Report by the NSW State Coroner

INTO DEATHS IN CUSTODY/POLICE OPERATIONS

for the year

2019

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custody/police operations

for the year 2019.

A report Prepared pursuant to s23 of the *Coroners Act 2009* (NSW)
NSW Office of the State Coroner
NSW Department of Community & Justice
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The Hon. Mark Speakman SC, MP
Attorney General and Minister for Justice
Level 15, 52 Martin Place
Sydney NSW 2000

30th April 2020

Dear Attorney General,

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

I attach a hard copy and an electronic copy of the 2019 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 police operations, or while the person is in or temporarily absent from a child detention centre or an adult correctional centre.

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

The inquest findings referred to are available on the Coroners Court webpage at: http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx 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 matters referred to.

Yours faithfully,

Magistrate Teresa O'Sullivan
NSW State Coroner

2019 – OVERALL SECTION 23 - SUMMARY IN BRIEF

- A total of 58 deaths subject to *s.23 of the Coroners Act* were reported to the NSW State Coroner in the calendar year 2019.

- In 2019, the State Coroner and Deputy State Coroners completed a total of 37, s.23 inquests. A further 2 inquests were suspended following the charging of a person with the death.

- The figure of 58 deaths represents an increase of 17 deaths from the previous Annual Report for the year 2018.

- All 58 deaths were male.

- 47 deaths were in custody compared to 27 in custody recorded for 2018.

- 44 of the 47 in custody deaths were in NSW Correctional facility custody.

- 2 of the 47 deaths in custody occurred in an Immigration Detention Centre at the Villawood Immigration Detention Centre.

- The 2 deaths at Villawood Detention Centre were probable suicides.

- The remaining death in custody was of a forensic patient who died of natural causes.

- 2 of the deaths in custody in the Correctional facility were as a result of an alleged homicide by another inmate.

- Of the 44 deaths in a correctional facility, 30 were serving a fulltime sentence and 14 were on remand.

- 11 s.23 deaths occurred within or as a result of a police operation compared to 14 of these types of deaths in 2018.

- 35 of the overall 58 deaths were as a result of natural causes, which remain the highest manner of death (60.34%). Followed by shooting/firearm deaths of which 8 deaths (13.79%) were recorded in 2019.

- 7 Aboriginal deaths were recorded in 2019 (12.07%) this represents the same figure as recorded in 2018.

- 5 of these deaths occurred in custody and 2 deaths were from within a police operation.

- Of the 7 deaths, 5 deaths were as a result of non-natural causes and 2 deaths were as a result of natural causes.

- Of the 58 deaths, all were male, 41 were over the age of 40 and 17 were under the age of 40 years.

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 2019 who undertook Section 23 Inquests

Her Honour Magistrate TERESA O'SULLIVAN NSW 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
2019	Appointed NSW 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

Her Honour Magistrate ELIZABETH RYAN

Deputy State Coroner

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

Her Honour Magistrate CARMEL FORBES

Deputy State Coroner

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

Her Honour Magistrate ELAINE TRUSCOTT

Deputy State Coroner

1984-1986	Barrister & Solicitor, Grey Lynn Community Legal Centre, Auckland NZ
1986-1987	Project Officer, Civil Rehabilitation Committee, Sydney
1987-1993	Solicitor, Legal Aid Commission, NSW
1993-2000	Barrister
2000	Appointed Magistrate Local Court, NSW
2010	Deputy State Coroner whilst Local Court Magistrate Newcastle
2014	Appointed NSW Deputy State Coroner.

His Honour Magistrate JEFFREY LINDEN

Deputy State Coroner (Northern NSW)

1970	Admitted as Solicitor of Supreme Court of NSW
1970 - 1987	Partner in legal firm Wood Linden @Co
1988	Appointed Magistrate of the Local Court of NSW
1990	Appointed regional coordinator for courts in Far North Coast of NSW
2004	Appointed member of Australian National Council on Drugs
2017	Appointed NSW Deputy State Coroner
2020	Appointed as permanent Magistrate Lismore Local Court

CONTENTS

Introduction by the New South Wales State Coroner

What is a death in custody?

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

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

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

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

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

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

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

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

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

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

Intensive Correction Orders

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

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

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

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

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

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

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

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

I also agree with Mr Waller that:

> *In the public mind, a death in custody differs from other deaths in a number of significant ways. The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution.*
>
> *When the death is by deliberate self-harm, the responsibility is seen to rest largely with the institution. By contrast, a civilian death or even a suicide is largely viewed as an event pertaining to an individual. The focus there is far more upon the individual and that individual's pre-morbid state.*
>
> *It is entirely proper that any death in custody, from whatever cause, must be meticulously examined.*

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

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

As soon as a death in custody/police operation occurs in New South Wales, the local police are to promptly contact and inform the Duty Operations Inspector (DOI) who is situated at VKG, the police communications centre in Sydney. The DOI is required to notify immediately the State Coroner or a Deputy State Coroner, who are on call twenty-four hours a day, seven days a week.

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

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

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

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 Lidcombe or Newcastle forensic facilities conducted the examinations.

Responsibility of the Coroner

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

81 Findings of Coroner or jury verdict to be recorded

(1) The coroner holding an inquest concerning the death or suspected death of a person must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so:

(a) the person's identity, and

(b) the date and place of the person's death, and

(c) in the case of an inquest that is being concluded the manner and cause of the person's death.

(3) Any record made under subsection (1) or (2) must not indicate or in any way suggest that an offence has been committed by any person.

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

78 Procedure at inquest or inquiry involving indictable offence

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

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

(i) a person has been charged with an indictable offence, and

(ii) the indictable offence raises the issue of whether the person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.

(b) an inquest or inquiry if, at any time during the course of the inquest or inquiry, the Coroner forms the opinion (having regard to all of the evidence given up to that time) that:

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

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

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

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

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

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

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

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

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

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

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

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

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

Role of the Inquest

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

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

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

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

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

Recommendations

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

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

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

Unavoidable delays in hearing Inquests

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

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

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

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

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

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

Table 1: Deaths in Custody/Police Operations, for the period to 2019.

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	37
1996	26	6	32
1997	41	15	56
1998	29	9	38
1999	27	7	34
2000	19	20	39
2001	21	16	37
2002	18	17	35
2003	17	21	38
2004	13	18	31
2005	11	16	27
2006	16	16	32
2007	17	11	28
2008	14	10	24
2009	12	18	30
2010	23	18	41
2011	20	9	29
2012	20	21	41
2013	26	17	43
2014	14	13	27
2015	26	15	41
2016	16	21	37
2017	28	19	47
2018	27	14	41
2019	47	11	58

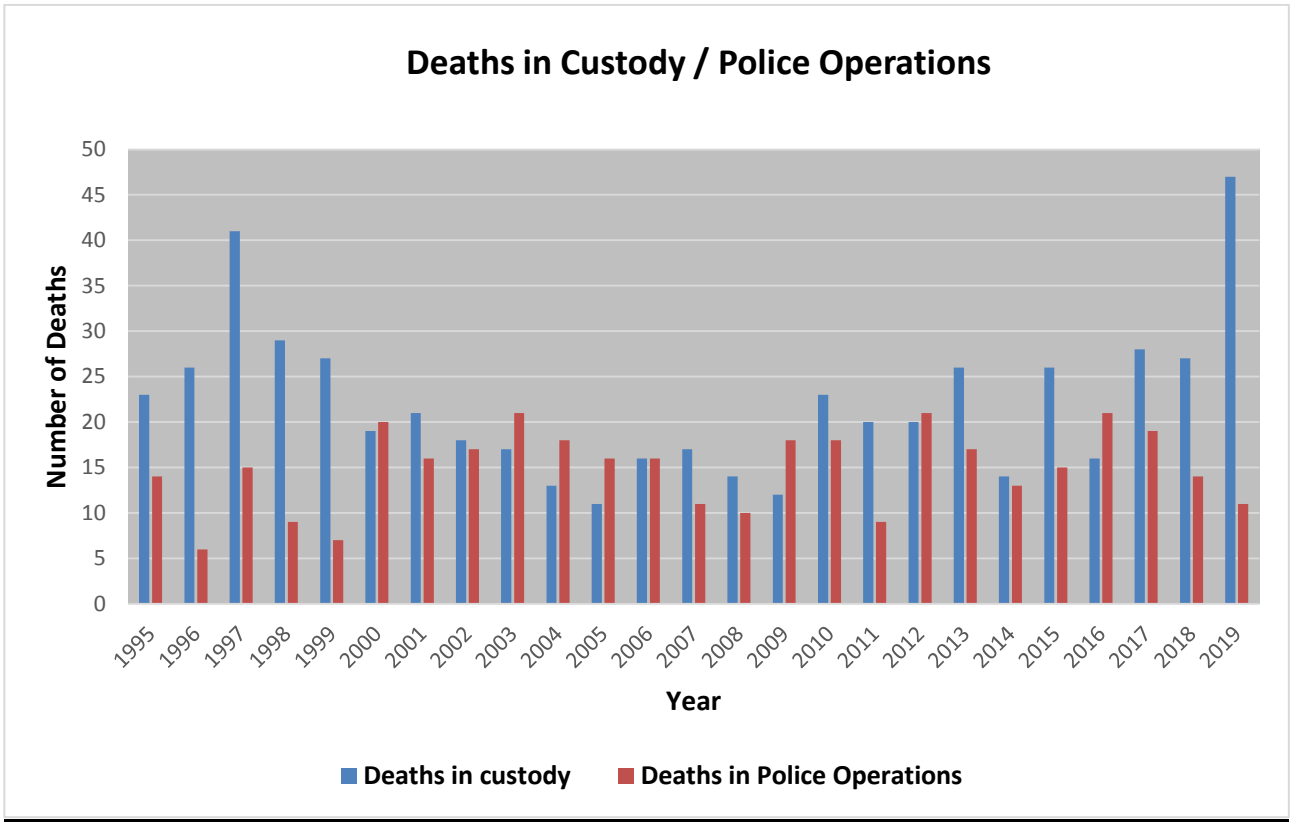

Deaths in Custody / Police Operations
Number of Deaths
50
45
40
35
30
25
20
15
10
5
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
Year
Deaths in custody
Deaths in Police Operations

Table 2: **Aboriginal deaths in custody/police operations 2019**

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	7	0	7
1996	2	0	2
1997	6	2	8
1998	2	3	5
1999	3	1	4
2000	4	1	5
2001	5	0	5
2002	3	1	4
2003	1	2	3
2004	2	3	5
2005	1	3	4
2006	4	0	4
2007	3	2	5
2008	0	0	0
2009	1	3	4
2010	3	3	6
2011	2	1	3
2012	1	1	2
2013	3	1	4
2014	1	1	2
2015	6	1	7
2016	1	3	4
2017	4	1	5
2018	3	4	7
2019	5	2	7


Aboriginal Deaths in Custody/Police Operations
Number of Deaths
0
1
2
3
4
5
6
7
8
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
Year
Deaths in Custody
Deaths in Police Operations

Circumstances of deaths of persons who died in Custody/Police Operations in 2019:

35 - Natural Causes

3 - Fall/Jump

8 - Gunshot/Firearm

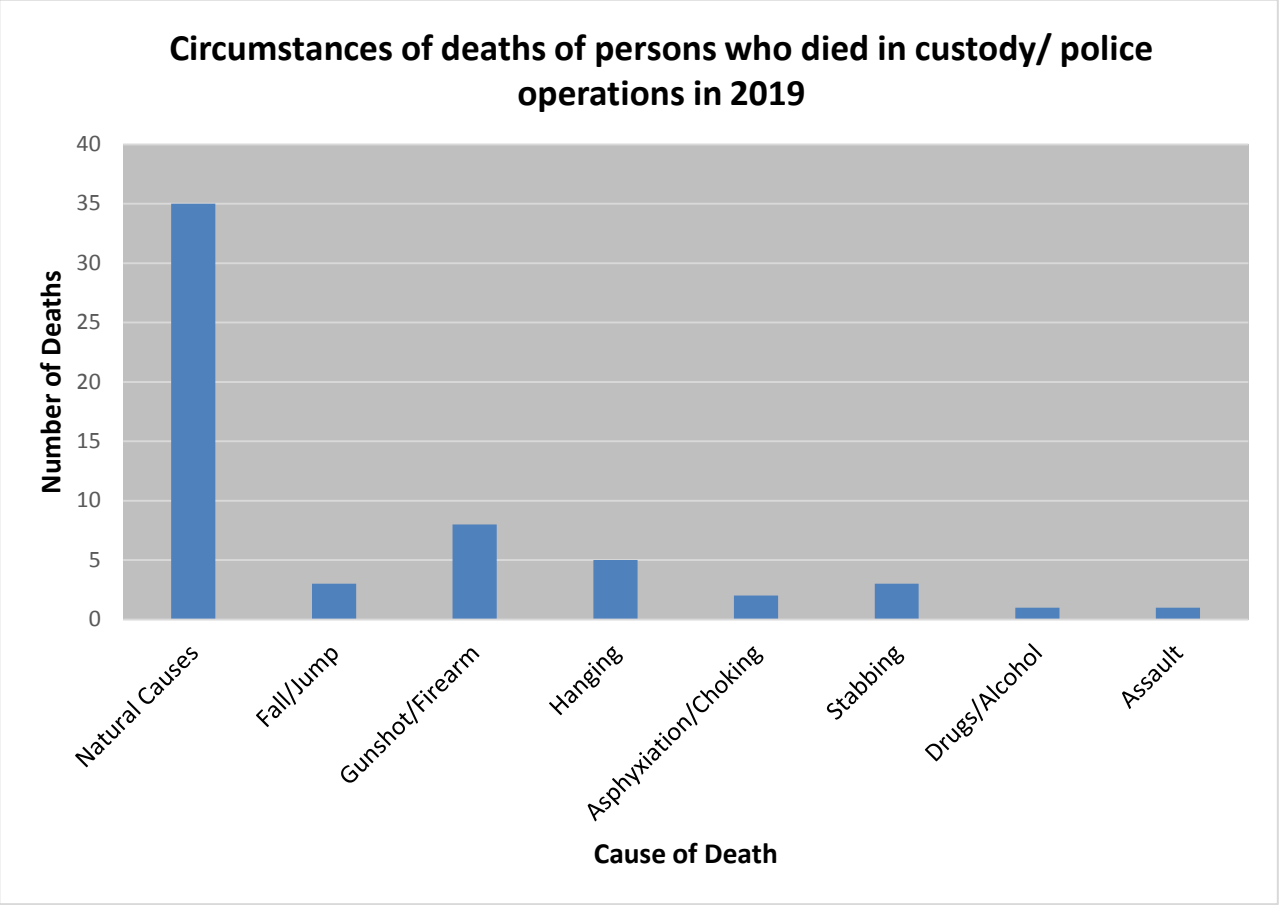
5 - Hanging

2 - Asphyxiation/Choking

3 - Stabbing

1 - Drugs/Alcohol

1 – Assault



SECTION 23 INQUESTS UNDERTAKEN IN 2019

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 a Deputy State Coroner in 2019.

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 in those cases will be referred to as a pseudonym.***

	Case No	Year	Name	Coroner
1	435610	2010	RP	DSC Grahame
2	273783	2012	DJ	DSC Grahame
3	381722	2015	David DUNGAY	DSC Lee
4	82254	2016	Stephen KLINE	DSC Lee
5	107266	2016	RN	DSC Truscott
6	110830	2016	Ossama Al REFAAY	DSC Ryan
7	214323	2016	L	DSC Ryan
8	218940	2016	Rebecca Lyn MAHER	SC O'Sullivan
9	273191	2016	MA	DSC Grahame
10	329687	2016	Paul LAMBERT	SC O'Sullivan
11	334771	2016	Bryce James DOYLE	SC O'Sullivan
12	350477	2016	Celal KIZILDAG	DSC Lee
13	361528	2016	GD	DSC Truscott
14	24726	2017	Kenneth HELLYER	DSC Truscott
15	43731	2017	Xavier Connor BURKE	DSC Lee
16	76874	2017	Ryan John Keith AUTON	SC O'Sullivan
17	81862	2017	Dawn Shirley JACOBS	DSC Linden
18	96394	2017	Terry Carl AH-SEE	DSC Ryan
19	225920	2017	AB	DSC Truscott
20	228552	2017	Danukul MOKMOOL	DSC Truscott
21	256295	2017	Arthur ROBERTS	DSC Truscott
22	266269	2017	Christopher Robert HILL	DSC Forbes
23	272539	2017	Shaun CRIGHTON-CROMB	DSC Lee
24	275550	2017	Ahmed RIZK	SC O'Sullivan
25	286401	2017	CD	DSC Forbes
26	343689	2017	AA	DSC Ryan
27	344706	2017	Cameron TOWNLEY	DSC Forbes
28	39867	2018	Anthony WRAY	DSC Forbes

29	40544	2018	Terence REDDY	DSC Truscott
30	41984	2018	Patrick Norman FISHER	DSC Forbes
31	79469	2018	Marlene MCHARDY	DSC Truscott
32	109798	2018	Ivan METCALFE	DSC Truscott
33	119731	2018	Douglas ANDERSON	DSC Ryan
34	142510	2018	Jordan Wayne CRUIKSHANK	DSC Ryan
35	150088	2018	Thomas MILLER	DSC Forbes
36	287982	2018	Graham Robert LAWSON	DSC Truscott
37	58026	2019	Ivan ALLWOOD	DSC Forbes

Section 23 Inquests completed in 2018 and not included in corresponding annual report

1	161961	2015	Jordan MORRIS	DSC Grahame
2	302875	2016	CK	DSC Grahame

1. 435610 of 2010 & 2. 272783 of 2012

Inquests into the deaths of RP and DJ. Findings handed down by Deputy State Coroner Grahame at Lidcombe on the 4th July 2019.

Introduction

This inquest concerns two deaths which occurred at the Metropolitan Remand and Reception Centre (MRRC), which is a metropolitan prison at Silverwater, NSW. DJ died on 1 September 2012 in cell 407 of Pod 16 Hamden Block at the MRRC. RP died at some time between 3.25pm on 23 April 2010 and 6.15am on 24 April 2010 in cell 108 of Pod 10 of Fordwick Block at the MRRC.

A decision to hold their inquests together is based on the similarities in the manner of the deaths of each man. Each man died in his cell after having been placed with an inmate suffering from an active schizophrenic illness. Each man died from injuries that had been inflicted upon him in circumstances where he had been unable to escape. It is clear in hindsight that the mental health of each of DJ and RP's cellmates, at the relevant times, was such that they should not have been placed in a cell with another person. In this sense both tragic deaths were potentially preventable. The inquest sought to understand the cell placement decisions that were made in an attempt to ascertain whether there are ways of reducing the likelihood of future similar tragedy. It is important to state at the outset that most deaths in custody are from natural disease or suicide. Deaths from violent assault in prison are fortunately rare. It appears that NSW Coroners have not frequently grappled with the specific issues raised in this inquest. I note that the families of DJ and RP were notified of these proceedings but had no wish to participate. Nevertheless, I offer them my sincere condolences. Their loss in such terrible circumstances is profound and ongoing.

The role of the coroner

When 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 in NSW 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 they receive care of an appropriate standard. Their living conditions are similarly restricted and prison authorities are called upon to manage an array of inmates, taking into account their often disparate needs and requirements. Cell placement is an important decision and can impact on an inmate's state of mind and physical wellbeing. In this case, the cell placement decisions made contributed to the tragic death of two prisoners.

These inquests follow criminal and forensic health proceedings and thus occur well after the events under investigation. Given the time that has passed, it was necessary to keep in mind whether practices and procedures in place at the time, remain current today.

The evidence

The court took evidence over eight hearing days. The court also received extensive documentary material in eleven volumes. This material included witness statements, medical records, photographs and expert reports. While I do not intend to refer to all the material in detail in these findings, it has been comprehensively reviewed and assessed.

A list of issues was prepared before the proceedings commenced. The following questions arose in relation to RP's death:

- What was the date of RP's death?
- Was there a systemic failure within CSNSW and Justice Health to identify/diagnose Mr A's mental illness and risk of harm to others, leading to his placement in a two-out cell with RP?
- Was the determination by the Risk Assessment Intervention Team (RAIT) on 20 April 2010 to require Mr A to be in a two-out cell appropriate in the circumstances and on the basis of the information available to the RAIT at that time?
- Was psychiatrist Dr Dall's assessment of Mr A on 22 April 2010 appropriate in the circumstances and on the basis of the information available to Dr Dall at that time?
- To what extent was information about Mr A's engagement with community mental health services available to Justice Health to inform decision-making about risk of harm to others and cell placement?
- Is there a need for CSNSW and Justice Health intake and screening processes, including RAIT protocols, to place a greater emphasis on identifying and escalating disclosure of delusional beliefs or hallucinations by inmates?
- When an inmate discloses delusional beliefs or hallucinations should CSNSW protocol, including RAIT protocol, mandate that such inmates be excluded from two-out cell placement until they have undergone an urgent psychiatric assessment for possible mental illness?
- Is there a need for CSNSW and Justice Health intake and screening processes, including RAIT protocols, to place a greater emphasis on interrogating the risk of harm to others presented by individual inmates, including through self-reporting of delusion beliefs and hallucinations and otherwise?

The following questions arise in relation to DJs' death:

- Was there a systemic failure within CSNSW and Justice Health to treat Mr B's mental illness and identify his risk of harm to others, leading to his placement in a two-out cell with DJ?
- Was the decision by the RAIT on 23 August 2012 to assess Mr B's risk of harm to others as low appropriate in the circumstances and on the basis of the information available to the RAIT at that time?
- Was the decision by the RAIT on 27 August 2012 to allow/require Mr B to be in a two-out cell appropriate in the circumstances and on the basis of the information available to the RAIT at that time?

- Was psychiatrist, Dr Gordon Elliott's, assessment of Mr B on 27 August 2012 appropriate in the circumstances and on the basis of the information available to Dr Elliott at that time?
- Was the decision by CSNSW officers to place Mr B in a cell with DJ appropriate in light of DJ being in custody for child-related sexual offences?
- To what extent was information about Mr B's engagement with and treatment by community mental health services available to Justice Health and to CSNSW to inform assessments of and decision-making in relation to, his mental illness and its treatment, his risk of harm to others?
- Did Mr B receive appropriate medical treatment by Justice Health?
- Did the information-collecting practices of CSNSW and Justice Health, and their information-sharing practices, contribute to a failure to properly assess and treat Mr B's mental illness and identify Mr B's risk of harm to others?

These questions directed the focus of the evidence presented in court. However as is often the case, a hearing can tend to crystallize the issues which are really at stake. For this reason, after dealing with the facts, I intend to distil my reasons fairly briefly under a small number of broad headings. The focus of the inquest became the systemic issues at play, rather than the many individual decsions made in relation to the medical and custodial management of DJ and RP's cellmates prior to their tragic deaths. At the end of the day, while no individual is held out for any particular criticism, the system in which they worked is exposed as inadequate and in need of review.

The deaths under investigation – fact finding

In this inquest there was no dispute in relation to the identity of the deceased men, or to the date and place of their deaths. The medical cause of each death was also clear. For this reason the inquest focused on the manner of the deaths. In particular the decisions leading up to the violence and whether or not there was a way of predicting or preventing what occurred.

Counsel assisting prepared a concise summary of the extensive documentary evidence. The summary of evidence was circulated to the parties during the course of the inquest for consideration and comment, prior to finalisation. The document was a careful synopsis of the salient facts leading up to the deaths under investigation. I indicated to the parties that I intended to adopt it as the basis of my fact finding and urged comment or correction. I was alerted to no particular controversy. In my view what follows is an accurate and useful distillation of the tendered material. I thank those assisting me for their hard work in the preparation of the following chronologies and on the final submission document on which I also rely heavily. I thank the various parties for their extensive written submissions and for the cooperative way the inquest was approached.

The death of RP

RP – Chronology

RP was born on 12 July 1991. At the time of RP's arrest, he was residing with his mother and brother and unemployed.
On 19 April 2010, RP was arrested and charged with:

- Aggravated indecent assault;
- Assault with an act of indecency and armed robbery.

On 19 April 2010, RP went before Liverpool Local Court and was refused bail. RP's matter was adjourned to 5 May 2010 at Liverpool Local Court for mention. RP was received at the Metropolitan Remand and Reception Centre ("MRRC") on remand from Liverpool Local Court on 20 April 2010. RP had not previously been remanded in custody. RP was assessed on 21 April 2010 and deemed suitable for normal placement. On 22 April 2010, RP was allocated and placed into cell 108 of POD 10 of F Block, a "two man cell" that had been occupied by Mr A since 20 April 2010.

MA

MA was born on 11 December 1991. MA was 18 years old as at the date of RP's death. MA reported that prior to his arrest, he had been unemployed and had lived alone in rented accommodation. Andrea Simpson, a registered mental health care nurse working for the Child and Adolescent Community Mental Health Service at Camperdown Mental Health Service, Sydney Local Health District ("**CAMHS"**), first had contact with MA and his family in September 2008. Specifically, Ms Simpson received a phone call from MA's mother on 11 September 2008 during which she raised concerns about MA's mental health and illicit substance use.

Ms Simpson conducted an assessment of MA on 17 September 2008 and formed the clinical impression that MA was a young man with a probable history of post-traumatic stress disorder as a result of incidents experienced as a child as well as severe, angry and violent thoughts which he had acted upon. Ms Simpson intended to discuss treatment options for MA with the CAMHS team and also offer support to MA through anger management and counselling. On 26 September 2008, MA's mother again requested a home visit as her son's behaviour had not improved. Ms Simpson attended the home of MA that afternoon but no person was home. A number of further attempts were made by Ms Simpson to contact MA but these attempts were unsuccessful and on 5 November 2008 MA was discharged from CAMHS.

Ms Simpson's next contact with MA and his family occurred on 15 April 2009 when Ms Simpson attended MA's home, however, MA had left the house as he did not wish to speak with Ms Simpson. Ms Simpson subsequently referred MA to the First Episode Psychosis service at Croydon Health Centre. MA was referred to Trish Lloyd, an Occupational Therapist with the First Episode Psychosis Team. On 7 May 2009 Ms Lloyd telephoned MA's mother.

During this conversation the mother provided a lengthy family history and indicated that MA had been abused by his father's family. She expressed concerns regarding MA's drug and alcohol use and noted that MA had been cruel to her cat, ultimately killing her cat. After numerous attempts by Ms Lloyd, MA attended the Croydon Health Centre on 29 May 2009. MA identified a number of issues including the following: paranoia; becoming angry or hostile when paranoid; and unable to identify what makes him paranoid. MA also disclosed that he had used illicit drugs including that he had been smoking ten cones of cannabis per week.

On 10 June 2009, Ms Lloyd again saw MA. MA identified anger as the main problem he required help with. MA stated that he had experienced conflicting thoughts towards the cat and that he had a 'split personality' at the time. Ms Lloyd's formulation was that MA was a 17 year old male with a significant history of physical abuse during his early childhood who had described features suggestive of dissociative symptoms but with no clear psychotic symptoms. Ms Lloyd recorded that a risk existed of impulsive anger outbursts and noted a history of acting on impulse. Ms Lloyd's intention for MA was for his case management to continue under the First Episode Team and for his mental state to be monitored with particular attention to MA's psychotic and mood symptoms. Ms Lloyd indicated that MA was not to commence medication at this stage.

On 18 September 2009, MA was discharged from the First Episode Psychosis Team due to his non-engagement with the service and other services he had been referred to. Ms Lloyd recorded in MA's progress notes that at the time of discharge, MA had been monitored for three months and there were no psychotic symptoms evident. On 4 March 2010, MA's mother telephoned the First Episode Psychosis Team. The following entry, inter alia, was recorded in the progress notes by S.Villagran:

"M ↑ aggressive
M taking illicit substances
M's behaviour towards her as ↑ threatening – she's moved out of her DOH, presently living with friends – afraid of M and that he may hurt her".

S.Villagran recorded that it had been determined that the First Episode Team would not engage MA in response to the concerns raised by the mother as this was more a legal and police matter.

Charges and entry into custody

On 14 April 2010, MA was charged with attempted murder and wound person with intent to cause grievous bodily harm. It was alleged that on 10 April 2010, MA had stabbed the victim – a neighbour – in the stomach. On 13 April 2010, MA participated in an electronic record of interview with NSW Police in which he admitted stabbing the victim in the stomach and stated that he was seeking revenge against the victim and that he had been unwillingly subjected to acts of violence and indecency committed by the victim and the victim's friends. MA later told a psychiatrist that he had been hearing voices. The alien voices told him that if he killed someone and sacrificed someone, he would go to paradise. At the time MA was arrested, he was on conditional bail for a break, enter and steal offence committed in February 2010 against the same victim.

His remaining criminal history comprised entries for: destroy or damage property (DV) and contravene prohibition/restriction in AVO (charge date: 20 January 2010); possess prohibited drug (charge date: 11 December 2009); and destroy or damage property (charge date: 27 October 2009). MA was remanded in custody by Burwood Local Court. MA was to appear at Burwood Local Court, via video link, on 9 June 2010.

The only time MA had spent in custody prior to being remanded in April 2010 was one night on 20 February 2010. The New Inmate Lodgement & Special Instruction Sheet, completed on 14 April 2010 at 9:00 am, recorded that MA was suicidal and that it was his first time in custody and, in response to "other immediate management or placement issues including cell placement", recorded "RIT".

Events of 14 April 2010 to 24 April 2010

At approximately 4:00pm on 14 April 2010, an "Inmate Identification & Observation Form" was completed. The author of this Form indicated that the author considered MA to be at risk of suicide. The Inmate Identification & Observation Form recorded, in response to the question "have you received psychological/psychiatric treatment", that MA had previously had contact with "Ashfield - Trish Loyd", (sic). At approximately 8:00pm on 14 April 2010, Ms Anna Grigore, registered nurse, conducted a health reception screening assessment on MA. Ms Grigore formed the opinion that MA was "mentally unwell" based on his presentation and lack of responses during the assessment. She was unable to say he was suffering a mental illness.

Ms Grigore completed a Health Problem Notification form. The Health Problem Notification form advised that MA should be placed in a camera assessment cell for his safety due to the serious charges and to observe his mood and stability until he was reviewed by the RAIT.

RAIT Assessment of 15 April 2010

On 15 April 2010, at approximately 9:20am, MA was assessed by the RAIT. The RAIT was comprised by Acting Assistant Superintendent Blacklock, Registered Nurse Skye Freeman and welfare officer, Joshua Evans. During the course of the RAIT, RN Freeman completed "Assessment Form A1". In the history of community mental health contacts, RN Freeman recorded:

"anger mx → saw psychologist
Mum organised it
→stated helped a little".

RN Freeman recorded MA's current risk status, with respect to harm to others, as low. MA was assessed by the RAIT as constituting a "medium" risk of harm to himself and as constituting a "low" risk of harm to, and from, others. The RAIT recorded, in the M.R.R.C – R.A.I.T Management Plan, in response to the question regarding whether MA suffered from a "mental health problem", "no". The RAIT determined that MA:

- was to remain on RIT;

- be subject to focused case management;
- be placed in a "safe cell"; and
- with respect to his daily routine, be "normal by day".

Ms Freeman completed and signed a Health Problem Notification form, which was also signed by Acting Assistant Superintendent Blacklock as the DCS Receiving Custodial Officer. The Health Problem Notification form advised:

"maintain MNF. Normal by day. Safe cell at night".
RAIT Assessment of 18 April 2010

On 18 April 2010, at approximately 10:40am, MA was assessed by the RAIT. The RAIT comprised Acting Assistant Superintendent Izgun, Registered Nurse Ali-Reza Akbari-Sepehr and welfare officer Michelle Curran.

MA was assessed by the RAIT as constituting a "medium" risk of harm to himself and as constituting a "low" risk of harm to, and from, others[1]. The RAIT determined that MA was:

- to remain on RIT;
- be subject to focused case management;
- be placed in a "safe cell"; and
- with respect to his daily routine, be "normal by day".

In MA's Justice Health records, Registered Nurse Akbari-Sepehr recorded the following:
"odd behaviour. Denies any sign of mental illness. Non-convincing"
and
"*hesitant to respond when asked … stated people has got the ability to read the others mind by telepathy when asked if he can do this refused to respond 'I don't know'*
… ↓ Risk of harm to others
Impression = not convincing ? Mental health issue"

The RAIT did not record a response in the M.R.R.C – R.A.I.T Management Plan to the question regarding whether MA suffered from a "mental health problem". The Management Plan included a referral to psychology. The Progress Notes record referral to a psychologist and to a psychiatrist. This latter referral was not recorded on the M.R.R.C – R.A.I.T Management Plan. The referral was recorded in the Justice Health patient administration system on 18 April 2010 by Mr Ali-Reza Akbari-Sepehr.

Intake Screening Assessment of 18 April 2010

On 18 April 2010, at 4:20pm, Ms Vanya Wit conducted a CSNSW intake screening assessment of M A.

Ms Wit noted that Mr A was being managed by the RAIT and referred Mr A to psychology for anger management and to alcohol and other drug counselling for his alcohol and other drug issues. Ms Wit recorded that, in response to the question "have you hurt others when stressed?" Mr A responded "I have been known to fight others when I am angry". Ms Wit also recorded that, in response to the question, "have you ever seen a counsellor or psychologist in custody or in the community? Mr A responded "anger management a psychologist in the community".

RAIT Assessment of 20 April 2010

On 20 April 2010, at approximately 11:00am, Mr A was assessed by the RAIT. The RAIT comprised Assistant Superintendent Lockwood, Registered Nurse Skye Freeman and welfare officer Joshua Evans. During the course of this assessment, Mr Evans telephoned Mr A's mother on two occasions. Mr Evans' case notes record the following in relation to his telephone conversation with the mother:

"call made to mother post-interview → mother reported he is normally emotionless and possibly depressed. Referred in the community to Croydon Youth team. Croydon Youth team inconsistently attended. Mother reported victim is 'improving', 'very well', 'stable'. Mother agreed to contact welfare staff prior to son if news of death of victim received. Mother reported nil hx of self harm acts known".

The RAIT assessed Mr A as a medium risk of harm to himself and at medium risk of harm from others and a low risk of harm to others. The RAIT noted referrals in place for review by a psychologist and the mental health team. With respect to whether Mr A suffered from a "mental health problem", the RAIT noted that Mr A was "to be assessed". No threat of self-harm or suicide was claimed.

The RAIT determined to alter Mr A's cell placement from "safe cell" to "2 x out cell" until review on 20 May 2010. Mr A's RIT status was terminated. Registered Nurse Freeman completed and both Ms Freeman and Assistant Superintendent Lockwood signed a Health Problem Notification form. The Health Problem Notification form advised:

"Terminate MNF
Clear from Darcy by Mental Health and RAIT".

In the "Mandatory Notification for Offenders 'At Risk' of Suicide or Self-Harm" form, signed by each member of the RAIT, it was noted that the reason for lowering the level of risk was *"Consistently denies self harm ideation".*

In the CSNSW Case Notes, Mr Evans recorded under the notation "IMP": "*Low risk of self harm – constantly denies self harm ideation, evidence of developing insight into situation coping with NBD routine coping with possible depression, settled and cooperative".*

In the Justice Health records, Registered Nurse Freeman recorded: "INP: *? H/O depression. Accepting of situation. Some situational distress but coping". Plan: terminate. 2 out. [?] psychology".*

Telephone call to Joshua Evans by MA's mother on 21 April 2010

On 21 April 2010, MA's mother telephoned Mr Evans. In a report following RP's death, dated 26 April 2010, Mr Evans noted the following:

"Mother expressed concerns for MA's capacity to cope given the situational issues and possible depression. Mother was reassured that services are available in custody to support MA and was advised that a referral had been generated for a review to take place by a psychologist".

Mental Health Review of 22 April 2010

On 22 April 2010, Dr Basem Dall, a psychiatrist conducted a mental health review of MA at MRRC's clinic which Dr Dall described as being similar to an outpatient clinic at a hospital. Dr Dall described the environment at the clinic as "quite a chaotic environment". Whilst Dr Dall is unable to be certain regarding the material available for his review, Dr Dall states that he would only have been provided with the Justice Health file for the prisoner and no more. Further, he did not have access to the prisoner's other files with the NSW Department of Corrective Services (**"CSNSW"**). Dr Dall states there was no referral document. The referral document is contained in the Justice Health file.

Dr Dall made the following entry in MA's progress notes:
"Difficult to engage with
Denied any Mental Health problem
denied feeling depressed
denied psychotic phenomena
Says he found talking to Mental Health difficult
Engaged well [with] other inmates – no fears or concerns
Mental State E(xamination
[Reduced] eye contact, difficult to engage, self-care appropriate
Speech – low rate, quantity
Flat / restricted
No Formal Thought disorder
No delusions
No hallucinations
Sleep [reduced]
Denied thoughts of Deliberate Self-Harm/ Suicide
Impression
Adjustment Reaction [with] depressed mood
Possible depression
Plan
[Review] in [one month]

Not for [medication] at present"

Dr Dall believes that he spent approximately 15-30 minutes with MA. Dr Dall did not prescribe any medication and his plan was for MA to be reviewed in one month.

Transfer to Cell 108

On 20 April 2010, MA was placed into cell 108. On 22 April 2010, RP was also allocated to cell 108.

The afternoon of 23 April 2010 and the morning of 24 April 2010

At approximately 3:25pm on 23 April 2010 MA and the deceased were locked in their cell for the evening. The following morning at about 6:15am, Correctional Services Officers began their morning head count of inmates within Pod 10 of the Fordwick Wing. At approximately 6:18am, Correctional Officer Fernando Alfonso opened the door to cell 108, and saw RP lying on his back on the floor and MA standing next to him. Correctional Officer Alfonso asked MA "is he alright?" and MA replied "I bashed him", repeating that statement several times.

MA was removed from the cell and placed in an isolation cell and nursing staff from Justice Health were contacted to attend to RP. The Fordwick Wing was placed into lockdown. Ambulance officers attended the scene at 6:45am but were unable to revive RP. At 6:50am a crime scene was established. At approximately 10:25am MA was placed under arrest and cautioned by police and later transferred to Auburn Police Station.

MA participated in an electronically recorded interview with police. He stated that, in the early hours of the morning when RP appeared to be asleep, he climbed on to RP's bed and commenced to "stomp" him with his feet. RP awoke and attempted to defend himself, whereupon MA put his arm around RP's neck and tried to choke him. The two men fell to the floor, where MA continued to choke RP. RP attempted to crawl away from MA and as he did so MA kicked him a number of times. Eventually RP stopped moving. He did not regain consciousness and died in the early hours of the morning. MA subsequently told forensic psychiatrists that he needed to kill RP in response to instructions from aliens that he needed to sacrifice someone in order to go to paradise.

Events following the death of RP MA's illness

MA was subsequently diagnosed with a treatment resistant schizophrenic illness and was found to have been suffering from a serious mental illness at the time of RP's death, with acute symptoms including persecutory and grandiose beliefs and auditory hallucinations.

Post-mortem examination

An autopsy completed by Dr Brouwer on 25 April 2010 revealed extensive haemorrhage of the soft tissues of neck with fractures of the hyoid bone and cricoid cartilage. The cause of death was recorded as fatal pressure to the neck.

Criminal proceedings against MA

On 16 May 2012, MA was found not guilty of the murder of RP by reason of mental illness in accordance with s 38 of the *Mental Health (Forensic Provisions) Act 1990* after a judge-alone trial. Pursuant to s 39(1) of the Act, MA was ordered to be detained in a correctional centre or at such place as may be determined from time to time by the Mental Health Review Tribunal until released by due process of law.

The death of DJ

DJ – Chronology

DJ was born on 26 June 1963.

In 2007, DJ was convicted of three counts of indecent assault, one count of assault and one count of committing an act of indecency. At the time of these convictions, DJ went by the name GC. DJ was sentenced to a good behaviour bond which included a supervision order expiring on 14 February 2010.

On 20 July 2012, DJ was arrested and charged with:

- five counts of producing, disseminating or possessing child abuse material; and
- four counts of failing to comply with reporting obligations.

Around 4:50pm on 20 July 2012, DJ was refused bail at Bankstown Police Station.

At 8:20pm on 20 July 2012, DJ entered into the custody of CSNSW at the Parramatta Court Cells. A Health Problem Notification Form (**"HPNF"**) was completed by Registered Nurse Soung Lee. RN Lee noted that DJ may suffer from "developmental (unclear)". RN Lee also indicated that CSNSW Officers needed to undertake the following: "while in Parramatta Police Cells: RIT; 24 hours camera cell monitoring; R/V daily". Joseph Zelezniak completed a "NSW Department of Corrective Services – Incident Details" Form which noted that DJ had been placed on RIT because "inmate presents as mentally handicapped. Would not guarantee his own safety whilst in cells".

On 21 July 2012, DJ appeared at the Parramatta Local Court where bail was refused and he was remanded in custody. Later on 21 July 2012, DJ was transferred to the Penrith Court Cells. Around 6:00pm on 22 July 2012, DJ was transferred to the MRRC.

Around 7:25pm on 22 July 2012, DJ was assessed by Ann Parker, a Welfare Officer employed by CSNSW. Ms Parker determined Mr J was possibly developmentally delayed and could be vulnerable to harm from others. Ms Parker noted that a Risk Intervention Team (**"RIT"**) had been raised by Parramatta Local Court. Around 8:25pm on 22 July 2012, DJ was reviewed by Registered Nurse Janis Wood. RN Wood completed a Health Problem Notification Form which stated DJ was subject to an RIT, possibly had epilepsy and was developmentally delayed. The HPNF directed that DJ was to be placed in an assessment cell subject to 24 hour closed-circuit television monitoring.

On 23 July 2012, DJ applied to be placed in protective custody. Later on 23 July 2012, Direction Number MRR1115970 was made, which placed DJ on a Protection Limited Association (**"PRLA"**) status.
On 24 July 2012, DJ was assessed by an RIT comprised of Assistant Superintendent Steven Tienstra, psychologist Rowena Friend and Clinical Nurse Consultant Marco Rec. DJ was assessed to be a low risk of suicide and self-harm, and he was cleared from the RIT for a normal cell placement with a referral to psychology.

