stating that he intended to commit suicide. General Duty’s police immediately drove to the scene which was his home while JC was still talking to the police operator. The phone call was timed at 8:39 PM and the police arrived at 8:47 PM to find JC sitting on a chair on the front veranda of his residence with the rifle between his legs in the barrel pointing towards his head. One police officer attempted to speak to JC, asking him to put the gun down and JC placed the barrel of the firearm under his chin and pulled the trigger. Police rendered medical assistance and called an ambulance, however JC was unable to be revived.

The Inquest:

JC’s death was a suspected suicide which occurred in the context of a police operation, as JC was on the telephone to an officer from New South Wales police force (NSWPF) just prior to apparently shooting himself. Officers from the New South Wales Police Force were present when JC pulled the trigger of the rifle that apparently caused his death.

As the death occurred during the course of a police operation, the holding of an inquest by a Deputy State Coroner is mandatory under sections 23 (c) and 27 of the Coroners Act 2009 (the Act).

The Evidence:

Background

JC was born on 4 March 1939 in Tamworth. On 27 August 1960, he married SB and in 1961, their son GC was born, followed by FC in 1964. The family moved to Armidale in around 1968.

Around 2005, JC was diagnosed with emphysema. In about 2012, he began using oxygen to assist in his breathing. Recently, he was on oxygen up to 16 hours per day.

In 2013, SB died after being diagnosed with gall bladder cancer.

Around about July 2015, JC had a number of conversations with his friend, Bruce Donnelly, about long term care and about what steps he would take to ensure that he had adequate care.

On 19 August 2015, JC was admitted to Tamworth Base Hospital with pneumonia after he had suffered injuries including broken ribs following a fall in June 2015.

On 19 August 2015, JC signed a "No Cardiopulmonary Resuscitation" order in the presence of his son FC.

On 13 October 2015, JC was moved to the Manilla Hospital and on 16 October, he was discharged to the BUPA nursing home in Tamworth. On 11 November 2015, GC had his last conversation with his father. On 26 November 2015, JC discharged himself from the nursing home and moved back to [REDACTED] Tamworth with his friend and now live in carer, Matthew Redden.

On 2 December 2015, following arguments about who would pay for household provisions and whether he could remain in the house after JC died, Matthew Redden ceased his carer duties and moved out of the house.

When he left the house, Matthew Redden took bullets for a .22 calibre rifle with him because he thought JC was a bit cranky and because he thought it was the right thing to do.

On 6 December 2015, JC spoke to his sister PW by telephone. JC reported that the carer hadn't worked out and that he wasn't feeling well. Otherwise, he seemed normal. PW said that she would visit soon and that he should call if he needed anything.

The events of 10 December 2015

At about 3pm on 10 December 2015, FC visited his father at home. He noticed that JC had lost a substantial amount of weight. His father replied, "You get that when you're finished."

JC asked if "tomorrow" was FC's day off and said he was going to call that night. FC observed that his father did not seem intoxicated during the visit, although he was drinking stubbies of Tooheys New and he seemed happy.

As FC was on the way out the door, JC said, "You will get a call tonight."

JC's friend, Dallas Croft, visited at about 7pm that night. Worried about his friend's health (his chest was heaving and he was trying to get air and he was having trouble talking), Dallas asked JC if he'd like him to call his doctor. Dallas Croft informed JC to call him at any time he needed him to come. According to Dallas, JC did not seem depressed.

When Dallas Croft was leaving JC shook his hand, something that he never did. JC said "Bye Dad" (a nickname for Dallas Croft) which Dallas Croft noted was strange for him to do.

The 000 call

At 8.38pm, JC called 000 and announced his intention to commit suicide by shooting himself.

At 8.39pm the job was broadcast over police radio. Senior Constable Kate Fletcher and Constable Michael Rainbow were the first to respond to the police radio broadcast at 8.40pm. They proceeded Code Red with lights and sirens.

Their police vehicle, *Bendemeer 30*, stopped by the Powerhouse Hotel so that its occupants could put ballistic vests on. The CAD Incident Log mistakenly records Fletcher and Rainbow as arriving at the scene at 20.43.

This was likely due to Constable Rainbow knocking a button when he reached to get the ballistic vests. It is likely they, in fact, arrived at about 8.47pm.