DJ was housed in the Darcy Block of the MRRC from 22 July 2012 until 22 August 2012. On 30 July 2012, DJ's PRLA status was renewed. On 17 August 2012, DJ was reviewed by psychologist Steven Barracosa. Mr Barracosa assessed that DJ was a "low intermediate" risk of self-harm or suicide. Mr Barracosa referred DJ for psychological follow-up to take place after DJ's next court appearance. On 22 August 2012, DJ was moved to Cell 407 of Pod 16 of the Hamden Block at the MRRC. On 23 August 2012, DJ underwent assessment for initial classification.

On 24 August 2012, the initial remand classification of B_U (Unsentenced B medium security) and RBP (remand bed placement) were approved for DJ. On 29 August 2012, DJ was notified of his classification, and he signed an initial classification document.

BB: Criminal history and mental health prior to 2012

BB was born on 16 February 1972.

BB was first placed into custody on 28 October 1991, after being convicted of larceny and sentenced to seven days imprisonment for default of payment of a fine. BB had further periods in custody in 1993, 1999, 2005 and 2006 for a variety of offences and due to breach of parole. On 22 August 2008, BB was convicted of shoplifting and driving whilst disqualified. For these offences, BB was sentenced to a total of twelve months imprisonment, with a non-parole period of eight months. The non-parole period for these offences expired on 14 October 2008.

On 13 October 2008, Dr Gordon Elliott, Staff Specialist Psychiatrist, Justice Health, wrote to the Admitting Doctor at Cumberland Hospital, noting that BB was being released from custody the following day. In that letter, Dr Elliott stated:

"Mr B has a psychotic illness of probably five years duration in the context of methamphetamine abuse. His illness is characterized by an ever more elaborate, but non-bizarre delusional belief [his partner] is having an affair with a man named Michael who has contacts with the "Fourth Reich" motorcycle gang. Mr B believes that this man has also sexually abused one of his daughters. He insists that he has … heard Michael and [his partner] plotting to kill him. Mr B believes Michael has placed a $30 000 contract out on his life. He believes this contract has been offered to other inmates in the jail, surmising this from the demeanour and behaviour of those around him. He has admitted to me in the past that he has heard his cell mate plotting with other inmates to kill him. … I am concerned about the potential risk he poses to his partner when untreated, or to anyone else he perceives to be involved in the plot to harm him."

On the same day, Dr Elliott certified under s 19 of the *Mental Health Act 2007*, that Mr B was mentally ill and that were reasonable grounds that temporary care, treatment or control were necessary for Mr B's and others' protection from serious harm.

In Part 2 of the relevant form, Dr Elliott expressed the opinion that there were serious safety concerns arising from Mr B being taken to a mental health facility without the assistance of a police officer, because "he has been refusing treatment and has been violent to others based on delusional beliefs". Mr B appears to have been at Cumberland Hospital until 16 October 2008 but was discharged after being observed as being free of symptoms.

A discharge summary from Graylands Hospital in Western Australia records that Mr B was admitted to Geraldton Hospital for four days in July 2009 and then to Broome Hospital on 18 July 2009, before being transferred to Graylands Hospital. The circumstances of his admission to Broome (and then Graylands) Hospital are recorded as:

"B called the police on the night of 18.07.09 saying 80 Coffin Cheaters were after him. He was hiding in the house though the police could not see anyone. On presentation at Broome Hospital he was frightened and distressed. He came into hospital with a large knife to defend himself, but this was taken from him for safety. He was talking to himself and seeing and hearing what others could not. His condition escalated on the second day of admission. He secretly stole three dinner knives, barricaded himself in the bedroom, was yelling and verbally aggressive. He refused to take medications. Police were called in for safety reasons. He was handcuffed and then sedated en route to Sir Charles Gardner Hospital for extubation before arriving at Graylands Hospital."

Mr B was discharged from Graylands Hospital after he was "aggressive no more and was complying with medication", being, relevantly, Olanzapine and Suboxone. Mr B was admitted to Cumberland Hospital on 6 August 2009 where he remained until 17 December 2010. Much of this admission appears to have been as an involuntary patient. The reason for referral is recorded as "long history of schizophrenia … at least since 2007 delusional beliefs that 'bikies want to get him' … several psychiatric admissions". The recorded diagnosis was treatment resistant schizophrenia, polysubstance abuse and antisocial personality traits. The summary of care records:

"Numerous difficulties in managing him during rehabilitation – was transferred to Waratah Cottage (independent living) but barricaded his room at night believing bikies would kill him. On one occasion he kept a knife in his room to defend himself. Also reported auditory hallucinations of persecutors outside his cottage. He was commenced on Clozapine + dose optimised with improvement in his symptoms. … Currently his mental state is stable."

When Mr B was discharged he was prescribed clozapine and buprenorphine. On 8 August 2011, Mr B was admitted involuntarily to Shellharbour Hospital, with diagnoses of drug induced psychosis, malingering and antisocial personality disorder. The circumstances of admission are described as:

"39 year old male patient who is unemployed, single and homeless with known forensic history and diagnosed paranoid schizophrenia non-compliant was brought into the hospital by police. The patient presented himself to police with a knife in his hand and stated that he would kill his sister, brother in law and his ex-wife's partner. H/O recent discharge from the hospital as he was found wandering the street with a knife and his desire to kill the people mentioned above."

Mr B was discharged from Shellharbour Hospital on 26 August 2011, with a plan to continue on Olanzapine, which had been started during his admission. Mr B was admitted to Cumberland Hospital on 30 August 2011. The circumstances of the admission are recorded as:

"…was brought in by police under section 22 when he called the police for help. He told that he had been following by [indecipherable] they want to kill him. He was also found in possession of morphine and a knife. He kept the knife for his safety. He denied any thoughts of self harm. He has a background history of treatment resistant paranoid schizophrenia."

Mr B was discharged on 14 September 2011, with a plan to continue on Amilsurpride and Diazepam. Mr B was also discharged from the Shoalhaven Community Mental Health Team on 22 September 2011, however he had been admitted to the Homeless Outreach service on 15 September 2011. The Discharge Summary from the Shoalhaven Community Mental Health Team identified Mr B as a potential aggression risk when acutely psychotic.

On 16 December 2011, Mr B was made subject to an order under s. 32(3)(a) of the *Mental Health (Forensic Provisions) Act 1990* (NSW), requiring him to comply with a treatment plan provided by Dr Joe Garside, a treating doctor at the Homeless Outreach service, dated 1 December 2011. Dr Garside's treatment plan was in the form of a letter,[2] which included the following:

"Mr B is suffering from schizophrenia. He was first unwell with psychotic symptoms in the 1990s. He was not formally diagnosed with schizophrenia until around 2007. He has had a number of admissions since. Typically he has presented with bizarre persecutory delusions about being followed, monitored with special devices and people having plans to harm him. He has responded to delusional ideas by being violent in the past. … [The antipsychotic amisulpride] has been continued and he has had a good response to it. He continues to have residual persecutory ideas but he is no longer agitated and he has been able to successfully reside in medium term homeless accommodation and find occasional labouring work."

On 16 February 2012, Mr B was admitted to Cumberland Hospital as a voluntary patient. Mr B stated his treating psychiatrist had changed his medication, but was not available for a consultation. During this admission, Mr B became agitated and demanded Seroquel so was placed in the high care unit under the "mental health act". Mr B's diagnosis was recorded as chronic paranoia, schizophrenia, ASPD, poly-substance abuse and non-compliance. Mr B was discharged on 17 February 2012 after his General Practitioner was contacted, with a plan to continue Amilsurpride as prescribed by Dr Garside and the General Practitioner.

On 2 March 2012, Mr B was admitted to Cumberland Hospital. During this admission, Mr B was made an involuntary patient due to his increasing agitation and threatening behaviour. He was commenced on Quetiapine and his mental state improved. Mr B was discharged on 14 March 2012 with a plan to remain on Quetiapine.

Mr B was discharged from the Homeless Outreach service on 11 July 2012 after being transferred to the MRRC.

Arrest on 5 June 2012

On 5 June 2012, Mr B was arrested and charged with the offence of robbery armed with an offensive weapon. Mr B was refused bail at Blacktown Police Station. While in police custody, Mr B attended the Emergency Department of Nepean Hospital seeking medication for his chronic shoulder pain. Transitional Nurse Practitioner Julie Eldridge wrote a letter noting Mr B had a past medical history of schizophrenia, and had been prescribed Oxycontin and Seroquel.

Around 8:15pm on 5 June 2012, Mr B entered into the custody of CSNSW at the Penrith Court Cells. A "New Inmate Lodgement & Special Instruction Sheet" and "Inmate Identification & Observation Form" was completed which noted that: Mr B required an Interview for Placement as a "previous SMAP inmate"; Mr B possessed concerns about being placed in a Correctional Centre as a "previous SMAP inmate – association alerts"; and Mr B was taking oxycontin for his shoulder injury and had schizophrenia.

It appears that the Inmate Identification & Observation Form was only partially completed.

Events prior to reception into the MRRC

Mental Health Assessment on 6 June 2012

On 6 June 2012, Clinical Nurse Consultant John McCallum of Justice Health completed a Mental Health Assessment for Mr B. The Mental Health Assessment completed by CNC McCallum states:

"Mr B presents as a man likely to be suffering from a psychotic illness. He currently manifests risk factors consistent with an elevated risk of harm to self and others."

The Mental Health Assessment completed by CNC McCallum states that CNC McCallum discussed Mr B with a consultant psychiatrist named Dr Zhang around 1:30pm on 6 June 2012. In relation to this conversation, CNC McCallum wrote:

"Due to the nature of [Mr B's] charges we are unable to recommend an order under section 33 of the Mental Health (Forensic Provisions) Act 1990. However, Mr B presents as likely to be suffering from a psychotic illness. … Mr B has been placed on a mandatory notification as an 'At risk' inmate and will need urgent psychiatric review in custody."

CNC McCallum completed a Mandatory Notification Form (**"MNF"**) and requested intervention from an RIT.

Appearance at Penrith Local Court on 6 June 2012

Mr B appeared at the Penrith Local Court on 6 June 2012. At this appearance, bail was refused and Mr B was remanded in custody. Apparently, the remand warrant issued on 6 June 2012 stated Mr B "*requires assessment and treatment for mental illness in custody*" and requested that he undergo a psychiatric assessment.

Reception into the MRRC- Events of 6 June 2012

Mr B was transferred to the MRRC on 6 June 2012 following his appearance at the Penrith Local Court. Mr B arrived at the MRRC around 7:00pm. At 8:20pm on 6 June 2012, Mr B completed an Intake Screening Questionnaire with Welfare Officer Ann Parker. During this assessment, Mr B advised that he was suffering from paranoid schizophrenia and had not been medicated for some time. Ms Parker noted that Mr B's status was "IFP and RIT raised by Blacktown CC.

At some time on 6 June 2012, a Justice Health "Reception Screening Tool" was completed. In this form, it was noted that Mr B had been diagnosed with schizophrenia "age of (unintelligible). On & off RX. Conf RX 2/12 ago". The author ticked "patient at risk and placed on MNF/RIT". At 9:15pm on 6 June 2012, Mr B was assessed by Registered Nurse Jian Zhang of Justice Health. RN Zhang completed a HPNF which directed that Mr B be placed in a safe cell until he was cleared by the RAIT and received a detoxification clearance.

Events of 7 June 2012

On 7 June 2012, Mr B made an application to be placed on protection. He was then subject to a Placement/Threat Assessment which recommended a Special Management Area Placement ("**SMAP"**) direction. A SMAP direction was made later that day. At 11:23am on 7 June 2012, Registered Nurse Shirley Graham completed a HPNF which stated Mr B had been "cleared form detox" and was to remain in a group cell in the Darcy Block until he was seen by a mental health nurse.

Also on 7 June 2012, Mr B was seen by an RAIT comprised of Assistant Superintendent Martin Cullen, psychologist Catherine Cheung and Clinical Nurse Consultant Marco Rec. This RAIT terminated the MNF and directed that Mr B be placed in a normal cell. Mr B was assessed as a "low" risk to himself, to others, and from others. A HPNF was completed by RN Rec which stated "MNF terminated by RIT" and "normal cell placement; hold in Darcy until R/V by MHN".

Events of 8-18 June 2012

On 8 June 2012, Mr B fell and sustained a small laceration on his forehead. On 9 June 2012, Registered Nurse Soung Lee completed a Mental Health Assessment of Mr B. RN Lee assessed Mr B's overall level of risk of suicide and violence as "low".

RN Lee completed a HPNF which directed that Mr B should be held in the Darcy Block in a normal cell until he was reviewed by a psychiatrist. RN Lee also completed a Consultation Sheet. The Consultation Sheet noted Mr B had schizophrenia and requested that a doctor review his medication. On 12 June 2012, Mr B was reviewed by Forensic Psychiatrist Dr Sarah-Jane Spencer. Dr Spencer documented the following plan for Mr B:

"I will recommence quetiapine, I will titrate dose in light of recent fall in his cell ? secondary to hypotension. To put on waiting list for Mental Health Screening Unit please. One out cell placement in light of psychosis and aggression."

Also on 12 June 2012, Registered Nurse J. Nguyen completed a HPNF which stated Mr B had been cleared from the Darcy Block by a psychiatrist and was suitable to be placed in a one-out cell in Pod 19 or 20 of the Mental Health Screening Unit (**"MHSU"**). On 14 June 2012, Registered Nurse Natalie Boorer completed a HPNF which stated Mr B had been cleared from the Darcy Block by a psychiatrist and was suitable to be placed in a one-out cell in Pod 19 or 20 of the MHSU .

Placement in the Mental Health Screening Unit (18 June 2012 – 26 July 2012)

On 18 June 2012, Mr B was admitted to the MHSU. At 2:19pm on 18 June 2012, Mental Health Nurse Donald Standring completed a HPNF which stated Mr B was to be placed in a normal cell in Pod 19 of the MHSU. At 8:46am on 19 June 2012, MHN Standring completed a HPNF which stated Mr B was to be placed in a one-out cell in Pod 19 of the MHSU.

Also on 19 June 2012, Angela Carroll of Cumberland Hospital's Health Information and Records Service sent a fax to Justice Health at the MRRC containing discharge summaries for Mr B's admissions to Cumberland Hospital in February and March 2012. On 20 June 2012, Dr Joe Garside and Deborah Burke from the Western Sydney Local Health Network Homeless Outreach Team set a fax to Justice Health at the MRRC containing their file for Mr B:

On 21 June 2012, Eileen Houston from Shellharbour Hospital's Medical Records Department sent a fax to Justice Health at the MRRC containing a discharge summary for Mr B's admission to Shellharbour Hospital in August 2011.

On 25 June 2012, psychologist Erin Minard completed an initial psychological assessment of Mr B. Ms Minard documented the following impression of Mr B: *"Mentally unwell. Minimising symptoms. Long history of interpersonal difficulties. History of violence in custody. Long history of paranoid persecutory ideation – currently describes "realistic" paranoia. Currently non-compliant with medication".*

Ms Minard documented in Mr B's case notes that she had no immediate concerns, and that Mr B was a low risk of self-harm at the time of the interview. Ms Minard also documented that further contact would be required to complete her assessment, and undertook to follow-up Mr B in approximately one week. On 5 July 2012, Mr B had a follow-up interview with Ms Minard. Ms Minard documented in Mr B's case notes that Mr B showed evidence of ongoing paranoia and was

a low risk of self-harm at the time of their interview. Ms Minard referred Mr B for psychological follow-up in the Hamden Block once he was discharged from the MHSU.

On 24 July 2012, Mr B was cleared by MHN Standring to be transferred from the MHSU to the Hamden Mental Health pods. Mental Health Nurse Standring completed an MHSU Discharge Management Plan dated 24 July 2012 which stated:

- *Mr B had a history of violence in custody;*
- *Mr B had a history of non-compliance and intermittent use of medications;*
- *Mr B had schizophrenia and "evidence of ongoing paranoia";*
- *Mr B "may pose risk to others when unwell"; and*
- *Mr B was to be placed in a one-out cell.*

Mental Health Nurse Standring also completed an HPNF dated 24 July 2012 which stated:

- *Mr B had been cleared from the MHSU by a psychiatrist;*
- *Mr B had mental health issues; and*
- *Mr B was to be placed in a one-out cell.*

Placement in Hamden Block (26 July 2012 – 20 August 2012)

On 26 July 2012, Mr B was transferred from the Mental Health Screening Unit to Pod 17 of the Hamden Block. On 27 July 2012, Mr B was transferred from Pod 17 to Pod 15 in the Hamden Block.

On 31 July 2012, Mr B made a written application for a Protection Non-Association direction ("**PRNA"**). The effect of a PRNA direction would have meant Mr B would not be required to associate with other inmates. In his application, Mr B stated he "*would like to be placed on* [non-association] *as I fear for my safety on SMAP and don't wish to be placed on* [limited association] *with sex offenders*".

On 1 August 2012, Mr B's PRNA application was considered by Assistant Superintendents Jasdip Gill and Martin Cullen. Mr B's application for a PRNA direction was refused. However, Assistant Superintendent Gill wrote on the application that Mr B should be placed in a one-out cell and exercised alone, however noted that if "*this doesn't work inmate to be changed to LA/NA after threat assessment*". Assistant Superintendent Gill also noted on the application that Mr B "*has mental health issues and maybe* [sic] *paranoid*". Assistant Superintendent Cullen, who was then acting as the Area Manager, endorsed Assistant Superintendent Gill's plan and recommended that Mr B be monitored for the following two days and reviewed on 3 August 2012.

Also on 1 August 2012, a reception committee convened for Mr B. The reception committee included Assistant Superintendent Gill and Welfare Officer Deborah Moffitt. Mr B was classified as "E2U Unsentenced 'E'" and RBP (remand bed placement). Assistant Superintendent Gill recommended that Mr B be managed in accordance with the plan which he had written on Mr B's PRNA application. On 6 August 2012, Mr B was due to see psychologist Alita Caon. However, Mr B refused to leave his cell.

Placement in Darcy Block (20 August 2012 – 30 August 2012)

Threat of self-harm on 20 August 2012

On 20 August 2012, Mr B spoke to Senior Correctional Officer Peter Wilson and threatened to harm himself. Mr B told Senior Correctional Officer Wilson that a number of inmates were "*out to 'get' him*". Mr B asked Senior Correctional Officer Wilson if he could be moved to Pod 16 of Hamden Block.

Senior Correctional Officer Wilson signed an MNF dated 20 August 2012, which was also partially completed by RN Guilfoyle, which requested intervention from an RAIT team.

RN Guilfoyle completed and signed a HPNF, which was also signed by Senior Correctional Officer Wilson as the DCS Receiving Custodial Officer which stated Mr B

- Had threatened self-harm and been placed on RIT;
- Had mental health issues;
- Had a history of impulsive self-harm; and
- Could not guarantee his own safety.

RN Guilfoyle directed that Mr B be placed in a safe cell.

RAIT Review on 21 August 2012

On 21 August 2012, Mr B be reviewed by an RAIT. However, Mr B refused to leave his cell to participate in the interview. Assistant Superintendent Stephen Tienstra, Welfare Officer Raquel Rodriguez and Registered Nurse Barbara Sullivan signed an RAIT Management Plan dated 21 August 2012 which noted that Mr B "*refused to participate in interview – refused to leave cell*", and stated:

- Mr B was to remain subject to the RIT and receive focused case management;
- Mr B was to remain one-out in a safe cell; and
- Mr B was assessed as a "high" risk to himself, to others, and from others.

RAIT Review on 23 August 2012

On 23 August 2012, Mr B was reviewed by an RAIT comprised of Assistant Superintendent Martin Cullen, psychologist Catherine Cheung and Clinical Nurse Consultant Marco Rec. Assistant Superintendent Cullen, Ms Cheung and CNC Rec signed an RAIT Management Plan dated 23 August 2012 which stated:

- Mr B's MNF had been terminated;
- Mr B was to be placed in a normal cell;
- Mr B was to be held in the Darcy Block until his mental health was reviewed; and

- Mr B was a “low” risk of harm to himself and to others, however he was a “medium” risk of harm from others.

Assistant Superintendent Cullen, Ms Cheung and CNC Rec signed an MNF dated 23 August 2012 which referred Mr B for routine case management and directed that he be placed in a normal cell .

CNC Rec signed a HPNF dated 23 August 2012 which stated:

- Mr B’s MNF had been terminated by the RIT;
- Mr B was to be placed in a normal cell; and
- Mr B was to be held in the Darcy Block until his mental health was reviewed.

Also on 23 August 2012, Direction Number MRR1116609 was made, which placed Mr B on PRLA status.

Threat of self-harm on 24 August 2012

Around 5:20am on 24 August 2012, Senior Correctional Officers Harbir Singh and Paul Verbeek attended cell 85 in Pod 2 of Darcy Block. Mr B was housed in this cell with another inmate. Mr B had activated an alarm within his cell. When the two Correctional Officers attended, Mr B threatened to harm himself. Mr B was placed on an RIT and an MNF was completed.

RAIT Review on 25 August 2012

On 25 August 2012, Mr B was reviewed by an RAIT comprised of Assistant Superintendent Carole Price, Registered Nurse Robin Osborne and Welfare Officer Sue Foster. The RAIT determined Mr B was to remain on the MNF/RIT and be referred to a psychiatrist. Assistant Superintendent Price, RN Osborne and Ms Foster signed an RAIT Management Plan for Mr B dated 25 August 2012. The Management Plan describes Mr B as currently being a “high” risk to himself and from others, but a “low” risk to others.

A Case Note signed by Ms Foster dated 25 August 2012 states “*At time of interview inmate was assessed as high risk of harm to self and others*”. On review of those notes however, Ms Foster made a correction, stating the Case Note entry should read, “At time of interview inmate was assessed as high risk of harm to self and from others”.

RAIT Review on 27 August 2012

On 27 August 2012, Mr B was reviewed by an RAIT comprised of Assistant Superintendent Stephen Tienstra, psychologist Catherine Cheung and Registered Nurse Astrid Munoz. An RAIT Management Plan signed by Assistant Superintendent Stephen Tienstra, Ms Cheung and RN Munoz dated 27 August 2012:

- Indicates Mr B's mandatory status had been terminated;
- Directed Mr B was to receive routine case management instead of focused case management;
- Directed Mr B be placed in a two-out cell until 27 September 2012 when he would receive a mental health review;
- Noted Mr B "*fears for safety from others*";
- Noted Mr B had guaranteed his own safety if placed in Pod 2 of Darcy Block or Pod 16 of Hamden Block;
- Noted Mr B had a mental health problem, with a history of threat and ideations, and that he was "*paranoid of others*"; and
- Assessed that Mr B's risk to himself, to others and from others was "low".

An MNF signed by Assistant Superintendent Stephen Tienstra, Ms Cheung and RN Munoz dated 27 August 2012:

- Referred Mr B for routine case management;
- Noted Mr B guaranteed his own safety if placed in Pod 2 of Darcy Block or Pod 16 of Hamden Block;
- Directed Mr B be placed in a two-out cell until 27 September 2012 when he would receive a mental health review; and
- Stated Mr B was "*paranoid of others*".

A HPNF signed by RN Munoz and Assistant Superintendent Tienstra dated 27 August 2012 states:

- Mr B has a history of "*mental issues*";
- Mr B has "*paranoid ideations*";
- Mr B's RIT had been terminated;
- Mr B is "*Cleared to Hamden Pod 16*"; and
- Mr B is to be placed in a two-out cell until 27 September 2012.

As a result of the RAIT review on 27 August 2012, Mr B was placed on a "Green Card". An inmate who is on a Green Card is required to be housed with another inmate ("two-out" in a cell).

Review by Dr Gordon Elliott on 27 August 2012 On *27 August 2012, Mr B was reviewed by Consultant Psychiatrist Dr Gordon Elliott. Dr Elliott did not have access to all of the Justice Health record and had no access to the CSNSW record. Dr Elliott noted Mr B had already retracted his threat of self-harm with a promised move to another pod. Dr Elliott did not consider Mr B was suicidal, and did not consider Mr B required containment in a safe cell. Dr Elliott agreed that Mr B should be transferred back to the Hamden Block.*

Request to remain in the Darcy Block from 28-30 August 2012

On 28 August 2012, Mr B approached Assistant Superintendent Martin Cullen. Mr B asked to remain in the Darcy Block until he was cleared to move to Pod 16 of Hamden Block. Assistant Superintendent Cullen placed an alert on the Offender Information Management System (**"OIMS"**) for Mr B to remain in the Darcy Block until 30 August 2012.

Placement of Mr B in Hamden Block on 30 August 2012

On 30 August 2012, Mr B approached Assistant Superintendent Martin Cullen. Mr B asked to move to Pod 16 of Hamden Block as soon as possible. Assistant Superintendent Martin Cullen spoke to Senior Correctional Officer Evan Panelo regarding Mr B's request to transfer to Pod 16 of Hamden Block. At approximately 12:40pm on 30 August 2012, Mr B was transferred from the Darcy Block to Pod 16 of the Hamden Block. Mr B was placed in a holding cage.

Senior Correctional Officer Evan Panelo:

- Reviewed Mr B's file;
- Interviewed Mr B;
- Reviewed information regarding other inmates housed in Pod 16 of Hamden Block; and
- Decided to place Mr B in Cell 407 with DJ.

Senior Correctional Officer Panelo was assisted at this time by First Class Correctional Officer Jeremy Leighton-Jones. Around 2:00pm on 30 August 2012, Mr B was transferred to Cell 407 and housed with Mr J.

Events of 31 August 2012 to 1 September 2012 - Review of Mr J by psychologist Alita Caon

(2:15pm-3:00pm)

Between 2:15pm and 3:00pm on 31 August 2012, DJ was reviewed by psychologist Alita Caon. Following this review, Ms Caon noted that DJ was housed with Mr B. Ms Caon then informed First Class Correctional Officer Jason Spooner that DJ was housed with Mr B, and noted Mr B had not been charged with a sex offence.

Following Ms Caon's contact with First Class Correctional Officer Spooner, Senior Correctional Officer Peter Wilson and First Class Correctional Officer Spooner reviewed documents relating to Mr B's placement in a cell with DJ and no change was made to the cell placements.

Head-check and lock-in (3:00pm-3:30pm)

Between 3:00pm and 3:20pm on 31 August 2012, Senior Correctional Officer Peter Wilson and First Class Correctional Officer Jason Spooner conducted a "head-check".

Neither DJ nor Mr B expressed any concerns to Senior Correctional Officer Wilson or First Class Correctional Officer Spooner at that time. Cell doors were locked for the night at 3:30pm.

Medication round (7:00pm)

Around 7:00pm on 31 August 2012, Registered Nurse Lauren Lennon attended Cell 407 to dispense Mr B's anti-psychotic medication. Mr B refused the medication.

Night-time disturbances and the death of DJ (12:30am)

During the night of 31 August to 1 September 2012, inmates heard disturbances and cries for help coming from the direction of Cell 407. Around 12:30am on 1 September 2012, inmate JD, who occupied Cell 411, heard someone crying "help me" about four or five times. Mr D heard these words coming from the direction of Cell 407, and believed they were spoken by DJ.

"Knock-up" and response (2:15am-2:45am)

Around 2:15am, inmate TM in Cell 413 heard somebody call out, followed by "*oh no, what have you done?* Mr M then heard somebody say "*He's hung himself. I can't get him down. He's too heavy*". Similar statements were heard around this time by Mr Ms' cellmate PT, and by inmate SM in Cell 412. Around 2:20am-2:25am on 1 September 2012, Corrective Services Officers received an emergency call (referred to as a "knock-up" call) from Cell 407. The call was made by Mr B and received by Corrective Services Officer Jason Baptista.

Corrective Services Officers Jason Baptista, Matthew Loftus, Tulo McDougal, Jason Trench, Chris Kaisa and Aukusitino Aukusitino made their way to Cell 407. They arrived at 2:29am. They found DJ had no pulse but was still warm. Corrective Services Officer Trench used a "911 tool" to remove white cloth material which was tied around DJ's neck.

Nurses Jiliane Sergeant and Natalie Apap also attended Cell 407 attempted cardio-pulmonary resuscitation (**"CPR"**) of DJ. Around 2:40am the nurses decided to cease CPR after determining any further attempt at resuscitation would be futile.

Attendance by Ambulance and Police officers (2:45am onwards)

Around 2:45am on 1 September 2012, Ambulance officers attended the scene and confirmed DJ was deceased. Police officers from Flemington Local Area Command attended from around 3:15am. Detectives from the Corrective Services Investigation Unit attended from around 4:25am.

A Senior Constable from the Forensic Services Group attended from around 4:40am. Detectives from the Homicide Squad attended from around 7:25am. The last police officers to leave the scene departed at 9:40am.

Arrest of Mr B (8:40am onwards)

Around 8:40am on 1 September 2012, Mr B was conveyed from the MRRC to Auburn Police Station. Mr B arrived at Auburn Police Station around 9:30am. Mr B was informed that he was under arrest for the murder of DJ.

Post-mortem examination (6:10am and 1:00pm onwards)

Around 6:10am on 1 September 2012, Forensic Pathologist Dr Istvan Szentmariay attended the scene. DJ's body was removed by Government Contractors around 8:55am.

Around 1:00pm on 1 September 2012, Dr Szentmariay performed a post-mortem examination on DJ's body. Dr Szentmariay found the cause of DJ's death was neck compression. Dr Szentmariay identified other injuries of recent origin which were the result of the application of blunt force.

Criminal proceedings against BB

On 7 May 2013, Mr B was charged with the murder of DJ. Mr B was tried before a judge alone in the NSW Supreme Court in September 2014. The evidence at trial included expert psychiatric evidence that Mr B suffers from a chronic schizophrenic illness and that he was psychotic throughout the majority of 2012 up to and including the time of his arrest in June 2012, especially given his history of treatment resistance. He remained psychotic at the time of DJ's death.

The expert evidence was that Mr B apparently heard voices he took to be from aliens, believed that he would be killed, and was suffering from self-referential thinking, and that Mr B also believed DJ wanted to kill him, despite never having met him before.

The trial judge found that:

- Mr B strangled Mr Jones to death using a power cord from a television in Cell 407;
- This was a deliberate act by Mr B;
- After Mr B strangled DJ, Mr B took steps to try to create the impression DJ had taken his own life; and
- At the time Mr B strangled DJ, Mr B "*held a belief that everyone, including the deceased, was trying to kill him*".

Mr B was found not guilty on the grounds of mental illness.

Scope for recommendations arising from the evidence

Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focusses on the specific lessons that may be learnt from the circumstances of each death. The evidence arising from this inquest, involving two deaths, draws into focus the difficulties medical professionals face in managing acutely mentally ill patients within the correctional environment. Coroners have previously examined some of these issues in relation to the particular needs of inmates at risk of suicide and serious self-harm. This inquest has focussed on the risk to others that some acutely ill inmates may pose.

In hindsight, there were clearly shortcomings in the medical care delivered to both Mr A and Mr B. These involved deficiencies in the level of dedicated psychiatric care they could receive within the prison environment. Mr B, for example was both under-medicated and his non-compliance was not adequately monitored or communicated. Both men may have benefitted from closer supervision had a psychiatrist been available for more frequent review. However, the focus during these proceedings has not been to criticise or single out individual decision makers or practitioners.

It is recognised that the conditions under which all staff work at the MRRC are extremely stressful and at times dangerous.

Staff are under-resourced and need to make clinical decisions with resourcing practicalities in mind. It is accepted that the options they have available for patients are often very limited. The only purpose of reviewing individual decisions in these proceedings is to better understand the conditions and stressors operating at the time with a view to discovering if systems can be enhanced to improve the care provided.

Dr Spencer, forensic psychiatrist and clinical director of custodial mental health employed by Justice Health, explained the difficult decisions medical staff face on a daily basis when discussing her care of Mr Brindley.

"I could have made a different decision on the day I saw him and I feel for colleagues who made the decisions they made but ultimately I don't think there is really an easy solution or an easy answer as to how we could do things better. Safe cells are awful places as well and being in custody is horrible. Being in Long Bay Hospital is pretty horrible and the screening unit is pretty horrible but it's the best we've got. Unless there is a massive overhaul people are going to keep dying either at the hands of their cellmate or because they take their own life. There is no easy answer." It may be that we need to work towards "a massive overhaul" in the long term. In the meantime it is helpful to examine the specific issues identified in the evidence where the need for immediate change is indicated.

The need to stop managing inmates who have an acute mental illness in the general prison population

The background risk factor, which cannot be ignored, is that we continue to house acutely mentally ill prisoners within the general prison population. While it may be possible to house those in remission or with a chronic but not acute mental illness appropriately in the general prison population, it is increasingly clear that the management of all acutely mentally ill prisoners outside a custodial setting would constitute best practice.

There is a related factor relevant to both deaths. The circumstances under which we conduct inmate health screenings may mean that we frequently fail to identify acute mental illness or underestimate its severity. Given the known lack of resources within the system, only the most obviously unwell prisoners will be escalated for immediate care.

The court was assisted by the evidence of Dr Westmore on this issue. Dr Westmore is an eminent forensic psychiatrist who has worked both in the community and in forensic settings both in Australia and overseas. He recommended that that whenever a prisoner is identified as being mentally ill (acute) they should never be managed within the general prison population. He stated "mentally ill prisoners should be transferred to the dedicated forensic hospital facility managed by the Health Department or, as an alternative, they should be managed within a dedicated medical psychiatric section of the general prison system".

Dr Westmore told the court that mentally ill people are over-represented in the prison population when compared to the general population. When managed in prison they are particularly vulnerable. Dr Westmore explained that when they are not managed primarily by health staff their needs may be misunderstood and unmet. It follows that their recovery is less than optimal. He explained that medication is a good example. In the general prison population the taking of medication may not be a priority. Refusal or non-compliance may take time to be reported to a relevant doctor, its significance not properly understood. Perhaps another example raised in the evidence was the routine placement of mentally ill patients with inmates who may have some other need for protection, such as sex offenders. The groups have no natural alliance, except that both may be vulnerable in custody. With hindsight it is clear that Mr B should not have been housed with somebody charged with a sexual offence, it was a situation that properly managed from a medical perspective should not have occurred. However, within the contingencies of a correctional environment it is not unusual.

Dr Westmore described the process of moving acutely unwell prisoners out of correctional settings and into secure hospital care, run by medical staff as the best way forward. He spoke enthusiastically of his experience in the UK, "they've been doing it all over the rest of the world for years." He stated that health staff have demonstrated over many years that proper security can be provided. He told the court "I guess, this is the future and, if we haven't got it yet, we've got to keep moving towards it. We've got to keep moving patients out of prisons and treat them."

The court heard that currently the Long Bay Hospital can treat only a tiny proportion of inmates requiring mental health services. Dr Spencer stated, in her evidence, that the capacity of Long Bay Hospital is 44 beds. The Mental Health Screening Unit (**"MHSU"**) always has a long waiting list, so eligible patients are at times not even put forward for admission. Dr Spencer stated, in her evidence, that as at the date of her evidence there was a waiting list across the state of approximately 30 to 40 prisoners. There is considerable pressure in Darcy and Hamden, where there may be greater access to mental health staff, but where conditions remain unconducive to appropriate medical care. Dr Spencer spoke eloquently of the difficulties of working within the system.

When asked if more beds were needed in units such as the MHSU and Long Bay Hospital she agreed, adding that *"I think it would be even more ideal if we had more beds available in the community, so no patients were ever treated in custody, but as it currently stands all our prisons are full of mentally ill patients and we just don't have the resources to be able to treat them, beds or psychiatrists or mental health nurses or psychologists, our hands are tied."*

The court accepts that to move all acutely mentally ill inmates into hospital care is currently impossible in practice in NSW. The facilities do not exist, nor are there enough appropriate medical staff on hand. Nevertheless, I heard considerable evidence about new custodial building projects currently underway at the MRRC and elsewhere. Long term plans and budgetary allocations are being made. Unfortunately I heard little about projects to build major new health facilities to treat acutely mentally unwell prisoners, despite the demonstrated need.

I am aware that following the *Inquest into the death of JF the* Acting State Coroner O'Sullivan made a recommendation to the Minister for Corrections, the Minister for Health and the Commissioner of Corrective Services that called for a comprehensive review to determine whether the number of beds available for mentally ill patients within the NSW correctional system is currently adequate. That important review is apparently underway and is certainly supported. However at the same time we need to be researching what is possible in the longer term. It may be that it is necessary to reframe and refocus the way we think of mental health treatment in a custodial setting in a much more profound way. Further research is needed. With some regret, I accept that it is well beyond the scope of the evidence before me to recommend an immediate transfer of all acutely mentally ill patients out of the custodial system for treatment, in line with Dr Westmore's suggestion. Nevertheless, there is a strong need for research to ground future planning. It is appropriate to make a recommendation to examine the feasibility and clinical benefits of making significant long term change in this area.

The need to improve information sharing between Justice Health and CSNSW – the HPNF and the RIT/RAIT process

There are very sound reasons for Justice Health to have strong policies around the privacy of health information. Justice Health submitted, and I accept, that effective treatment is supported by providing a forum where open and free exchange of health information between practitioner and patient is protected. It is necessary for the inmate patient to have confidence in the privacy of their exchanges to develop a sound rapport with relevant health professionals.

Justice Health also accept that the right to confidentiality is not absolute, and guidelines already make it clear that information may be disclosed if the relevant Justice Health practitioner forms the view that a custodial patient's mental or physical condition constitutes a risk to the life, health or welfare of another person. I accept that there may be a delicate balance between a patient's right to privacy and the need to disclose sufficient information if a risk of harm is identified. The court was concerned with learning how information sharing between CSNSW and Justice Health currently works and if there are ways of improving that exchange without damaging the therapeutic relationship. If one accepts that large numbers of mentally ill prisoners will continue to be managed in the mainstream prison population, there is a need to have confidence in the methods in place.

Currently, and at the time of the deaths under investigation, the main conduit of information between Justice Health and CSNSW is the Health Problem Notification Form ("**HPNF"**). The policy governing HPNFs, which has remained relatively static between 2010 and 2019, presently states:

"The [HPNF] communicates Justice Health & Forensic Mental Health Network (JH&FMHN) advice and recommendations regarding an adult patient's clinical status to [CSNSW]. This information may concern cell placement recommendation, or possible signs of conditions and illness, such as substance withdrawal, mental health, or patients on blood thinning agents… JH&FMHN clinicians have a duty of care and a statutory duty to advise CSNSW custodial officers of actual or potential "at-risk" health problems. The HPNF is specifically for this purpose. … Relevant signs of symptoms must be expressed in 'lay language' for CSNSW custodial officers."

Where an inmate is in a state of crisis there may be a number of HPNFs created in a short time frame, as the policy for HPNFs requires a new HPNF to be created whenever a patient's clinical presentation changes. For example a Mandatory Notification Form ("**MNF"**) is required when CSNSW suspect an inmate to be at risk of suicide or self-harm and is used to notify the relevant officer in charge of an inmate of that risk. A new HPNF is generated as a result of an MNF.

Once a risk of suicide or self-harm is identified, the inmate will be placed on a RIT (Risk Intervention Team). The Court heard from a number of witnesses that a RIT is a multidisciplinary team with staff from CSNSW and Justice Health responsible for assessing inmates at risk of suicide or self-harm. For historical reasons, RITs at the MRRC are referred to as Risk Assessment and Intervention Teams or "**RAIT**s". A RAIT generally consists of the CSNSW custodial RIT co-ordinator – in this inquest it appears that this role was always performed by an Assistant Superintendent – a CSNSW psychologist or member of Offender Services and Programs and a Justice Health staff member, which at the MRRC is intended to be always a registered mental health nurse. These arrangements appear to have remained consistent from 2010 until today.

The RAIT meet and discuss the risk a particular inmate presents and formulate an agreed risk management plan for the inmate. The plan must have three components:

- consideration of accommodation options;
- observations/monitoring; and
- access to amenities.

The RAIT will also identify specialist or other appropriate referrals as necessary. A new HPNF is generated following the RAIT meeting.

Assistant Superintendent Cullen gave evidence that at the end of a RAIT interview the HPNF issued would be placed in the Justice Health file and a copy on the CSNSW case file and a copy would also go to the officer in the relevant wing so that he knows what type of regime was going to be put in place for the inmate. Assistant Superintendent Cullen gave evidence that the form is used to inform officers who are running the relevant pod of what accommodation was appropriate and what other measures need to be taken to ensure the safety of the inmate.

He gave evidence that although the information on the HPNF was a recommendation it would be followed in 99% of the cases he sees. It is intended that the HPNF will provide information about chronic mental health problems that may be classed as "at-risk" health conditions. It is noted, in this context, that the *Crimes (Administration of Sentences) Regulation 2014* requires a Justice Health officer to disclose certain matters to CSNSW officer as soon as practicable after the Justice Health officer forms the opinion that the mental condition of an inmate constitutes a risk to the life, health or welfare of any other person. Evidence provided by Justice Health states that the HPNF policy is relevant to this statutory requirement.

Close examination of the evidence tendered in relation to the death of Mr J revealed at the time of Mr B's cell placement with DJ, Justice Health held significant information on file which indicated that Mr B was unwell and likely to be a risk of harm to others.

This information included material written by Dr Elliott as early as 2008. Dr Elliott agreed in evidence that the features of Mr B's illness had been consistent between 2008 and 2012. This is not to suggest that all the information was readily available to any individual, but that it existed in Justice Health records.

By the time of DJ's death, Mr B had 12 HPNFs created between 6 June 2012 and 27 August 2012. There was no continuing reference to Mr B's mental health condition and no reference to signs and symptoms that indicated that he was unwell and, as a result, a risk of harm to others, apart from the final HPNF prepared before DJ's death. It is noted that there was an active alert on Mr B's Inmate Profile Document dated 3/9/2012 for serious mental illness - medication – DCS (dated 24/2/2009) but without further information this alert was of little apparent utility. It is also noted that in Mr B's MHSU discharge management plan, which appeared in Mr B's CSNSW file, it is stated that Mr B had a history of "paranoia and may be a risk to others". However, nowhere was it said that *when* Mr B was exhibiting signs of paranoia he may be a risk of harm to others, being key in the context of the features of Mr B's illness.

There are two aspects of the events leading up to DJ's death that demonstrate the importance of information about the features of Mr B's illness being readily available to CSNSW officers. Firstly, at the RAIT meeting on 23 August 2012, Mr B was unable to be persuaded that he would be safe where he was housed at that time. Assistant Superintendent Cullen accepted that this presentation to the RAIT would have demonstrated that Mr B was extremely unwell had relevant background information regarding the symptoms of Mr B's mental illness been available, but did not accept that it would have made a difference to the RAIT decision. Ms Cheung gave evidence that it was "very likely" that the RAIT decision would have been affected by background information about Mr B's illness, given his presentation. Secondly, the decision to place Mr B in a cell with DJ is likely to have been affected by the availability of more information about Mr B's history. Mr Wilson gave evidence that had he and other officers involved in the decision about where to place Mr B had access to information about Mr B's mental health, they may well have changed their decision as to whether he was suitable to be housed with a sex offender – DJ had been charged with sexual offences.

In particular, Mr Wilson gave evidence that information about Mr B's non-compliance with medication would have been significant to him, but only if he had also had information about Mr B's pattern of functioning relatively normally while on his medication and then slowly deteriorating into a world of paranoia and delusion when he stopped his medication. While Mr Wilson said in evidence that he understood the need for patient privacy, he also considered that it was important that CSNSW officers be provided with information about a person's health needs that, in the opinion of those treating them might cause that person to be a risk of harm to others. He did not understand – perhaps incorrectly – that the HPNF was the form by which that information could have been provided to him but he specifically identified information about non-compliance with medication as being something that officers would like access to.

Consistent with Mr Wilson's evidence, the CSNSW internal report into DJ's death commented that CSNSW officers are provided with little information as to an inmate's medical history or current conditions, noting that once an inmate is cleared for placement by way of HPNF, officers have to house and manage them accordingly.

Mr Rec gave evidence that there was no reason to put information about the nature of Mr B's illness or lack of treatment, such as symptoms, onto an HPNF. However, Mr Rec subsequently gave evidence that information about the features of Mr B's illness, such as that it was characterised by paranoia of harm from others, is information that should be on an HPNF.

Dr Elliott gave evidence that information of that kind was information that he would expect to see on an HPNF, albeit very succinctly stated. He also gave evidence that, to the extent that Mr B's illness indicated that it was contrary that he be put in a cell with a sex offender that information would be provided to CSNSW through the HPNF. He gave evidence that the HPNF would carry forward because it is retained at the front of CSNSW case files, but acknowledged that the information would not remain on each subsequent HPNF, as they change. Dr Elliott gave evidence of his opinion that information - such as information about the features of Mr B's illness - that are consistent over time as a concern should carry over from HPNF to HPNF.

Dr Westmore gave evidence that he considered that it was important that Justice Health provide CSNSW with information about whether or not an inmate is taking their anti-psychotic medication in order to assist in determining cell placement. Dr Westmore also gave evidence that Mr B's history meant he should not have been housed with a sex offender. The evidence set out above suggests that a change to policies and practices governing information sharing between CSNSW and Justice Health may be appropriate. It appears from the evidence that it may be that the HPNF is the correct mechanism by which such information can be provided to CSNSW, but that that it was not being used in that way in Mr B's case.

A change to the current HPNF policy may be required to make this function of the HPNF clearer than it currently is, and some mechanism may need to be added to ensure that signs and symptoms of chronic, relevant health problems are carried over from HPNF to HPNF. If that is not possible, it may be necessary to create an alert system that includes relevant health information, such as that outlined above.

Given time and resourcing constraints in the custodial environment, these changes are likely to be more achievable than requiring the preparation of a discharge summary each time an inmate is moved from place to place within custody, as recommended by Dr Westmore. I note that CSNSW does not oppose examining ways to improve information sharing through the HPNF. While Justice Health was concerned to stress the importance of patient confidentiality, it agreed that effective communication between custodial staff and health staff should be encouraged.

Counsel for Mr B urged the court to consider a recommendation which would require CSNSW to "develop a specific process to assess the risk of harm of an inmate to others, including the risks posed by inmates with mental health issues, which take account of historical information held by CSNSW, including any records of segregation". I presume the specific process in mind would take into account information contained on the HPNF, but also require an officer to review information on the CSNSW system, including records in relation to segregation, and then independently assess "risk of harm". I have considered the proposal carefully and am concerned it could confuse the task correctional officers must undertake. The primary focus in relation to "risk of harm to others" should be the HPNF. I have not been convinced that segregation records would necessarily assist given the varied reasons for segregation.

Counsel for Mr B urged that a further recommendation in relation to the RAIT/RIT process be directed to reviewing whether inmates on an MNF in Darcy are currently being assessed every 24 hours by a RAIT. While I consider this best practice and in line with stated policy I have decided that the recommendation is not directly relevant to the deaths before me.

The need to improve conditions for Justice Health staff and visiting doctors

It became clear during the inquest that information sharing is only possible if it is efficiently stored and available to the nurses, general practitioners and psychiatrists who may need to access it. Staff must also be provided with an environment which is conducive to gathering information. If inmates are seen in chaotic or degrading circumstances it will be difficult to establish rapport and commence effective treatment. A number of information issues were revealed during the inquest.

Record keeping

Difficulties with the evidence-gathering process in respect of Mr B's Justice Health files during the inquest means that it is not possible to say with any certainty what information was available to Justice Health staff at any given time. Nevertheless, there was evidence that notes and/or other parts of Mr B's files were often unavailable to Justice Health staff (including during a RAIT meeting). Dr Spencer gave evidence that when assessing and/or reviewing a patient the psychiatrist undertaking the assessment would often not have access to a patient's notes, or if they did, generally just to the most recent volume. Ms Munoz gave evidence that she did not have access to any of Mr B's files other than the most recent volume during the RAIT meeting. Mr Rec also gave evidence that he would generally only have the most recent part of a patient's file with him for the purposes of a RAIT interview.

It is also noted that Mr Rec recorded in the notes for the RAIT interview of 23 August 2012 that *"Old notes not available. CS New South Wales file in MHSU - D/C MHSU"*.

Mr Trevor Perry gave evidence by way of a statement that consent to obtain information from each patient's community health provider is requested on reception. If consent is given, the release of information (ROI) form is scanned and emailed to an ROI coordinator on completion of the reception screening assessment. This form is then sent to community health providers by ROI clerks at the MRRC. When the information is received from the community provider it is scanned into the Justice Health electronic Health System [JHeHS] and a waitlist appointment is made in the Patient Administration System for review by a clinician. The health information in JHeHS is available to all clinicians and can be viewed at any stage.

It is unclear to what extent RAIT members and assessing clinicians currently have access to the JHeHS at the time of performing assessments. The evidence on access to computers was not entirely clear. Assistant Superintendent Tienstra gave evidence that Justice Health staff have access to a computer in the RAIT area. Mr Rec gave evidence that a mental health nurse performing a mental health assessment may not always have access to a computer to check the JHeHS. However, Dr Elliott gave evidence that he is never in a situation where he is conducting a mental health assessment of a patient without access to a computer.

Governor Woods provided evidence that a computer was installed in the RAIT interview room for custodial staff in May 2011 and whilst there is also a Justice Health Computer in the RAIT interview room that provides access to Justice Health specific platforms, he was not sure when it was installed. It is also unclear whether the current JHeHS system provides for easy access to summary information such as discharge summaries in one central location where it can be easily reviewed by busy clinicians. In the absence of this information, it is difficult to make specific recommendations in this regard. However, it is clear that a lack of access to this information was relevant to the events leading to DJ's death.

Accordingly, a recommendation related to ensuring that such information is easily and quickly available is appropriate. A different information management issue was raised in the RP inquest. Dr Dall gave evidence that had information about Mr A's engagement with mental health services in the community been available to him at the time he conducted his assessment of Mr A in 2010, it may have made a difference to the course he took, however he could not say whether it would have been significant enough to have caused him concern about Mr A being required to be placed in a cell with another person. In any event it was not available at the time. It is acknowledged that resources to chase community information can also be scarce.

Medication charts

The court heard that access to medication charts was less than optimal. Dr Spencer gave evidence that both in 2012 and today an assessing psychiatrist may not have access to a patient's medication chart. Access to medication charts was, and is, particularly difficult in Darcy because medication charts are stored in the main clinic, which is some distance from Darcy, as was seen during the view of the MRRC.

Dr Spencer gave evidence that lack of access to medication charts means that practitioners cannot see the medication that a patient has been on or whether they have been taking it. Instead the practitioner is reliant upon a self-report. Ms Munoz gave oral evidence in the DJ inquest that Justice Health nurses participating in RAITs did not look at the medication charts, and did not have them available to them. In response to questions by Mr B's legal representative, Ms Munoz said that the RAIT team never, ever had access to medication charts. However, she agreed that it would have been good to have had access to the medication chart when performing the task of the RAIT. She gave evidence that if she had had access to the medication chart in this case, and it had indicated that Mr B had not taken his medication six times in the fortnight before he was seen by the RAIT, she would have told a psychiatrist straight away and would likely have told the other members of the RAIT team.

In the RP inquest, Ms Freeman gave evidence that members of the RAIT team did not have access to medication charts from within MRRC. Mr Rec gave evidence in the DJ inquest that in Darcy medication charts are kept in the main clinic and that they were not available to RAITs in 2012. Mr Rec gave evidence that access to the medication chart allows an assessment to be made of whether or not a patient is a good or bad historian. For example, Mr B had reported that he had been compliant with his medication, however his medication chart indicated that he had not.

Mr Rec gave evidence that this was significant as it indicated that this would demonstrate that Mr B was a poor historian and that you could not believe everything that he said. Mr Rec gave evidence that had he had the information from the medication chart that demonstrated that Mr B was non-compliant with his medication, he would have shared that information with the other members of the RAIT team. Perhaps most concerning, Dr Elliott also gave evidence that he did not have access to Mr B's medication charts when assessing him in 2012. In oral evidence he said that it was common not to have access to medication charts, describing it as "routine". Dr Elliott said that this was a problem in Mr B's case because it meant that he was unable to see that Mr B had been refusing his antipsychotic medication.

He gave evidence that the refusals indicated on Mr B's medication chart were significant in that they would have demonstrated to him that Mr B was non-compliant and that the idea of increasing his medication was redundant or ineffective. When asked whether that information would have weighed heavily enough that it may have affected the outcome of his decision on the day that he assessed Mr B he responded *"I mean it's fundamental when you have got someone who, I think, has got a psychotic illness that is not taking any psychotic medication"*. Dr Elliott gave evidence that lack of access to medication charts was a problem which needed to be fixed, but that this was nearly the case in that access to an electronic medical record would solve the problem, which he understood was coming to Justice Health. There can be little doubt that lack of access to Mr B's medication chart was significant in the DJ inquest. It is unacceptable that psychiatrists such as Dr Elliott are routinely assessing patients in the absence of information as fundamental as that recorded on medication charts. Until electronic medication charts are available, urgent action ought to be taken to ensure that medication charts are available to assessing clinicians and Justice Health staff members participating in a RAIT.

I note that Justice Health did not support a recommendation in this area. Justice Health maintains the most effective way of addressing multi-point access to medication charts is an electronic Medication Management (eMM). This may very well be the case, but it is some years away from implementation. Justice Health also observed that coronial recommendations made subsequent to the death of DJ and RP have been targeted at training in relation to medication administration requirements. This is to be applauded. However, I remain of the view that medication charts should be available to RITs/RAITs and to mental health nurses and psychiatrists conducting mental state examinations. If this cannot be achieved through an electronic system for some years, a temporary solution must be found.

Physical environment

In his statement dated 17 August 2018, Dr Elliott described the environment where assessments were conducted in Darcy in 2012 as follows:

"The table [where assessment were conducted in 2012] is surrounded by the safe cells with their heavy Perspex doors. The cells themselves were noxious environments, being noisy both day and night, and pungently malodorous as a result of particular inmates smearing urine and faeces all over the walls, door and camera units, or flooding the cells with water from the toilet.

Also, there was usually a small number of protection inmates circulating in this area hence there was minimal privacy. The assessments also frequently had to take place amidst the shouting and banging of inmates in the safe cells demanding to see the psychiatrist."

Dr Spencer gave evidence about the area in which RAIT assessments and mental health assessments are conducted in Darcy. She agreed that Dr Elliott's description of the environment in his statement was consistent with her own experience. Assistant Superintendent Tienstra gave evidence that the area is always noisy, extremely noisy, with yelling, screaming abuse and a constant smell.

Dr Elliott gave evidence orally that the environment in Darcy would be considered abhorrent in a mental health unit of a public health hospital where mental health assessments are undertaken, and this environment impedes an ideal mental health assessment. Dr Westmore gave similar evidence about the effect of a noisy environment on an ideal mental state examination.

Ms Freeman described the physical environment as at the MRRC in 2010 as being a very difficult environment to work in. Assistant Superintendent Lockwood described the environment where the RAIT interviews are conducted as "putrid". He gave evidence about the noise in the area and said that it does make it hard to do the task he is required to do in the RAIT, with the banging and the screaming.

Mr Evans gave evidence that in 2010 the environment where the RAIT's were conducted was not a professional environment, not least because it was hard not to be distracted by the noise and other distractions such as views out into the wing where there were semi and sometimes fully naked people in the cells. Mr Evans gave evidence that he has since transferred to another correctional centre where there is a professional interview room which provides the person being interviewed with dignity – they come to the room and sit down in an office space.

Specifically, he described the first RIT interview that he conducted at Cessnock Correctional Centre, being a maximum security environment, as being like a job interview in a professional environment with a desk and computers. Evidence was received from CSNSW that a building project is currently underway at the MRRC. Specifically, Mr Wayne Taylor, General Manager of the Prison Bed Capacity Program, identified key infrastructure and construction enhancements as follows:

4x110 modular cell blocks, which includes interview and medical dispensary rooms within the block; Satellite Health Centre, being a health centre situated in close proximity to the new accommodation to provide health services to the 440 bed expansion; and

Offender Services and Programs Building (OS&P), which includes the construction of a building located in close proximity to the new accommodation blocks to provide OS&P to the expanded beds. It was submitted by CSNSW, at the close of the inquest, that this evidence indicated that there would be sufficient accommodation and separate interview rooms to allow for the maintenance of privacy and dignity of inmates. However, in my opinion it is unclear from that evidence whether there are plans to build any new areas specifically for the purposes of RAIT interviews.

If that is not currently intended, it is appropriate that it be considered, given the evidence heard in these inquests, and the example provided by Mr Evans of RAIT interview spaces that provide dignity to the inmates involved.

The need to reduce pressure on medical and correctional staff at the MRRC

It is abundantly clear that there was and continues to be enormous pressure to move inmates through the reception area at MRRC. This pressure operates negatively.

Governor Woods provided evidence:
"MRRC is the largest centre in NSW with a maximum capacity of over 1199. It has the largest number and proportion of remand inmates in the state. The MRRC is the main reception for NSW receiving over 40 percent of all new receptions into the correctional system. The inmates are received from NSW police and courts."

Dr Spencer gave evidence that there is huge demand on cells in the reception area in Darcy at the MRRC, because there are patients waiting in police cells to come into custody, so both Justice Health and CSNSW staff are very keen to move people out of Darcy as soon as possible. She described there being "huge pressure on Darcy". Dr Spencer also gave evidence that the section of Darcy that is subject to clearance pressures is also the section of Darcy that inmates who are placed on an MNF/RAIT are sent to. Dr Spencer also gave evidence around huge pressure on beds in the MHSU and in Hamden pods 17/18, both in 2012 and today. Dr Spencer also made reference to CSNSW officers being under pressure to make sure there is enough room for new inmates.

Assistant Superintendent Cullen gave evidence that those in the system are under pressure to move inmates around, particularly out of Darcy. He indicated that because Darcy is a screening area for inmates it was necessary to process inmates to make way for the next incoming inmate, so an attempt is made to move inmates as quickly and easily as possible to the other areas of the MRRC.

Assistant Superintendent Cullen also gave evidence that there was pressure to make one-out cells available, as there were very few one-out cells at the MRRC. Assistant Superintendent Cullen gave evidence that these pressures influence the RAIT decision-making process through unintentional pressure placed on Justice Health nurses to clearly look at an inmate's placement and to make sure that an inmate really needs to be placed in a one-out cell.

Ms Cheung gave evidence that pressure on bed space in Darcy and elsewhere was something she was aware of and that, as at 2012, while an attempt was made not to allow it to affect the RAIT decision making process, in her view, it was inevitable that it impacted in some way. Assistant Superintendent Tienstra gave evidence that there was always pressure to move inmates on because of the numbers and, while management never gave instructions to clear someone if he wasn't comfortable to do so, he also knew if one inmate was cleared there were two more waiting to come in. He also gave evidence that the pressure is much worse now than it was in 2012. Ms Munoz gave evidence that there was always pressure to clear cells because police cells are full.

Mr Evans gave evidence that in 2010 there was an underlying pressure to clear inmates from Darcy and that he recalled being asked the question "how many did you clear today?" He also indicated that it was not unusual to hear about the pressure on the system directly, for example by hearing that all of the safe cells were full and that there were a large number of inmates at Surry Hills Police Station waiting to come to the MRRC.

Ms Freeman gave evidence that there was pressure upon all services within the system to clear people, and that if you did not clear people, others were sitting in police cells, which was a worse environment than being at the MRRC. She gave evidence that the pressure had no bearing for her in terms of the RAIT decision making process. However, she did say that she left Justice Health in 2011 because she was seen as being someone who was very cautious who did not like to clear people and did not like to put people in a normal cell placement, and was often reprimanded for that. She gave evidence that she was concerned that she was fairly newly qualified to mental health and had not had the opportunity to observe or have any formal orientation and that she got to the point where she felt that she was unable to work in an appropriate manner and for that reason left Justice Health.

Assistant Superintendent Lockwood gave evidence that there was pressure to clear the safe cells in 2010 as beds were needed and there were no vacancies. Mr Rec gave evidence that there was a demand for safe cell beds in Darcy because they were very overcrowded and if they block up in Darcy they will block up in Surry Hills Police Station. The only effect that Mr Rec identified this may have had on the RAIT process was officers verbalising that they needed to get a particular inmate out of a safe cell. Mr Rec appeared to say that this pressure was continuing when he retired in 2017.

Dr Elliott gave evidence that pressure for one-out cells was "always lurking over all of us in our decision-making", that there is just not that many one-out cells and so decisions are being made based on practical considerations. Dr Elliott said in oral evidence that his role as an assessing psychiatrist in Darcy was "really to keep Darcy moving". He said that the current situation was no better than it was in 2012 in fact it is currently worse.

He told the court:

"there's 50 people on the waiting list for the screening unit and its taking weeks to get in there. So those people are now languishing in regional gaols without regular psychiatric care and amongst those are seriously mentally ill or alternatively, they're backed up in Surry Hills Police Station with nothing. So there are practical considerations that you need to consider about where these people go and that's only gotten worse since 2012. It's – you know, going back to Darcy, a few weeks ago it's significantly worse."

The "Visual Management Board" in Darcy, indicating the daily inmate intake and movement of inmates, including a daily target for number of inmates to be cleared, seen during the view of Darcy at the MRRC, provided a stark visual representation of the pressures described in the evidence above. Dr Westmore gave evidence that while witnesses who referred to the pressure to clear beds in Darcy indicated that it had not affected their decision-making processes, in his view, that pressure had obvious potential to compromise care.

Dr Westmore also characterised this as a professional risk due to the chance of making rushed or incorrect decisions because of pressure to move people on.

In the *Inquest into the death of JF*, Acting State Coroner O'Sullivan made a recommendation to the Minister for Corrections, the Minister for Health and the Commissioner of Corrective Services that:

"CSNSW and Justice Health, undertake a review to determine whether the number of beds available for the treatment of mentally ill patients is adequate for the demand for such beds by those in the NSW correctional system and whether additional beds may be provided for those who are mentally ill and in need of various levels of mental health care. This review should include inpatient, step-down and low acuity beds Statewide."

Evidence was received in the present inquest that this recommendation was considered at the Management of Deaths in Custody Committee Meeting on 25 September 2018 and that it would be considered at a Joint Senior Level Working Group between Justice Health and CSNSW, which first met on 27 February 2019. There was also evidence that as at 27 February 2019, a briefing note, together with a draft letter prepared by CSNSW to the Attorney General was under consideration by the Minister for Corrections, in relation to the implementation of a number of coronial recommendations, including those of Acting State Coroner O'Sullivan in the *Inquest into the death of JF*.

A review of the kind recommended Acting State Coroner O'Sullivan is supported in light of the evidence in the present inquest. However, the evidence in this inquest went to the particular pressure to clear inmates from Darcy generally, including inmates in Darcy who were there for mental health purposes. For example, Mr Green stated that resourcing issues arising from mental health and/or primary health can result in "inmate blockage" and Darcy being "jammed". In these circumstances a recommendation specifically directed to a review of the availability of cells and resources in Darcy is appropriate.

It may be that any such review could be conducted with the review recommended by Acting State Coroner O'Sullivan, assuming that review has not commenced since the recommendation was considered on 27 February 2019.

Submissions provided by Justice Health at the conclusion of proceedings urge against a recommendation aimed at specifically reviewing the need for assessment cells and other resources at the MRRC. It states "CSNSW has confirmed that 50 additional assessment cells will be made available within the 440 bed expansion to the MRRC due to be delivered in March 2021.The Network will continue to work collaboratively with CSNSW to develop a service model for those additional beds". It was submitted that this and the possibility that improved patient flow systems may be developed should allay concerns. The submissions provided by CSNSW at the conclusion of the inquest also argued that such a recommendation was unnecessary because, in view of the expansion project at MRRC, "the desired outcome had already been achieved". It was further submitted that the Commissioner had already identified the pressing need for expansion, which will include an increased number of assessment and other cells. In this regard, I note the following evidence of Mr Wayne Taylor, General Manager, Prison Bed Capacity Program, CSNSW:

"The project scope considered the management of at-risk prisoners with an increase of 55 CCYV monitored beds. The exact design as to how many of these beds will be assessment as high risk or step down moderate risk is still under review as part of the final project development".

I have considered the matter carefully and my concerns remain. In my view the situation is urgent. Numerous witnesses discussed the terrible pressure within the system, which meant that inmates were backed up in police cells and arrived at MRRC to experience further overcrowding and delay. Access to medical services can involve long waiting times and the options remain limited. Changes to the physical environment in 2021 may improve the current situation, but more needs to be done and sooner.

Conclusion

One must not forget the violent and frightening deaths these two men must have suffered while living under the care of this State. While the deaths under investigation occurred some years ago, the background pressure which affects cell placement decisions and the medical management of mentally ill patients appears to remain today. In my view it is a significant problem.

I offer my sincere thanks the many witnesses who came to court and relived difficult events and decisions. I was enormously impressed with medical professionals and custodial staff who spoke with great openness about the conditions in which they work and the difficult decisions they face. The transcript may not reflect the palpable sense of despair some witnesses communicated when describing trying to treat patients in such degrading and stressful conditions. I thank them for their honesty.

Findings

The person who died was DJ

Date of death

He died on 1 September 2012

Place of death

He died at cell 407 of Pod 16 of Hamden Block at the Metropolitan Remand Centre (MRRC) in Silverwater, NSW

Cause of death

He died from neck compression.

Manner of death

He died of injuries inflicted by his cellmate.

RP

The person who died was RP

Date of death

He died on at some time between 3.25pm on 23 April 2010 and 6.15 am on 24 April 2010

Place of death

He died at cell 108 of Pod 10 of Pod 10 of Fordwick Block at the Metropolitan Remand and Reception Centre (MRRC) in Silverwater, NSW.

Cause of death

He died from fatal pressure to the neck. An autopsy revealed extensive haemorrhage of the soft tissues of the neck with fractures of the hyoid bone and cricoid cartilage

Manner of death

He died of injuries inflicted by his cellmate

Recommendations pursuant to section 82 *Coroners Act 2009*

To the Minister for Corrections, Justice Health and the Commissioner of Corrective Services

A review be carried out urgently of the need for assessment cells at the MRRC and the extent to which a lack of access to such cells and other resources for assessment including health services provided for the purposes of assessment, are delaying the intake of new inmates.

That consideration is given to conducting research into the feasibility and clinical benefits of treating all acutely mentally ill inmates in NSW in a secure health facility rather than in the general prison population

To the Minister for Corrections and the Commissioner of Corrective Services

As part of the building project currently being undertaken at the MRRC the creation of a new space to conduct RAIT assessments and mental state examinations be considered, such space to be appropriate for the proper conduct of RAIT assessments and mental state examinations.

To Justice Health

Steps be taken to ensure that inmates' medication charts are routinely available to RITs/RAITs and mental health nurses and psychiatrists conducting mental state examinations of inmates.

File keeping practices be adjusted to ensure that discharge summaries received through the request for information process be collated and held together in one part of the file and that this part of the file be moved from any closed volume of a file into any new volume of a file opened so as to be easily accessible to those conducting mental state examinations and RITs/RAITs.

To the Joint Working Group between Justice Health and CSNSW

Existing policies governing the exchange of information between Justice Health and CSNSW be amended to ensure that health information relevant to an inmate's risk of harm to others be included on the HPNF, or some other form, and that this information remain current and available to any CSNSW officer making cell placement decisions.

Following any amendment, consideration is given to implementing training for staff involved in the RIT/RAIT process in relation to purpose of the HPNF

3. 381722 of 2015

Inquest into the death of David DUNGAY. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 22nd November 2019.

Introduction

On 29 December 2015 David Dungay was housed as an involuntary patient inmate within a mental health unit at Long Bay Hospital in Long Bay Correctional Complex. David was serving a custodial sentence and was due to be considered for parole on 2 February 2016. David had been diagnosed with chronic schizophrenia, was acutely psychotic and had a longstanding history of type I diabetes which was poorly controlled.

During the afternoon, David retrieved some rice crackers and biscuits from his belongings, returned to his cell, and began to eat them. Nursing and correctional staff within the ward where David was housed expressed some concern about this, given David's elevated blood sugar levels which had been measured earlier that day. Requests were made of David to return his biscuits and crackers. David refused to do so.

This resulted in David being forcibly moved by correctional officers from his cell to a different cell so that his condition could be observed. Less than 10 minutes after the cell move began David suddenly became unresponsive whilst being restrained in a prone position. Resuscitation efforts were commenced but were unsuccessful. David was pronounced deceased a short time later.

Why was an inquest held?

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

By depriving a person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an objective inquiry, that the State discharges its responsibility appropriately and adequately. As David was in lawful custody at the time of his death an inquest into his death is mandatory.

Further, the events of 29 December 2015 and the circumstances surrounding David's death raised a number of questions about the manner of his death. The inquest sought to explore key issues related to these questions, and whether any factor contributed to David's death. The purpose in doing so is not to attribute blame to any person or organisation, or to penalise or punish any person or organisation. These are concepts that are incongruous with the purpose and functions of the coronial jurisdiction. Rather, the purpose is to identify deficiencies or shortcomings of a broader, systemic nature so that, with the benefit of hindsight and appropriate reflection, lessons may be learned and opportunities for improvement identified.

It should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process is very much a public intrusion into what would otherwise be a very private and personal experience for members of our community.

However one of the fundamental principles underlying the coronial process is that it is an independent and transparent. Another fundamental principle is that a coronial process seeks to identify in a public forum health and safety issues which may affect the broader community at large. It should also be acknowledged that the closing of an inquest represents the end of a legal process where a family of a deceased person has come into contact with the coronial system. The end of that process represents the conclusion of a confronting, arduous, and distressing chapter following the death of a loved one. It should be recognised that long after the conclusion of an inquest, the sorrow and immeasurable loss experienced by families will continue to endure.

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

David's life

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

David was born in Kempsey at Old Burnt Bridge Reserve, the youngest son to his mother, Leetona Dungay and his father, David Hill. David had two older half siblings, Christine and Ernest, and a younger sister, Cynthia. On his father's side, David had five half-siblings: Janeeka, Jakiah, Jivarhn, Janessa and Jehziac. David's mother described him as a proud Dunghutti warrior.

David enjoyed sports as a child. He played rugby league at a young age for the Sharks club in Port Macquarie, and later continued playing in Kempsey. David initially attended Melville High School in Kempsey before transferring to a vocational college in South Kempsey where he later obtained his Year 10 School Certificate. David's family were extremely proud of his achievement.

Despite the challenges faced by early school leavers to secure employment in Kempsey, David was determined to do so. After leaving school David successfully found casual work with a government funded program for Aboriginal youth. His mother describes David at this stage in his life as simply a lovely young man growing into his independence.

David's family knew him to be happy-go-lucky, kind and loving. He had a talent for writing poetry and an ability to convey enormous meaning with his poems. David was extremely loyal and dependable, willing to give up his own time for his siblings, and to always be there for them when they needed him. At the conclusion of the evidence in the inquest it was most distressing to hear the words spoken by some of David's siblings and how his separation from them has caused so much grief and pain.

David's sense of family, and his bonds with those closest to him, only serves to emphasise how much he is missed and what his heart-rending loss means to those who loved him most. For his family to lose David at a time where, in his mother's words, he was ready to return home and simply be with his family is indeed most tragic.

4. Background to the inquest

The inquest began on 16 July 2018. There were an initial 10 days of hearing concluding on 27 July 2018. The matter was then adjourned part heard to 4 March 2019, with an additional five days of hearing concluding on 8 March 2019.

At the conclusion of the evidence the matter was adjourned for findings to be delivered, with a timetable set for the filing of submissions by Counsel Assisting and the various interested parties. A number of applications were made by Counsel Assisting and some of the interested parties for the timetable to be extended. These applications were granted resulting in postponement of the original date for findings to be delivered.

A total of 31 witnesses were called throughout the course of the inquest, including the following expert witnesses:

Associate Professor Mark Adams, cardiologist;

Dr Kendall Bailey, forensic pathologist;

Professor Anthony Brown, emergency physician;

Dr Thomas Cromer, endocrinologist; and

Mr John Farrar, consultant forensic pharmacologist.

David's custodial history

After leaving high school David began coming under the notice of the local police in Kempsey. David was charged with a serious robbery offence relating to a home invasion that occurred on 23 November 2007. He was also charged with an aggravated attempted sexual assault offence in relation to an incident on 19 January 2008. Further, he was charged with an offence of assault occasioning actual bodily harm in relation to an incident on 21 January 2008. On 22 January 2008 David was received into custody.

David later pleaded guilty to the robbery in company offence, and was convicted of the sexual assault and assault occasioning actual bodily harm offences. He was sentenced in the District Court on 26 June 2009. David later appealed against his conviction in relation to the aggravated attempted sexual intercourse offence and the Crown appealed against his sentences. On 13 May 2010 the New South Wales Court of Criminal Appeal dismissed the conviction appeal and allowed the sentence appeal. The effect of this was that David received an overall sentence of nine years and six months with a non-parole period of five years and six months. This meant that David was eligible for parole on 20 July 2014.

During the period from 2008 to 2015, David was housed at a number of different correctional centres across New South Wales. He was initially housed at Mid-North Coast Correctional Centre before later being transferred to Junee Correctional Centre, Parklea Correctional Centre, Lithgow Correctional Centre, the Metropolitan Remand and Reception Centre (**MRRC**) at Silverwater, the Metropolitan Special Program Centre at Long Bay Correctional Centre and the Long Bay Hospital at Long Bay Correctional Centre. On 25 November 2015 David was transferred to G Ward in Long Bay Hospital. David was initially housed in a camera cell. However following a recommendation made on 30 November 2015, David was later moved to a non-camera cell.

On 14 September 2009, following sentencing, David was classified from A2 Maximum Security to C1 Minimum Security. On 14 January 2013 David was reclassified to B medium security following a number of aggressive episodes. On 18 June 2013 David was reclassified as A2 maximum security following an assault of a Correctives Services New South Wales (**CSNSW**) officer at Long Bay Hospital. This classification was subsequently reviewed several times and remained unchanged until David's death.

On 12 March 2014, David was informed that he was not recommended for parole by Community Corrections because of his failure to engage in programs to address his offending behaviour. On 29 May 2014 the State Parole Authority (**SPA**) refused David's application for parole. David sought a review of that decision but it was confirmed by the SPA on 3 July 2014.

On 21 May 2015, the SPA deferred consideration of David's parole to 30 July 2015 so that a further Community Corrections report and a psychiatric report could be obtained. On 13 August 2015 the SPA further deferred consideration of parole to 26 November 2015, so that a supplementary Community Corrections report could be obtained.

On 30 November 2015, the SPA again refused parole on the basis that David needed to complete a program to address his offending behaviour and needed to undergo a psychological assessment. The parole application was due for further consideration on 2 February 2016.

David's physical health history

David had a lengthy history of type I diabetes. It was first diagnosed when David was five or six years old. He required daily injections of insulin as part of his diabetic management. Whilst in custody these daily injections of insulin continued. During the latter part of 2015, he was being treated with three injections per day of Novorapid, a fast-acting insulin, as well as one injection of Lantus, a long acting basal insulin analogue, at night.

Management of David's diabetes whilst in custody proved to be challenging at times. From 2010 David was known to experience periodic seizures related to episodes of hypoglycaemia which required treatment from Justice Health & Forensic Mental Health Network (**Justice Health**) staff. Some of these seizures resulted in David being transferred to hospital. As a result, by December 2015, alerts within the CSNSW electronic records noted that David had very uncontrolled diabetes, numerous hypoglycaemic episodes, and required strict monitoring. There is also evidence that David experienced hyperglycaemic episodes, albeit on a less frequent basis, although there is no evidence to indicate a David suffered any serious physical effects as a result of these episodes.

The available records indicate that at times David was non-compliant with treatment for his diabetes. For example records indicate that in September 2013, when David was housed at Lithgow Correctional Centre, there were instances when he did not attend a Justice Health clinic to receive his insulin injections. On one occasion David was questioned by a Justice Health nurse regarding his non-attendance to receive insulin. David indicated that he had difficulty getting out of bed because of low blood sugar.

The records also indicate that at other times David intentionally circumvented management of his diabetes. It appears that David was motivated by an intention to self-harm when he did so. For example: On 11 June 2012 David attended the Justice Health clinic at Junee Correctional Centre and drew a large dose of insulin and injected himself with it when he was unobserved by Justice Health staff;

Records from 19 January 2013 indicate that when David was asked about his frequent low blood sugar levels he voiced suicidal ideation and confirm that he was deliberately sabotaging his diabetic management; On 26 January 2014 David suffered a fall, due to low blood sugar levels, whilst at Lithgow Correctional Centre. David's condition deteriorated into a diabetic coma, requiring the attendance of an ambulance. David subsequently indicated that he had been non-compliant with his insulin regime.

From 25 November 2015 through to 29 December 2015, David experienced frequent fluctuations in his blood sugar levels. In the period immediately before 29 December 2015, David's blood sugar level remained unstable and was more often elevated.

David's mental health history

Available records indicate that David was admitted to Kempsey District Hospital as an involuntary patient on 7 March 2005 after a community diabetes worker expressed concern about his unusual behaviour. During this admission David was described as appearing agitated, confused, aggressive and requiring sedation. It appears that David was diagnosed as suffering from a brief, limited psychotic episode requiring treatment with antipsychotic medication. There is also evidence of David being involuntarily admitted to Taree District Hospital in 2005, however the details of this admission are not known.

During David's initial period in custody in 2008 and 2009 he was seen by a number of psychiatrists. No diagnosis of a major mental illness or mood disorder was made although David's history of alcohol and cannabis abuse was referred to in the context of emergent antisocial behaviour. Whist in custody it became apparent to David's treating clinicians that he suffered from psychosis. This manifested itself in the form of behavioural issues in David's interactions with CSNSW and Justice Health staff, aggressive confrontations with other inmates. David also exhibited self-harming behaviour. In January 2010 it was noted by a psychiatrist, Dr Richard Furst, that David reported previously hearing voices that told him to harm himself. However at the time of Dr Furst's review David denied hearing any voices or having any feelings of paranoia. Dr Furst concluded that David had depression with psychotic features and noted that treatment with the anti-depressant mirtazapine had brought about some improvement. However by mid-2010 David had become non-compliant with the prescribed mirtazapine.

Dr Furst considered that it was likely that David had an underlying psychotic disorder and recommended treatment with antipsychotic medication. However David declined such treatment. It appears that David's mental health worsened in 2013. In April 2013, whilst housed at Parklea Correctional Centre, David reported to psychologists that he was experiencing non-threatening visual and auditory hallucinations. David was later transferred to Long Bay Correctional Centre. He was observed to be highly irritated, disorganised, and describing persecutory themes after it was found that he had damaged his cell on 15 May 2013. On psychiatric assessment David was diagnosed by Dr Anthony Samuels, a consultant psychiatrist, with schizophrenia. On 17 May 2013 David was assessed as a mentally ill person and transferred to a mental health facility pursuant to section 55 of the *Mental Health* (*Forensic Provisions) Act 1990*.

On 5 June 2013 David was reassessed and found to no longer be a mentally ill person. However he remained at Long Bay Hospital until he was transferred to Lithgow Correctional Centre on 29 June 2013.

There is also evidence that in August 2014 David had reduced a dose of risperidone, after taking it for a period of time, because it made him too drowsy. In October 2014 David ceased taking risperidone completely and because he had no overt psychotic symptoms at the time further medication was not enforced. On 20 November 2014 David was transferred from Lithgow Correctional Centre to the MRRC. An intake mental health assessment was conducted by a psychiatrist, a mental health nurse, and correctional centre staff. David was observed to be withdrawn, despondent and avoiding eye contact. He was guarded and difficult to engage with, and reported ceasing his antipsychotic medication (risperidone) about five weeks earlier. David reported that he felt that the risperidone was "*spinning him out*" and producing suicidal ideation with thoughts of self-harm. David reported that since ceasing the risperidone he had been able to resist the suicidal urges. David also reported hearing the voices of other inmates who were encouraging him to kill himself. During the interview David's demeanour quickly changed and he became emotional, teary and pulled his shirt over his head in order to hide his face. David also apparently continued to respond to internal stimuli and described hearing "*spirits*", and hearing other voices for most of the year. The assessment resulted in an impression that David was acutely psychotic with a schizophrenic relapse.

Following his admission to the MRRC David continued to be non-compliant with his risperidone. As a result, and because David was found to be highly distressed and agitated, he was commenced on monthly depot injections of paliperidone, an atypical antipsychotic. David agreed to this treatment but the available records indicate that his mother, Leetona, was unhappy that David was receiving the depot injections. She expressed a preference that David be treated with tablets. After starting the monthly depot injections David still reported hearing voices. In mid-February 2015, he asked to go back on oral medication due to sexual dysfunction. He was then treated with a combination of oral and depot paliperidone. In June 2015, David had become non-compliant with the anti-psychotic treatment as he stated that it made him sick.

On 9 November 2015, Dr Gordon Elliott, consultant psychiatrist, wrote to Dr Tobias Mackinnon, Justice Health Statewide Clinical Director seeking David's urgent transfer to the Long Bay Hospital as a mentally ill person. At the time, David was housed at Lithgow Correctional Centre. On 9 November 2015 David's treating psychiatrist, Dr Gordon Elliott, noted that David had a history of recurrent psychosis and had been non-compliant with his antipsychotic medication "*for months*". At the time Dr Elliott noted that David "*has been noted to be increasingly suspicious and uncooperative with nurses attempting to monitor his blood sugar levels*", that he had been "*floridly psychotic*" over the past week, and that "*he suddenly became violent with officers escorting him for a blood sugar level*", resulting in the use of force. Dr Elliott noted that David's "*blood sugar level control is usually poor*" and raised concerns regarding David's "*risk of acute diabetic complications in his current mental state and the safety of nurses attempting to manage his blood sugar level*".

On 20 November 2015, David was transferred to the MRRC, where he was assessed by the Risk Intervention Team. On 23 November 2015, he was reviewed by Dr Elliott and Dr Smith. They both provided medical certificates describing David as suffering from a mental illness. In particular, Dr Elliott indicated that David was completely uncooperative with the interview and observed to be talking and laughing to himself, as well as shadow boxing and pacing back and forth. Dr Elliott described David as extremely agitated and expressed concern that his behaviour was consistent with auditory hallucinations and formal thought disorder. As a result of this assessment, an order was made on 23 November 2015 for David to be transferred to an in-patient mental health facility pursuant to section 55 of the *Mental Health (Forensic Provisions) Act 1990*.

David's admission to Long Bay Hospital from 25 November 2015

David was admitted to Long Bay Hospital on 25 November 2015 under the care of Dr Robert Reznik, consultant psychiatrist. On admission to Long Bay a mental state examination was conducted. It noted that David was uncooperative, that his affect was blunted, that it appeared he was responding to internal stimuli (auditory hallucinations) and that his insight and judgment were impaired.

Dr Sergiu Grama assessed David at 11:00am on 25 November 2015 in G Ward. He found that David was acutely psychotic and at significant risk of violence. Dr Grama discussed his assessment with his supervising psychiatrists, Dr Antonio Simonelli and Dr Matthew Hearps. Dr Grama charted aripiprazole 20mg in the morning, zuclopenthixol 10mg twice daily, lantus insulin 46 units at night, Novorapid insulin as a sliding scale and perindopril 2.5mg in the morning. David was prescribed an injection of zuclopenthixol acetate, a parenteral antipsychotic medication. When told he was to be given this injection, David kicked the cell door and challenged the Immediate Action Team (**IAT**). He was subsequently given Cogentin 2mg (anticholinergic medication to prevent Parkinsonian symptoms), midazolam 10mg (sedative) along with the zuclopenthixol acetate, in the presence of the IAT and with their assistance. Following initial treatment David was observed later that day to remain floridly psychotic but appeared to be more settled and accepting of his prescribed medication.

Dr Reznik saw David for the first time on 26 November 2015. On examination he found David to be non-cooperative, guarded, displaying poverty of thought and speech and to have poor insight and judgement. Dr Reznik formed the impression that David was acutely psychotic and suffering from chronic schizophrenia. Plans were made for David to be reviewed daily and monitored for management of his diabetes mellitus. Dr Trevor Ma, psychiatric registrar, saw David on 27 November 2015. David denied having a diagnosis of schizophrenia but could not explain his previous symptoms. Dr Ma explained the need to re-commence intramuscular objections. David did not oppose this. David also raised no concerns about his diabetic management and said he would accept regular nursing monitoring.

On 30 November 2015 it was noted that David had been compliant with his medication and had been self-administering insulin and checking his blood sugar levels appropriately. Dr Ma reviewed David again on 4 December 2015.

A plan was made to refer David to the general practitioner for medical advice for diabetes management. Dr Grama reviewed David at 9:00am on 7 December 2015. David reported auditory hallucinations overnight and feeling unwell, but feeling better in the morning. Dr Grama discussed David's presentation with Dr Hearps who ordered that PRN medication in the form of chlorpromazine 100mg up to three times per day be added to David's charted medication.