Sergeant Timothy Ginman soon followed in *Tamworth 14*. He also proceeded Code Red with lights and sirens, turning off the sirens when he turned onto JC's street.

Senior Constable Garry Irvine and Constable Antoine Wolds responded in *Tamworth 17* Code Red with lights but not sirens. They left the sirens off so as not to alert JC to their arrival. About half-way to JC's property, they stopped their vehicle and put on ballistic vests, and then continued onwards.

Arrival at the scene

It appears all of the vehicles arrived at [REDACTED] Tamworth at about the same time, at 8.47pm. Sergeant Ginman put on his ballistic vest on arrival.

Their arrival and approach towards the house set off a sensor light on the property and JC cut off his triple 0 call, saying, "here comes the police now, bye." This was at 8.47.45pm.

The police officers variously saw JC standing, moving towards a chair and sitting down. He held a firearm.

The police officers looked for cover behind a tree in the case of Constable Rainbow and a telegraph pole in the case of Constable Wolds, Senior Constable (SC) Irvine attempted to speak to JC.

SC Irvine stated "put the gun down, it's the police, we're here to help you". Sergeant Ginman said Irvine was really calm, didn't yell but was loud and clear. Constable Wolds says there was nothing in Irvine's voice that was threatening or confrontational. It was assertive, loud, and clear. Not a challenge. JC's neighbour David Miles who overheard the exchange said he was "just talking in a normal voice".

JC didn't appear to react at all and SC Irvine was concerned with what he was doing with the gun. He was concerned that JC might point the gun at the police so he too tried to find cover behind a telegraph pole on his right.

Within seconds of SC Irvine speaking, JC placed the barrel of the gun under his chin and pulled the trigger.

Immediately following the shot being fired, the following happened:

- a) SC Irvine and Constable Rainbow both ran towards JC and noted that he was slumped forward in his chair with a gunshot wound to the head.
- b) Constable Rainbow removed the gun from JC's legs and placed it on the ground. SC Irvine then took the gun, cleared the breach and turned it around so one spent cartridge fell to the ground.
- c) Using her police radio, SC Fletcher requested an ambulance.
- d) Sergeant Ginman requested a Duty Officer, Detective and Crime Scene Section.
- e) Constable Rainbow and SC Fletcher secured the property, front and back to ensure no other persons were present.
- f) Constable Wolds placed police tape around the house and commenced a crime log.

At 9.40pm, Inspectors French and O'Reilly arrived on the scene and at 10.05pm, Inspector French notified Constable Wolds, Sergeant Ginman, SC Irvine, Constable Rainbow and SC Fletcher not to discuss the matter with anyone. Those involved officers later travelled back to Tamworth Police Station with Inspector O'Reilly where they submitted to drug and alcohol testing and participated in recorded interviews.

At 10.08pm, the matter was declared to be a critical incident by Assistant Commissioner McKechnie.

Cause of death

An autopsy was conducted by Dr Vuletic on JC on 16 December 2015. Dr Vuletic came to the conclusion that the death was caused by a gunshot wound to the head.

Manner of death

One of the functions of an inquest is to ensure that there are no hidden homicides. The evidence in this inquest makes it clear that JC shot himself in the head.

The issue is whether it was intentional or not. That question is live because there is a presumption against a finding of death by self-inflicted injury, or suicide.

The law provides that: "suicide is not to be presumed. It must affirmatively be proved to justify the finding." The standard of proof is not the criminal standard – beyond reasonable doubt – it may be the higher form of the civil standard; I must be comfortably satisfied that this is the correct conclusion.

In making a determination as to whether JC intended to end his life, I have taken into account the following material in the brief of evidence :

a) JC had previously indicated his preferred method of suicide on a number of occasions:

i. During a conversation with barrister and friend Bruce Donnelly earlier in the year, JC raised the idea of shooting himself because he did not want to waste away. When Mr Donnelly asked if JC had any firearms, JC said he had a couple of guns and that if things got difficult, he would just shoot himself. He said they were hidden where nobody would find them.

ii. Following his admission to Tamworth Base Hospital, JC had the following conversation with his son GC,

JC said, "I only need to be home for 3 minutes."