On 7 December 2015 David became verbally abuse during his night time medications. He was given an insulin pen to self-administer but later refused to return it. CSNSW staff eventually persuaded David to return the insulin, but it was unclear if he had used it. Plans were made to monitor David through the night and review his blood sugar level the next morning. Dr Grama saw David on the morning of 8 December 2015. David reported hearing voices but said that he was happy taking his oral medication because it relaxed him. David was commenced on oral chlorpromazine 100mg three times a day.

Dr Mica Spasojevic, a Career Medical Officer, reviewed David on 8 December 2015. She reduced the sliding scale amounts of insulin and ordered Novorapid. Dr Spasojevic also referred David to the Prince of Wales diabetic clinic for follow up. Dr Reznik saw David again on 8 December 2015. He formed the impression that David was a chronic schizophrenic, still psychotic but less disturbed and more settled than when David was last reviewed. David's current management plan was continued. Dr Reznik reviewed David again on 10 December 2015. David reported that the chlorpromazine had been helpful, and that he felt calmer although was still disturbed by voices. Dr Reznik increased David's chlorpromazine to 200mg three times daily and his clopixol to 300mg fortnightly. Due to the possibility of interaction between the chlorpromazine and perindropil, plans were also made to increase David's blood pressure monitoring.

Dr Hannon reviewed David on 17 December 2015. David's blood sugar at the time was 23.4. He was noted to be asymptomatic but when reviewed later the same day he was dismissive and guarded. Dr Hannon reviewed David again the following day on 18 December 2015 when he was thought to be guarded with limited rapport and underlying irritability.

Dr Sharma reviewed David on 19 December 2015 when it was noted that his glucose was high. On review David was noted to be clinically asymptomatic but remained psychotic with grandiose religious delusions. On 20 December 2015 David was noted to be compliant with his medications with nil behavioural issues. David reported that he was feeling good, that the voices were down, and that his mental state was fluctuating but improving. It was thought that David was more settled but with ongoing mental illness. Dr Grama reviewed David that day as part of a daily review that had been requested by Dr Reznik and Dr Ma. Dr Grama noted that David remained mentally ill but presented as settled and accepting of his prescribed medications which he tolerated well. Dr Reznik reviewed David on 22 December 2015. David reported feeling better with no voices at the time. His blood sugar level was noted to be high. Dr Reznik decided to maintain the existing management regime noting that if David was refusing oral medications and behaviourally disturbed that consultation with a registrar could be considered for administration of intramuscular Acuphase and 10mg midazolam.

Dr Spasojevic saw David on 22 December 2015 due to his unstable blood sugar level. Dr Spasojevic discussed David's condition with an endocrinology registrar at Prince of Wales Hospital (**POWH**) and arrangements were made for information regarding David's blood sugar level and medication insulin to be sent to the registrar for further review and follow up. Dr Spasojevic reviewed Davis again on 24 December 2015 and arrangements were made for David's blood sugar levels to be sent to the registrar for review.

What happened on 29 December 2015?

A summary of the events of 29 December 2015 is set out below. A number of issues related to these events will be examined in greater detail later in these findings.

Registered Nurse (**RN**) Charles Xu was the Justice Health nurse assigned to care for David on 29 December 2015. David was housed in cell 71 in G Ward, the Mental Health Unit at Long Bay Hospital. RN Xu checked on David at approximately 8:00am and took his blood sugar level, which was 3.2 mmol/L. RN Xu spoke with Dr Ma and it was decided to withhold David's pre-breakfast Novorapid because of the low blood sugar reading.

RN Xu took David's blood sugar level again at approximately 10:00am. By this time it was 17.4 mmol/L, which was a high reading RN Xu attempted to locate Dr Ma to discuss the reading. When he could not do so he spoke to Dr Grama instead. On Dr Grama's advice, no treatment was given pending the next blood sugar level which was to occur just before lunch.

RN Xu took David's blood sugar level again at approximately midday, noting that it was high (over 25 mmol/L). At that time, David did not agree to having his vital signs taken and informed RN Xu that he felt fine. RN Xu noted that David was asymptomatic, with no signs of being physically unwell, despite having an elevated blood sugar level. RN Xu discussed David's treatment with Dr Ma, who ordered a unit of regular Novorapid, plus 8 units of sliding scale Novorapid.

At various times during the morning of 29 December 2015, David spent time in the exercise yard of G Ward. He had morning exercise between approximately 8.35 am and 10.43 am, during which time he ate what appeared to be some crackers. David again entered the exercise yard between about 1.10 pm and 2.04 pm. At about 2.00 pm, RN Xu re-took David's blood sugar level and found that it was 24.2 mmol/L (slightly reduced from the midday reading). David again refused to have his observations taken, but RN Xu observed that he remained asymptomatic. RN Xu discussed David's treatment again with Dr Ma, who recommended withholding a dose of Novorapid pending an endocrine review.

Officer D saw David in the smoking yard close to lock in time at 2:30pm. She saw that David was calm and let him out of the yard so that he could return to his cell. Once inside David asked if he could make a phone call. He was still calm and respectful at this time. Officer D said that he could but told him to do so quickly. After the call David asked if he could get something out his buy up. Officer D saw him retrieve a packet of rice crackers and a packet of biscuits.

She said to David, "*Remember what the nurse said, you've got to watch what you eat*". According to Officer D's account, this was a reference to her hearing RN Xu telling David sometime that morning whilst in the smoker's yard to "*watch his food intake*".

After giving this reminder to David, Officer D said that there was a rapid change in David's behaviour and that he "*immediately became very aggressive and abusive*". David reportedly responded by saying, "*I'm going to go off my fucking cunt if I can't have these biscuits. I fucking paid for them and they're mine*". Officer E and then Officer F took turns speaking to David in an unsuccessful attempt to persuade him to return the biscuits. David remained angry and agitated and informed the officers that he would do what he wanted with the biscuits, and continued to eat them. Just before 2:30pm a decision was made that it would be safer to move David to a camera cell, so that he could be better observed. Officer F asked the IAT to facilitate the move.

As this was occurring RN Xu had a discussion with a medical officer and his nurse colleagues about administering an intramuscular injection of midazolam to address David's agitation and aggression. After the IAT was summoned, the six members – Officer A, Officer B, Officer C, Officer M, Officer N and Officer O – all assembled at G Ward at approximately 2.35 pm. After a briefing by Officers A and F, the team proceeded to the door of cell 71. They arrived at just before 2.40 pm. Consistent with procedural requirements that were in place relating to the duties of the IAT, a video recording was commenced using a handheld camera operated by one of the IAT officers (**the IAT footage**).

Officer A spoke to David through the door of cell 71 and twice asked him to come to the door, place his hands through it so that he could be handcuffed and then moved to another cell. Officer A also indicated that if David did not comply with the direction, force may be used. David continued to eat his biscuits and did not comply with the direction. At one point, he pulled his shirt over his head and appeared to shadow box. At about 2.43pm, the IAT entered cell 71. Officer C was the first officer into the cell. He was carrying a riot shield. As the officers entered David collided with the shield. The IAT members gained control of David and restrained him, pinning him down on the cell bed. It is evident from the IAT footage that David resisted and officers described him clawing at them and attempting to bite.

In the course of David being restrained on the bed of cell 71, with officers above him and seemingly placing weight on him, he began to scream "*I can't breathe*". He repeated those words on a number of occasions while he was in cell 71, while being transferred to cell 77 and inside cell 77. The IAT members moved David from the bed onto the floor of cell 71. After the IAT members gained control of David, they applied handcuffs to him, with his arms in front. He was then raised from the ground, though his head was kept down, with the officers stating that David continued to spit blood.

At approximately 2:46 pm, David was led by the IAT from cell 71 into corridor A and then through corridor B to cell 77. David continued to scream that he could not breathe and at one point during the transfer dropped to his knees. The officers remonstrated with David to stand up and to stop spitting blood. David was led into cell 77 at approximately 2:47 pm.

He was placed onto the bed face down and again restrained by the IAT officers placing weight onto him. Soon after David's arrival in cell 77, and after being summoned by the IAT, RN Xu entered and administered an intra-muscular injection of midazolam into David's right buttock. David continued to scream that he could not breathe while RN Xu was in the cell.

RN Xu departed the cell after administering the injection of midazolam. He said that he observed David becoming increasingly aggressive during the midazolam injection and that as a result, he spoke to Dr Ma to report the further escalation of aggression. Dr Ma subsequently provided a verbal order for an intramuscular injection of haloperidol, an anti-psychotic. While RN Xu was absent from cell 77, CSNSW officers continued to restrain David, based on their understanding that a second sedative was to be administered. Officer G says that he yelled out to Officer F to say that the IAT members should continue to restrain David based on a discussion he had with nursing staff regarding the need for a second sedative to be administered. The CCTV from Corridor B is consistent with that evidence.

David continued to be restrained by the IAT members and he continued to scream that he could not breathe. At one point during the restraint, Officer B asked that David's head be turned to the side, which Officer C attended to. The officers observed that David appeared to be breathing and said to him that as he was talking, he was breathing. Approximately 60 to 90 seconds after the midazolam injection was administered, David became unresponsive and the CSNSW officers described his body going limp. That seems to have occurred at approximately 2:49 pm. After David became unresponsive, IAT members called for a nurse and began providing cardiopulmonary resuscitation (**CPR**) after moving David to the floor.

Within roughly 90 seconds of David becoming unresponsive, nurses from Justice Health were on the scene with resuscitation equipment. About 30 seconds later, Dr Ma attended and took over the attempts at resuscitation from the CSNSW officers. A call was made for an ambulance and it was booked at 2.52 pm. In the interim, Dr Ma led the resuscitation efforts, with RN Netra Thapa and RN Rajana Maharjan also assisting. A defibrillator was used. Dr Ma also utilised a hand held suction device because of concern about an obstruction in David's airway.

After attempts at resuscitation did not result in David breathing or any chest rise, bag ventilation was attempted. David vomited onto the floor. Continued attempts with the defibrillator resulted in no shockable rhythm being identified. Paramedics from NSW Ambulance arrived at the Long Bay Correctional Complex at 3:01 pm and made contact with David at 3:07 pm. The paramedics continued to attempt to resuscitate David, after having him brought out into the corridor, for just over half an hour. As there were no signs of life in response to treatment, resuscitative efforts ceased and David was pronounced deceased at 3.42 pm.

Issues for consideration at inquest

Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the matters to be considered. That list identified the following issues:

1. The nature of David's behaviour and in particular, the status of his psychiatric and diabetic conditions in the period leading up to his death.

2. The need for any intervention on 29 December 2015 on the part of CSNSW staff or Justice Health staff in light of issue 1 above.

3. Whether it was necessary and appropriate to move David from cell 71 to cell 77 (a camera cell) on 29 December 2015 in light of issue 1 above.

4. Whether it was necessary and appropriate to utilise the Immediate Action Team (IAT) to facilitate the move between cells on 29 December 2015. What alternatives to using the IAT were available?

5. Whether the IAT team members acted in accordance with CSNSW Policy and Procedures in facilitating the move of David between cells on 29 December 2015.

6. Whether the IAT members acted appropriately in the application of force to David/restraint of David on 29 December 2015.

7. Whether the IAT team members were appropriately trained in respect of the application of force/restraint of inmates, including any risk of positional asphyxia, prior to 29 December 2015.

8. Whether appropriate and timely steps were taken to establish cells 71 and 77 as a crime scene after David was moved between cells on 29 December 2015.

9. Whether video evidence was appropriately collected and retained after David was moved between cells on 29 December 2015.

10. Whether Justice Health staff acted appropriately and in compliance with Justice Health policies and procedures in administering a sedative (Midazolam) to David on 29 December 2015.

    10A. Whether Justice Health staff were appropriately trained on the risks and use of restraint?

10B. Was it appropriate to administer a second injection to David, as was planned on 29 December 2012, and who had the responsibility to decide whether such an injection should occur? What effect did the ensuing delay and further restraint have on David?

11. Whether Justice Health staff acted appropriately in providing life support to David between the time he became unresponsive through to the arrival of NSW Ambulance Paramedics on 29 December 2015.

12. The likely cause of David's death and in particular, which of the following matters caused or contributed to it (whether separately or in combination):

- David's diabetic condition;
- the manner of David's restraint/positioning;
- the medications David was on for his diabetes and/or his psychiatric condition as at 29 December 2015;
- the Midazolam administered to David on 29 December 2015;
- any inadequacies in the life support provided to David.

Issue 1: The nature of David's behaviour and in particular, the status of his psychiatric and diabetic conditions in the period leading up to his death

David suffered from a significant psychiatric condition during the period he was admitted to the Long Bay Hospital from 5 November 2015 to 29 December 2015. Dr Reznik diagnosed David as suffering from chronic schizophrenia, with multiple assessments conducted indicating that David was acutely psychotic, although his psychosis settled to some extent during the course of his admission. During his admission David reported hearing voices that argued with him and told him not to comply with his medication regime.

Dr Reznik and Dr Ma reviewed David at 9:00am on 29 December 2015. David reported feeling better and was looking forward to calling his mother. He said that the auditory hallucinations were still present but no longer bothering him. On examination David was noted to be settled, polite and cooperative giving rise to an impression that he remained psychotic but was less aggressive, with sudden and dramatic changes in his mental state. By 29 December 2015 David's diabetes remained poorly controlled, despite the slow and fast-acting insulin which he had been prescribed. Dr Spasojevic noted that David had experienced recent hypoglycaemic episodes and that his blood sugar levels were unstable. This resulted in adjustment of David's insulin therapy and contact with the endocrinology clinic at POWH for review.

The solicitor for Ms Leetona Dungay and the Dungay side of David's family (**the Dungay Family**) submitted that there was a failure to provide David with timely access to specialists review regarding his diabetic management, and a failure to act on specialist's advice that was provided. It is also submitted that available medical records indicating wide fluctuations in David's blood sugar levels are consistent with improper management of David's diabetic condition. However, the medical records establish that David had a lengthy history of poorly controlled diabetes and that he had been insulin-dependent since the age of six. The records also establish that David's blood sugar levels were regularly monitored. Where appropriate, advice was given to David about food consumption which may impact upon such measurements, in the absence of any ability to directly control his eating habits. It should be noted that there is no evidence to indicate that David had diabetic autonomic neuropathy, which is a complication of long-standing, poorly controlled diabetes. Further, as discussed in more detail below, there is no evidence to indicate that David's diabetes (and consequently the management of it) led to the development of an acute condition proximate to his death, or was contributory to it.

The solicitor for the Dungay Family also submitted that "*improvements in David's psychiatric condition were compromised by the character of mental health treatment he received in G Ward*". In support of this submission reference was made to the unique position that G Ward occupies as the only mental health facility in New South Wales that sits within a correctional centre, and the necessary consequences which this brings. The submissions have been understood to be a re-agitation of what was described as "*the proposed 11A issue*" during the course of the inquest. Broadly put, the proposed 11A issue sought to examine the appropriateness of mental health treatment being provided to involuntary patients, who are also inmates, in a correctional setting. On several occasions during the inquest it was determined that consideration of this proposed issue falls outside the scope of an inquest, particularly so far as consideration of the manner of death is concerned. On this basis any consideration of the matters submitted by the solicitor for the Dungay Family with respect to broader issues relating to management of David's mental health fall outside the parameters of the inquest.

Similarly, the solicitor for the Dungay Family submitted that it was necessary or desirable to make a number of recommendations in relation to the "*proposed 11A issue*". As already noted above, it has previously been determined that matters which might give rise to the making of any such recommendations were not examined at the inquest. The inquest did not receive any direct evidence in relation to such matters and any consideration of such matters would have warranted other organisations (such as New South Wales Health) being regarded as having sufficient interest in the proceedings in accordance with section 57 of the Act. Having regard to these factors, it would be inappropriate, and procedurally unfair, to give consideration to the submissions that have been made on this issue.

Issue 2: The need for an intervention on 29 December 2015 on the part of Corrective Services New South Wales Staff or Justice Health Staff in light of issue 1 above

Having regard to the nature of David's mental and physical health conditions on 29 December 2015, the question arises as to whether any intervention, either by Justice Health or CSNSW staff, was warranted at the time that David returned to his cell with his buy up of biscuits. Several considerations are relevant to consideration of this question and are set out below.

Blood sugar levels

The first consideration relates to any impact which consumption of the biscuits might have had on David's blood sugar levels given his history of poorly controlled diabetes. RN Xu measured David's blood sugar levels a number of times over the course of the morning and early afternoon of 29 December 2015. The measurements recorded were:

- 3.2mmol/L at about 8:00am a low reading. RN Xu noted that David was asymptomatic. RN Xu spoke with Dr Ma who ordered that David's pre-breakfast dose of Novorapid should be withheld.

- 17.8 mmol/L at about 10:00am, a high reading. RN Xu noted that David remained asymptomatic but attempted to speak to Dr Ma again regarding the elevated blood sugar level. RN Xu could not locate Dr Ma and instead spoke to Dr Grama, suggesting that a stat dose of Novorapid be administered. According to RN Xu, Dr Grama directed that no further action was to be taken until the next blood sugar level measurement which was to occur just before lunch. Although Dr Grama said that he had no recollection of such a discussion taking place, he did not "*strongly disagree*" that it did not take place.

- More than 25 mmol/L at about 12:00pm, a high reading. RN Xu noted that David said that he felt fine, and did not show any physical signs of being unwell. RN Xu spoke to Dr Ma who directed that eight units of regular Novorapid and eight units of sliding scale Novorapid be administered.

- 24.2 mmol/L at about 2:00pm, another high reading. RN Xu noted that David remained asymptomatic. RN spoke to Dr Ma and suggested another stat dose of Novorapid. However Dr Ma instructed RN Xu not to administer Novorapid as an endocrine review was being undertaken which would result in David's insulin regime being subsequently adjusted by an endocrinologist.

RN Xu said he was confident that he spoke to Dr Grama after taking David's blood sugar level of 17.8, and being unable to locate Dr Ma. RN Xu said that he recalled trying to call Dr Ma but there was no answer. RN Xu said that Dr Grama was onsite and that he had been the admitting doctor and spoke to him. RN Xu confirmed that at no time did he continue to try to locate Dr Ma and explained that David was very agitated and, as time was a primary concern, he could not wait.

Conclusion: RN Xu measured David's blood sugar levels four times on 29 December 2015. On each occasion the measurements raised concerns as they were outside acceptable clinical ranges. On each occasion RN Xu appropriately sought advice from a medical officer as to whether to withhold or administer Novorapid in order to normalise David's blood sugar levels. In this regard it is accepted that RN Xu sought appropriate advice from Dr Grama following the 10:00am blood sugar level reading. Although Dr Grama has no specific recollection of discussing David's blood sugar level with RN Xu, he left open the possibility that such a discussion took place. On this basis, it is most likely that RN Xu discussed this issue with Dr Grama.

Removal of the biscuits

Officer D said that she accompanied RN Xu each time he measured David's blood sugar level at about 8:00am, 10:00am, and 12:00pm. She said that David was compliant on each occasion. At some stage during the morning, whilst David was in the yard, Officer D said that she heard RN Xu tell David to "*just to watch his food intake*". Officer D said that she could not recall the circumstances in which this was said, or whether it was said when RN Xu was measuring David's blood sugar levels. In his statement and in evidence RN Xu made no reference to making such a comment to Officer D. However, it is clear that RN Xu held some concerns about David's blood sugar levels given the e had taken at different times on 29 December 2015. So much is clear from RN Xu's contact with Dr Ma and Dr Grama regarding aspects of David's insulin therapy. The making of the statement which Officer D attributes to RN Xu is consistent with these concerns.

David was out of his cell and in the yard from between 12:40pm until 2:20pm. He was scheduled to be locked back in his cell at 2:30pm. Shortly before 2:30pm Officer D saw that David was calm and let him out of the yard so that he could return to his cell. Once inside David asked if he could make a phone call. Officer D described David as calm and respectful at this time. Officer D told David that he could make his phone call, but to do so quickly. After the call David asked if he could get something out his buy up. Officer D saw him retrieve a packet of rice crackers and a packet of biscuits. She said to David, "*Remember what the nurse said, you've got to watch what you eat*". Officer D knew nothing about David's medical conditions or the fact that he had diabetes. However, on Officer D's account, her comment to David was a reference to what she heard RN Xu tell David earlier that day regarding his food intake.

After giving this reminder to David, Officer D said that there was a rapid change in David's behaviour and that he "*immediately became very aggressive and abusive*". In evidence Officer D said that David responded by saying, "*I'm going to go off my fucking cunt if I can't have these biscuits. I fucking paid for them and they're mine*".

On hearing this, Officer D formed the view that David was angry and aggressive and wanted to secure him in his cell and then have the biscuits removed.Officer D said that she spoke to RN Xu about David's reaction. She said that she was certain that RN Xu told her, "*We have to get the biscuits out of his cell*".

Officer D said that Officer E was present at the time. However, she rejected the possibility that another CSNSW officer had said something about removing the biscuits from David's cell. In evidence Officer D initially said that after David reacted aggressively she spoke to RN Xu who suggested that the biscuits needed to be removed. However, later in her evidence Officer D indicated that she had independently formed the view that the biscuits needed to be removed before she spoke to RN Xu.

RN Xu said that at no point did he say to Officer D or Officer F that the biscuits had to be removed from David's cell. RN Xu said that he had no recollection of saying to David that the biscuits had to be removed. He agreed that whilst it was a concern that he was eating them his focus at that point was on David's mental state. RN Xu maintained that he did not speak to Officer F who was nearby but RN Xu not engage him in conversation. He said that it was not possible that it was not Officer F, and instead Officer E, who was there. He said that he never spoke to Officer E and that he was positive that he had no discussion regarding any concerns about David's blood sugar level.

Officer E prepared an incident report on 29 December 2015. In it he wrote: "*At about 14:10hrs I was approached by [RN Xu] whom [sic] indicated to me that he was concerned about the amount of buy-up that [David] had taken into his cell. The reason for this concern was that [David] was a diabetic and that he was consuming too much [sweet] type food*".

In evidence Officer E said that he was sure that it was RN Xu who expressed concern about David taking his buy up back to his cell. When asked whether it was another officer who might have expressed such concern, Officer E said that he could not recall but relied on the contemporaneous record made at the time in his incident report. He initially said that Officer D told him that David had buy up in his cell and that RN Xu was concerned because of his high blood sugar levels that day. Later he agreed that it was possible that he was confused and that it might have been Officer D who expressed a concern and not RN Xu. It is clear that there is a factual dispute on the oral evidence as to who raised the need for the biscuits to be removed. The contemporaneous records provide some assistance in this regard. On the one hand the incident report created by Officer E on 29 December 2015 indicates that it was RN Xu who raised a concern about David eating his biscuits. It is important to note that the incident report attributes only a concern on the behalf of RN Xu, and no reference to any request made by RN Xu regarding removal of the biscuits.

In his incident report prepared on 29 December 2015, Officer F recorded: "*Officer E informed me that 20 minutes prior to having his rice crackers the nurse informed him that his blood sugar levels were high and that the crackers had to be removed from his cell. This was in case he went into a diabetic coma by eating too many of them which he had bought on buyouts which were delivered today*". Similarly, in his statement of 30 December 2015 Officer F said: "*[Officer E] stated that inmate Dungay did not want to return the crackers that he had taken to his cell and was consuming them. He further told me that he was gorging them into his mouth and that the nurses had informed him [Officer E] that [David's] blood sugar levels were already high prior to him consuming the crackers and that the nurse requested the food be taken from [David]*".

In contrast Officer D, in her very brief incident report of 29 December 2015, makes no mention at all of any conversation with RN Xu. Instead that conversation is raised for the first time in Officer D's statement made on 1 June 2016, some six months after the event. On the other hand, RN Xu made a retrospective entry in the clinical progress notes at about 7:30pm on 29 December 2015. In that entry no mention is made of any conversation with Officer D regarding removal of the biscuits.

Conclusion: As noted in the submissions by Counsel Assisting, it is acknowledged that there are certain limitations associated with RN Xu's evidence which made it unreliable in some respects. These limitations are discussed further below. The solicitor for RN Xu submits that RN Xu observed that David was asymptomatic each time his blood sugar levels were taken and that on each occasion RN Xu sought instructions from medical officers as to whether any clinical intervention was warranted. On this basis, it is submitted that if RN Xu formed the view that removal of the biscuits was warranted he would have, consistent with his practice earlier that day, sought instructions from a medical officer before actioning such a course. There is some force to this submission given that there is no evidentiary basis to suggest why RN Xu would have departed from the practice that he had followed earlier in the day with respect to the issue of removal of the biscuits.

This submission is accepted because it is consistent with Officer D's evidence. In re-examination by Counsel Assisting, Officer D clearly acknowledged that she independently formed the view that the biscuits needed to be removed from David before she spoke to RN Xu. Further, Officer E's evidence leaves open the possibility that it was indeed Officer D who expressed a concern about David's consumption of the biscuits.

Of course, the fact that Officer D independently formed the view about removal of the biscuits does not preclude RN Xu from also reaching a similar view, and expressing it to Officers D and E. However, given the contemporaneous incident report prepared by Officer E, and the absence of any similar contemporaneous record created by Officer D, it is most likely that any view which RN Xu might have conveyed was limited to concern about David eating the biscuits, rather than an express request that they be removed. This is consistent with the similar concern attributed to RN Xu in relation to his measurements of David's blood sugar levels earlier in the day. On the basis of the above, it is most likely that any concern expressed by RN Xu was conveyed by Officer D, together with her own independently formed view, to Officer E. As Officer E was receiving the information indirectly it seems likely that these two factors led to an understanding in the mind of Officer E that a request had been made by RN Xu for the biscuits to be removed. Officer E in turn conveyed this purported request to Officer F.

Escalation to Officer F

Officer E said that after RN Xu expressed his concern he (Officer E) approached David in his cell. Officer E told David that "*if he ate all the food he had in his cell he would become sick due to his diabetic condition*". According to Officer E, David said, "*It's my buy up and I'll fucking eat it. Fuck off".* Officer E then saw David start to "*stuff rice crackers into his mouth*".

Officer E said that he had seen David leave his cell on two occasions earlier in the day and had been calm and cooperative at the time. He said that nothing about David's behaviour prior to about 2:10pm had caused him any concern. Officer E initially said in evidence that he spoke to David on two or three separate occasions in an attempt to negotiate with him. However he agreed that there was no reference to this in his incident report, and later acknowledged that he had only made one visit to David's cell. It was suggested to Officer E that he only spoke to David for between 30 to 60 seconds. Officer E said instead that he possibly spent five to 10 minutes trying to negotiate with David, but acknowledged that it could have been less time than this.

After unsuccessfully attempting to negotiate with David, Officer E called Officer F, the Acting Assistant Superintendent, to attend G Ward. Officer E said that he did not see David's aggression as a security issue. Officer E said that he did so because he knew that Officer F was the regular senior officer in G Ward. When asked why he didn't choose medical staff to speak about a dietary issue, he said that it was just a decision he made at the time, and thought that Officer F would have more luck communicating with David.

Conclusion: Having been informed of a concern regarding the consumption of his buy up, it was appropriate for Officer E to attempt to negotiate with David to return the biscuits. When this was unsuccessful, it was also appropriate for Officer E to escalate the issue to the most senior officer on the ward, Officer F. Officer E knew that Officer F was also familiar with David and his history, and that Officer F might have had greater success in negotiating with David.

Issue 3: Whether it was necessary and appropriate to move David from Cell 71 to Cell 77 (a camera cell) on 29 December 2015 in light of issue 1 above

Following Officer F's unsuccessful negotiations with David, a discussion reportedly took place between himself, Officer E, and RN Xu. There is a dispute on the evidence as to who participated directly in the discussion and as to what precisely was discussed. Officer E's evidence was to the effect that in his view RN Xu had already "*made the call*" about what needed to happen, namely that the crackers were to be removed. To this extent, Officer E agreed that RN Xu expressed a concern about David having biscuits, and that eating them could affect his elevated blood sugar level. Officer E agreed that someone had to go into the cell to remove the biscuits, but no one did and instead David was taken from the cell. When asked why RN Xu's concern was not acted upon Officer E said that when David was asked to hand over the biscuits he instead ate them. Because this happened it was decided by RN Xu and Officer F that David should be placed in a camera cell to be observed. He said that Justice Health made the decision to move David and that CSNSW had no reason to move David. However, he agreed that the extent of what he and other CSNSW officers were asked to do (by RN Xu) was to get the biscuits.

Officer E said that it was for RN Xu and Officer F to decide whether David should be moved to a camera cell. He said that he understood the basis for the decision to move David was so that he could be moved to a camera cell and be monitored in case anything went wrong with the biscuits he was eating.

On this basis, he agreed that there was no security issue and that there was no discussion about any security concerns. He agreed that it was a medical issue and needed to be managed as such. Officer E said that ultimately a decision was made between Officer F and RN Xu for David to be transferred to a camera cell. Officer E said that he was he was present during the discussion between Officer F and RN Xu when this decision was made. However, he said that he had no active input into the discussion. This is contrary to what is set out in Officer E's incident report which records: "[Officer F]*, [RN Xu] and I decided it would be safer to move DUNGAY to a camera cell so he could be observed better*". In evidence Officer E maintained that he was not part of the decision-making process and he simply heard the decision that had been made by Officer F and RN Xu.

Officer F maintained that "*the nurses*" had asked for David to be transferred, although he could not identify which nurse or nurses told him that the transfer was required. Officer F said that a nurse had told Officer E that the crackers needed to be removed and that this was not something that Officer E had decided. He said that he was sure Officer E had not expressed concern of his own accord. Officer F said that he was sure he was told that David could go into a diabetic coma and indicated that he had referred to this in his incident report. Officer F said that he was aware that David's diabetes was difficult to manage and that on the basis of a previous alert the significant problem was hyperglycaemic episodes.

Officer F was asked how a request for biscuits to be removed became a request for the IAT to facilitate a cell transfer. He replied: "*Due to his volatile nature on the day and Justice Health nurse saying to us he needs to be moved to the ob cell for observation and the amount of biscuits he was eating*". It was pointed out that neither his incident report nor his statements made any mention of a nurse requesting a cell change. He said that he had no reason to move David and that the only reason for the move was so that he could be moved to a cell where he could be observed for health reasons. He maintained that the CSNSW officers were asked to move him there. He rejected the suggestion that he took the request to remove the biscuits to prompt a response to have him move cells. He explained that David would not be moved because of security concerns because he was already within his cell and secure.

Officer F said that his best recollection is that he returned from attempting to negotiate with David, spoke to Officer E and then made the decision to call the IAT. When asked whether he agreed that there was no reference in his report to having a conversation with a nurse, he did not answer the question directly. This was indicative of the quality of evidence given by Officer F. Instead he answered obliquely by saying that he was not medically qualified and that if a nurse said that a patient needed to be moved, they would be moved. Later he agreed that he was reaching this conclusion based on his understanding and experience of usual practice and that it was not based on any actual recollection of a conversation. Ordinarily, the transfer of an inmate, on medical grounds, required a medical officer or nurse to complete a Justice Health document titled "*Medical Officer/Nursing Certificate*". Such a certificate had previously been completed for David most recently on 30 November 2015 (when he was transferred to a non-camera cell) and on 14 December 2015 (when he was transferred to a different ward). Officer F agreed that if normally seeking a cell move on medical grounds he would seek such a certificate.

When it was suggested that "*the nurses*" did not request a cell move he said that he would not move an inmate without a request from a nurse. He agreed that he did not seek a transfer certificate and said that it was because he was told the move was on medical grounds and that the certificate would be done later when the move was completed.

In his evidence RN Xu said that it was not true when Officer E had said that he and Officer F made the decision together to move David. RN Xu was asked whether he thought David could be safely housed in cell 71. He said that he gave no thought to a cell transfer and said: "*My understanding - my worry about his - the possibility of him being harming himself that day was based on my observation of him being uncontrollably angry. My worry was that based on he was actually - I, I didn't see it but I was pretty close to the cell door at the time I could, I could sense he was throwing himself to the door*".

RN Xu explained that he understood the general practice to be that the decision to medically transfer an inmate can only be made by a doctor by completing a certificate. He agreed that if he wanted David to be moved out of concern for his condition he would have spoken to a doctor who would have then assessed David and completed a certificate. Upon the arrival of the IAT in G Ward, RN Xu said that he saw the IAT officers proceed directly to cell 71. Having drawn the midazolam by this stage, RN Xu followed the IAT officers to cell 71 with the understanding that it was to be administered in cell 71. At that point one of the officers told him that the injection would not occur in cell 71. He explained that this was the first time that he became aware that David was to be transferred to a camera cell. He said that the IAT directed him to leave straight away, and he returned to the treatment room.

RN Xu's account is clearly depicted on the CCTV footage of the corridor leading to cell 71. This footage shows RN Xu following the IAT to cell 71, wearing gloves and carrying a yellow kidney dish. This is the same dish captured on the IAT footage later in cell 77. Therefore if RN Xu had requested the cell transfer it can reasonably be concluded that he would have waited until the cell transfer had been effected, before attending cell 77 (and not cell 71) to administer the injection. The footage of RN Xu following the IAT to cell 71 and then leaving a short time later is consistent with RN Xu's version that he first became aware of a cell transfer *after* the arrival of the IAT on G Ward. Dr Cromer expressed the view that in a scenario where David's blood sugar level was initially low but then seemed to increase after breakfast, but that he was observed to be asymptomatic, he would not consider removal of the biscuits from David to be a medical emergency. He further explained that whilst it would be preferable to remove them, it would not be considered to be a pressing matter from a medical perspective.

In evidence Dr Ma was asked what consideration he would give if he had been asked whether David should be moved to a different cell. He explained: "*But whether [the cell move] needed to be done immediately, given that [David] was quite aggressive at the time, potentially that could have, they could, they, they, they could have waited.*

There could have been further attempts, potentially of, of de-escalation, or potentially, as I was under the impression, that intramuscular emergency sedation could have been administered, to then safely take him to a camera cell at a point in time where he might have been more settled". Dr Ma eventually agreed that other options were available which meant that an immediate cell transfer was not required.

Conclusion: It is most likely that Officer F made the decision that David be moved to a camera cell. The oral evidence of both Officer F and Officer E was inconsistent with aspects of their contemporaneous incident reports. Officer F maintained in evidence that "the nurses" had requested the cell move. However, no mention of this was made in Officer F's incident report and in evidence he was unable to identify any nurse who had made such a request. Similarly, in evidence Officer E disavowed any participation in the decision-making process to effect a cell move. However, this was inconsistent with the content of his incident report.

The evidence establishes that RN Xu was aware that if a cell transfer was to be effected on medical grounds, that was a matter for a medical officer to decide. If such a decision was made it required completion of an appropriate certificate. The absence of such a completed certificate on 29 December 2015 tends to support RN Xu's evidence that he made no request, on medical grounds, for David to be moved. Importantly, the video evidence supports RN Xu's version that he was not aware of any proposed cell transfer until after the IAT arrived in G Ward. Therefore it appears that the concern previously expressed by RN Xu, coupled with Officer D's request for the biscuits to be removed, was misinterpreted as a request for David to be moved from a non-camera cell to a camera cell so that he could be observed. It is likely that this misapprehension can be attributed to the nature of the indirect communication between RN Xu and Officer F. This issue is discussed further below.

Ultimately, it was neither necessary nor appropriate for David to be moved. Officer F acknowledged that David was already safely contained within his cell, and therefore did not pose a security risk. Similarly, Officer E held no security concerns regarding David's circumstances at the time. From a medical point of view there was no evidence of any acute condition which would have warranted a cell transfer and the need for David to be observed in a camera cell. Indeed the evidence points to the contrary in the sense that whilst David's blood sugar level was elevated, and he was consuming biscuits, he had been observed to be asymptomatic.

As counsel for CSNSW correctly submitted the appropriate response to the circumstances which confronted Officer F on the afternoon of 29 December 2015 was for advice to be sought from a medical officer as to whether a cell transfer was necessary, and could be effected safely. The solicitor for the Dungay Family submitted that Officer F "embarked on a 'power play' in response to David's defiant behaviour, which can only be described as repugnant and reprehensible". It could not be said that this is the only reasonable conclusion that could be drawn from Officer F's decision to effect a cell transfer for David. As already noted above, the rationale given by Officer F as to his decision-making process was that it was based on medical grounds. Whilst the evidence demonstrates that there was no medical basis to support such a rationale, this was not known to Officer F at the time.

It has already been noted that the quality of Officer F's evidence was deficient in some regards. However an appropriate concession was ultimately made by Officer F that his oral evidence relevant to whether there had been a request for a cell move by RN Xu was based on previous experience rather than actual recollection. Further, given that Officer F was not medically qualified, his belief that David needed to be moved on medical grounds (regardless of how that belief was ultimately formed) is consistent with a misunderstanding that an acute deterioration in David's condition was either imminent or likely. On this basis it could not be reasonably concluded that Officer F's actions were representative of a "power play".

Issue 4: Whether it was necessary and appropriate to utilise the Immediate Action Team (IAT) to facilitate the move between cells on 29 December 2015. What alternatives to using the IAT were available?

Section 12.1 of the CSNSW Operations Procedures Manual (**OPM**) was in force as at 29 December 2015. It related to general matters affecting the safety, security, good order and discipline of a correctional centre. Specifically, section 12.1.9.2 of the OPM identified the role of an IAT and set out a bullet point list of responsibilities. Relevantly, section 12.1.9.2 identified that one of the responsibilities of an IAT was to "*respond to security and emergency situations at their respective correctional centres at the direction of the Manager Security*".

Officer F agreed that it was his decision to call the IAT to facilitate the cell transfer. As noted already above, neither Officer F nor Officer E considered the circumstances of David being in his cell eating his biscuits to be a security issue. Officer F also agreed that there was no emergency situation. The question which therefore arises is whether there was a proper basis for the IAT to be utilised in such circumstances. In evidence it was suggested to Officer F that the circumstances of 29 December 2015 did not fall within the scope of section 12.1.9.2 of the OPM. Officer F explained that as long as he had been working in G Ward if an inmate who needed to be moved was being volatile or irate a call would be made to the IAT. However he agreed that none of the criteria set out in section 12.1.9.2 provided that the IAT had a general role to respond to medical issues.

It was suggested to Officer F that the circumstances of David refusing to hand over his biscuits where his blood sugar level was elevated was not a medical emergency. As already noted, Officer F referred to the fact that "*the nurses*" had made a request for David to be moved, and that he would not have been moved if it was not a medical emergency. When it was suggested that a mentally ill man eating biscuits did not amount to a medical emergency Officer F responded by saying that they had been asked to move David so that he could be in a camera cell. He disagreed with the propositions that he was not asked by a doctor or nurse to move David, that without a doctor's input the reaction was excessive, and that the IAT was not required and that their presence was not a reasonable response to the circumstances.

Officer F said that Officer E passed on to him a nurse's concern that David was at risk of diabetic coma. When asked what his understanding was of when such an event might occur, he said that it could have been any time after David ate the biscuits. Officer F agreed that he made no reference to this in his incident report.

He agreed that if he had been told that David was at risk of falling into a diabetic coma then it would have been included in his second statement. On this basis Officer F appeared to agree with the proposition put to him by the solicitor for the Dungay Family that given there was no reference to risk of diabetic coma in his second statement he was never told about it. However during later questioning by counsel for CSNSW, Officer F reverted to his original position and maintained that, based upon what he had been told, he held a concern that David was at risk of a diabetic coma. In re-examination by Counsel Assisting Officer F was questioned about whether or not he considered such a risk to be imminent or whether any potential intervention could be taken later.

Officer F agreed that what any nurse might have said had been conveyed to him by Officer E. He agreed that he had no face-to-face discussion with any nurse and that one option would have been to speak to a doctor or nurse to determine how imminent any risk might have been. Officer F said that he spoke to David three times in an attempt to persuade him to hand over the biscuits. He told David that the IAT were on their way and that they were going to transfer him to cell. Officer F said that David replied, "*Send the squad, I'll fight them all*". Officer F agreed that David's response indicated that it was likely that physical force would be applied. Officer F also agreed that by calling the IAT it meant that force and restraint would be used and that there was a likely risk of injury to David or the IAT officers. In these circumstances it was suggested that it was sensible to see a doctor or nurse to see if the risk of diabetic coma meant others were to be put at risk. In response Officer F said that it had been explained to him that there was a need to move David and the reasons why. He said that he did not think it was appropriate to speak directly to a doctor or nurse because a nurse had already spoken to Officer E about the need to move David.

Officer E was also asked whether he thought that the situation was so urgent that there was no time to see if a Justice Health staff member could complete a certificate for David to be moved to a different cell. He said that he did not consider the situation to be urgent because David was in his cell, but that his impression of the sense of urgency was conveyed to him by RN Xu. He said there was never any mention about a doctor needing to be consulted. He agreed that this sense of urgency was not conveyed in his incident report. Officer E agreed that he did not seek a doctor's view about a diabetic condition because he had been briefed by a nurse on the ward. He said that he did not think to see whether a doctor might de-escalate the situation and said that this was because in his experience doctors and nurses only inflame a situation more than help it.

He expressed the view that CSNSW officers were better at de-escalating situations than Justice Health staff, despite being aware there were trained psychiatric nurses experienced in dealing with psychiatric patients on the ward. After agreeing that he had no medical training, or training in relation to managing patients with psychiatric or diabetic issues, Officer E said that his opinion about whether he was able to make such an assessment that the involvement of Justice Health staff would be likely to inflame the situation, was based on watching past interactions. Regardless, he said that he gave no thought to calling doctors or nurses in any event. Officer E agreed that he knew David suffered from a mental disorder and diabetes, that David could be aggressive, his behaviour could be unpredictable, and that this information apprised him about David's condition and the way he might act on a particular day. He agreed that this was information he did not need in writing.

In addition he agreed he had access to information written on the patient whiteboard and that he had access to nursing and medical staff who could inform him of changes in a patient's condition that might affect the management of a patient.

Conclusion: The evidence establishes that there was no proper basis for Officer F to request the attendance of the IAT in G Ward on 29 December 2015. None of the criteria set out in section 12.1.9.2 of the OPM relating to the roles and responsibilities of the IAT provided for their involvement in a medical issue, as understood by Officer F. On this basis alone, it can be concluded that it was neither necessary nor appropriate to utilise the IAT to facilitate David's cell transfer.

Counsel for CSNSW submitted that whether or not Officer F considered that David represented a security threat whilst inside cell 71 is not to the point. Rather, it is submitted, once Officer F made the decision to open the cell door to move David a security situation did arise which required the involvement of the IAT. In support of this submission reference was made to the evidence of Shane Bagley, the senior investigation officer who completed the Death in Custody Report following David's death, who sought to explain that a security situation arises in circumstances where an inmate is unwilling to voluntarily move to another cell and, because of the inmate's demeanour, mechanical restraint is required to effect the cell move. However, the evidence of Officer Bagley does not take into account the fact that the decision made by Officer F to involve the IAT was only made after David had refused to return the biscuits. Therefore, the relevant point for determining whether or not there was a security issue is at the time that Officer F made the decision to request the attendance of the IAT. At that point in time the evidence clearly establishes that David was secured within his cell, with no security issues present.

Officer F was plainly aware that requesting the involvement of the IAT carried a risk, particularly given his interactions with David and knowledge of his volatile condition, that the use of force would be likely. Officer F was also aware that the likely use of force in turn carried a risk of injury to David and the IAT officers. With this awareness in mind, it would have been appropriate for Officer F to confirm his understanding of the acute nature of David's condition, whether any risk to his health was imminent, and whether any such risk warranted the involvement of the IAT. It should be noted that the incident report prepared by Officer F does not suggest that he considered that urgent intervention was warranted. Officer F's explanation that he had already been provided this confirmation by RN Xu is flawed.

The evidence establishes that the purported confirmation was only provided indirectly through Officer E. With this in mind, it was again neither necessary nor appropriate for Officer F to request the attendance of the IAT without conducting proper enquiry as to whether there was a basis to do so. Having concluded that it was neither necessary nor appropriate to utilise the IAT, the question that arises is whether there were any alternatives available to Officer F to properly manage the situation he was confronted with.

Alternative: use of Aboriginal inmate delegates and welfare officers

Officer F was asked whether he considered seeking the assistance of a doctor, an Aboriginal inmate delegate, or an Aboriginal welfare officer to de-escalate the situation. Officer F said that the Justice Health nurses had already spoken to David unsuccessfully, and that he did not consider seeking the assistance of an Aboriginal delegate or welfare officer. Officer F agreed that Aboriginal welfare officers and delegates were available to be used. However, he said that he did not give any thought to such alternatives because he had already tried to reason with David three times and he remained unreasonable, and that he had known David for a number of years.

He also said that unlike other wards, he had never taken an Aboriginal delegate or welfare officer into G Ward. However, when taken in evidence to certain CSNSW records, Officer F agreed that an Aboriginal delegate was previously used in another volatile situation involving David on 22 August 2012. Officer F explained that the process involved for calling Aboriginal welfare officers to attend G Ward meant that he had to ring up or do a referral in an electronic case note for a welfare officer to attend when available. If called, it was likely that they would attend later that day, or the next day. He said that in his experience it was unlikely welfare officers would have attended at short notice due to officer shortage. However, notwithstanding, Officer F said that he gave no consideration at all to this process.

Alternative: removal of the biscuits

Officer F was asked whether he considered that a way of dealing with the situation was to ask the IAT to simply remove the biscuits. He said that David would not return them to him or the IAT. When it was suggested that he could not know what David might do he said that he knew David better than the IAT, that he had attempted to negotiate with David three times, and there was nothing that made him think that David would give the biscuits to the IAT. When it was suggested that the difference was that the IAT could forcibly remove them from him, Officer F said that it was still the case that the nurses had asked that David be moved to a camera cell.

Alternative: allow David to remain in his cell

Officer F agreed that by calling the IAT and having what could be a violent confrontation that there was a risk of serious harm to David and the CSNSW officers. Officer F agreed that any proper risk assessment had to take into account such risk, but disagreed that he failed to appropriately conduct such an assessment. When asked what risk there was if nothing was done, he said that there was a risk to David's health and that he was not qualified to answer what might happen if no action were taken. Officer F agreed that he was bound to consider alternatives to the use of force and indicated that in this sense he went three times to see David and at no time was he compliant. Officer F said that to him de-escalation meant leaving the inmate in his cell where he was contained with no risk to any officer. He was asked whether he considered an option of tactically disengaging. He said that if there was no need to move on non-medical grounds then this would have been considered.

Conclusion: Regrettably, alternatives to involvement of the IAT on 29 December 2015 were not considered. Seeking the involvement of an Aboriginal inmate delegate or welfare officer, requesting the IAT to simply remove the biscuits from David (rather than effect cell transfer), and simply allowing David to remain in his cell (with appropriate observations to be performed) were options that were potentially all available to Officer F. However, the evidence established that either no enquiries were made by Officer F regarding utilising these options, or that Officer F predetermined that the options were unavailable to him.

In circumstances where Officer F appropriately acknowledged that involvement of the IAT carried with it the likely use of force and consequent risk of injury, it was appropriate for at least some enquiry to be made as to whether any alternatives were available. Even allowing for the fact that Officer F believed that a cell transfer was warranted on medical grounds, he acknowledged that no proper enquiry was conducted to allow for a determination to be made as to whether the risks associated with a likely use of force were outweighed by any risks associated with David's medical condition. Although Officer F indicated that he gave no consideration to possibly seeking the assistance of an Aboriginal inmate delegate or welfare officer, his evidence also demonstrated a lack of awareness of such personnel as an available alternative. Further, even if Officer F had sought to utilise such an alternative, the evidence suggests that possible utilisation would likely have been constrained by resource limitations.

Recommendation: I recommend to the Commissioner for Corrective Services New South Wales that all necessary steps be taken to make an Aboriginal Welfare Officer or Aboriginal Inmate Delegate available within Long Bay Hospital to assist where required, in interactions with Aboriginal or Torres Strait Islander inmates in the Mental Health Unit and that Corrective Services New South Wales inform and train officers working in the Mental Health Unit to utilise this process where appropriate.

Issue 5: Whether the IAT team members acted in accordance with Corrective Services NSW policy and procedures in facilitating the move of David between cells on 29 December 2015

As already noted above section 12.1.9.2 of the OPM provided the basis for an IAT to respond to a security or emergency situation. In evidence Officer A, the IAT Team Leader, accepted that this formed part of the core duties of the IAT. Officer A said he was not told directly who had requested the cell move. However he said that based on his experience it involved a consultation between Justice Health and CSNSW. He said that after being told that David had been non-compliant with directions and that negotiation had failed he formed the view that there was a proper basis for the IAT to attend.

On this basis Officer A said that he regarded the incident as a security situation. He said that the fact David had been non-compliant with staff directions made it a security issue. Officer A said that based on being told that David was "*messing*" with his blood sugar level, he considered there to be an element of self-harm in relation to the request. He said it affected the overall security of the centre as he considered David's continued eating of food to be an attempt at self-harm and that he needed to be placed in a camera cell. He explained:

"*The overall security of the centre [was at risk], for the fact that…Mr Dungay was eating copious amounts of food in what was explained to me as an attempt of self-harm, that I took as an attempt of self-harm, and that he needed to be placed into a camera cell due to that risk of self-harm and non-compliance*".

Officer A agreed that self-harm in relation to diabetes was a medical issue but said that he also considered it to be a security issue. Officer O also considered the matter to be a security situation. He explained that it related to the security of the staff in G Ward because of David's behaviour. He said that Officer A briefed him that David was an enforced medication inmate who refused to be medicated, was highly aggressive, and needed to be moved to a camera cell.

Negotiation and persuasion

The policy statement in the CSNSW use of force policy provides that persuasion and negotiation is a strategy to minimise risk when managing non-compliant behaviour by inmates. Further, section 2.1.1 provides: "*A planned use of force is one with prior indication that it **may** be necessary and there is time to prepare for its use - for example, an inmate refuses to come out of their cell, to get into a vehicle or refuses to be searched. These situations and others like them do not necessarily require the immediate use of force*" (original emphasis).

Officer A agreed that he approached the job with the view of avoiding the use of force if possible. He explained that the inmate dictates the terms, but agreed that by removing the biscuits it would have changed the approach taken by the IAT. He agreed that it would have been valuable information to him to have known if the nurse had only asked for the biscuits to be removed. He said he approached the cell with the assumption that whoever was in charge had already tried and exhausted other options. Officer A explained: "*…that would just be an assumption that the staff working in that area on the day, or the assistant superintendent, or management on that day working down in that area would have already [tried other options], hence the reason they've called us in as a last resort*".

Officer A was asked about using strategies in order to minimise risk in accordance with the OPM. He said the proclamation given to David by the IAT to comply with their directions within one minute, prior to entering the David's cell, amounted to negotiation and a risk mitigation strategy. He explained:

"*I'm not saying that I never go into any negotiation with an inmate. In the brief we were informed that negotiations had failed, which indicated to me that negotiations had took place. The way that I negotiate in a situation where negotiations have failed, the way that I've been trained to do that, is by providing an initial proclamation, and it clearly states and outlines what is required of the inmate, what is being directed of the inmate*".

Officer A said that the proclamation was the only negotiation skill that he had ever been taught, apart from referring to a specific training module for IAT members in relation to hostage response. He said that he had never received any training in relation to mental health issues. He agreed that avoiding the use of force would be a good outcome for all concerned.

The OPM provided the basis for the proclamations issued by Officer A:

"*You must give the inmate clear instructions about what you want the inmate to do and when you want them to do it. Clearly explain the consequences for failing to comply and give them a reasonable opportunity to comply. When all else has failed, only then instruct personnel to use force*".

Consistent with his training, Officer A issued the following proclamation to David:

"We need to do a cell move on you right now. What I want you to do is come to the door and place your hands through the door, you're going to be handcuffed and moved to another cell. Fail to comply with any of my directions, it may result in the use of force. Do you understand? I'll give you one minute to comply with my directions".

When David did not comply Officer A issued the proclamation for a second time. David again did not comply and the IAT entered cell 71 approximately 90 seconds after arriving at the cell door.

The view taken by Officer A regarding the proclamation given to an inmate relevant to the issue of possible negotiation was shared by some of the other IAT officers. Officer C was asked whether it was standard practice for the IAT to not be involved in negotiations. He said the only negotiation is the presence of the IAT or the proclamation. Officer O was asked whether the IAT discussed alternatives to the use of force. He referred to the first proclamation, explained that David was given the opportunity to comply, and that this amounted to use of persuasion and negotiation. He said that there was no discussion within the IAT about seeing whether someone else might be able to reason with David. Officer O said that he was not aware of any attempt to de-escalate the situation in the one minute between proclamation and entry. It was suggested that the extra information that David wanted to take on the IAT was a perfect chance to employ de-escalation techniques. Officer O said that the presence of the IAT is a form of de-escalation and that if the inmate chose to continue on a path that was a matter for them.

It was suggested that David's indication that he was going to take the IAT on was important information and that it was important not to proceed in a rigid manner until all other options had been exhausted. Officer A referred to a previous training scenario where non-compliance had been indicated after a proclamation but when the cell door was opened the inmate complied. He said that he had never not entered a cell after a proclamation had been given.

Officer O did not agree that it was unreasonable that an involuntary patient had only been given one minute for de-escalation. When taken to the fact that David was becoming more aggressive he said that it was the job of the IAT to deal with non-compliant inmates. Officer C similarly said that he considered it reasonable to ask a mentally ill person to comply within one minute. Officer C agreed that there was nothing physically preventing Officer A from spending 10 minutes at the cell door (attempting to negotiate with David) but expressed some reservations as to whether that would be in accordance with the policies and procedures specific to the IAT.

Officer A said that if appropriate training was provided he might be able to agree that an inmate might not be able to respond rationally, and that therefore there was a need to deal with them in a different way. He said that he understood that perhaps there was a need for a different approach when dealing with mentally ill patients who are not rational.

However Officer A's view was not shared by some of the other IAT officers. It was suggested that if the IAT was given further training then it could play a role in further negotiation or attempts to de-escalate the situation upon their arrival. Officer C disagreed with this proposition and said: "*Our name stipulates that immediate action needs to take place, sir. All four points of the de-escalation strategies were met by IAT. The persuasion and negotiation - persuasion, in itself, is our presence. Actually having us arrive is the persuasion tactic. The negotiation is the proclamation that we deliver and the minutes they have to think about it. The presence of senior officers, there's always a senior officer-in-charge of IAT. We always video record events and we are the IAT which is the fourth point of the list*".

Chemical aids

Section 2.3.1 of the OPM provides for the use of chemical aids in the use of force. Officer A was asked about using gas in G Ward. He said that he had always been informed by management that in a cell or interior environment gas was not to be deployed because of the air conditioning system. He said that the only time he had seen it deployed was 18 months ago in a training exercise outside G Ward. Officer O agreed there was an option to use capsicum gas but said that it was only used in situations where an inmate was armed or if there were multiple inmates and said he was not aware of it ever having been used in G Ward.

Conclusion: CSNSW policy identified that negotiation and persuasion is a risk minimisation strategy when dealing with non-compliant inmates. Notwithstanding, no actual active negotiation or persuasion was conducted by Officer A, or any other member of the IAT, upon their arrival at cell 71. Rather, the IAT considered that the proclamation issued to David, and the mere presence of the IAT, amounted to negotiation. Officer A explained that in David's case he understood that any attempt at negotiation had already failed, thus necessitating the involvement of the IAT as a measure of last resort. However, even with this understanding, it did not abrogate the responsibility of the IAT to actively negotiate with David in order to avoid the use of force, and its associated risks, if at all possible. So much is made clear by the provisions of the OPM which applied at the time.

The evidence given by Officer A that, in his experience, he had never not effected a cell entry after giving a proclamation clearly indicates that the same unreasonably rigid adherence to past practice was followed on 29 December 2015. It is accepted that the rigidity of the approach by the IAT was to a large degree dictated by training which had been provided to them and the distinct lack of emphasis on de-escalation techniques in CSNSW policies which applied at the time. Even so, it was acknowledged by Officer C that there was nothing to prevent Officer A spending considerably more time outside cell 71 attempting to negotiate with David. Adopting, or at least contemplating, such a course would have given appropriate effect to the OPM requirements that force was to be used when all else has failed, and that the situation which confronted the IAT on 29 December 2015 did not necessarily require the immediate use of force.

It was submitted by the solicitor for the Dungay Family that the use of the proclamation process, when used in Long Bay Hospital, should be reviewed on the basis that inmates suffering from a mental illness may not be able to respond rationally. Counsel for CSNSW submitted that such a review was not warranted on the basis that the proclamation process serves a different purpose to de-escalation techniques which are addressed in new Local Operating Procedures at Long Bay Hospital (discussed further below) introduced since David's death. Whilst this is so, it is evident that the proclamation is regarded as the final attempt at negotiation before use of force is imminent. Further, it was recognised by Officer U that taking a more considered position regarding a proclamation issued to a mentally ill inmate patient was warranted.

Recommendation: I recommend that Corrective Services New South Wales review the use of the proclamation process by the Immediate Action Teams in Long Bay Hospital to ensure that appropriate consideration is given, at the time the proclamation issued, to the possibility that a mentally ill inmate patient may not be in a position to comply or respond to the proclamation in a rational manner. It can be accepted that the use of chemical aids, as an alternative to the use of force, was not available on 29 December 2015. However, there is no evidence that any other alternative was considered, let alone explored, by the IAT members.

Issue 6: Whether the IAT members acted appropriately in the application of force to David/restraint of David on 29 December 2015

Section 5 of the CSNSW Custodial Operations Policy and Procedures (**COPP**) relates to using force on inmates. The policy statement provides the following instruction: "*You must use alternative methods to resolve problematic behaviour whenever possible. A peaceful, injury-free solution is the first objective*".

Section 2.1 relevantly provides: "*The type of force you use will depend on the circumstances and what resources are available. It must be reasonable, appropriate for the circumstances, and no more than necessary to manage the risk… You must give the inmate clear instructions about what you want the inmate to do and when you want them to do it. Clearly explain the consequences for failing to comply and give them a reasonable opportunity to comply. When all else has failed, only then instruct personnel to use force*".

Section 2.2 relevantly further provides: "*Once an inmate has been satisfactorily restrained you must not apply additional force. If the force is no longer necessary, you must stop applying it. That includes the use of restraints. Force must be applied in a way that minimises the injury risks to staff and the involved inmate(s). In every case, a correctional officer using force must justify the type of force they used, why they use it, and the duration of its use. This includes the use of security equipment*".

Officer A indicated that he understood these limitations on the use of force, and that these limitations applied not only to the IAT officers, but to all CSNSW officers.

A summary of the force applied by the IAT officers on 29 December 2015 follows:

The door to cell 71 was opened at approximately 2:43pm. Officer C was the first IAT officer to enter cell 71 carrying a shield, which David immediately collided into. Officer C used the shield to push David back in the cell, and used the shield to make contact with David for a second time.

Officer C released the shield and used his upper torso in a "*sort of a rugby style tackle*" to collide into David and force him backwards and onto the mattress of the cell bed. This caused David to land in a partially sitting position on the bed.

Officer C pushed down on David's upper torso, and then used his left hand to restrain David's left hand whilst using his other hand to turn David's face towards the cell wall to gain control.

Officers A, B, M and O entered the cell and assisted Officer C in restraining David on the bed. David was positioned in a partially sitting, partially supine position on the bed. Officer B and Officer O controlled David's arms and his hands were eventually cuffed at the front of his body. Officer M applied downward pressure onto David's legs. Some of the officers reported that David had been spitting blood.

David was restrained on the bed for approximately 1 minute and 37 seconds before being moved off the bed and onto the floor.

David was restrained for a further 1 minute and 25 seconds on the floor by Officers A, B, C M and O.

David was stood up and led from cell 71 to cell 77. Officer A directed the other IAT officers to control David's neck so that he could not spit blood at any of the officers. This resulted in David walked whilst bent forward and hunched over.

Whilst being escorted along the corridor between the cells, David said that he could not breathe and suddenly collapsed to the ground. He was lifted back to his feet by the IAT officers and continued to be escorted to cell 77.

Inside cell 77 David was placed onto the cell bed in a prone position with his head near the end of the mattress, whilst remaining handcuffed. Officer O used the Figure 4 technique to apply pressure to David's legs in order to restrain them. Meanwhile Officer C employed a technique known as a knee ride as a control measure to prevent David from moving his hips in order to avoid restraint. This involved Officer C placing his hands on David's shoulders, between his shoulder blades, with one foot on the ground and his knee against David's lower back. Officer B maintained handcuff control.

David remained restrained in this position in cell 77 up until the point that he became unresponsive, at approximately 8 minutes and 16 seconds after the IAT footage commenced.

David's inability to breathe

David first complained that he could not breathe whilst being restrained on the bed inside cell 71 (at approximately 2 minutes and 24 seconds into the IAT footage). He repeated his complaints of being unable to breathe on multiple occasions whilst restrained on the floor of cell 71, whilst being escorted from cell 71 to cell 77, and whilst on the bed inside cell 77.

In evidence, a number of the IAT officers were asked about what consideration they gave, if any, to David's complaints that he could not breathe:

Officer A said that he considered David's complaints to be "*a diversionary tactic employed by Mr Dungay so that we would loosen the restraint*". He explained that he considered this to be the case because although he thought David was exerted he could still hear his breathing. Officer A was asked, even accepting that it was his experience that past inmates had used a complaint of not being able to breathe as a tactic to loosen a restraint, whether he considered it was also possible that the complaint was genuine. Officer A said that he did not think that this was the case in David situation. Officer A explained that David followed instructions from the IAT, and the fact that David continued to talk to the IAT officers made him think that the complaints were not genuine.

Officer A agreed that he thought because David could talk he could breathe. He said that this was based on his own experience as a child when he experienced panic attacks and hyperventilated. He said that he recalled his father used to calm him down by telling him that because he could talk he could breathe and this always stuck with him: "*And my father used to always, in a way to calm me and reassure me, would say, "If you're talking, you can breathe. Just talk to me. Talk to me. If you're talking, you can breathe". That's something that always stuck with me*". Officer A agreed that he was not taught this as part of any training that he had received.

Officer A said that he had no concern regarding the amount of weight on David's back in terms of whether it would restrict his ability to breathe. Officer A said that the amount of pressure applied was dictated by an inmate. He was asked whether increased struggling meant more pressure. He said that it would not necessarily mean more pressure but instead more coverage of an area, particularly to stop an inmate rolling their hips and rising up.

When asked if he heard David gasping Officer A said that David sounded physically exerted and not like he was gasping. He disagreed that he could hear David struggling to breathe and instead said he sounded like "*someone that was short of breath from resisting restraint from officers*". He was asked whether he thought he had a responsibility to ensure that David was completely well when he said he could not breathe. Officer A replied, "*I agree that I had a duty of care to make sure he was okay, yes*".

Officer O was asked what his understanding was of the force permitted to be used. Similar to Officer A, he said that it was dictated by the inmate in the sense that if the inmate was compliant minimal force was used. However, if there was resistance shown by the inmate then only enough force would be used in order to gain control.

When the IAT footage was played to Officer O he disagreed that David could be heard gasping and instead described the sounds as heavy breathing. He said that at no point did he form the view that David's complaints about being unable to breathe were genuine. He said that he did not see anything from his observations to think that the complaints were genuine. When asked whether he considered the heavy breathing to be a sign of breathing difficulty, he said that everyone in the cell had been involved in the use of force and that it had been a physical interaction and that everyone was breathing heavily.

Officer B said that his view about the genuineness of the complaint only changed within seconds after the first injection. He said that this was because David's breathing appeared more laboured and that he was trying to take in more air and agreed that it could be described as David gasping. Officer B said that he asked Officer C to turn David's head in his direction. Officer B said that he then monitored David airway and could see him breathing and his chest expanding. Officer B described David's breathing as him being out of puff from taking on the IAT. He said that he gave no thought at that time to the fact that David might have been struggling to get air in. He was asked whether he thought the complaints were genuine and said that he thought it was a bluff or tactic used to relax the restraint as it had been used in the past. However he acknowledged that he had to try to assess what was in front of him.

Officer B said that he had watched a video in his own time – he believed it was an instructional type video in relation to a US prison – in which he had heard someone telling an inmate that if they could talk they could breathe. He said that that he also recalled reading some literature that his partner had regarding first aid which indicated that for a person who was choking if they could talk it only indicated a partial lodgement and that the airway was still open. He said that what he saw in the video informed his thinking on 29 December 2015. He said that he now understood what he had previously seen and read to be a "*total myth*".

Officer C was asked about David's breathing. He said that he noticed David was breathing heavily and puffing from exertion. He said he would not use the term gasping. He was asked whether he thought the complaints were genuine. He said that he thought David was puffed from exertion. He said that he did not see how David could not breathe as no one was compressing his chest.

Officer C was asked whether it appeared that David was trying to take deep breaths. He said that it sounded like deep puffs and that he did not consider that David was gasping. He agreed that if there were no physical exertion that would be gasping and compared it to a panic attack. Officer C was asked about his understanding of the repeated statements made to David that if he could talk he could breathe. He said that he considered it to be a "*calming measure*", to remind a person that if they are speaking they are actually breathing.

Officer C agreed that David was not struggling in the same way during the transfer but said this did not cause him to become concerned that David's complaints might be more than merely exertion. He was asked if it was fair to say that no consideration was given to David's breathing at this time. Officer C said that he was always conscious of David's breathing and that he heard he was breathing deeply and often.

Officer F agreed that he possibly thought David saying he could not breathe was a tactic to get out from his restraint. He said that he did not take it seriously and did not think to call a doctor. He agreed he heard David scream a number of times that he could not breathe and saw him collapse to his knees at one point. He said that despite officers being around David and David's head turned towards the wall he believed David was breathing because he could hear his breath and see the rise and fall of his chest, even though he was face down on his stomach with one officer's knee on his back. It was suggested to Officer F that he could hear David gasping and that David was audibly having difficulty with his air intake. Officer F rejected this suggestion and said that he could only hear David taking "*deep breaths*".

Officer F was asked whether he thought the laboured breathing meant that David could not get any air. He said that was possible but that it also might have meant that David was attempting to rest in order to fight again. He said that from hearing David say he couldn't breathe he thought that due to the number of people in the cell, and the increased temperature, David may have found it hard to get air.

Officer F said that he thought David was faking difficulty breathing in cell 71, but not during the move, and initially said that in cell 77 he thought David was taking deep breaths but with no trouble breathing. Eventually he accepted that David was having trouble breathing when he was in cell 77.

Officer F said it didn't occur to him to call for medical help because he was waiting the nurse to return and he didn't feel any concern as David was lying on the bed with his arms out and breathing. It was indicated that the nurse was returning to give an injection not check David's breathing. He was asked whether he thought he should indicate that David's breathing should be checked and said no. Officer F agreed that if he was not happy with the actions of the IAT that he had the authority, as the senior officer on scene, to order them to stop. When asked what dangers there were to David as a result of the position he was in, he said that there was no danger and that whilst he had difficulty breathing, he was still breathing.

He said that the fact that David was face down and the length of time under restraint caused him no concern. He said that the further wait for a second injection to be given also caused him no concern.

Conclusion: It is evident that most of the IAT officers considered David's complaints of being unable to breathe as being disingenuous, and amounting to an attempt to avoid further restraint. However some officers, such as Officers B, C and F, indicated that their concerns about the genuineness of David's complaints lessened as David was escorted from cell 71 to cell 77 (during which time he collapsed to his knees), and once he had been placed on the bed in cell 77.

Notwithstanding this acknowledged possibility that David's complaints were in fact genuine, no enquiry was made with any available Justice Health staff so that a proper determination could be made. Instead, several of the officers relied upon their own personal experiences or personally acquired understanding, which were inherently flawed.

It is acknowledged that all but one of the IAT officers were, to a significant degree, constrained by the limitations of training which had not been provided to them prior to 29 December 2015. This issue will be considered in more detail below in the context of risk factors associated with positional asphyxia. However, even leaving aside any gap in training, David's persistent complaints of being unable to breathe, together with his audible gasping respirations should have prompted action in the form of a request for nursing or medical assessment. Instead, David's complaints were ignored and his gasping was incorrectly attributed to exertion.

Restraint on the floor

As noted above, David was moved from the bed to the floor of his cell and restrained for a period of almost 90 seconds. As this occurred he continued to complain of difficulty breathing. Several of the IAT officers provided explanations regarding the need to move David to the floor under continued restraint: Officer A said David was placed on the floor because it allowed for more room, compared to the awkward positioning on the bed. He agreed that David had been handcuffed on the bed but disagreed with the suggestion that David was under control. He said that he was more satisfied that David was under control when he was placed on the floor.

In contrast, Officer B disagreed with the suggestion that it was possible David was taken to the floor in order to gain control. He said that once David had been cuffed on the bed he was under control. Instead, Officer B said that David was placed on the ground because he was spitting. Officer C said that he understood the need to move David to the floor was because the IAT needed to prepare him to get him to his feet to walk by himself to cell 77.

Conclusion: The conflicting accounts given by the IAT officers regarding the need to move David to the floor suggest that there was confusion amongst the IAT as to whether the move, and David's continued restraint on the floor was warranted.

It is accepted that there was a basis for the IAT to use continued mechanical restraints to restrain David until the cell transfer could be effected. However, the evidence of Officer B raises the possibility that, in accordance with the OPM, David had already been satisfactorily restrained on the bed prior to being moved to the floor. If this was the case then the application of additional force whilst David was on the floor would not have been warranted and David could have been walked to cell 77 at an earlier stage.

Escort from cell 71 to cell 77

During the escort from cell 71 to cell 77 the IAT officers maintained David in a hunched over and bent forward position. This was to prevent David from spitting blood which had occurred whilst in cell 71. Officer A was asked whether as at 29 December 2015 the IAT officers had available to them equipment to deal with an inmate spitting. He indicated that the officers had access to a riot helmet provided by CSNSW, and an elasticised spit mask which could be provided by Justice Health. Officer A said a spit hood was not available on hand but was available in the IAT office, although it was not taken to incidents to which the IAT were called as a matter of course. He explained that it was his understanding that use of the spit hood needed to be approved by the Commissioner. Training provided to IAT officers established that they were to always wear riot helmets with visors when assigned to attend incidents. However in practice this did not always occur. Officer C expressed certain difficulties associated with wearing a riot helmet. He described them as ill-fitting, uncomfortable and cumbersome. He explained that because the helmets were designed to allow a gas mask to be worn underneath it, they sit further out rendering them ineffective.

Conclusion: The absence of an approved spit hood on 29 December 2015 and difficulties associated with the functionality of riot helmets which were available to the IAT meant that alternative measures had to be adopted during David's transfer between cells. This had the consequence of additional force being applied to maintain David in a bent forward position to reduce the possibility of spitting towards the IAT officers. Given David's continued complaints about difficulty with breathing during the transfer, and the fact that he collapsed to his knees during it, the maintenance of David in this position was undesirable.

Use of the knee ride in cell 77

Once David had been placed on the bed in cell 77, Officer C was asked whether it was possible to restrain David adequately just by Officer B maintaining control of David's arms and Officer O using a Figure 4 leglock to restrain David's legs. Officer C said that David still had the opportunity to roll his hips and make the Figure 4 leglock useless. Therefore, there was a need to use his shin to prevent rolling of David's torso. Officer C agreed that he had applied what he described as "*very minute*" pressure to David's shoulder blades and legs. When the IAT footage was played to Officer C in evidence he agreed that his knee was in David's lower back and towards his upper back. He also agreed that David was adequately restrained by this point. This continued in circumstances where David continued to complain of difficulty breathing.

Conclusion: By Officer C's own acknowledgment, David was adequately restrained on the bed in cell 77 when the knee ride continued to be applied. Consistent with the provisions of the OPM, the application of such additional force was not warranted in circumstances where satisfactory restraint had been achieved.

Overall, counsel for Officers A, B and C submitted that any criticism of the actions of these officers is not warranted on the basis that their actions were a reasonable response to David's actions and aggression. In support of this submission counsel referred to two authorities which refer to an objective test in determining the question of reasonableness. However the submission made by counsel for Officers A, B, and C incorrectly applies a subjective test. On this basis alone, the submissions cannot be accepted although it is noted, for clarity, that objective consideration has been given to the conduct of all of the IAT and CSNSW officers.

Other considerations

The solicitor for the Dungay Family submitted that a referral ought to be made to the NSW Director of Public Prosecutions pursuant to section 78(4) of the Act with respect to the conduct of Officer A and Officer F. On this basis it was submitted that the evidence in the inquest enlivened section 78(1)(b) of the Act.

That section does not provide the basis for a sufficiently interested party to make an application for a referral pursuant to 78(4) of the Act. Rather, section 78(1)(b) provides the basis for certain procedural steps to be taken in relation to the conduct of an inquest if a coroner forms an opinion as to the likelihood of a known person being convicted of an indictable offence that is causally related to the death of the person who the inquest is concerned with. Its purpose in doing so is to preserve the rights of any such person of interest and the integrity of any consequent criminal proceedings, and to separate the role and functions of the coronial and criminal jurisdictions.

If an issue had arisen during the course of the inquest as to the possible enlivenment of section 78(1)(b) then, as a matter of procedural fairness, the opportunity to make submissions regarding this issue would only have been extended to any interested party in potential jeopardy, and to Counsel Assisting. The opportunity would not have been extended for submissions to be made on behalf of the Dungay Family, or any other party with sufficient interest in the inquest but that was not in jeopardy. This is on the basis that any party's right to be afforded procedural fairness could in no way be effected by whether section 78(1)(b) was enlivened or not.

On this basis, upon receipt of the written submissions by the solicitor for the Dungay Family, the legal representatives for each of the interested parties were advised in writing of the above on 8 August 2019. The legal representatives were also advised that there was no requirement for any interested party, or for Counsel Assisting, to provide submissions on this issue. Accordingly, it is not proposed to give consideration to the submissions made by the solicitor for the Dungay Family.

However, for avoidance of doubt, it can be indicated that even if there was a proper basis to consider these submissions, they are constrained by the operation of section 61 of the Act. During the course of the inquest, counsel for Officers A and F raised an objection pursuant to section 61(1)(b) of the Act to those officers giving evidence. It was indicated on behalf of the officers that their evidence would be given willingly if they were issued with a certificate pursuant to section 61(5) preventing their evidence from being used against them (except in relation to criminal proceedings in relation to the falsity of their evidence). Certificates pursuant to section 61(5) were subsequently given to both officers.

Had Officers A and F (and other officers who were also given section 61(5) certificates) been placed on notice of a real possibility that section 78(1)(b) would be enlivened, then it is likely that that they would not have given their evidence willingly. This eventuality would have required consideration of section 61(4) of the Act. It would be procedurally unfair to now consider the submissions made by the solicitor for the Dungay Family regarding the potential operation of section 78(1)(b) having regard to the history which has just been outlined. Further, by virtue of the protection provided by the 61(5) certificates themselves, the evidence given by Officer A and Officer F raise clear admissibility issues in any prospective criminal proceedings and therefore cannot be taken into account when considering the matters set out in sections 78(1)(b)(i) and 78(1)(b)(ii). These same considerations also apply in relation to further submissions made by the solicitor for the Dungay Family regarding potential work, health and safety prosecution. Having regard to each of these matters, the submissions cannot be accepted.

Issue 7: Whether the IAT members were appropriately trained in respect of the application of force/restraint of inmates, including any risk of positional asphyxia, prior to 29 December 2015

CSNSW officers are trained in the use of force as part of the Weapons and Officer Safety Training (**WOST**) component of their primary training. Additionally, officers are required to complete the Emergency Response Operators Course (**EROC**) to be eligible to perform IAT duties. The EROC replaced the former Security and Emergency Procedures Training Course (**SEPTC**) in around 2012 to 2013. Instruction regarding positional asphyxia has been included in the WOST Participation Guide since at least January 2013. The January 2015 version of the WOST Participation Guide relevantly provided:

"*Any, [sic] body position that interferes with a muscular or mechanical components of respiration, or that obstruct the airway, may result in positional asphyxia. There is an even greater risk where the person is unable to move in order to breath [sic]. This inability may be as a result of the effects of drugs or exhaustion or they may be restrained so they cannot move. Death can occur rapidly. Depending on the individual circumstances, death may occur unexpectedly and within a very short period of time*".

The WOST Participation Guide identified obesity, psychosis, pre-existing physical conditions, respiratory multiple fatigue, multiple officers holding an inmate in the prone position, and chemical agents as all being risk factors for positional asphyxia death.

The WOST Participation Guide goes on to provide that "*operational recognition of risk factors is the first step in [positional asphyxia death] prevention… Close attention should be given when the correctional officers recognise the following signs or symptoms, taking immediate action to remedy the problem:*

Telling you that they cannot breath [sic]

Gurgling gasping sounds

Cyanosis (face is discoloured blue due to lack of oxygen)

Panic, prolonged resistance

Sudden tranquillity - an active offender suddenly becomes passive."

The EROC Manual relevantly provides: "*Positional Asphyxia is most simply defined as when the position of the persons [sic] body interferes with respiration, resulting in death from asphyxia or suffocation [original emphasis]*". It goes on to identify the same risk factors, and signs and symptoms, for positional asphyxia as contained in the WOST Participation Guide.

Training records of the six IAT officers revealed that officers A, B, C, M and N all completed their WOST and SEPTC training prior to September 2011. This meant that none of these five officers had, prior to 29 December 2015, received any training or instruction regarding the risk of positional asphyxia generally in relation to restraint, particular risk factors, or its signs and symptoms. Officer O completed his WOST training in March 2014 and his EROC training in July 2015. This meant that he was the only officer in the IAT on 29 December 2015 that had received any training or instruction regarding the risks associated with positional asphyxia.

Even so, the Death in Custody Report prepared by Officer Bagley identified that insufficient emphasis was given to positional asphyxia risk in EROC training. Specifically it was identified that instructions regarding positional asphyxia risk in the EROC Manual was effectively an abridged version of the same information contained in the WOST Participation Guide; the risk of positional asphyxia was limited to classroom instruction without any inclusion of practical or scenario-based training, and the risk of positional asphyxia was not a distinct part of the situational assessment for planning of cell extractions.

The Death in Custody Report (dated 21 September 2016) made a recommendation "*that CSNSW immediately advise all correctional officers of positional asphyxia risk, particularly the dangers of prone restraint, prolonged restraint, and placing of any pressure on a person's torso or neck while under restraint*". The first response to this recommendation appears to have been a memorandum issued by the Security Operations Group - Training dated 3 July 2017 (**the July 2017 memorandum**). The July 2017 memorandum notes that "*there is a need to highlight the implications of positional asphyxia*". It goes on to define positional asphyxia "*as when the position of a person's body interferes with their breathing, resulting in death from asphyxia or suffocation*".

It also advises that the EROC Manual and WOST Participation Guide have been updated to include information about what positional asphyxia is, its risk factors, and the signs and symptoms of positional asphyxia. It also requests recipients of the memorandum to ensure that staff read the relevant updated section of the EROC Manual, and includes an intranet link to the document.

The evidence established the specific understanding of the IAT and other CSNSW officers as at 29 December 2015 with respect to positional asphyxia, its risk factors, and signs and symptoms as follows:

Officer A said that he did not learn about positional asphyxia in training and did not know what the term meant as at 29 December 2015. He said that he had not received any refresher training between 2009 and 2015 in relation to the use of force. He said that he had received ongoing training more recently, but not up to 29 December 2015. He said that the only refresher training he had received regarding use of force was in relation to the use of equipment such as batons and chemical munitions. He said that he had not been told of changes to the EROC prior to the July 2017 memorandum but said that it would have been useful if he had been told.

Officer A was taken to the July 2017 memorandum in evidence and said that this was the first time he had received any information regarding positional asphyxia. He agreed that all the risk factors identified were present on 29 December 2015. He agreed that it was valuable to have this information on 29 December 2015 and accepted that without this information he was not in a proper position to minimise risk to the IAT members and inmates.

He also accepted that if he had information regarding positional asphyxia it would have made a significant difference to his assessment of whether David genuinely could not breathe, and that it made it more likely for him to consider that the complaint was genuine. Officer A was asked if the information regarding positional asphyxia had been provided to him whether it would have made it more likely that he would have treated it as a medical problem that needed medical attention. He said: "*Not so much medical attention the first instance, but it would have provided me the tools I needed to possibly change the position so that I could take the complaint as serious, and then if it further developed I could definitely seek medical attention immediately*". He agreed that if confronted with the same situation now and it looked like the complaint was genuine he would take rapid action to seek medical assistance.

Officer A agreed that he had not been asked to repeat EROC training since 2015. When asked if he thought it was beneficial for the IAT to receive additional training about restraint and how to identify positional asphyxia he said that the information he had been given was a start but that training would be beneficial. He agreed that training should be face-to-face and involve role-play and health professionals. He said that it would be beneficial for all CSNSW officers, not only IAT officers. Officer B said that from the time of his primary training up to 29 December 2015 he had never received any training in positional asphyxia in relation to the use of force and restraint. He said: "*All training I received up until that time, zero reference*". Officer B said that the July 2017 memorandum was handed to him by another IAT member.

He said that since 29 December 2015 he had not received any refresher training in relation to restraint or positional asphyxia, and that it had all been literature-based. He agreed that face to face training would not only be beneficial to IAT members but all CSNSW officers, and agreed it would have been valuable to have known about in on 29 December 2015.

Officer C said that he had not received any training in relation to positional asphyxia prior to 29 December 2015. He said that the only refresher training he had received since had been in relation to equipment use. He agreed that the last training he had received in relation to restraint was the SEPTC course in 2011. He said that it absolutely would have been valuable for him to have known information regarding signs and symptoms of positional asphyxia on 29 December 2015. He was asked whether he felt handicapped in carrying out his duties by not knowing this. He said that he would not use the term handicapped but said that he felt more equipped with the benefit of this knowledge.

Officer C was asked if he thought whether the information should have been passed on by CSNSW if they had it in their possession. He said that was a question for the executive but said that he thought all information should be shared in order to meet the duty of care to inmates. He said that if the organisation had information regarding risks it was important to pass that on so that he could carry out his job. He agreed that it would have been useful to know all the information about positional asphyxia, however he said that it would have made no difference to the restraint and cell extraction on 29 December 2015.

He said that if David needed to be moved and restrained for medication that the cell entry would remain the same but that the restraint would change. He said that a spit hood would be used so that David could walk upright. He also said that if they knew there would be a long period between the first and second injection that David would be placed in the recovery position, that he would be reassured, and that a nurse would possibly be requested to monitor his breathing.

Officer F said at the time of restraint he had no idea that a warning sign of positional asphyxia was a person struggling to breathe and complaining of it. He said he assumed that by a person talking meant that they could breathe but agreed that this assumption could be challenged by medical evidence. He said that he had no awareness of positional asphyxia until reading it in the COPP in 2018. He agreed that apart from the OPM, which governs the use of force, there was no other CSNSW policy applicable at the time which covered the restraint of patients in Long Bay Hospital. He agreed that the OPM contains nothing about the techniques for restraint or the dangers of prone restraint.

Officer O described the risk of positional asphyxia when someone is placed in the prone position as being "*quite rare*". He said that on 29 December 2015 the prospect that David might have been at the risk of positional asphyxia did not enter his thinking at all. Officer O said that he thought the way that David was restrained best minimised the risk to David and to CSNSW staff. When asked if he thought there was increased risk with the weight of an officer on David's back he said that there was an officer continually checking his breathing so he was unconcerned.

He was asked whether he gave thought to restraining David on his side. He said that it was standard practice for an inmate to be restrained in that way so that an injection could be given in the buttocks. Officer O said that he was unaware why psychosis was a risk factor for positional asphyxia and said that he had received no training on this issue. He agreed that other than the July 2017 memorandum he had received no remedial training in relation to the IAT actions on 29 December 2015. He agreed that even though attempts had been made to check David's breathing the fact that David became unresponsive despite this suggested that something needed to be done earlier.

Officer O was asked what he would do differently now. He said that after an injection a patient would be rolled to their side whilst waiting for any subsequent injection. He said that this was based on his own experience of the events of 29 December 2015 rather than any training he had received. When asked whether he would normally restrain a person in the prone or another position he said that it would depend on the job. He was asked whether he would do anything in relation to a patient with known risk factors in the prone position. He said that he would move the inmate to the side and continually check their airway. Officer O said that he would avoid having persons on the inmate's back and said he would call a doctor or nurse if the inmate was having trouble breathing. When asked what was needed to satisfy him that an inmate was having trouble breathing he said that he would need to hear choking or wheezing and see that the inmate's chest was not moving.