GC said, "Why?"

JC said, "Bang bang."

iii. On 10 December between 3 and 3.20pm while FC was visiting, JC said (in response to a comment that he had lost a substantial amount of weight) "You get that when you're finished." As FC was leaving, JC said, "You will get a call tonight."

i. When Dallas Croft was leaving JC's house, at about 7pm, JC shook his hand said "Bye Dad" (a nickname for Dallas Croft). Dallas Croft noted this was strange for him to do.

ii. Sometime, possibly on 10 December, JC wrote a number of messages to family and friends. In particular one note stated "To kids, Pat and Sue, family and friends. I am sorry for doing this, legal in Darwin should be in NSW. No more hospital or aged care for me. I am completely stuffed, can't breather (sic) or do anythink (sic) and I don't want to be handicapped for anyone. Sorry.."

iii. During the course of his triple 0 call, JC said the following things:

- "I'm just about to commit suicide...I've had it.... I'm too old." (Tab 36, p. 1)
- When the operator asked the deceased if he needed an ambulance he was responded "no I'll commit suicide before that". (Tab 36, p. 1)
- That he was planning on "Shooting myself" (Tab 36, p. 2)

- “Too late love.... I’m stuffed” (Tab 36, p. 3)
- “ Never again will I go into a nursing home... Too late...The gun’s cocked and ready.” (Tab 36, p. 4)
- “Don’t send my son out till youse arrive.” (Tab 36, p. 5)
- He kept repeating “too late.”

As he heard and later saw the police arriving, the operator pleaded with him to speak to the police and JC refused. (Tab 36, p. 8)

iv. SC Fletcher saw JC put the barrel under his chin.

Based on the evidence before me, I am satisfied in this case that JC intended to end his life when he pulled the trigger of the rifle.

The police investigation

A very important part of any coronial inquest is the investigation. I am of the view that a very thorough investigation has taken place in this case. The involved officers that is, those five officers who immediately responded to the incident, took part in a recorded interview. This evidence provides a great source of information regarding not only what those police officers did, but what was going through their minds when they made the decisions to act as they did.

Other police officers who responded after the incident have also provided statements.

In my view, there was nothing that the responding police could or should have done differently in the circumstances to prevent this sad outcome. JC had made up his mind about what actions he was going to take that night; he appeared to have been waiting for the police to arrive at his house. Once they were there, he shot himself. There simply wasn’t time for those responding officers to do anything other than arrive, identify themselves and assess the situation.

I am satisfied that all officers responded immediately, urgently and appropriately and I commend them.

I also commend the 000 operator, Tegan Poulton, at Policelink Tuggerah for her professionalism and efforts to keep JC on the phone for as long as possible.

The officer in charge, Detective Inspector Joy is commended for her professionalism and her thorough investigation.

I would like to thank Counsel Assisting, Ms Jessica Murty and her instructing solicitor, Hannah Sewell, from the Crown Solicitor's Office, for their excellent work in assisting me.

Finally, I would like to offer my sincere condolences to JC's family and friends, in particular, his sons, GC and FC, for the very sad loss of their father. His death must have been a terrible shock to them. I hope this inquest has answered some of the questions they may have had and helped them even in a small way come to terms with the death of their father.

Formal Finding:

The identity of the deceased

The deceased person was JC.

Date of death

10 December 2015.

Place of death

Tamworth.

Cause of death

The death was caused by a gunshot wound to the head.

Manner of death

The death was caused by JC shooting himself in the head with a .22 calibre rifle with the intention of ending his life.

Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed as at 31 December 2016

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	192526/12	19/06/12	Randwick	27	In Custody
2	273783/12	01/09/12	Silverwater	49	In Custody
3	114526/13	14/04/13	Cessnock	32	In Custody
4	162787/13	24/05/13	Junee	49	In Custody
5	177495/13	08/06/13	Malabar	37	In Custody
6	354840/13	24/11/13	Westmead	33	In Custody
7	59894/14	25/02/14	Parklea	42	In Custody
8	261690/14	04/09/14	Ryde	54	Police Op
9	286081/14	29/09/14	Baulkham Hills	60	Police Op
10	307093/14	18/10/14	Silverwater	56	In Custody
11	315543/14	25/10/14	Malabar	60	In Custody
12	343092/14	20/11/14	Hurstville	18	Police Op
13	368701/14	16/12/14	Sydney	-	Police Op
14	368881/14	16/12/14	Sydney	-	Police Op
15	369898/14	16/12/14	Sydney	50	Police Op
16	6538/15	06/01/15	Malabar	32	In Custody
17	11170/15	11/01/15	Bowral	38	Police Op
18	23577/15	24/01/15	Malabar	30	In Custody
19	24641/15	26/01/15	Randwick	82	In Custody
20	42730/15	10/02/15	West Hoxton	22	Police Op
21	59013/15	24/02/15	Ballina	40	Police Op
22	64099/15	01/03/15	Gosford	45	Police Op
23	116507/15	19/04/15	Randwick	91	In Custody
24	124748/15	27/04/15	Camden	43	Police Op
25	125390/15	27/04/15	Cessnock	32	In Custody
26	139332/15	10/05/15	Berkshire Park	48	In Custody
27	141693/15	12/05/15	Silverwater	31	In Custody
28	155740/15	25/05/15	Silverwater	31	In Custody
29	208086/15	15/07/15	Maryvale	18	Police Op
30	254391/15	29/08/15	Young	36	Police Op

31	265616/15	09/09/15	Warners Bay	51	Police Op
32	288035/15	01/10/15	Malabar	67	In Custody
33	289369/15	02/10/15	Parramatta	15	Police Op
34	323840/15	03/11/15	Malabar	74	In Custody
35	323811/15	03/11/15	Wellington	34	In Custody
36	329568/15	09/11/15	Camperdown	25	In Custody
37	336444/15	13/11/15	Malabar	65	In Custody
38	351469/15	26/11/15	Goulburn	46	Police Op
39	381722/15	29/12/15	Malabar	26	In Custody
40	1459/16	31/12/15	Malabar	44	In Custody
41	11257/16	12/1/16	Chatswood	72	Police Op
42	180889/16	18/01/16	Lismore	23	Police Op
43	19119/16	19/01/16	Quakers Hill	46	Police Op
44	24535/16	22/01/16	Malabar	19	In Custody
45	26063/16	26/01/16	Randwick	56	In Custody
46	56536/16	20/02/16	Marayong	37	Police Op
47	56558/16	20/02/16	Marayong	35	Police Op
48	56518/16	20/02/16	Westmead	36	Police Op
49	71814/16	05/03/16	Malabar	64	In Custody
50	72079/16	05/03/16	Allandale	43	Police Op
51	73098/16	07/03/16	Ingleburn	33	Police Op
52	82254/16	15/03/16	Concord	51	In Custody
53	87470/16	18/03/16	East Lismore	33	Police Op
54	88742/16	21/03/16	Bradbury	36	Police Op
55	94829/16	27/03/16	Randwick	76	In Custody
56	107266/16	07/04/16	Parklea	58	In Custody
57	110830/16	11/04/16	Malabar	37	In Custody
58	149781/16	14/05/16	Westmead	84	In Custody
59	151275/16	17/05/16	Coraki	51	Police Op
60	186812/16	19/06/16	Westmead	28	In Custody
61	199540/16	30/06/16	Waterloo	78	Police Op
62	214323/16	14/07/16	Parklea	43	In Custody
63	218940/16	19/07/16	Maitland	36	Police Op

64	231300/16	31/07/16	Bathurst	46	In Custody
65	234818/16	04/08/16	Randwick	63	In Custody
66	273191/16	11/09/16	Parklea	44	In Custody
67	280295/16	17/09/16	Malabar	73	In Custody
68	290240/16	27/09/16	Sth Windsor	46	Police Op
69	29151/16	27/09/16	Orange	23	Police Op
70	314488/16	21/10/16	Randwick	69	In Custody
71	329687/16	03/11/16	Bonville	36	Police Op
72	334771/16	08/11/16	Narromine	22	Police Op
73	347726/16	20/11/16	Terrigal	64	Police Op
74	350477/16	22/11/16	Westmead	22	Police Op
75	361528/16	01/12/16	Appin	62	Police Op
76	371530/16	09/12/16	Camperdown	52	Police Op