CSNSW systems as at 29 December 2015

In evidence Officer Bagley made a number of concessions relevant to the lack of appropriate training provided to the IAT officers on 29 December 2015 including: It was fair to say that if the information contained in the WOST had been given to the IAT on 29 December 2015 they could have applied force in a different manner, and they should have done so. If the IAT had knowledge of the signs and symptoms of positional asphyxia "*they would be far more alert to the situation*".

It was a significant failing if only the most junior members of an IAT had any training in relation to the risks of positional asphyxia, and that it was the IAT leader more than anyone who needed to be made aware of such risks. Officer Bagley said that he had no idea why the training for an IAT member via the EROC was less fulsome than the training provided by the WOST, but agreed that as a matter of logic the IAT should receive the more detailed training.

It would be helpful for the IAT to have a ready reckoner of information relevant to a patient and said that it would be helpful for an Assistant Superintendent to provide a briefing about this. Officer Bagley agreed that information contained in an inmate profile was very helpful as part of the situational awareness process. He also agreed that a reference to David being acutely psychotic was also useful for any situational assessment, and that it would be useful to have a proforma document to guide the IAT and help them go about their duties in a way which minimised risk to inmates and officers.

Steve Davis, the General Manager of the Security Operations Group (**SOG**), also made a number of similar concessions including: When the risks of positional asphyxia were introduced to WOST training in 2013 no advice was given to existing officers who had already undertaken the training. Knowing not to use more force than necessary in accordance with the training provided to IAT and other CSNSW officers is different to knowing about positional asphyxia and its risk factors. It was a significant failure in training that existing officers were left ignorant until 2017. IAT officers need to be aware more than others of the dangers of restraint. The same information as contained in the WOST should be in the EROC, or even further information contained in the EROC.

It was a significant failure in training for existing officers to not be told of the EROC changes.

CSNSW systems after 29 December 2015

Officer Bagley was asked to assume that the July 2017 memorandum was the first response in relation to the Death in Custody recommendations from September 2016. He said that he did not regard this as a sufficiently urgent response and agreed that something should have been disseminated within weeks. He expressed the view that it would also be preferable for a document-based response to also be coupled with face-to-face training, particularly for IAT members.

Officer Bagley said that he was not aware whether the IAT were advised about the updated EROC. He agreed that the July 2017 memorandum did not contain strong advice about the dangers of prone restraint relative to the contents of the Death in Custody report. Officer Bagley said that he was confident that the dangers identified in his report had been covered thoroughly in the COPP. However, he agreed that the July 2017 memorandum did not warn against the use of prone restraint, and that just by reading the memorandum, and not accessing the COPP, a reader would not know about the dangers of prone restraint.

Mr Davis said that he did not receive a copy of the recommendations arising from the Death in Custody report until February 2017. He was asked about any urgent advice that might have been provided by the SOG in response to the Report's recommendations relating to the risks of positional asphyxia. He indicated that an IAT conference was conducted on 8 March 2017 which brought together IAT officers and team leaders from across the state so that awareness could be raised regarding positional asphyxia and its risk factors. When it was suggested that the response should have occurred earlier Mr Davis referred to the fact that the Death in Custody Report recommendations were only received in February 2017. Mr Davis agreed that in order for him to do his job properly, the recommendations should have been received earlier.

Mr Davis agreed that one of the outcomes of the 8 March 2017 conference was that it was still necessary to restrain people in the prone position. He agreed that this was in complete opposition to recommendations arising from the Death in Custody Report but said that consideration needed to be given to the fact that in most uses of force the person restrained will end up on the floor the majority of the time.

He agreed that no decision was made by CSNSW as an organisation regarding any amendment to the WOST or EROC because the prone position was regarded as the most effective way to restrain a person for the safety of the inmate and staff. He agreed that no expert medical advice was received at the conference. Mr Davis was asked whether his view (as at July 2018) was that prone restraint was a safe technique for CSNSW officers to undertake. He replied: "*Providing - absolutely in the circumstances and providing that the restraint is not held for any long periods of time. In some circumstances it is the safest of means and that's from all, in our specialised areas it would be their view*".

Mr Davis disagreed with the suggestion that no IAT members had been retrained since receiving notification of the Death in Custody Report recommendations in February 2017. Instead, Mr Davis repeatedly referred to the fact that there was now an awareness of positional asphyxia and its signs and symptoms. He referred to the COPP and the fact that there had been follow-up with an online training module to reach officers in the most timely manner. Mr Davis sought to explain: "*All I can say is we have addressed the awareness of position asphyxia [sic] in relation to the conference, in relation to our memo with the information on position asphyxia [sic] and also in relation to the new custodial operations policies and procedures which clearly outlines the signs, the symptoms and what to do in relation should - should position asphyxia [sic] become an issue*".

Later in evidence Mr Davis was asked whether he thought there was any benefit to having officers practically trained rather than having them read documentary updates. He replied, "*I think it's an awareness. I think the information needs to get out there as quickly as possible in relation to position asphyxia [sic] and I think the quickest way to do that is through the Learning Management System where all staff could have access to it, know the symptoms. Know the signs, know what they need to do and at the same time this can also be used as a management training so it can be done every two years as opposed to a face to face training which would be nothing more than a theory based session as well*".

Mr Davis repeatedly stated this position even when it was pointed out to him that the IAT were paying close to David's breathing and he still collapsed. It was suggested that this highlighted the need for training. He said that instead there was a need to identify the symptoms and respond to the issue. It was suggested that it would be useful to use role-play scenarios. However he referred to the Learning Management System and indicated that it was interactive and able to reach officers in the shortest time possible.

The matters raised with Officer T and Mr Davis were also raised with Assistant Commissioner Kevin Corcoran. He agreed that more urgent action could have been taken in relation to making officers aware of the dangers of positional asphyxia. He also expressed concern that junior officers had this awareness but that senior officers did not. Assistant Commissioner Corcoran agreed that in hindsight it would have been a good thing for CSNSW as an organisation to have issued a memorandum around the time of David's death expressing the need for caution with prone restraint, and agreed that doing so would not have been an onerous task for CSNSW. He acknowledged that the first communication to the IAT being in the July 2017 memorandum was too slow of a response.

Assistant Commissioner Corcoran was asked about his view of the use of prone restraint generally in correctional centres. He replied: "*Look the view I have I think is shared by other senior people in the agency is that we need to use that prone restraint for as short a time as possible to gain control of a situation and hopefully you wouldn't have to use that. But every situation is different and you know there is still a time that that may need to be used but for as short a period as possible*".

Assistant Commissioner Corcoran agreed that the possibility of death occurring suddenly from positional asphyxia highlighted the need to call for medical advice when a planned use of force was to occur. He agreed that G Ward was unique, as was Long Bay Hospital as a whole. He agreed that it would "*be a good thing*" to require a doctor or nurse to be present in the case of a planned use of force to assist in identifying risk factors and the possibility of positional asphyxia. He agreed that CSNSW needed to look at G Ward closely and see what practices were occurring there in relation to enforced medication.

Assistant Commissioner Corcoran said that it would have been appropriate to retrain all officers who had received their WOST training prior to 2013. To address this issue Assistant Commissioner Corcoran indicated that a training course would be rolled out to all correctional centres with an IAT and would involve theory, case studies and practical application. He said that field training officers would also take this training to other correctional centres without an IAT.

Assistant Commissioner Corcoran said that he was aware that Officer E expressed the view that he would still restrain an inmate in the same manner. On this basis Assistant Commissioner Corcoran said that there was a need to treat G Ward differently and referred to the intention by CSNSW to form a Working Group with Justice Health to consider such issues.

Conclusions: The evidence given by the various IAT officers, and the appropriate concessions made by Assistant Commissioner Corcoran, Officer Bagley and Mr Davis clearly establishes that there was a significant insufficiency in the training provided to IAT officers as at 29 December 2015. In circumstances where IAT officers are more likely to be involved in the use of force than other CSNSW officers, it was incumbent to provide them with sufficient training regarding positional asphyxia, its risk factors, and its signs and symptoms. This plainly did not occur, leading to a situation on 29 December 2015 where David's individual risk factors were unknown to the IAT officers, and his symptoms either inappropriately minimised or ignored entirely.

It was also appropriately conceded by Assistant Commissioner Corcoran that the organisational response by CSNSW following David's death, and in particular following the Death in Custody Report recommendations relating to positional asphyxia, was not timely. It was readily acknowledged that dissemination of information to CSNSW officers regarding the risk of positional asphyxia could have occurred in the immediate period following David's death. Instead, a period of 18 months elapsed before the issuing of a memorandum which itself was not entirely sufficient in the sense that, read on its own, it provided no explicit warning regarding the dangers of positional asphyxia.

Further, the July 2017 memorandum was not accompanied by any practical retraining for CSNSW Officers in relation to positional asphyxia and its warning signs. Nor was any re-training provided to CSNSW officers who had completed their WOST Participation Guide prior to 2013. The absence of such training is reflected in the intransigent nature of Mr Davis's evidence. He repeatedly, and inappropriately, maintained that the documentary-based awareness of positional asphyxia provided to CSNSW officers was sufficient, and that scenario-based practical training was seemingly, and incorrectly, without merit.

Remedial action taken since 29 December 2015

In July 2018 CSNSW introduced an online training package titled *Positional Asphyxia Awareness*, which had been developed by the SOG (and an external organisation), that could be accessed via the CSNSW Learning Management System. The training was mandated for all custodial staff up to and including the rank of Functional Manager/Senior Assistant Superintendent and was to be completed by 1 October 2018. Further, the training was required to be undertaken every two years. In evidence Officer U (the Acting General Manager of the Special Operations Group between December 2018 and February 2019) indicated that as at 22 January 2019 approximately 10 percent (or approximately 500 officers) of applicable CSNSW officers were yet to complete the *Positional Asphyxia Awareness* online training. Officer U indicated that there is a means by which completion of training by all applicable offices can be verified.

Recommendation: I recommend that Corrective Services New South Wales continue to provide Positional Asphyxia Awareness online training to all custodial staff up to and including the rank of Functional Manager/Senior Assistant Superintendent, and audit completion rates annually to identify correctional staff who have not yet completed such training.

In August 2018 CSNSW also introduced a four hour training module on positional asphyxia available to SOG officers who have undertaken Learning Management System training and are qualified, and regularly rostered, to perform IAT duties. The training module includes a theory revision component, a practical teaching component, and two assessment-based practical scenarios. Between 24 August 2018 and 23 October 2018 327 IAT and SOG officers completed the training module at 18 correctional centres across New South Wales. However not all officers qualified to undertake IAT duties completed the training module due to roster and leave constraints. As at 8 March 2019 Officer U was unable to provide a more up-to-date and precise indication as to how many IAT and SOG officers had completed the training module, but agreed that it was important to have as many applicable offices complete the training as possible. Further, the training module only targets CSNSW officers regularly rostered to perform IAT duties. It is evident that there are other officers working in the Mental Health Unit, not performing IAT duties, who have not received the benefit of such specialist training.

Recommendation: I recommend that Corrective Services New South Wales continue to provide specialist practical training on positional asphyxia to Immediate Action Team and Special Operations Group officers, and audit completion rates annually to identify officers who have not yet completed such training.

Recommendation: I recommend that Corrective Services New South Wales provide training to all Corrective Services Officers working in the Mental Health Unit in restraint techniques, positional asphyxia and the risks of sudden death from restraint.

Section 13.7.8 of the COPP provides for restraint for medical treatment and Section 13.7.9 provides for medical considerations in the context of force. Relevantly (as noted above), section 13.7.8.3 provides that correctional officers should follow directions from Justice Health medical personnel regarding the positioning of a patient during enforced medication procedures. Equally relevantly, section 13.7.9.2 sets out a list of warning signs of positional asphyxia and notes the following: "*attention must be given to a person's claims that they cannot breathe. All reasonable efforts must be made to ensure the person has unrestricted breathing. It is a common misunderstanding that a person who can talk must be able to breathe… A person under restraint who is asphyxiating may resist restraint in an attempt to breathe which can be easily mistaken as non-compliance or violence towards officers it can be hard for correctional officers to distinguish between violent resistance and a struggle to breathe. Therefore ensuring unrestricted breathing and close monitoring for warning signs is extremely important*".

In evidence Officer U indicated that it would be possible to review the video footage commonly recorded by IAT teams in the use of force to identify whether the training provided by CSNSW regarding positional asphyxia and prone restraint was being put into practice. However, Officer U indicated that such a review process had not been discussed or considered because every use of force in a correctional centre is already reviewed by the manager of security or functional manager at a centre, as well as the general manager of the centre.

Recommendation: I recommend that Corrective Services New South Wales audit at least one-third of all video recordings, as a representative sample, of uses of force by Immediate Action Teams in order to verify that sections 13.7.8 and 13.7.9 of the Custodial Operations Policy and Procedures have been complied with, with consideration to be given to additional auditing if the nominated representative sample does not allow for such verification.

As part of the Working Group meeting that took place on 29 December 2018, a number of recommendations arose. The first recommendation was for CSNSW to source a suitable soft-restraint system for the mental health unit as an alternative to the use of metal handcuffs where appropriate. It was noted that such a system should be designed in a way that permits reasonable freedom of movement patients while protecting persons from harm. The second recommendation was for the SOG to adopt a revised use of force training package for mental health unit staff which places greater emphasis (50% weighting) on de-escalation techniques versus physical control and restraint techniques.

In December 2018 a number of different soft restraints, including the ones used at the Forensic Hospital, were reviewed to identify a suitable soft restraint to conduct a trial. In evidence Officer U indicated that a decision had been made to trial the soft restraint used at the Forensic Hospital, with plans to provide relevant training to staff from the court escort and the SOG, with a view to extending back training to correctional staff in G Ward.

In relation to the second recommendation Officer U indicated that as at 8 March 2019 a working group within the training arm of the SOG have been tasked with the creation of such a training package.

Recommendation: I recommend that Corrective Services New South Wales complete the trial of a suitable soft restraint system for use in the Mental Health Unit as an alternative to the use of handcuffs, with the relevant training to be provided to applicable staff including staff in G Ward.

Recommendation: I recommend that Corrective Services New South Wales, through the Special Operations Group, create and implement a revised use of force training package for Mental Health Unit staff which places greater emphasis (50% weighting) on de-escalation techniques versus physical control and restraint techniques.

Issue 8: Whether appropriate and timely steps were taken to establish cells 71 and 77 as a crime scene after David was moved between cells on 29 December 2015

The evidence establishes that following David's transfer from cell 71 Officer E instructed RN Amanda Jay to clean cell 71. The motivation in doing so was because bodily fluids, including blood, had been identified within cell 71.

This cleaning was done so that another inmate, who had been housed in cell 77 prior to David's transfer, could be moved into cell 71. When asked whether he thought it was appropriate to order the cell to be cleaned whilst an IAT operation was underway Officer E sought to explain that he was unable to house an inmate in a cell with bodily fluids in it, and that there was no other housing option for the inmate. He agreed that if the order was made after learning of David's collapse it would be inconsistent with the OPM requirements for crime scene management.

Officer E also agreed that it was important to preserve cell 71 after learning of David's collapse and agreed that cleaning the cell would affect the integrity of the scene. On this basis he was asked whether he directed that the cleaning be stopped when he learned of David's collapse. He agreed though that he was aware that force had been applied in the cell move. However, Officer E said that the cleaning had already been completed, and the inmate who had previously been housed in cell 77 had been locked in cell 71 by the time he learnt of David's collapse. Officer E said that he was positive that the order to clean cell 71 was not made after David's collapse.

Notwithstanding, Officer E agreed that it was possible to keep the inmate from cell 77 in one of the two yards in G Ward, in circumstances where all the cells were full that day. At the same time he acknowledged that force had been used at the scene and that mandatory reporting was required afterwards. When asked why the inmate from cell 77 was not placed in the yard when it was apparent that there was blood within cell 71 Officer E said that he did not know the cell had blood until the transferred inmate picked up a biscuit with blood on it in cell 71.

Officer F said he saw David bleeding in cell 71 and saw blood in the cell. He said he did not see blood coming from David during the transfer or in cell 77. He said he did not hear Officer E order an inmate to be put in cell 71, or order that the cell be cleaned.

He said that although he was aware that force had been applied and David had become unconscious he did not think that there might be a subsequent police investigation. He said that in such a case there would be an obligation to preserve the scene but did not think there was a need in this particular case. If there was, he said the obligation rested with Officer A, the head of the IAT, to preserve the scene. He said that it did not occur to him that there was a need to preserve it (despite force having been used and David had become unconscious) because he said he did not know the outcome of subsequent events.

The CCTV and IAT footage indicates that David became unresponsive shortly before 2:50pm. In her clinical note entry, RN Jay indicated that she arrived in G Ward at approximately 2:50pm. However, in her statement, RN Jay placed her arrival in G Ward at about 2:53pm.

Conclusion: Examination of the CCTV and IAT footage as to the timing of when David became unresponsive and RN Jay's arrival in G Ward is not inconsistent with Officer E's assertion that he only ordered that cell 71 be cleaned before he became aware of David's collapse.

However, even accepting Officer E's version as to the timing of events, it would have been prudent for any further cleaning to have stopped once it was identified that there was blood in cell 71. This is because of Officer E's acknowledged awareness that force had been used. It would therefore have been logical to assume that the blood found in cell 71 might be attributable to the use of force. Further, being aware that force had been used meant that a mandatory report was required. Even though all the cells in G Ward were full, it would have been possible to place the inmate from cell 77 in the yard until enquiries could be made regarding the origin of the blood and the circumstances in which it came to be deposited within cell 71.

The solicitor for the Dungay Family submitted that consideration should be given to the referral of Officers A, C, E and F for disciplinary proceedings. On this issue it should be noted that counsel for Officer A and Officer C submitted (not in response to the submissions made by the solicitor for the Dungay Family, but instead to Counsel Assisting's submissions) that the Act contains no provision which allows for the referral of information to a disciplinary body, and that the referral of an individual for disciplinary action would be ultra vires. This submission is rejected. It ignores section 3(e) of the Act which provides that one of the objects of the Act is "*to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies*)".

Further, it is noted that section 151A of the *Health Practitioner Regulation National Law (NSW) No 86a* provides:

"*If a coroner has reasonable grounds to believe the evidence given or to be given in proceedings conducted or to be conducted before the coroner may indicate a complaint could be made about a person who is or was registered in a health profession, the coroner may give a transcript of that evidence to the Executive Officer of the Council for the health profession*".

Whilst section 151A obviously has no application in relation to any CSNSW officer, it demonstrates that, even in the absence of section 3(e) of the Act, a referral of an individual for disciplinary proceedings is not precluded. Returning to the submissions made on behalf of the Dungay Family, it is submitted that Officer A failed to cease restraint and address David's complaints of difficulty breathing, that Officer C used excessive force in maintaining restraint, that Officer E failed to preserve evidence in cell 71, and that Officer F acted beyond power in deciding to move David from cell 71 to cell 77.

It has already been noted above that the conduct of the IAT officers was limited by systemic deficiencies in training which had been provided to them. It has also been noted that the available evidence does not rise so high as to suggest that the actions of the CSNSW officers in moving David between cells, and in cleaning cell 71, were motivated by malicious intent, but rather a product of their misunderstanding of information that was conveyed at the time. On this basis, the submission is not accepted.

Issue 9: Whether video evidence was appropriately collected and retained after Mr Dungay was moved between cells on 29 December 2015

Detective Sergeant Damien Babb, the police officer in charge of the coronial investigation, and Inspector Garry James arrived at Long Bay Hospital at 4:47pm on 29 December 2015. Detective Sergeant Babb attended the office of the manager of security and watched some of the IAT footage at about 5:30pm. Detective Sergeant Babb requested the footage from the IAT handheld camera as well as footage from the cameras within Long Bay Hospital "*relating to the incident*", meaning the incident leading to David's death. In response to his request Detective Sergeant Babb said that he was told that the footage would be obtained. He understood that this process would be facilitated by an external service provider which managed the relevant footage.

Detective Sergeant Babb explained that after the initial period of investigation (and the subsequent Christmas holiday period), he next returned to his office on 4 January 2016. By that stage he had been sent a copy of some CCTV footage. Upon viewing it Detective Sergeant Babb discovered that it only captured events from which David was being escorted between cell 71 and cell 77. Detective Sergeant Babb said that he wanted more footage specifically from 2:30pm onwards on 29 December 2015 including when David retrieved the crackers from his buy up. Detective Sergeant Babb explained: "*…I would have just wanted footage for the whole day, of [David's] movements for the whole day, everywhere he went during the day*". Detective Sergeant Babb said that he contacted the CSNSW officer responsible for all correctional centre footage state-wide and was informed, sometime around mid-January 2016 that the footage had already been written over.

Officer Bagley agreed that it would have been appropriate for all CCTV footage from 29 December 2015 to have been collected. He agreed, for example, that there was no footage showing the attempts at negotiation before the arrival of the IAT. He indicated that there was no written protocol at the time regarding how to carry out an internal investigation. He agreed that as much footage as possible needed to be provided, that it would be of crucial importance in relation to a death in custody matter, and that it would have been beneficial to have all of the CCTV footage from cameras within G Ward for the entirety of 29 December 2015.

Conclusion: The subsequent coronial investigation following David's death was deprived of relevant footage showing key events in the timeline of events, namely David's retrieval of biscuits from his buy up and attempts to negotiate with David to return the crackers prior to the arrival of the IAT officers in G Ward.

Given that by the time of Detective Sergeant Babb's attendance at Long Bay Hospital it was apparent that force had been used in the context of a death in custody, and that this fact alone made it mandatory for an inquest to be eventually held, there was clearly a missed opportunity to retain all footage from 29 December 2015 so that it could have been made available to police investigators. It is clear that the unavailability of the footage has had profound and distressing consequences for David's family. It has only added to their sense of uncertainty about aspects of David's death in circumstances where objective footage might have possibly allayed some of their concerns. Whilst it is not possible to understand precisely why the entirety of the relevant footage was not retained it is evident that there is scope for improvements in processes.

Recommendation: I recommend that Corrective Services New South Wales review the current version of the Custodial Operations Policy and Procedure to ensure that clear instructions are provided requiring the retention of all potentially relevant video footage, including CCTV footage, in the event of a death in custody.

Issue 10: Whether Justice Health staff acted appropriately and in compliance with Justice Health policies and procedures in administering a sedative (Midazolam) to David on 29 December 2015

As at 29 December 2015 the *Enforced Medication and Rapid Tranquilisation - The Forensic Hospital and Long Bay Hospital Mental Health Unit (Policy Number 1.180)* (**the Enforced Medication Policy**) governed the responsibilities and obligations of clinical staff relating to the administration of rapid tranquilisation and enforced medication to involuntary patients. Section 5.3 of the Enforced Medication Policy provided for the following in relation to administering rapid tranquilisation:

- An emergency assessment of the patient's airway breathing and circulation must take place concurrently with the restraint and tranquilisation process;

- Observation and monitoring of vital functions and supplementary observations must be commenced as soon as it is safe to do so;

- Emergency resuscitation equipment, benztropine and flumazenil injection must be immediately available before proceeding to administer rapid tranquilisation.

- Section 5.2 of the Enforced Medication Policy also provided that:

- The patient must be given every opportunity to accept prescribed treatment voluntarily;

- A nurse must consult a nurse unit manager, nurse in charge, a consultant psychiatrist or psychiatry registrar before medication is administered without a patient's consent;

- The patient must be given information about any medication prescribed to them, including the reasons for the prescription, the effects of the medication, the side effects and risks of the medication, and the likely effects on the patient's health in not taking the medication.

Assessment of airway, breathing, circulation

RN Xu said that he was unaware of the Enforced Medication Policy as at 29 December 2015, and that it was never brought to his attention during induction, and that he was never told anything about it. He agreed that if he had known the requirements contained in the Enforced Medication Policy he should have observed David's vital signs concurrently with the injection procedure. In contrast, RN Michelle Neumann said that she had seen the Enforced Medication Policy prior to 29 December 2015 (having been first made aware of it sometime in 2012). When asked how she had become aware of it, RN Neumann explained, "*Because being a Justice - being employed by Justice Health, it is my responsibility to be aware of the policies and procedures and the guidelines that I work under*".

RN Xu said that during induction training run by both Justice Health and CSNSW he received advice that all restraint was the responsibility of CSNSW officers, as was the responsibility for checking airway and monitoring a patient after an injection. He said he was told: "*I was aware the first time I was told, 'Okay, it's a, this is gaol, not hospital. You guys, nursing staff, are not allowed to touch the patient in the restraint. We do the job'. We monitor his airway for which we received mandatory training for which we were accredited*".

RN Xu referred to an induction conducted sometime in 2014 by three IAT officers and said that he was surprised by this and raised it with the CSNSW staff member conducting the training and was told that if he was needed he would be called and that he was otherwise to stay away. He explained: "*So I was told, 'Look', we were specifically training first aiders and we, we were, it's our role to observe the patient's airway during the, during the restraint of the enforced medication. 'If we need you we call you otherwise keep away.' That's so clear it was given*". He was asked whether he sought clarification from any Justice Health staff member and said: "*I did not clarify that question with anybody else because I, at the time I did not have a reason to, to have it out in that because I thought, "That's just a unique environment of the gaol*".

He said that in seven months he had worked within Long Bay Hospital not once did he observe a nurse monitor a patient's airway. He said that he never saw a nurse stay in a cell before or after a sedation. In this regard section 5.2 of the Enforced Medication Policy provided: "*Justice Health staff should maintain their presence during the administration of enforced treatment process but remove themselves from the immediate vicinity of the restraint. [Justice Health] staff must follow reasonable security direction from CSNSW*".

RN Xu said that his previous experience, whilst working at POWH, was for a person to be restrained in the prone positon with their head over the end of the bed, but for a nurse to position the patient's head on their chest with hands on their chin and forehead. He was asked whether, because his prior experience had been so different, whether he sought to clarify this with anyone in the Justice Health hierarchy. He said that he did during induction and thought it was clarified by CSNSW staff.

It was suggested to RN Xu that, even if he was not aware of the Enforced Medication Policy, at the time he was administering the injection and he heard David screaming that he could not breathe, there was a powerful clinical basis to make proper observations of David's breathing and airway. RN Xu replied: "*If under normal circumstance, yes, but as I said there was a terrifying moment that was - my role was so clear - to inject him, to retreat. That would - never crossed my mind. That would be my focus and that would be against my behavioural pattern through the eight-year period so it never crossed my mind I would be doing that. That would be also against the DCS direction. From my understanding I believe I was given that direction*".

RN Xu agreed that he still had an obligation to his patient but said that he knew that midazolam took about 15 minutes to take effect. He said that he became concerned when he heard David say that he could not breathe but did not believe that he was in any immediate danger. He indicated that it was his experience that half of the patients in POWH made a similar statement and that there clear indication in all such cases it related to pressure and exertion.

RN Xu said that he was aware of the risks of prone restraint, and that he was concerned that David was restrained in the position whilst being given an injection and screaming that he could not breathe. RN Xu said that his first thought was that best practice would have been to release the restraint and retreat immediately. However he did not do so because: "*Again, that's, that was not my jurisdiction of how to restrain a patient. I did not suggest because in my mind any - that's like to order the officer to, "Leave him. Leave him alone," and that was unthinkable to me at the time*". RN Xu was asked whether he kept the thought to himself that David needed to be released immediately. He said he went to the cell with the expectation that the officers would release David immediately after the injection and then retreat. He explained that his had been his experience in previous enforced medications.

RN Neumann said that if a restraint was occurring and she noticed that someone was experiencing a problem that she would speak up and advise the CSNSW officers of any concerns in relation to the patient's breathing or airway.

She said that she had not received any training from Justice Health in relation to the dangers of restraint because they were not involved in it. She was asked whether she felt the same as RN Xu in relation to having no jurisdiction over such an issue. She replied by saying that she had a duty of care to a patient and if she felt that a patient was at risk she would definitely speak up on that patient's behalf. She said that she was unaware of any policy that allowed a nurse to direct a CSNSW officer to stop doing something however she said that she took it on herself to communicate with officers if she felt the need to do so. She said that she did not believe that the current policy allowed a nurse to direct a CSNSW officer to stop restraining a patient if there was a medical issue; rather, she believed it allowed a nurse to request a CSNSW officer to hold so that an assessment could be performed.

In contrast to RN Xu's evidence, RN Neumann agreed that section 5.3 of the Enforced Medication Policy was the practice she had adopted. She said that she was never told that it was the responsibility of CSNSW officers to check a patient's airway. She said that it was general practice for two nurses to be present when conducting a tranquilisation, with the non-injecting nurse to assist with the sharps bin and observe the patient during restraint. She said that was a seldom occurrence for only one nurse to perform the enforced medication injection of a patient themselves.

Conclusion: RN Xu's asserted that he was told during an induction process that responsibility for assessing patient's breathing and circulation during a tranquilisation process that involved restraint rested with a non-medically trained CSNSW officer, rather than a health care professional. RN Xu also asserted that he had never previously seen a nurse within Long Bay Hospital monitor a patient's airway in such circumstances. These assertions simply defy logic and common sense, are inconsistent with the evidence of RN Neumann, and are not accepted. Even if it were accepted that RN Xu was never made aware of the Enforced Medication Policy and, in particular, the application of Section 5.3, it remained incumbent on him to make himself aware of the Justice Health policies that applied to his functions.

Notwithstanding RN Xu's assertions, the evidence establishes that he clearly recognised that there was a clinical basis to make an appropriate assessment of David's breathing and circulation when he heard David complaining of difficulty breathing. Consistent with the practice described by RN Neumann, RN Xu ought to have brought the issue to the attention of the CSNSW officers, including the IAT, in cell 77 so that a proper assessment of David could be conducted.

Observations

RN Xu said that he was instructed to enter the cell to administer the midazolam injection. He saw that David was "*struggling pretty hard*". He administered the injection and then one of the IAT officers immediately directed, possibly with a gesture, for him to leave the cell. The IAT footage was played to RN Xu and he was asked whether he heard David screaming that he could not breathe, both before he entered the cell and whilst he was in the cell.

As to the former, RN Xu said: "*I did not recall any of that. I - the moment I stepped in the cell I was like, basically just committed to that, you know, five seconds. Physically step in, we step out. That usually takes me five seconds, less than ten seconds*".

As to the latter, RN Xu said: "*It sounds to me as that was once I could hear clearly he said that from the footage. It appears to me when the second time he yelled out he can't breathe the injection was already, yeah. But at the time I was, I was quite frightened and I was - just tried to be collected to complete the injection and my focus for that couple of seconds was 100% on the injection alone, that job. I could not recall I hear anything at that moment when, when a needle was still inside the body just there is no way - sorry, I just, I, I was very sure I did not hear him making that, you know, complaint*".

RN Xu said that he did not agree that David was screaming that he couldn't breathe before the injection was given, only during when it was given, and after. On playback of the footage he expressed the view that by the time of David's second scream the injection had already been given. He said that he did not notice David's breathing but on playback of the video agreed that it was loud and laboured. Following playback of the video RN Xu maintained that he was directed to leave the cell at the time the needle was removed. He said that the word "*go*" might have been said, accompanied by a gesture from one of the officers. He said that he was positive he was given a direction. The video appears to show a CSNSW officer tapping him on his left shoulder following the injection.

RN Neumann said it was part of training she was given, and also routinely voiced by officers, to enter a cell, sedate a patient and then leave ASAP. She said that informal observations would only be performed if a patient was cooperative. She said if there were no concerns then the nurses would return to the cell as soon as possible and offer a debrief. However if the patient was not agreeable or uncooperative then no observations would be performed following an injection. If a patient was agitated she said she would dispose of any sharps, document the medication given, then return to the cell within five minutes and make observations through the cell door and ask if they had any injuries, attempt to engage them and offer a debrief.

RN Neumann said that she understood the requirement under section 5.3 in practice to mean that there was a requirement to vacate a cell as soon as the injection was given but to return as soon as possible so that observations could be performed.

Conclusions: It can be accepted that RN Xu found the situation within cell 77 to be a confronting one, and that he felt obliged to leave cell 77 at the implicit direction of one of the CSNSW officers.

However, RN Xu allowed the clinical need to perform proper observations of David to be inappropriately overborne by these considerations. As already noted above RN Xu ought to have familiarised himself with the terms of the Enforced Medication Policy. In doing so he would have recognised that Section 5.2 did not prevent compliance with Section 5.3.

Even absent any awareness of the Enforced Medication Policy, on the basis that RN Xu heard David scream at least once that he could not breathe and that he saw David struggling to resist the restraint, there was a clinical basis for RN Xu to return to the cell as soon possible to perform appropriate observations.

Counsel Assisting submitted that, on this basis, the conduct of RN Xu in failing to make any relevant observations of David warranted referral for review of his professional conduct. Senior counsel for Justice Health and the solicitor for RN Xu resisted the submission effectively on the basis that RN Xu was confronted with a difficult and complex situation in cell 77, that he has since undertaken further appropriate training, and that, on this basis, there is no possibility that RN Xu remains a danger to the public.

It does not appear to the case that the only determinant as to whether the professional conduct of an individual should be the subject of formal review is to be determined by whether or not sufficient remedial action has been taken. Such factors may be more relevant to the issue of mitigation of any ultimate outcome. Rather, it is objective examination of the conduct itself which grounds consideration of whether review is warranted. In the present case, the evidence establishes that RN Xu recognised that there was clinical need in general, and having particular regard to David's repeated complaints of being unable to breathe, to assess David's breathing and perform observations. Notwithstanding the complexity of the situation which RN Xu was in, which has already been acknowledged, it remains the case that the review of RN Xu's professional conduct at the time that midazolam was administered to David is warranted for the reasons set above.

Recommendation: I recommend that, pursuant to section 151A of the Health Practitioner Regulation National Law (NSW) No 86a, the transcript of the evidence of Registered Nurse Charles Xu be forwarded to the Chief Executive, Nursing and Midwifery Board of Australia for consideration of whether the professional conduct of Registered Nurse Xu on 29 December 2015 should be the subject of review.

Resuscitation equipment

Section 5.3 of the Enforced Medication policy required that emergency resuscitation equipment, and benztropine and flumazenil injections to be available before rapid tranquilisation was administered.

RN Xu said that he was unaware of this requirement, having not seen the Enforced Medication policy as at 29 December 2015. In evidence it was suggested to RN Xu that, notwithstanding his assertion, he should have known that there was a need to take emergency resuscitation with him in circumstances where he knew that an intramuscular injection was about to be given. RN Xu disagreed and claimed that it was never the practice to do so. RN Xu was asked whether he considered it good nursing practice to do so. RN Xu agreed that it was but referred to the policy directive requiring that the equipment be kept close by.

In this context, RN Xu pointed to the fact that the equipment was never brought in a trolley to a cell but kept some 15 or 20 metres away (at the nurses' station). He said that it was never his experience that the equipment was taken to the site (either at Long Bay Hospital or at POWH) where the injection was to be given.

RN Xu said that he had never heard of flumazenil and that "*it was a non-existence [sic] in either Prince of Wales or Long Bay*", although he agreed that benztropine was available at Long Bay Hospital. This was supported by RN Neumann who also indicated that flumazenil was not available. She explained: *"…flumazenil is not a medication that we use in - on the mental health unit…It's an IV medication and we do not do intravenous medications in the mental health unit*". However, RN Neumann said that she believed that other medication to reverse the effects of sedatives was contained in the emergency resuscitation bag. RN Neumann agreed with RN Xu that benztropine (known as Cogentin) was kept in the emergency resuscitation bag. However, she explained that the bag itself was kept in the treatment room and the practice was not to take it the cell. RN Neumann explained that usual practice was to take only the injection itself and a sharps disposal unit.

Dr Ma said that he was also aware that flumazenil was not available. However, he said that he understood that this was because it could induce cardiac arrhythmias and seizures, and so the benefit of using it was outweighed by the risk.

Conclusions: Whilst flumanzil was not available within G Ward as at 29 December 2015, other medication capable of reversing the effects of sedatives was contained within the emergency resuscitation equipment. Section 5.3 required this and other emergency resuscitation equipment to be available in proximity to where the enforced medication was administered. Given that, by its very name, the use of emergency resuscitation equipment is often time-critical, it cannot be accepted that the location of the emergency resuscitation equipment within the nurses' station was clinically appropriate.

Further, even although RN Xu was unaware of the provisions of Section 5.3 of the Enforced Medication Policy, his understanding of good nursing practice alone suggested that the emergency resuscitation equipment ought to have been taken to cell 77.

Remedial action taken since 29 December 2015

RN Xu was asked about current practices regarding emergency equipment for enforced procedures. He said that there are now six nurses and all practice is conducted in accordance with new procedures. He said that all equipment is brought to outside the cell and nurses are allocated roles to maintain the resuscitation bag, the timer, the sharps bin, the syringe, with one nurse to monitor observations and time the duration of the prone position.

RN Neumann was asked about the differences now for enforced medication and where CSNSW officers were required to restrain a patient. She said that there was now more effective planning and nurses take verbal and documented observations as required.

She was asked whether any changes have been made regarding situations where a patient remains agitated and observations cannot be performed. She said that an oximeter is placed on a patient, otherwise no injection occurs. She said that an inservice was provided a few weeks ago but that the policy changes regarding enforced medication had not yet been put into practice yet, although other strategies had been implemented. She said that there had been a lot less enforced medication since the policy change, but there had been no change to the positioning of patients, who were still placed in the prone position. She said that there have been changes in terms of how long a patient is restrained in the prone position (no longer than three minutes) and that an emergency bag is now always available. She said that it still remained the case that if a patient was agitated the nursing staff would remove themselves, but return to take observations when it is safe to do so.

Issue 10A: Whether Justice Health staff were appropriately trained about the risks and use of restraint?

Section 4 of the Enforced Medication Policy defined enforced medication as: "*Medication given to a patient without consent and with the use of force to restrain the patient in order to administer the medication*". In this regard it is plainly evident that the Enforced Medication Policy contemplated the use of restraint during administration. However the Enforced Medication Policy did not otherwise make mention of restraint other than to note that only CSNSW staff may restrain a patient in the Long Bay Hospital Mental Health Unit, and that CSNSW have their own protocols and procedures in relation to restraint of a patient. Section 5.3.2 of the Enforced Medication Policy identified the need for special care to be taken in a number of specific circumstances. However the use of restraint, and its associated risks, is not mentioned in Section 5.3.2.

The New South Wales Health Policy Directive, *Aggression, Seclusion and Restraint in Mental Health Facilities New South Wales* (PD2012_035) published on 26 June 2012 (**the Restraint Policy Directive**), provided the following: "*It is the position of NSW Health that clinical and non-clinical staff working in mental health facilities in NSW will undertake all possible measures to prevent and minimise disturbed or aggressive behaviour and reduce the use of restrictive practices such as seclusion and restraint. When making decisions about strategies to manage disturbed behaviour, it is important that health workers do not place themselves, their colleagues or mental health consumers at unnecessary risk*". The Restraint Policy Directive applied to, among other things, Specialty Network Governed Statutory Health Corporations such as Justice Health, a fact acknowledged by Therese Sheehan, the Deputy Director of Nursing and Midwifery Services Custodial Health.

Section 4.1 of the Restraint Policy Directive provided that: "*Physical/manual restraint should be an option of last resort to manage the risk of serious imminent harm because it involves a risk to the physical and psychological health of both staff and consumers*". Further, section 4.1.1 noted that "*there have been instances both in Australia and internationally in which young apparently healthy people have died suddenly while being held in a physical/manual restraint… The mechanism of death is unclear, but most deaths have been attributed to positional asphyxia or cardiac arrest*".

Section 4.1.1 goes on to identify a number of factors that appear to be involved with sudden deaths in restraint including prone positioning, a period of combative struggle of more than two minutes, obesity, underlying physical condition, acute mental disturbance, and prescribed medication. It also stipulates the following: "*In view of the possible connection between facedown restraint and sudden death, Local Health Districts should provide appropriate training to staff on the use of restraint*".

RN Neumann said that coming from a public hospital background she was at first taken aback by the fact that Justice Health staff did not perform restraint and that instead it was performed by CSNSW staff. RN Neumann said that she had not seen the Restraint Policy Directive prior to 29 December 2015. Ms Sheehan acknowledged that no training had been provided to clinical staff in G Ward regarding the policy directive and that this represented a deficiency in training staff as to the dangers of prone restraint.

Conclusions: Given the acknowledgement made by Ms Sheehan, it is abundantly clear that no training was provided to Justice Health staff in relation to the Restraint Policy Directive. As a result Justice Health staff were plainly not appropriately trained in the use of prone restraint and its associated risks.

Recommendation: I recommend that Justice Health implement training for all clinical staff working at Long Bay Hospital Mental Health Unit, including medical officers, in relation to the NSW Heath Policy Directive Aggression, Seclusion and Restraint in Mental Health Facilities New South Wales (PD2012_035).

Remedial action taken since 29 December 2015

Consistent with the evidence given by Assistant Commissioner Corcoran, a Working Group consisting of Justice Health and CSNSW staff, was developed to review the procedures and processes surrounding the treatment of mentally ill patients within G Ward and Long Bay Hospital. The Working Group initially met on 20 August 2018, and again on 29 November 2018 during which a number of recommendations were made. The meetings resulted in the development of draft Local Operating Procedures for Long Bay Hospital related to enforced medication and Joint Planned Interventions by Justice Health and CSNSW: *Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital* (January 2019) (**the Joint Planned Interventions LOP**) and *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) (**the Enforced Medications LOP**). These Local Operating Procedures were approved by the Chief Executive of Justice Health on 31 January 2019. On 1 February 2019 the Commissioner of CSNSW endorsed the two Local Operating Procedures.

Shaun Connolly, the Justice Health Nurse Manager Operations, Access and Demand Management, and the legal representative for Justice Health on the Working Group explained that a training calendar had been developed for joint ongoing training between Justice Health and CSNSW staff working in the Long Bay Mental Health Unit.

Whilst the training calendar was still in development as at the date of Mr Connolly's evidence (6 March 2019) he indicated that proposed dates for the training had been identified, with the first training to occur on 3 April 2019, and an audit to be conducted by the Nurse Unit Manager at the Mental Health Unit.

Recommendation: I recommend that training on the Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital (January 2019) and Enforced Medications - Long Bay Hospital Mental Health Unit (January 2019) be provided to all CSNSW and Justice Health staff working at Long Bay Hospital, including theory, practical training and assessment.

Recommendation: I recommend that CSNSW and Justice Health audit compliance with the Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital and Enforced Medications - Long Bay Hospital Mental Health Unit Local Operating Procedures.

Section 4.6 of the Joint Planned Interventions LOP provides for the roles and responsibilities of psychiatrists and medical officers, stipulating that "*the psychiatrist/medical officer must attend the ward and assess the patient and need for Joint Planned Intervention*". A similar provision is contained also within section 4.6 of the Enforced Medications LOP. However, it stipulates that "*the psychiatrist/medical officer must attend the ward and assess the patient and need for Joint Planned Intervention – if possible".* Mr Connolly accepted that the Joint Planned Interventions LOP would apply to an enforced medication event. On that basis he accepted that there is inconsistency between the equivalent provisions of the two Local Operating Procedures. Mr Connolly attributed this inconsistency to the absence of an on-site medical officer after hours in the Mental Health Unit. However, he explained that whilst enforced medication primarily occurs during business hours in the event that it occurred after hours recommendation would be made for a psychiatrist or psychiatry registrar (who would be on call) to attend Long Bay Hospital so that the enforced medication procedure could occur.

Recommendation: I recommend that Section 4.6 of the Enforced Medications - Long Bay Hospital Mental Health Unit (January 2019) be amended to mandate the attendance of a psychiatrist/medical officer to assess a patient in the event of administration of enforced medication.

Section 6.4 of the Enforced Medications LOP provides for a number of procedural steps to be followed for the administration of enforced medications. One step is the completion of a Joint Planned Medication Checklist (**the Checklist**) indicating proposed roles and the procedure to be taken. The Checklist (identified in the Appendix to the Enforced Medications LOP) includes information such as whether a de-escalation plan was attempted, and a patient's medical alerts. In evidence Mr Connolly was asked if there was a reason why the Checklist does not include information relating to risk factors associated with restraint and positional asphyxia. Mr Connolly indicated that he did not know of any reason why this was the case, and acknowledged that such information would be relevant particularly if Justice Health staff had not received training in relation to the Restraint Policy Directive.

Recommendation: I recommend that the Joint Planned Medication Checklist of the Enforced Medications - Long Bay Hospital Mental Health Unit (January 2019) be amended to include information indicating that risk factors for restraint and positional asphyxia have been considered by Justice Health and CSNSW staff prior to the administration of enforced medications.

Section 8.3 of the COPP relates to enforced medication in mental health facilities. It provides that: "*Correctional officers should follow directions from JH&FMHN medical personnel regarding the positioning of a patient for the administration of injections*". In evidence Mr Connolly agreed that medical advice from Justice Health staff is to be followed when it comes to making decisions about the safety of a patient being restrained, and agreed that this should be clearly set out in the Local Operating Procedures.

Recommendation: I recommend that the Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital (January 2019) and Enforced Medications - Long Bay Hospital Mental Health Unit (January 2019) be amended to provide that Justice Health medical personnel are able to give directions to CSNSW correctional officers regarding the positioning of a patient for the administration of injections.

In evidence Professor Brown was asked whether he had any personal experience, in the hospital where he works, of prone restraint being used for the purposes of administering enforced medication to patients. Professor Brown indicated that he cares for many agitated patients and that his hospital uses an equivalent security response team. However he explained: "*what we do is we give an injection with them lying flat. We always, always keep the patients lying flat face up, always, and then the injection goes into the upper outer thigh and we do it through clothing, so we never, ever roll a patient over to use the buttock. It's not necessary. You've got a perfectly good muscle at the front. It also means you can watch the patient, watch the airway and see everything happening*".

Prior to the 29 November 2018 Working Group meeting Mr Connolly and CSNSW staff attended mental health units at POWH and St Vincent's Hospital. Mr Connolly was asked whether during either visit specific advice was sought regarding the use of prone restraint for enforced medication or emergency sedation. Mr Connolly indicated that although specific advice is not sought, the issue of patient positioning during medication administration was discussed. Mr Connolly indicated that the information obtained was that the prone position was the most commonly used position for the administration of medication. Mr Connolly indicated that within the Working Group there had been some discussion about use of the supine position and whether it would be discussed at a risk briefing as part of risk management.

It is noted that, contrary to submissions made by the solicitor for the Dungay Family regarding extension of the recommendation below to CSNSW, the positioning of a patient for the purposes of enforced medication within a mental health facility is a matter for Justice Health.

Recommendation: I recommend that Justice Health give consideration to whether a position other than the prone position should be utilised for enforced medication to be administered under the Enforced Medication and Rapid Tranquilisation - The Forensic Hospital and Long Bay Hospital Mental Health Unit (Policy Number 1.180) and emergency sedation to be administered under the Emergency Sedation – Forensic Hospital and Long Bay Hospital Mental Health Unit (Policy Number 1.441).

It was submitted by the solicitor for the Dungay Family that:

Justice Health staff working in the Mental Health Unit should attend mandatory violence prevention and management training undertaken by Justice Health staff at the Forensic Hospital. However, the operation of the Forensic Hospital, and training provided to staff within it, did not form part of the issues considered at inquest. Accordingly there is no evidentiary basis upon which the submission could be accepted.

Input should be sought by Justice Health from family members of involuntary mental health patients and, where possible, involve such family members in the patient's treatment. The submission acknowledges that the inquest did not receive any evidence on this issue. On that basis alone the submission cannot be accepted. It is acknowledged that the submission arises from concerns expressed by David's family (following the conclusion of evidence in the inquest) as to why there was not an opportunity for them to be more involved in David's care. Non-acceptance of the submission is not intended to minimise such concerns. However, the exercise of the power afforded by section 82 of the Act must be evidence-based and within scope.

Steps be taken by Justice Health to make an Aboriginal Health Worker available to assist with de-escalation and discussion of treatment options involving an Aboriginal or a Torres Strait Islander patient in the Mental Health Unit. The submission acknowledges that progress has already been made in the form of the Enforced Medication LOP, with recruitment action underway, and that the purpose of any recommendation in this regard would be to emphasise its importance. Given the acknowledgement, and the absence of evidence to suggest that repeat emphasis is necessary, this submission cannot be accepted.

Issue 10B: Was it appropriate to administer a second injection to David, as was planned on 29 December 2015, and who had the responsibility to decide whether such an injection should occur? What effect did the ensuing delay and further restraint have on David?

Officer G said that he raised the topic of additional sedation with RN Xu. He said that he did not think sedation for one hour was enough and raised the possibility of additional sedation on the basis of an earlier incident some two or three years earlier which involved David acting aggressively. He was asked to describe this earlier incident and referred to a situation where David became aggressive and shattered some glass which caused an opening in his cell, which in turn resulted in his extraction from the cell.

On this basis Officer G maintained that he had safety concerns even after David woke up from sedation, and that he had concerns for the security of the centre even beyond the cell. Officer G said that he could not recall at what point he yelled down the corridor to Officer F for continued restraint of David in cell 77, whether it was before or after RN Xu came out of the cell. However Officer G said at the time he yelled out to Officer F he had not received confirmation that a second injection would be given. Officer G said that he had no specific recollection of any conversation with RN Neumann, and that he did not recall being told by her to have the officers continuing to restrain David. However, he agreed that he thought David needed to be restrained until there was confirmation about whether there would be a second injection or not. He denied asking RN Neumann to make a phone call so that a second injection could be given.

RN Neumann was asked whether her recollection accorded with Officer G's account. She said that at the time she was in the nurse's station calling Dr Ma and she did not know what was occurring in cell 77. She said that she recalled a conversation with Officer G (but did not recall RN Xu being present) where he asked whether it was a good idea to give David an extra sedative. She agreed that it fit with her recollection that after Officer G spoke to her she called Dr Ma.

RN Neumann said that whilst on the phone to Dr Ma she said that she knew the midazolam was being given and her concern was that due to the rapid escalation and agitation she did not feel that the midazolam would achieve the desired outcome and she wanted further medication to calm David down. She agreed that it was Dr Ma who suggested the haloperidol, explaining that it would not have been up to her.

Dr Ma confirmed that he had a discussion with RN Neumann and indicated that haloperidol could be administered. Dr Ma was asked whether it was possible that he was told that midazolam had already been administered and that there was some desire to administer additional medication, namely haloperidol. He replied: "*No, my impression was that they were planning to give the midazolam and they wondered whether it would be clinically indicated as to whether they also give haloperidol and [RN Neumann] was asking for my advice*". Dr Ma indicated that he considered that administration of both midazolam and haloperidol was clinically indicated based on the level of aggression described by RN Neumann to him, which was considered to be high. Dr Ma said that, although it would vary between individuals, he understood the midazolam in David's case would be effective from between 15 to 20 minutes, and up to one hour. He explained that the "*haloperidol in addition to providing an extra sedative effect, which would have worked synergistically with midazolam to heighten the level of sedation, it would also reduce psychotic symptoms, such as delusions and hallucinations*".

Dr Ma was asked why he settled on haloperidol. He explained that David had been given it previously with no acute side effects, and that it can take effect within 15 minutes and last up to 12 hours. On this basis Dr Ma explained: "*I felt that given the level of aggression that Nurse Neumann had described that adding the haloperidol would be a more effective means in reducing Mr Dungay's distress more immediately and also ensuring that the staff were safe*".

Dr Ma said that it was his practice at the time to examine a patient before ordering enforced medication "*if the situation and time allowed*". He said that there would have been a need on 29 December 2015 to review David. However he said: "*I was satisfied that based on what Nurse Neumann had conveyed to me in the handover, and, you know, my knowledge of her experience, was that I was happy for her administer, or the team to administer those medications and I would review as soon as practical*". RN Xu said that he had no understanding that there was an intention to give David a second injection. He said he only learned about this intention after the incident when he sat down with the other nurses at about 7:30pm to write up the retrospective progress notes. He said that at the time he did not hear anyone say anything about "*one more needle"* when the IAT footage was played back to him. However he said that if had heard this he would clarify with the officer what he meant.

Officer G said that he saw no barrier in making a suggestion to RN Neumann that a second sedative be considered. He said he felt free making a suggestion of a medical nature which he thought might calm David down. He said that one of the reasons for this was because it would make David easier to manage. He said that he could not recall whether he had done this before; that is, speak to a nurse to make sure that an inmate was easier to manage because of their aggression. Officer G agreed that at the time he yelled for continued restraint RN Neumann was picking up the phone and that at that time there was no order for extra medication and no guarantee that such an order would be given. He agreed that RN Neumann didn't ask for continued restraint and that that was his decision.

Counsel Assisting suggested to Officer G that even allowing for the earlier 2013 incident, seeking some consideration for a second injection was excessive. Officer G disagreed. He also disagreed with Counsel Assisting's suggestion that there was no good reason to call for a second injection if David was going to be secured in his cell. When asked what he expected to happen after one hour, Officer G replied:

"*Based on previous experience with Mr Dungay…my concern was that Mr Dungay had effectively breached a cell on a prior occasion, and, taking into consideration the level of aggression that Mr Dungay was displaying at the time, I believe I had good cause to be concerned about potential breach of the cell that he was being moved to…the day shift, including the IAT, would have ceased duty upon the finalisation of managing Mr Dungay, leaving me in charge of the correctional centre, with a skeleton staff, which is not enough staff to respond to - effectively respond to an aggressive inmate who has breached their cell*".

Officer G confirmed that in 2013 David did not exit his cell but said that if the entire glass had been removed he could have easily done so.

Conclusions: The prospect of sedation in addition to the injection of midazolam was first raised by Officer G. It was raised on the basis of Officer G's concerns in relation to a previous incident in 2013 in which David had acted aggressively and damaged his cell. On that occasion David did not breach his cell.

There was no reasonable basis to believe that this would occur either on 29 December 2015 given that, following the cell transfer, it was intended for David to be left alone in cell 77 with the midazolam to take effect. In this regard, Officer G unreasonably allowed a perceived security issue to dictate management of a medical issue which did not fall within his remit.

The responsibility for deciding whether additional sedation was appropriate rested with Dr Ma. In describing David's level of aggression to Dr Ma, RN Neumann sought advice in relation to the possible administration of haloperidol only. It can be inferred from this that there was no basis for Dr Ma to consider that his advice was being sought about both midazolam and haloperidol. In these circumstances, the administration of an additional sedative was not warranted. Firstly, there was no sound reason to consider additional sedation when the effects of the midazolam had not been allowed to take effect, and in circumstances where David was to be secured in cell 77. Secondly, consideration of whether additional sedation was warranted could have been deferred until an assessment could be performed after the midazolam had taken effect. Indeed, Dr Ma, in accordance with his usual practice, considered that there was a need to review David.

Had advice and authorisation for the additional sedative not been sought, it is most likely that David would have been released from restraint following the administration of midazolam. Observations in accordance with the Enforced Medication Policy should have then been performed. Instead, the consequence of authorising additional sedation was that David was subjected to additional prone restraint which was not warranted in the circumstances.

Issue 11: Whether Justice Health staff acted appropriately in providing life support to David between the time he became unresponsive through to the arrival of NSW Ambulance paramedics on 29 December 2015?

Dr Ma, RN Thapa and RN Maharjan had not previously been involved in a real life resuscitation attempt prior to 29 December 2015. Professor Brown described the inherent challenges with resuscitation attempts in this way: "*…the commonest reason of a suboptimal or a challenging resuscitation is just literally the confronting nature. This is a very frightening situation for medical staff. It's quite possible that the medical and nursing staff may not have had experience in real life of a cardiac arrest. It's very, very different performing a cardiac arrest, basic life procedure, in real life where you've got a patient who…is not breathing*". Nonetheless, Professor Brown explained that in making his criticisms he was conscious of the fact that the clinicians involved were likely confronted with a stressful and confronting situation.

In evidence the IAT footage was played to Professor Brown. He identified the following deficiencies with the resuscitation attempt: At 10:11, Professor Brown did not support a CSNSW officer being in charge of the airway. He described it as a technically difficult procedure. He said what was required was a jaw thrust or chin lift to achieve a patent airway. He said that he would have preferred a nurse to manage the airway, with a jaw thrust or chin left, and then a CSNSW officer would be able to provide ventilation. He explained that the necessary skill was not ventilation, but the proper application of the bag valve mask (**BVM**) with an airtight seal, which requires training.

At 10:20, cardiac massage had ceased and there was no evidence of rise in the chest which suggested that the airway was not open optimally.

At 11:50, the defibrillator pads should have been put on in seconds and there was "*a little bit of a lack of urgency*". Once the defibrillator identified no shock rhythm external cardiac massage should have been immediately restarted.

At 12:25, even though there was a suggestion of a weak pulse external cardiac massage should have continued to augment resuscitation attempts until return of signs of life.

At 13:36, at Dr Ma's direction, David was moved from a supine position to the recovery position. Professor Brown accepted that the purpose of the manoeuvre was to ensure that there was no fluid or obstruction in the airway. However he explained that cardiac massage can only be performed when a person is in the supine position, and that suction devices should be used to remove fluid or obstruction from the airway. He explained: "*You don't normally put someone in the recovery position in the middle of a cardiac arrest. It's just not, not helpful*".

At 14:50, external cardiac massage should have continued irrespective of any airway concerns. Airway management required a nurse to be at the patient's head rather than attempting to do so from the side, because it makes "*the technical aspect of this much more challenging*".

At 16:10, again external cardiac massage should have continued in conjunction with airway management. There was no need to place David in the recovery position.

At 17:31, assessment of a possible airway obstruction was being performed in the recovery, rather than the supine, position. Professor Brown explained: "*I believe the reason possibly that it's perceived there's an airway obstruction is simply the tongue has fallen back, which is a common problem when you have an unconscious person that the tongue drops into the back of the mouth and literally obstructs the airway. That's why one of the manoeuvres you do is called a jaw thrust or you can put in an airway, but I think again, the sentiment is correct, the process is not*".

At 18:29, there was no indication to perform a Heimlich manoeuvre middle of basic life support, with the manoeuvre usually only performed in the event of a person choking.

At 19:40, there was an "*enormously prolonged gap in any basic life support*". Professor Brown expressed the view that "*what's happened is that the struggle to work out why has Mr Dungay stopped breathing has taken over from the process of resuscitation*". Professor Brown indicated that this was followed by an approximately eight minute hiatus where no cardiac massage was performed apart from two compressions.

In summary, Professor Brown noted that the medical treatment provided by Justice Health staff overall "*was of a low standard*" and "*lacking in essential aspects*", and that the lack of provision of continuous basic life support "*rendered the resuscitation attempts by Justice Health doctors and nurses effectively without value, and was incompatible with survival*".

Professor Brown was asked what should have occurred at the point of injection when David screamed he could not breathe. He said that the injection should be forgotten and attention given to deal with the perceived or actual problem concerning the airway. He said that the nurse should look at the airway, see the colour of the face, and see whether the chest was expanding. David could be placed on his side or back. Although this might have created a risk of spitting a mask could have been placed over his mouth. Professor Brown opined: "*I think to give an intramuscular injection when a patient is complaining they can't breathe is not the right priority*".

Professor Brown was taken to the IAT footage at 3:09. He said that the breathing sounded laboured and said that it suggested that David was having difficulty expanding his chest, although he said that he understood that an inmate may be saying that they could not breathe in order to release the restraint. He said that the heavy breathing was not consistent with asthma as that specifically involves difficulty breathing out and is an expiratory wheeze. In contrast, he explained that difficulty breathing in is an inspiratory noise which is more of a gasping sound which sometimes involves a whistle called a stridor. He said that from what he heard he did not think that Mr Dungay was experiencing an issue with asthma.

Professor Brown was asked about what recommendations might be possible having regard to the clinicians having no real life experience of dealing with a cardiac arrest. He highlighted the importance of having a team leader who can stand back and direct things and maintain team cohesion, and the use of simulated training.

RN Xu agreed that the initial step in providing ventilation involves proper positioning of the airway but said that he could not recall whether he did it. He said: "*At the time I was - sorry, I was in a mess I guess. I was very shaken and terrified with disbelief and I knew the, the process is - there are strict guideline for first, for basic life support…I noticed from very beginning it's already went to the fifth step which is, "Compression."…so I just assumed everything was done already before this compression, you know, was started so I don't - I think I didn't specifically check the airway but I did look through the clear mask. At the time I was sure there was nothing there*".

RN Xu was asked about Professor Brown's criticisms regarding the consistency of ventilation. He said that he only used the BVM briefly and that another nurse then took over. He said that he vaguely recalled seeing David's chest rise and fall. He said that he did not pay attention to whether there were big gaps in the ventilation.

When asked about differences in practices now RN Xu said that there would be someone designated as team leader. He said that person could be a doctor or nurse, and would be responsible for supervising the process in a hands-off but organised way.

He said that the resuscitation would be more role focused, involve simulation-type training, and that a Medical Emergency Response Team Leader (**MERTL**) would assist in responding in a more team-oriented way. RN Neumann explained that this was the first emergency resuscitation that she had been involved in. She said that she had received previous training but to the extent that she had been trained after David's death. She said that she was not trained at all in relation to taking a team approach to the resuscitation.

Prior to 29 December 2015 Dr Ma had never performed resuscitation on a real person, and had not been given training in relation to assigning roles for the purposes of resuscitation. He acknowledged, "*unfortunately and regrettably*", that he had no discussion with the nursing staff about their roles in the resuscitative effort. Dr Ma said that he was aware of Professor Brown's criticisms regarding the absence of continuous external cardiac massage and consistency of cycles and said that he "*definitely*" accepted that these critical aspects of the resuscitation effort could have been done better and more consistently.

Conclusions: The resuscitation attempt conducted by Justice Health staff on 29 December 2015 was of a low clinical standard and lacking in several vital areas. There was a fundamental deficit in failing to provide continuous basic life support to David in the absence of consistent external cardiac massage and maintenance of ventilation. These deficits can primarily be attributed to three factors: the inexperience of the clinicians in providing life support in a real life setting; the absence of resuscitation team leadership and assignment of key roles; and focus on the cause of David's collapse rather than the resuscitation efforts.

It was submitted by the solicitor for the Dungay Family that the professional conduct of Dr Ma, RN Tharpa and RN Maharjan relative to the resuscitation attempt warrants review. Counsel for Dr Ma and the solicitor for RN Tharpa and RN Maharjan submit that such a review is not warranted. On their behalf it is submitted that the confronting nature of the resuscitation attempt, coupled with 29 December 2015 being the first occasion in which the clinicians had to apply their training and skills to a real-life situation, led to inadequate life support being provided to David. As noted above, the evidence establishes that this was indeed the case. The evidence does not establish that the inherent quality of clinical care was so deficient, absent the identified considerations regarding the resuscitation itself, as to warrant review of professional conduct. It is accepted that the clinicians were endeavouring to do their best to provide life support to David, but were overcome by the enormity and stress of the situation they were confronted with. On this basis, the submissions on behalf of Dr Ma, RN Tharpa and RN Maharjan are accepted.

Remedial action taken since 29 December 2015

At present, the Justice *Health Long Bay Hospital Medical Emergency Response Procedure* identifies the recommend a course of action to be taken by Justice Health clinicians during a medical emergency response within Long Bay Hospital wards.

In 2016 Long Bay Hospital implemented a process to delineate the roles and responsibilities of nursing staff involved in medical emergencies, including cardiac arrest. The process assigns the role of a MERTL, which is held by a registered nurse in each ward and on each shift.

The role of the MERTL is to coordinate and support staff in medical emergencies including, relevantly, to assign staffed roles such as airway management, external cardiac massage, and application of a defibrillator. The procedure provides that a MERTL provides "*leadership and coordination of the team treating the patient. MERTL will ensure that the process in the Emergency Response Checklist is followed*".

In evidence Paul Sonntag, the Justice Health Nurse Educator - Clinical Practice, was asked about this. He was asked whether the intention of the MERTL program was for the team leader to not actively participate in the resuscitation attempts, but to instead direct it. Mr Sonntag indicated that this would be dependent on the time of day, with this being more possible during daytime with more staff, but less likely during the day when less staff would mean that the MERTL would be actively involved. Mr Sonntag agreed that in hindsight to clarify in the Medical Emergency Response Procedure that the MERTL normally directs the process, but does not participate in it. Mr Sonntag also agreed that would be helpful to specify the roles to be assigned during a medical emergency response.

Mr Sonntag indicated that whilst staff have been trained in the procedure there had been no attempt to audit compliance with the procedure in practice, due in large part to the rare instance of medical emergencies in Long Bay Hospital.

Recommendation: I recommend that Justice Health amend the Medical Emergency Response procedure and training/educational materials in respect of the Procedure to include a statement to the effect that it is the responsibility of the Medical Emergency Response Team Leader to assign roles to team members in the event of a Medical Emergency Response and to oversee and direct the Response, but not to actively participate in it.

Recommendation: I recommend that Justice Health amend the Medical Emergency Response Procedure and training/educational materials in respect of the Procedure to include specific reference to the roles which the Medical Emergency Response Procedure Team Leader is to assign to Response participants.

Recommendation: I recommend that Justice Health audit staff performance under the Medical Emergency Response Procedure and the Medical Emergency Response Procedure Checklist to ensure compliance.

Issue 12: The likely cause of David's death and in particular, which of the following matters caused or contributed to it (whether separately or in combination): (i) David's diabetic condition; (ii) the manner of David's restraint/positioning; (iii) the medications David was on for his diabetes and/or his psychiatric condition as at 29 December 2015; (iv) the Midazolam administered to David on 29 December 2015; (v) any inadequacies in the life support provided to David.

Following his death David was taken to the Department of Forensic Medicine (at its former location) in Glebe. On 30 December 2015 Dr Bailey performed an autopsy. In her autopsy report of 28 July 2016 Dr Bailey opined that the cause of David's death could not be ascertained, but noted several abnormalities which potentially contributed to death:

- petechial haemorrhages, a feature associated with impaired blood drainage from the head which may occur through neck or torso compression that might be occasioned during restraint procedures;

- compression of the torso in the prone position which may reduce the entry of air into the lungs, ultimately resulting in hypoxia and/or cardiac arrest;

- aspirated foreign material in the lungs;

- biochemistry test results possibly reflective of early dehydration due to high blood glucose levels; and

- a possible temporal relationship between the administration of midazolam and cardiac arrest.

In evidence, Dr Bailey explained: "*I could not identify a pathology that was incompatible with life and therefore accounting for his sudden death. Having said there, there are many physiological causes of death that cannot be identified at autopsy, but in - my inability to scientifically demonstrate one, I can't give you a cause of death*".

Diabetic condition

Dr Cromer found that there was no evidence to suggest that David had hypoglycaemia or diabetic ketoacidosis. Whilst noting that David most likely had documented elevated glucose levels which possibly rose after he ate the crackers, Dr Cromer opined that this would not have contributed to David's sudden death. Dr Cromer also indicated that hyperglycaemia may lead to a loss of consciousness and then death, but that it is a slow process. He said that there would be evidence of other symptoms prior to loss of consciousness. He said that he would not expect there to be a period of shortness of breath, but that in the event of severe diabetic ketoacidosis there would be a period of hyperventilation in the form of rapid and deep breathing.

The manner of David's restraint/positioning

Professor Brown was asked whether a failure to cease restraint at some point contributed to death. He explained: "*I think it was contributory. I can't tell you at which point ceasing it was important. It's, it's an impossible situation where you have an agitated person and a danger to others, a danger to, to themselves, it's a no-win situation. I think, I can't tell you at what point restraint - sorry - at what point ceasing any sort of hands on would've made a big difference*".

Professor Brown was also asked whether positional asphyxia was a substantial cause of the cardiac arrest. He said: "*I put in my report it was a contributory, with a combination of prone positioning and restraint. I haven't been able to say it was substantial and I don't say that now. I, I don't know what ultimately causes the cardiac arrest. A different arrhythmia is possible but I don't believe that, but I've said that both prone positioning and restraint were contributory*".

However, Professor Brown went on to explain that if restraint was removed from the equation, but regard was still had to David's obesity, psychosis, and agitation, it is likely that David would not have suffered a cardiac arrest.

Medication regime

Associate Professor Adams explained that "*it has long been noted that patients with schizophrenia have a higher incidence of sudden death than the general population*", with one of the reasons being that psychotropic drugs essential for the control of schizophrenia have the effect of prolongation of the QT interval. Associate Professor Adams noted that David had been prescribed both chlorpromazine and zuclopenthixol, both medications of which are known to increase the QT interval. Therefore Associate Professor Adams opined that "*it is likely that the combination of antipsychotic drugs may have contributed to development of a cardiac arrhythmia due to their combined effects on contributing to QT prolongation*".

In expressing this opinion Associate Professor Adams was not critical of use of the antipsychotic medication. He noted that "*the risk of their use was greatly outweighed by the potential clinical benefit*" and that their use was carefully managed as demonstrated by ECG results on 4 and 8 December 2015, which showed no signs to suggest that the medications were contraindicated.

Administration of midazolam

Professor Brown noted that there was only a short time interval (two minutes and seven seconds) from the intramuscular injection of midazolam to cardiorespiratory arrest. He explained that this would not have allowed time for the midazolam to be absorbed and noted that there was an almost negligible subtherapeutic midazolam level in the post-mortem blood sample. Professor Brown therefore expressed the opinion that these factors indicated that the midazolam did not contribute to David's cardiorespiratory arrest, and concluded that the injection of midazolam "*played no part at all in the cause of David's death*".

Similarly Mr Farrar expressed the view that "*the subtherapeutic concentration of midazolam in the post-mortem blood sample indicates that [David's] death occurred prior to any significant absorption of midazolam*" and opined that "*midazolam therefore did not cause [David's] death*".

Inadequacies in the life support provided

Professor Brown indicated that he was unable to say whether David would have survived even if excellent basic life support had been provided from the time of his collapse until the arrival of NSW Ambulance paramedics. However Professor Brown noted that "*whatever chance [David] had, however low, was lost by the inadequate and interrupted care he received from Justice Health*".

Professor Brown indicated that if an assessment had been conducted prior to the midazolam being administered David's distress would have been recognised. He was asked what would have been detectable at that point. He explained: "*…to have a cardiac arrest in asystole doesn't happen in an instant. You don't go from a normal pulse to a stop. You go through whatever insult is causing the heart to slow down and so this, to me, based on the fact that he had petechia or little tiny bruising on the face and a congested head, this would've been visible, I believe, by now. This would've been visible as a suffused possibly purple-looking face, purple lips*". Professor Brown went on to explain: "*So if you'd noticed a purple face, cyanose purple lips, a thready pulse, a slow pulse or possibly an extreme pulse, I would've said okay, just stop what you're doing, stop what you're doing, he's not well. And I can't say with any certainty but at some point, the cardiac arrest becomes inevitable, therefore there's a point prior to that where it's reversible, and it's possible, whilst he's still calling out, 'I can't breathe'. Certainly that means his brain is being perfused, it's possible had everything stopped then and focused on putting on oxygen, getting optimal mechanics of the circulation, that the cardiac arrest could, and I don't say would but I say could have been averted*".

Professor Brown referred to the significance of the two minutes and 17 seconds between the midazolam injection and David's cardiac arrest. He explained that by David saying that he could not breathe demonstrated that his brain lungs and pulse were all working. This meant that there was a reversible window before the brain was starved of oxygen and circulation failed which would lead to bradycardia, asystole, and full cardiac arrest. He explained that at that point the chance of recovery would be exceptionally small (less than one percent) despite even the best resuscitation.

Cardiac arrhythmia

Associate Professor Adams opined that it is likely that David died due to a fatal cardiac arrhythmia noting that there are three main reasons to support this:

- no obvious cause of death at autopsy, which is consistent with what might be expected at autopsy when an arrhythmia is the cause of death;

- the IAT footage is consistent with development of an arrhythmia and its deterioration into a fatal arrhythmia; and

- David had multiple potentiating factors for the development of an arrhythmia including: antipsychotic medication with a propensity to prolong the QT interval, type I diabetes, hyperglycaemia, possible evidence of hypoxaemia (in circumstances where David was complaining of difficulty breathing and was restrained in a prone position), and a situation of extreme stress and emotional upset.

Associate Professor Adams explained that it was possible that David's arrhythmia commenced in cell 71 and that this explained his shortness of breath. Associate Professor Adams noted: "*I was a little concerned that that may have been when his arrhythmia had started, that he may have developed ventricular tachycardia, which at that point would have had the effect of lowering his blood pressure to make him feel dizzy and also causing increased pressure within his heart, which has the effect of making you short of breath as well*.

Associate Professor Adams went on to explain that if David was already in ventricular fibrillation in cell 71 then any exertion or struggle "*could have made the ventricular tachycardia faster and less effective at providing a cardiac output and increasing the degree of failure*". Associate Professor Adams also noted that restraint "*could cause a degree of hypoxia, which would further accentuate any sort of arrhythmias that would, would have occurred or may have occurred*." However, Associate Professor Adams expressed the view: "*Whether that's significant, it's probably a little doubtful in that I'd suspect [David] probably already had the arrhythmia before, any restraint might have caused, caused hypoxia*".

Dr Bailey considered the following factors to be important:

- David's heightened agitation increased his blood pressure and heart rate;

- there are higher incidences of sudden cardiac death in persons with diabetes and some obesity;

- David had been placed in the prone position which would decrease his mechanical ventilation capacity which might decrease his blood oxygen level.

Dr Bailey went on to note: "*So you have somebody who is agitated, whose metabolic demands are very high, who also already has a little bit of metabolic derangement, because of the diabetes, they're put face down, they have a little bit of hypoxia from being placed face down, he may or may not have aspirated. All of this could precipitate a potentially fatal cardiac dysrhythmia. That's an absolutely hypothetical scenario, but these are all of the contributing factors that I think have come together in this case. I think he's also starting to get a little bit dehydrated, if you look at his biochemical testing, which again a little bit of dehydration on the background of his diabetes and his obesity and his agitation, all of the tiny little things, whilst in isolation are not a problem, in total create the possibility for a sudden cardiac death*".

Ultimately Dr Bailey explained that she did not doubt that the mechanism of death was cardiac arrhythmia, and that she could find no other reason for David's sudden collapse, but said that she did not know what the underlying reason for the arrhythmia was.

Professor Brown was taken to Associate Professor Adams' opinion that David may have been experiencing an arrhythmia in cell 71. He said that he considered it but thought it was unlikely because he considered that this would be associated with a sudden collapse. In David's case there was a period of struggle and repeated complaints of difficulty breathing, which Professor Brown considered to be unusual in the context of suspected cardiac arrhythmia. However Professor Brown acknowledged that it is possible for ventricular fibrillation (a cardiac arrhythmia) to convert to asystole (the absence of electrical and mechanical activity of the heart). Professor Brown expressed the view that the asystole was related to a deterioration in David's general circulation, associated with his difficulty breathing. He said that it was possible that the arrhythmia was the early trigger and that it converted to asystole but thought it unlikely and that he could not demonstrate this. However, ultimately Professor Brown said that he would defer to the expertise of the cardiologist.

Conclusions: Having regard to the opinions expressed by Associate Professor Adams and Dr Bailey it is most likely that the cause of David's death was cardiac arrhythmia. It is noted that David had a number of comorbidities, both acute and chronic, which predisposed him to the risk of cardiac arrhythmia such as long-standing poorly controlled type I diabetes, hyperglycaemia, prescription of antipsychotic medication with a propensity to prolong the QT interval, elevated body mass index, a degree of likely hypoxaemia caused by prone restraint, and extreme stress and agitation as a result of the events of 29 December 2015. The expert evidence established that the administration of midazolam was not contributory to Davis's death. However, the expert evidence also established that prone restraint, and any consequent hypoxia, was a contributing factor although it is not possible to quantify the extent or significance of its contribution.

As Dr Bailey noted it is not possible to precisely identify the degree to which each of these comorbidities contributed to cardiac arrhythmia. Rather, the various comorbidities in combination increased the risk of cardiac arrhythmia. Whilst Professor Brown considered that a cardiac arrhythmia whilst David was still in cell 71 was unlikely, and preferred the view that David suffered a cardiac arrest which proceeded to asystole in cell 77, he ultimately deferred to the opinion of Associate Professor Adams.

The expert evidence established that because David was continuing to complain of difficulty breathing prior to becoming unresponsive, there was a small window in which interventional life support might have made a difference to the eventual outcome. However, Professor Brown posited this only as a possibility and noted that even if adequate life support had been provided the chances of recovery for David were exceptionally small.

Acknowledgments

For a variety of reasons, the conduct of this inquest was challenging and complex. Throughout it, the Assisting team of Jason Downing, Counsel Assisting, and his instructing solicitors, James Loosley and Jessica Murty, have been resolute in their approach to examine the evidence meticulously, present the evidence fairly and impartially, afford respect and dignity to David and his family, and to assist the Court in a professional and meaningful manner. Their considerable efforts and diligence should be gratefully acknowledged and recognised as embodying the fundamental principles of the coronial jurisdiction.

The work of Detective Sergeant Babb in conducting the initial police investigation and compiling the voluminous brief of evidence is also acknowledged and appreciated.

Findings pursuant to section 81 of the Coroners Act 2009

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

Identity

The person who died was David Dungay.

Date of death

David died on 29 December 2015.

Place of death

David died within the Mental Health Unit at Long Bay Hospital, Long Bay Correctional Centre, Malabar NSW 2036.

Cause of death

The cause of David's death was cardiac arrhythmia.

Manner of death

David died whilst being restrained in the prone position by Corrective Services New South Wales officers. David's long-standing poorly controlled type I diabetes, hyperglycaemia, prescription of antipsychotic medication with a propensity to prolong the QT interval, elevated body mass index, likely hypoxaemia caused by prone restraint, and extreme stress and agitation as a result of the use of force and restraint were all contributory factors to David's death.

Epilogue

It is fitting to conclude some words from a poem written by David's sister, Cynthia, to David: "*Only a heart as dear as yours would give so unselfishly the many things you [have] done, all the time, that you were there for me. Help me to know deep down inside how much you really cared. Even the thoughts I might not say, I appreciate all you do for me. Greatly blessed is how I feel having a brother just like you*".

On behalf of the Coroner's Court of New South Wales, and the Assisting Team, I offer my deepest sympathies, and most sincere and respectful condolences, to Leetona, Cynthia, Ernest, Christine and other members of the Dungay family; to David, Janeeka, Jakiah, Jivarhn, Janessa and Jehziac, and other members of the Hill family; and to David's friends for their immeasurable and tragic loss.

Recommendations made pursuant to section 82(1) *Coroners Act 2009*

To the Commissioner, Corrective Services New South Wales (*CSNSW*) and Chief Executive, Justice Health & Forensic Mental Health Network (*Justice Health*):

1. I recommend that training on the *Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital* (January 2019) and *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be provided to all CSNSW and Justice Health staff working at Long Bay Hospital, including theory, practical training and assessment.

2. I recommend that CSNSW and Justice Health audit compliance with the *Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital* and *Enforced Medications - Long Bay Hospital Mental Health Unit* Local Operating Procedures.

3. I recommend that Section 4.6 of the *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be amended to mandate the attendance of a psychiatrist/medical officer to assess a patient in the event of administration of enforced medication.

4. I recommend that the Joint Planned Medication Checklist of the *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be amended to include information indicating that risk factors for restraint and positional asphyxia have been considered by Justice Health and CSNSW staff prior to the administration of enforced medications.

5. I recommend that the *Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital* (January 2019) and *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be amended to provide that Justice Health medical personnel are able to give directions to CSNSW correctional officers regarding the positioning of a patient for the administration of injections.

To the Commissioner, Corrective Services New South Wales:

6. I recommend that all necessary steps be taken to make an Aboriginal Welfare Officer or Aboriginal Inmate Delegate available within Long Bay Hospital to assist where required, in interactions with Aboriginal or Torres Strait Islander inmates in the Mental Health Unit and that Corrective Services New South Wales inform and train officers working in the Mental Health Unit to utilise this process where appropriate.

7. I recommend that Corrective Services New South Wales review the use of the proclamation process by the Immediate Action Teams in Long Bay Hospital to ensure that appropriate consideration is given, at the time the proclamation issued, to the possibility that a mentally ill inmate patient may not be in a position to comply or respond to the proclamation in a rational manner.

8. I recommend that CSNSW continue to provide *Positional Asphyxia Awareness* online training to all custodial staff up to and including the rank of Functional Manager/Senior Assistant Superintendent, and audit completion rates annually to identify correctional staff who have not yet completed such training.

9. I recommend that CSNSW continue to provide specialist practical training on positional asphyxia to Immediate Action Team and Special Operations Group officers, and audit completion rates annually to identify officers who have not yet completed such training.

10. I recommend that CSNSW provide training to all Corrective Services Officers working in the Mental Health Unit in restraint techniques, positional asphyxia and the risks of sudden death from restraint.

11. I recommend that CSNSW audit at least one-third of all video recordings, as a representative sample, of uses of force by Immediate Action Teams in order to verify that sections 13.7.8 and 13.7.9 of the Custodial Operations Policy and Procedures have been complied with, with consideration to be given to additional auditing if the nominated representative sample does not allow for such verification.

12. I recommend that CSNSW complete the trial of a suitable soft restraint system for use in the Mental Health Unit as an alternative to the use of handcuffs, with the relevant training to be provided to applicable staff including staff in G Ward.

13. I recommend that CSNSW, through the Special Operations Group, create and implement a revised use of force training package for Mental Health Unit staff which places greater emphasis (50% weighting) on de-escalation techniques versus physical control and restraint techniques.

14. I recommend that CSNSW review the current version of the Custodial Operations Policy and Procedure to ensure that clear instructions are provided requiring the retention of all potentially relevant video footage, including CCTV footage, in the event of a death in custody.

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

15. I recommend that Justice Health implement training for all clinical staff working at Long Bay Hospital Mental Health Unit, including medical officers, in relation to the NSW Heath Policy Directive *Aggression, Seclusion and Restraint in Mental Health Facilities New South Wales* (PD2012_035).

16. I recommend that Justice Health give consideration to whether a position other than the prone position should be utilised for enforced medication to be administered under the *Enforced Medication and Rapid Tranquilisation - The Forensic Hospital and Long Bay Hospital Mental Health Unit* (Policy Number 1.180) and emergency sedation to be administered under the *Emergency Sedation – Forensic Hospital and Long Bay Hospital Mental Health Unit* (Policy Number 1.441).

17. I recommend that Justice Health amend the Medical Emergency Response procedure and training/educational materials in respect of the Procedure to include a statement to the effect that it is the responsibility of the Medical Emergency Response Team Leader to assign roles to team members in the event of a Medical Emergency Response and to oversee and direct the Response, but not to actively participate in it.

18. I recommend that Justice Health amend the Medical Emergency Response Procedure and training/educational materials in respect of the Procedure to include specific reference to the roles which the Medical Emergency Response Procedure Team Leader is to assign to Response participants.

19. I recommend that Justice Health audit staff performance under the Medical Emergency Response Procedure and the Medical Emergency Response Procedure Checklist to ensure compliance.

To the Chief Executive, Nursing and Midwifery Board of Australia:

20. I recommend that, pursuant to section 151A of the *Health Practitioner Regulation National Law (NSW) No 86a*, the transcript of the evidence of Registered Nurse Charles Xu be forwarded to the Chief Executive, Nursing and Midwifery Board of Australia for consideration of whether the professional conduct of Registered Nurse Xu on 29 December 2015 should be the subject of review.

4. 82254 of 2016

Inquest into the death of Stephen KLINE. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 1st March 2019.

Introduction

On 8 March 2016 Stephen Kline was at home when he was told that his electricity would be disconnected. He reacted in a way that resulted in the attendance and involvement of a number of police officers. The situation quickly escalated culminating in a taser being deployed at Stephen. The taser ignited some nearby flammable liquid causing an explosion and burns to Stephen's leg. He was taken to hospital for treatment.

Whilst there, and whilst under the guard of Corrective Services NSW officers, Stephen swallowed a set of keys in an apparent act of self-harm. This meant that Stephen's expected brief hospital admission became an admission of some seven days as the keys could not be surgically retrieved. On the morning of 15 March 2016 Stephen unexpectedly and suddenly collapsed, and went into cardiorespiratory arrest. An emergency response was mounted but Stephen could not be revived and was later pronounced deceased.

Why was an inquest held?

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

As a consequence of the incident involving the police officers on 8 March 2016 Stephen was arrested and taken into police custody. He was later refused bail and remanded into custody pending a future court appearance. As he could not be transferred to a correctional centre before the keys which he had swallowed had passed, he remained at hospital under the guard of Corrective Services NSW (**CSNSW**) officers.

This meant that at the time of Stephen's death he was being held in lawful custody. By depriving a person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately.

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

Stephen's life

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

Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

Unfortunately very little is known about Stephen's life. He was born in 1964 and was 51 years old at the time of his death. Stephen grew up in the suburb of Tregear in Sydney's western suburbs. He and his three siblings attended primary school in Tregear and then high school in St Marys. Stephen left school in Year 10 and lived with a friend in Tregear. As Stephen had challenges with his literacy, he found it difficult to maintain employment. However Stephen was skilled in mechanical work, eventually finding casual work as a boiler maker, and he later worked in the concrete industry.

Due to his heritage Stephen identified as an Aboriginal man. Stephen married in 1989 after meeting his wife at a nursery where they both worked. They had a daughter together a year later. Between 1992 and 1993 Stephen encountered difficulties in his relationship, and he and his wife later separated. For reasons unknown Stephen became estranged from the members of his family over time and had little contact with them.

In around 2001 Stephen moved to his home in Riverstone. Stephen lived alone and reportedly kept mostly to himself. He enjoyed working on older model Holden cars which he would repair and then sell. Stephen was also devoted to the large number of dogs that he kept at his home in Riverstone. Many of the dogs had been rescued by Stephen, he loved them dearly and regarded them as his family. Stephen's admission to hospital following the events of 8 March 2016 distressed and upset him greatly because it meant that he was separated from his beloved dogs. The impact that this had on Stephen was painfully clear.

Although no member of Stephen's family was present during the inquest and able to provide more of a glimpse into the person that Stephen was, the importance of his life should not be diminished. From all that is known about him he was a man proud of his heritage and who cared deeply for his dogs who he regarded as family rather than pets.

Tuesday, 8 March 2016: background events

Stephen was at his home at 110 Regent Street, Riverstone on the morning of 8 March 2016. He had been told that his electricity would be disconnected as he had not paid his electricity bills. Two workers from Stephen's electricity provider were on site to perform the disconnection. However, because Stephen became upset at the prospect of losing his electricity he began to behave in an aggressive manner. This prompted a call being made to the police to provide assistance.

Local police officers arrived on the scene at about 8:30am. The workers from the electricity provider told police that they only needed to access a power pole located across the street from Stephen's house. As the workers climbed up the pole and began to disconnect the electricity to Stephen's house, Stephen appeared at the front gate of his house and began yelling and swearing. Stephen yelled out, "*I've got a fucken chain saw, when you guys leave I'm going to cut the pole down*". The police officers attempted to reason with Stephen in an attempt to calm him down. However, Stephen remained angry, started up a chain saw and again threatened to cut the pole down. This behaviour prompted the police in attendance to call for assistance.

Sergeant Jason Shaw was one of the police officers who responded to the call for assistance. He arrived on scene at about 9:14am. Upon arrival Sergeant Shaw saw one of the electricity company workers place a piece of paper in Stephens' letterbox. Stephen emerged from his house a short time later, yelling and swearing into a mobile phone which he was holding, and making threats to cut down the power pole.

Sergeant Shaw told Stephen that he needed to talk to him, but that Stephen needed to first calm down and to stop making threats. Sergeant Shaw told Stephen to look at the piece of paper that was in his letterbox. Stephen retrieved the paper but told Sergeant Shaw that he could not read. Sergeant Shaw took the paper and saw that it was a disconnection notice with a telephone number on it. Sergeant Shaw told Stephen that if he called the number he could speak to someone about the disconnection. However Stephen showed no interest in calling anyone.

Sergeant Shaw informed Stephen that he could not threaten to cut down the power pole and that he would be arrested if he did so. Leading Senior Constable Michael Hurst, another one of the officers in attendance, heard Stephen tell the police officers, "*When you leave I'll just cut the power pole down*". Sergeant Shaw informed Stephen that if he did that he would be charged with an offence and detained. Stephen was heard to respond by saying, "*I don't give a fuck*". Stephen walked away and went back inside his house, whilst continuing to swear. A short time later, the sound of further swearing and threats, together with the sound of a motor revving, came from Stephen's carport area, and later stopped.

Sergeant Shaw left the scene a short time later and began to patrol the area, driving past Stephen's house on several occasions in order to maintain police visibility in the area. On one occasion whilst driving past, Sergeant Shaw saw that Stephen was standing in his front yard holding a chainsaw. However, on another occasion Stephen was no longer in the front yard. After patrolling the area for about 15 minutes Sergeant Shaw left and returned to Quakers Hill police station.

Tuesday, 8 March 2016: Police enter Stephen's front yard

At about 11:10am a job was broadcast over police radio indicating that a male person residing at 110 Regent Street Riverstone was using a chain saw to cut down a power pole. Initial attending police, including Sergeant Shaw and Leading Senior Constable Hurst, returned to Stephen's address and inspected the power pole opposite his house. They saw that there were two diagonal cuts in the pole, at a depth of about one centimetre. No person was sighted in the vicinity of the power pole.

Some of the attending police officers commenced patrolling the surrounding area. Meanwhile Leading Senior Constable Hurst canvassed the residents of the neighbouring properties to enquire whether they had seen any person in the vicinity of the power pole.

Sergeant Shaw, Leading Senior Constable Hurst and Constable Diane Simkins walked to the front of Stephen's house. Stephen was in the front yard of his property, which was surrounded by a metal fence. At the right hand side of Stephen's property was a driveway with a gate locked by a chain and padlock. The police officers saw that there was a large dog running around in the front yard. Sergeant Shaw asked Stephen to approach the front gate so that the police officers could speak with him. Leading Senior Constable Hurst noted that Stephen was pacing around the yard and mumbling something which the police officers could not hear. Sergeant Shaw repeated his requested several more times, and also told Stephen that the police officers had the right to approach his front door. He instructed Stephen to put the dog away, warning him that if the dog approached the police officers they would deploy their tasers. Stephen responded by saying, "*Fucken try it*".

However, Stephen called the dog to him and put it inside his house. When he returned to the yard he walked behind two cars that were parked in the driveway. Having formed the view that Stephen was responsible for damaging the power pole across the street, Leading Senior Constable Hurst prepared to enter Stephen's front yard by jumping over the front gate in order to arrest him. Leading Senior Constable Hurst placed his hands on the fence and was about to jump over it when he heard Stephen say, "*If you come on my property I'll fucken burn…*". Leading Senior Constable Hurst saw that as he said this, Stephen was holding a red plastic fuel container similar to a jerrycan.

Leading Senior Constable Hurst jumped over the fence and saw that Stephen was attempting to open a cap on top of the jerrycan. Believing that Stephen was approaching him with the jerrycan (and that it contained petrol), Leading Senior Constable Hurst withdrew his oleoresin capsicum (**OC**) spray and deployed a one second burst at Stephen.

According to Leading Senior Constable Hurst this appeared to have no effect as Stephen took the cap off the jerrycan and began splashing fuel on the parked cars and in the direction of Leading Senior Constable Hurst. Leading Senior Constable Hurst smelled petrol fumes and deployed a second burst of OC spray at Stephen. At this time Stephen was approximately two metres from Leading Senior Constable Hurst and continued to splash the petrol from the jerrycan, some of which landed on Leading Senior Constable Hurst's shirt and upper torso.

Leading Senior Constable Hurst continued to deploy the OC spray whilst retreating backwards until he backed onto the front fence. Not wanting to turn his back on Stephen (in order to climb back over the fence) due to a fear that Stephen might produce a lighter and ignite the petrol, Leading Senior Constable Hurst decided to instead advance and tackle Stephen to the ground. As he did so, Stephen splashed some further petrol which came into contact with Leading Senior Constable Hurst's eyes.

Leading Senior Constable Hurst felt a burning sensation in his eyes and was unable to see properly. He began to grab onto Stephen in an attempt to bring him to the ground. It appears that Leading Senior Constable Hurst tripped Stephen and he fell down, landing on top of Leading Senior Constable Hurst. Leading Senior Constable Hurst yelled out a number of times that he could not see and asked for help.

At this time Sergeant Shaw was still standing on the other side of the front fence. He ran to the right hand side of the fence and attempted to climb over it but found that it could not support his weight. Instead he ran back to the front fence, climbed over it and moved to where Leading Senior Constable Hurst was still on the ground, grappling with Stephen.

Sergeant Shaw withdrew his taser, pointed it at Stephen and pressed the trigger, causing the taser to deploy its probes which struck Stephen in the torso area. Stephen fell to the ground and stopped struggling, indicating that neural muscular incapacitation had occurred. Sergeant Shaw left the taser armed active and about three to four seconds into the five second cycle he saw that the lower portion of Stephen's left shin was surrounded by flames. Moments later there was a large explosion in the area surrounding where Stephen had splashed petrol onto the ground.

Sergeant Shaw grabbed Stephen under his armpits and dragged him away from the explosion area which by this time was alight. He attempted to put out the fire on Stephen's legs by smothering it with his hands but this had little effect. Instead, Sergeant Shaw filled up a bucket near a tap in Stephen's yard with water and poured it over Stephen's legs, extinguishing the flames. Sergeant Shaw repeated this process of retrieving water several times in order to pour it over the flames on the ground, over Leading Senior Constable Hurst's face, and over Stephen's legs again. Sergeant Shaw returned to Leading Senior Constable Hurst to help him climb over the fence before going back to Stephen to help him stand up. Stephen started to walk towards his front door but Sergeant Shaw stopped him and told him that an ambulance was on its way and that he needed to be treated. Stephen was later charged with a number of offences relating to damaging the power pole and his interaction with the police officers in the front yard of his home.

NSW Ambulance paramedics arrived on the scene a short time later and Stephen was taken by ambulance to Westmead Hospital emergency department. An initial assessment was performed which indicated that Stephen had suffered a partial thickness burn of approximately 1.5% to his left lateral calf. It was later decided that Stephen should be transferred to a different hospital so that his burn could be treated by a specialist Burns Unit.

Admission to Concord Repatriation General Hospital

Accordingly, Stephen was subsequently taken to Concord Repatriation General Hospital (**Concord Hospital**), arriving at about 6:55pm. He was immediately transferred to the Burns Unit via the emergency department. Dr Chris Ahn was the on-call plastic surgery registrar who was on duty and covering the Burns Unit at the time. Dr Ahn assessed Stephen and found that he had a partial thickness burn injury to the anterior, lateral and posterior surfaces of his left leg to his left toe, comprising 5% of his total body surface area. Dr Ahn formulated a treatment plan which involved Stephen's burn wounds being scrubbed and a Xenograft Biobrane dressing applied. Given the relatively minor nature of Stephen's burn injury Dr Ahn considered that Stephen would be discharged shortly. However, given the timing of Stephen's admission that evening, it was decided that he should remain admitted overnight with the expectation of being discharged sometime the next morning.

Sometime later that evening Stephen received a visit from Inspector Skye Adams from the Royal Society for the Prevention of Cruelty to Animals (**RSPCA**). She had attended Stephen's home earlier that afternoon and seized two of Stephen's dogs. Inspector Adams told Stephen that two of his female dogs were in the care of the RSPCA and suffering from prolapsed uteruses which required urgent veterinary intervention. Ms Adams told Stephen that whilst the dogs were in the care of the RSPCA that he was responsible for veterinary and boarding fees, but that he if was unable to pay he could surrender the dogs. Stephen belligerently told Ms Adams that he did not wish to do so.

Overnight, Stephen complained of chronic pain in his right hip as well as a burning pain in his chest. His vital signs were taken and a review was planned for the following morning.

Wednesday, 9 March 2016

Ms Adams returned the following day to speak with Stephen. She discussed the care of Stephen's dogs that remained at his house and he told her that he had a friend who could look after the dogs. Ms Adams later contacted Stephen's friend to make arrangements for him to provide short term care.

During the morning, Stephen complained of dizziness, together with pain and stiffness due to bed rest. At around 2:45pm a physiotherapist attempted to mobilise Stephen but he declined, stating that doing so made him feel uncomfortable and anxious.

At about 3:00pm Dr Paul Tyrrell, a psychiatry registrar, visited Stephen in his room. Due to the unusual circumstances surrounding Stephen's admission the Burns Unit had referred Stephen for a psychiatric review. It was intended to identify whether Stephen had a mental illness and, if so, how it was to be managed. As Stephen was sedated and uncooperative at the time Dr Tyrrell was only able to conduct a preliminary assessment in which he formed the view that Stephen showed no signs of psychosis or having any evidence of depression or suicidal thoughts, but suspected that Stephen may have a personality disorder.

Dr Tyrrell later spoke to Dr Danielle Vandenberg, the consultant psychiatrist, about Stephen's management. A plan was formulated for Stephen to be commenced on an Alcohol Withdrawal Scale to monitor for alcohol withdrawal and started on a regimen of diazepam for agitation if there was evidence of this. Further, Stephen was also prescribed thiamine and plans were made to obtain as much collateral information as possible about his past mental health history. Finally, plans were made for daily psychiatric review in order to monitor Stephen's risk for possible self-harm.

Shortly after Dr Tyrrell's preliminary assessment, a bedside hearing was conducted in relation to the offences that Stephen was charged with. He was refused bail and remanded into custody. Up until this time Stephen had been under the guard of police officers stationed at the hospital but following the refusal of bail Stephen was placed under the guard of CSNSW officers from the Court Escort Unit. Stephen's next court appearance was scheduled for 15 April 2016 at Penrith Local Court.

Thursday, 10 March 2016

Inspector Adams returned to the hospital on the morning of 10 March 2016. She told Stephen that his friend would not be able to look after his dogs in the long term. However Stephen expressed confidence that his friend could look after the dogs and refused to surrender them.

Later in the morning a physiotherapist returned to see Stephen to help him to mobilise. Stephen was reluctant to do so and complained of pain in his right hip and knee.

Dr Vandenberg later reviewed Stephen at about 11:50am The review lasted about 60 minutes and Dr Vandenberg noted that Stephen was preoccupied with certain themes such as perceived harassment by others, and the potential loss of his dogs. She noted that Stephen became distressed when talking about the possible loss of his dogs and in this context admitted thoughts of self-harm and wanting to die. Towards the end of the interview Stephen told Dr Vandenberg that he had swallowed a set of keys he had taken out of the bedside locker.

Dr Vandenberg formed the view that Stephen's swallowing of the keys represented an act of intentional self-harm in the context of his distress at the possibility of losing his dogs, house and property. Accordingly, Dr Vandenberg informed the Burns Unit nursing staff of this and noted in Stephen's progress notes that he was at ongoing risk for self-harm and needed to be monitored.

Chris Parker, the Nursing Unit Manager (**NUM**) for the Burns Unit, learned that Stephen had swallowed the keys and in turn advised Dr Arridh Shashank, the Burns Unit Senior Medical Officer. An x-ray was performed and the location of the keys was identified. The hospital's gastroenterology team were contacted and, following an assessment, plans were made to perform a gastroscopy to remove the keys. However, shortly before the procedure a further x-ray was performed which revealed the keys had progressed meaning that the procedure could not be performed. A plan was formulated to wait for Stephen to pass the keys. Accordingly, he was placed on a clear fluid diet with his stools to be monitored. Given the possibility that the keys might cause an obstruction, necessitating surgical intervention, daily x-rays were required to monitor the progress of the keys. As these x-rays could not be performed at Long Bay Correctional Centre (where Stephen was to be transferred to), he needed to remain admitted at Concord Hospital.

Sometime during the day Janette Pittorino, a social worker, went to see Stephen to perform a psychosocial assessment. She found that he was unhappy, aggressive and verbally abusive. Stephen was reluctant to discuss anything with Ms Pittorino or pass on any information. Stephen continued to be monitored and it was noted that his vital signs were stable that evening and the following morning.

Friday, 11 March 2016 to Sunday, 13 March 2016

Dr Vandenberg reviewed Stephen again on the morning of 11 March 2016. At this time Stephen appeared very flat in his mood and started to cry. He told Dr Vandenberg again that his life was not worth living and that he wanted to die in the context of losing his dogs, house, and other property.

At some time during the day a physiotherapist visited Stephen and again attempted to mobilise him. Stephen refused to do so, complaining of dizziness. Throughout the day and night Stephen's observations were noted to be normal.

Ms Pittorino also returned to see Stephen. She found him to be in a calmer mood than the previous day, and he apologised to her for his earlier behaviour. Stephen spoke with Ms Pittorino for a short time about his dogs, expressing some concern about the security of his property. However, Stephen declined any other social work support.

Stephen complained at times of dizziness and pain in his right hip and left leg. However, his vital signs were noted to be stable when routine observations were performed between 11 and 13 March 2016. On 13 March Stephen was able to shower independently and was noted to be ambulant with the assistance of two members of the nursing staff.

Monday, 14 March 2016

Dr Vandenberg returned to review Stephen briefly for a few minutes at 9:25am on 14 March 2016 but could not see him for longer as his burns dressings needed changing. Stephen was noted to be more settled and plans were made to return later in the day to review him.

At about 12:30pm, a physiotherapist returned to see Stephen again at which time he complained again of dizziness, together with pain in his abdomen and left leg. Stephen's vital signs were taken and found to be normal.

At about 12:50pm Stephen complained to Registered Nurse Alyce McNabb that he was feeling dizzy and nauseous, and was noted to be sweating heavily, after walking to the shower. Stephen's blood pressure was taken and found to be within normal limits.

Sometime during the day the Burns Unit contacted the hospital's surgical team to recommend that a computed tomography (**CT**) scan of Stephen's abdomen and pelvis be performed. The purpose of the CT scan was to locate where the keys were in the gut, whether there were any complications, and whether surgical intervention would be required. The CT scan was later performed at 4:47pm. A radiology registrar subsequently reported on the scan and generated a preliminary report at 5:10pm. In accordance with usual practice relating to the reporting of scans, this preliminary report was to be later be reviewed by a consultant radiologist and finalised.

At the time that the preliminary report was being written, members of the general surgical team came to the radiology department to view and discuss the CT scan. It was determined that the scan showed no bowel perforation or any other complications in the abdomen.

Tuesday, 15 March 2016: Stephen's sudden collapse and death

Dr Shashank and Dr Constant Van Schalkwyk conducted a daily ward round at about 7:15am on 15 March 2016. Stephen remained afebrile but it was noted that he had an elevated heartrate. Stephen's other vital signs remained below the levels for clinical review (there was no evidence of hypoxia or change in respiratory rate) and Stephen appeared to be sleeping comfortably. As Stephen's burn had healed adequately, the plan was to transfer him to the medical unit at Long Bay gaol as soon as possible.

CSNSW First Class Correctional Officers Jason Baptista and Vidaya Sharma were on duty on 15 March 2016 having commenced their shift at 5:30am. At that time Stephen was sleeping on his back on his bed with one hand cuffed to the bed. Stephen woke up sometime between 8:30am and 8:45am. The correctional officers did not hear Stephen make any complaints and he was helped to the shower a short time later at around 9:00am.

Upon returning to his room Stephen remained uncuffed so that he could more easily eat his breakfast which was to be served shortly. Officer Baptista had received information from the previous shift that Stephen had swallowed a set of keys. Therefore, as a precaution, Officer Baptista removed all metal cutlery from Stephen so that he only had access to plastic cutlery during breakfast. Dr Vandenberg and Dr Tyrrell returned to see Stephen again at about 9:30am. However Dr Vandenberg and Dr Tyrrell were unable to complete a review as Inspector Adams and Ms Pittorino arrived a short time later to speak with Stephen. Dr Vandenberg made plans to return to review Stephen later in the day.

During the meeting Ms Adams again raised with Stephen that his friend was unable to look after his dogs, particularly bearing in mind that Stephen's criminal proceedings had been adjourned until 15 April 2016 and that Stephen would remain in custody until then unless he was granted bail. Ms Adams sought to explain to Stephen that as the dogs were untrained and aggressive (because they had never been out of their yard) that they could not be placed with an organisation such as a security company. This meant, according to Ms Adams, that the dogs could either be seized by the RSPCA and detained until they could be legally euthanised, or Stephen voluntarily surrendered them so they could be sedated at Stephen's home.

Ms Adams and Ms Pittorino spoke with Stephen for about 40 minutes. Stephen was visibly upset following the meeting and was seen to be crying loudly. Stephen asked for assistance to be helped back to his bed and so Officer Baptista approached the nurses' station which was a short distance (approximately 10 metres) from Stephen's room. As he did so Officer Sharma left the room and remained at the doorway so that he could still see into the room. As Officer Baptista was making his way back to the room Officer Sharma heard the sound of something falling, and looked into the room to see Stephen fall off his chair and collapse face down on the floor. When Officer Baptista and a nurse returned to the room a short time later (about 30 seconds) Stephen was found lying face down on the floor and unresponsive. Urine and vomit were seen on the floor and Stephen was found to be cyanosed with no pulse.

Nursing staff immediately made a call at 10:15am for emergency assistance. Medical staff from the intensive care unit, anaesthetics and cardiology departments responded to the call and arrived a short time later. Cardiopulmonary resuscitation was commenced but Stephen could not be revived. He was pronounced deceased by Dr Shashank at 10:58am.

At about the time that emergency action was being taken to revive Stephen, Dr Kate Archer, consultant radiologist, produced the final report in relation to Stephen's earlier CT scan. The report was completed at 10:47am on 15 March 2016. It noted that, "*There are possible filling defects within pulmonary arteries in the right lower lobe, raising the possibility of pulmonary emboli. A CT pulmonary angiogram is suggested to further assess this. The admitting team has been notified*".

What was the cause of Stephen's death?

Stephen was later taken to the Department of Forensic Medicine at Glebe where Dr Rianie Janse Van Vuuren, forensic pathologist, performed a postmortem examination on 18 March 2016. The autopsy identified deep vein thrombosis in Stephen's legs and thromboemboli in both lungs. Dr Van Vuuren also noted that there were thrombi in some vascular spaces and that there was also evidence of marked coronary atherosclerosis.

Dr Van Vuuren later prepared an autopsy report dated 12 October 2016 in which she opined that the cause of Stephen's death was pulmonary thromboemboli due to deep vein thrombosis on a background of a leg burn wound.

CONCLUSION: The burn injury which Stephen suffered on 8 March 2016 required treatment at hospital and subsequent admission. Given the sudden and unexpected nature of Stephen's collapse on 15 March 2016, and the findings of the autopsy, the cause of Stephen's death was pulmonary thromboemboli due to deep vein thrombosis on a background of a leg burn wound.

Issues examined by the inquest

Prior to the inquest a list of issues that the inquest proposed to examine was circulated to the various parties of sufficient interest. That list set out the following issues:

1. The adequacy of Concord Hospital's care of Mr Kline, including:

    (a) In relation to deep vein thrombosis and pulmonary embolism:

        (i) Assessment of risk of deep vein thrombosis;

        (ii) Management of risk of deep vein thrombosis and embolism;

        (iii) Observations and any follow-up;

        (iv) Monitoring and any follow-up;

        (v) Whether the formation of deep vein thrombosis and pulmonary emboli might have been prevented and/or detected earlier.

    (b) Whether Mr Kline's risk of deliberate self-harm was appropriately assessed and managed at the time of his admission to Concord Hospital.

2. The adequacy of relevant practices and procedures of Concord Hospital.

3. The adequacy of Corrective Services' actions, including:

    (a) Guarding of Mr Kline (including appropriateness of restraint and observations);

    (b) Whether Mr Kline's risk of deliberate self-harm was appropriately assessed and managed at the time of his entry into custody.

4. The adequacy of relevant practices and procedures of Corrective Services.

5. The appropriateness of the actions of members of the NSW Police Force on 8 March 2016 (including but not limited to compliance with any relevant protocols concerning negotiation, the use of force and Tasers).

6. The adequacy of NSW Police Force training and guidelines in relation to firing Tasers in the presence of flammable liquids.

7. Whether the investigation by the NSW Police Force ought to have been handled as a critical incident investigation.

To assist with the coronial investigation, expert opinion was sought from an independent vascular and general surgeon, Associate Professor Anthony Grabs. In response to a number of questions posed by the Assisting team, Associate Professor Grabs prepared a report in which he offered an opinion in relation to a number of matters relevant to points 1 and 2 above.

During the course of the coronial investigation, and the inquest itself, the evidence gathered brought some issues into sharper focus than others. The issues will be addressed below in chronological order.

Were the actions of members of the NSW Police Force on 8 March 2016 appropriate?

This issue can be conveniently separated into two discrete questions: whether it was appropriate for the police officers to enter Stephen's front yard, and whether it was appropriate for Sergeant Shaw to have deployed his taser.

(a) Was it appropriate for police to enter Stephen's front yard?

Two further matters relevant to this question are whether the police officers who approached Stephen's front gate (Sergeant Shaw, Leading Senior Constable Hurst and Constable Simkins) formulated a plan prior to Leading Senior Constable Hurst jumping over the fence, and whether Stephen had already produced the jerrycan containing petrol by this time.

As to the first matter, Leading Senior Constable Hurst explained in evidence that he did not discuss with Sergeant Shaw or Constable Simkins any plan of action regarding Stephen. Leading Senior Constable Hurst said that based on his discussions with one of Stephen's neighbours in relation to the damaged power pole, he had formed a reasonable suspicion that Stephen had committed an offence. On this basis, it was Leading Senior Constable Hurst's intention to arrest Stephen. Leading Senior Constable Hurst's version of events is in conflict with that of Sergeant Shaw and Constable Simkins, both of whom gave evidence that the three police officers discussed an intention to arrest Stephen.

As to the second matter, Leading Senior Constable Hurst said that he had almost finished jumping over the fence, and was in mid-air, when he first saw Stephen holding the fuel container. Similarly, Constable Simkins said that Leading Senior Constable Hurst was near the top of his jump when she saw Stephen splashing petrol from the jerrycan. In evidence Sergeant Shaw initially said that he saw Stephen walking with purpose towards where the police were at the front gate and that he splashed petrol towards where the police were standing as Leading Senior Constable Hurst was in the process of jumping over the fence.

However, Sergeant Shaw later agreed in evidence that when he made his statement (on 10 March 2016) the events of 8 March 2016 were much clearer in his mind. On this basis Sergeant Shaw later conceded in evidence that his recollection of the sequence of events on 8 March 2016 was that Stephen first removed the cap of the jerrycan and had already splashed it towards the police officers from a distance of about two metres *before* Leading Senior Constable Hurst jumped over the fence.

In evidence Leading Senior Constable Hurst conceded that before he jumped the fence he knew that Stephen had:

(a) been behaving in an aggressive and threatening manner;

(b) refused to comply with police directions to approach the front gate and (at least initially) to put his dogs away;

(c) been verbally abusive towards police; and

(d) used a chainsaw to cut into the power pole.

It was suggested to Leading Senior Constable Hurst that having regard to the above factors there would have been a better chance of successfully negotiating with Stephen if the police officers did not enter the front yard. Leading Senior Constable Hurst said that he was unable to comment on this suggestion but agreed that it would have, at least, been safer if he did not enter the front yard. Further, Leading Senior Constable Hurst agreed that if the fence was between Stephen and himself, Stephen was better contained because he was not armed with anything which caused Leading Senior Constable Hurst any fear. Ultimately Leading Senior Constable Hurst agreed that in hindsight it would have better if he had not jumped over the fence. However, Leading Senior Constable Hurst sought to qualify this comment by offering the view that he did not think negotiating would have been fruitful give that Stephen had refused to comply, listen to, or follow directions. Leading Senior Constable Hurst expressed doubt that any type of negotiation with Stephen would be effective.

Sergeant Shaw said that in speaking with Stephen his intention was to calm Stephen down to a level so that the police officers could gain access to the front yard in order to place Stephen under arrest. However, Sergeant Shaw explained that Stephen remained aggressive, appeared irrational and dismissive, and did not want to listen to reason, or to what Sergeant Shaw had to say.

CONCLUSION: There is conflicting evidence about whether an intention to arrest Stephen was discussed at any time between Sergeant Shaw, Leading Senior Constable Hurst and Constable Simkins. On the corroborated accounts of Sergeant Shaw and Constable Simkins it appears that this intention was discussed. However the evidence is silent as to whether there was any further discussion as to how this intention was to be effected.

There is also conflicting evidence about when in the sequence of events Stephen began splashing petrol from the jerrycan, relative to Leading Senior Constable Hurst jumping over the fence. Again, the corroborated accounts of Leading Senior Constable Hurst and Constable Simkins suggests that Stephen began splashing petrol as Leading Senior Constable Hurst was in the midst of jumping over the fence, and not before.

What this means is that there was an opportunity for the attending police officers to at least persist with negotiating with Stephen before taking more overt action. It is true that Stephen had largely been non-compliant with police directions up to that point. However it should be remembered that despite an initial reluctance to do so, Stephen eventually complied with the direction to put away his dog, which occurred almost immediately prior to Leading Senior Constable Hurst jumping over the fence. Although this demonstration of compliance by Stephen could not guarantee that the prospect of further negotiation might be fruitful, it at least demonstrated that an opportunity existed to explore this possibility further.

Given the concessions made by Leading Senior Constable Hurst, it can be concluded that a police officer entering Stephen's front yard was likely only going to serve as a catalyst for the interaction between Stephen and the police officers deteriorating further. At the very least, as Leading Senior Constable Hurst acknowledged, it would have been safer if he had not entered the front yard. On this basis the evidence establishes that it was not appropriate for Leading Senior Constable Hurst to enter the front yard at the time that he did. The opportunity for further negotiation had not been exhausted and it should have been recognised that direct action by the police would only serve to exacerbate an already volatile situation.

(b) Was it appropriate for Sergeant Shaw to deploy the taser?

There are two important matters to consider in answering this question: whether Sergeant Shaw gave appropriate consideration to other options that might have been available to him, and whether Sergeant Shaw gave appropriate consideration to the fact that Stephen had splashed flammable liquid in the vicinity of where the taser was deployed.

The NSW Police Force *Use of Conducted Electrical Weapons (Taser) Standard Operating Procedures* (**the Taser SOP**) governs the use of tasers by NSW police officers, and includes the applicable criteria by which an officer may draw and discharge a taser. Section 8 of the Taser SOP sets out the criteria to discharge a taser noting that it may be discharged, "*after proper assessment of the situation and environment, to:*

- *Protect human life;*
- *Protect [the taser user] or others where violent confrontation or violent resistance is occurring or imminent;*
- *Protect an officer(s) in danger of being overpowered or to protect [the taser user] or another person from the risk of actual bodily harm; or*
- *Protection from animals*".

In a statement made on 10 March 2016, Sergeant Shaw described his actions in this way:

> "*At that time I believed that the tactical option of OC spray was not effective to control [Stephen]. [Stephen] was displaying violence and this violent confrontation was occurring and not stopping. To protect myself and Constable [sic] Hurst who continued to scream, 'I can't see', and to protect myself and Constable Hurst from being overpowered, I drew my police issued X26 Conducted Electrical Weapon (Taser) from its holster and activated it by moving the safety to the 'on' position*".

Sergeant Shaw was taken to the Taser SOP in evidence and explained that the criteria that he applied in deploying his taser were to protect human life and to protect himself. He said that be believed that it was the only option he had left available to him and expressed his belief that it was appropriate to deploy the taser because of the "*exceptional circumstances*" that existed.

Section 8 of the Taser SOP provides that "*officers should consider all tactical options available to them in the Tactical Options Model*" when considering the discharge of a taser and that they "*should only use force that is reasonable, necessary, proportionate and appropriate to the circumstances*". The NSW Police Tactical Options Model (contained in Annexure A to the Taser SOP) identifies the following options available to a police officer: Officer Presence, OC Spray, Baton, Communication, Tactical Disengagement, Weaponless Control, Conducted Electrical Weapon (Taser), Firearm, and Contain & Negotiate.

In evidence Sergeant Shaw explained that his intention was to control Stephen and to take him into custody. In carrying out this intention Sergeant Shaw further explained that the OC spray deployed by Leading Senior Constable Hurst had no impact, that communication with Stephen had failed, that weaponless control had been ineffective due to Stephen's size, and that he believed that a baton strike would be ineffective due to the difficulty in extending the baton in a closed area, and because he did not believe that a baton strike would have assisted the situation. Having considered that it was inappropriate in the circumstances to use lethal force by drawing his firearm, Sergeant Shaw explained that use of his taser was the only option left available to him under the Tactical Options Model. Sergeant Shaw further explained that he considered taser deployment to be the most appropriate option to exercise due to his belief that Leading Senior Constable Hurst could have been seriously or fatally injured, and because he wanted to cease the immediate violence and threat that Stephen posed.

In evidence Sergeant Shaw said that it took five or six seconds from the point at which he jumped over the front gate to the point where he deployed his taser. Although this short period of time suggested that it might limit any decision-making process which Sergeant Shaw might apply to the situation, he explained that consideration of the Tactical Options Model is a process which he continuously undertakes in the performance of his policing duties. He described the process as "*microsecond thinking*" and explained that it involved a continual process of assessment; it was this process that led him to believe that use of his baton would not be effective.

However, in evidence Sergeant Shaw agreed that he did not warn Stephen before he deployed the taser because he had no time to do so. He further variously described Stephen as being "*half-up*", "*not bolt upright*", "*trying to stand upright*", and on his two feet with his hands off the ground but off balance at the time that the taser was fired. Sergeant Shaw also agreed that usually when a taser is drawn a red light will be illuminated on a target. However, in this instance Sergeant Shaw said that he saw no red light because he deployed the taser almost immediately. In this sense, he agreed that it was fair to characterise his actions as "*drawing and firing*".

It should be noted that other evidence supports this characterisation. Leading Senior Constable Hurst was asked to estimate the time between when he tackled Stephen to when he heard the sound of the taser being deployed. Leading Senior Constable Hurst described the timeframe as "*not long at all*" and said that the two events happened reasonably quickly in succession. Similarly, Constable Simkins described the two events happening quickly and soon after one another.

The second matter which warrants consideration is whether it was appropriate for Sergeant Shaw to deploy his taser in circumstances where Stephen had splashed petrol on the ground and on Leading Senior Constable Hurst immediately prior to deployment.

The Taser SOP provides that "*when considering the use of a taser an assessment of the surrounding environment should be made with consideration given to crowded situations and secondary hazards*". Section 8.2 of the Taser SOP specifically provides that "*a taser **should not** be used in any mode…near explosive materials, flammable liquids or gases due to the possibility of ignition*" (original emphasis).

Sergeant Shaw agreed in evidence that he was aware of this aspect of the Taser SOP prior to 8 March 2106. He said that before deploying the taser he saw Stephen splash petrol on Leading Senior Constable Hurst and in the area around where Leading Senior Constable Hurst landed after jumping over the fence. Sergeant Shaw said that he was therefore aware that there were splashes of petrol on the ground (although he was unsure how much) and that he assumed that Leading Senior Constable Hurst had petrol on his clothes. Ultimately, Sergeant Shaw accepted that Stephen was positioned near petrol which had been variously splashed in the vicinity of his driveway area, but expressed the belief that Stephen was sufficiently distant from the petrol to allow the taser to be deployed.

In contrast Constable Simkins described Stephen as splashing the petrol around in a rapid manner and said that "*a lot*" of petrol was splashed, resulting in the concrete of Stephen's driveway area appearing to be "*saturated*" and "*quite wet*". It should be noted in this regard that Constable Simkins also drew her taser but then decided to holster it. In evidence she explained that she believed that it could not be safely deployed without placing Leading Senior Constable Hurst at risk due to the fact that he was covered in petrol.

Initially in evidence Sergeant Shaw said that after jumping over the fence he pushed and "*manhandled*" Stephen away from where he and Leading Senior Constable Hurst were grappling, and pushed Stephen down the driveway. Later in his evidence, Sergeant Shaw said that after jumping over the fence he separated Stephen and Leading Senior Constable Hurst by pushing them away from each other.

Following the events at Stephen's house on 8 March 2016 Sergeant Shaw took part in a debriefing conducted by a police review panel. A review form was later prepared in relation to that review (**the Taser Review Form**). Further, Sergeant Shaw also provided a version of events on 8 March 2016 to allow a taser situation report (**the Taser Sitrep**) to be completed. Within the Taser Review Form, under the heading "*Comment of Deploying Officer*" the following is recorded:

> "*I then jumped the fence and went to Leading Senior Constable Hurst's aid. [Stephen] was still being violent and resisting. As a result of the OC spray having no effect and due to [Stephen's] large build and violence I deployed my taser striking [Stephen] in the upper torso area. I was about one metre from [Stephen] at the time of deployment and Leading Senior Constable Hurst was to the right… When I deployed the taser [Stephen] had moved approximately 2 metres from where he threw the petrol. I did not think that the fuel would be an issue and believed that the taser was an appropriate response under the circumstances*".

A similar narrative to that set out above was also included in the Taser Sitrep under the heading "*Brief Outline of Incident*".

During the debriefing, Sergeant Shaw was asked what Stephen was doing prior to the taser being deployed. Sergeant Shaw responded in this way: "*Leading Senior Constable Hurst and [Stephen] were half on the ground. As [Stephen] began hopping up, that's when I tasered him*".

In a statement made on 8 March 2016 Leading Senior Constable Hurst said that after calling out for help he heard Sergeant Shaw say, "*Get up, get back*". In response, Leading Senior Constable Hurst said that he "*moved back towards the gate and the corner of the fence*" when he heard the sound of the taser deploying. In evidence during the inquest Leading Senior Constable Hurst gave a similar account regarding his actions, and added that Stephen was still on the ground at the time. Constable Simkins was also asked about this point in time during her evidence. She said that she was unable to recall seeing Sergeant Shaw doing anything in relation to Stephen before he deployed his taser. However, in a statement (also made on 8 March 2016) Constable Simkins said the following: "*Sergeant Shaw jumped over the fence and the next thing I remember was the sound of the taser being activated and deployed*".

CONCLUSION: The available evidence establishes that a very short period of up to six seconds passed between Sergeant Shaw jumping over the fence and when the taser was deployed.

On Sergeant Shaw's evidence this brief period of time allowed him to make an assessment, pursuant to the Tactical Options Model, that taser use was the most appropriate option in the circumstances. However, the evidence does not support a conclusion that Sergeant Shaw embarked on such an assessment or, that if he did, that his assessment was correct.

Firstly, on Sergeant Shaw's account he drew and immediately fired the taser, without warning Stephen of its imminent use and without visualising the illuminated targeting sight. The evidence from both Leading Senior Constable Hurst and Constable Simkins supports the conclusion that Sergeant Shaw's actions in jumping over the fence and deploying the taser occurred instantaneously. Secondly, Stephen was rising to his feet and off balance at the time that the taser was deployed. This suggests that he did not pose an immediate threat at the time of deployment and that an opportunity most likely existed for other tactical options to be considered. Thirdly, Sergeant Shaw's oral evidence that he "manhandled" Stephen down the driveway away from Leading Senior Constable Hurst, or that he pushed the two men apart before deploying his taser is not supported by other evidence. In the three contemporaneous accounts given by Sergeant Shaw (in his statement, the Taser Review Form, and the Taser Sitrep) there is no reference to these actions occurring. Instead, the accounts are consistent with the evidence offered by Leading Senior Constable Hurst and Constable Simkins that Sergeant Shaw jumped over the fence and immediately deployed his taser, without any intervening action in between.

It should be noted that on Leading Senior Constable Hurst's own account he responded to Sergeant Shaw's instruction to "get up, get back" by moving himself away from Stephen and to the fence. Leading Senior Constable Hurst makes no mention of being separated or pushed away by Sergeant Shaw. Finally, the immediacy with which Sergeant Shaw deployed his taser suggests that insufficient consideration was given to the secondary hazard posed by flammable liquid being present in the vicinity of deployment. Whilst Sergeant Shaw expressed the belief that Stephen had moved sufficiently far away from where the petrol had been splashed, it should be noted that Constable Simkins formed the belief that the ground area was "saturated" with petrol and that it was unsafe to deploy her taser.

It is accepted that the situation that confronted Sergeant Shaw on 8 March 2016 was a dynamic and volatile one which did not allow for a careful and measured analysis of the influencing factors such as that undertaken during the course of the inquest and subsequently. The evidence established that Sergeant Shaw is an experienced police officer generally, is experienced in the use of taser specifically, and that he brought this experience to bear on 8 March 2016. However the analysis of the documentary and oral evidence that has been conducted establishes that it was inappropriate for Sergeant Shaw to deploy his taser at the time that he did, having regard to Stephen's position and the absence of any immediate threat, and Stephen's proximity to a secondary hazard in the form of flammable liquid.

Has adequate training and guidelines been provided to police officers regarding the deployment of tasers in the presence of flammable liquids?

As noted above, Section 8.2 of the Taser SOP specifically provides for tasers to not be used near flammable liquids due to the risk of ignition. The evidence established that both Sergeant Shaw and Constable Simkins were aware of this restriction regarding use as at 8 March 2016.

Sergeant Shaw explained in evidence that he received annual training regarding the Taser SOP and estimated that he had last received training about six to eight months prior to March 2016. He further explained that both theoretical and practical training was provided and that it occupied about three hours out of a day of training. Constable Simkins gave similar evidence in relation to training which she had received.

CONCLUSION: The Taser SOP appropriately identifies the inherent risk associated with taser use in the presence of flammable liquids and mandates against its use in such circumstances. The evidence establishes that appropriate training is provided to police officers regarding the provisions of the Taser SOP and that both Sergeant Shaw and Constable Simkins were aware of the restrictions on taser use which applied to the particular circumstances of 8 March 2016.

Should the events of 8 March 2016 been declared a Critical Incident?

Section 3.1 of the NSW Police Force Critical Incident Guidelines provides that a critical incident "*is one involving a member of the NSW Police Force which has resulted in the death or serious injury to a person:*

- *arising from the discharge of a firearm by police;*
- *arising from the use of appointments or the application of physical force by police;*
- *arising from a police vehicle pursuit or from a collision involving a NSW Police Force vehicle;*
- *who was in police custody at the time;*
- *arising from a police operation*".

Section 3.1 also provides that a critical incident may also be "*any other incident that a region commander considers could attract significant attention, interest or criticism, such that the public interest will be best served by investigating the matter under the Critical Incident Guidelines*".

Section 3.6 of the Critical Incident Guidelines provides that "*the type of injuries that are 'serious' enough to invoke an investigation under these guidelines include:*

- *Life threatening injuries;*
- *An injury that would normally require emergency admission to a hospital and significant medical attention;*

- *An injury likely to result in permanent physical impairment or require long term rehabilitation*".

A consequence of a matter being declared a critical incident is the formation of a Critical Incident Investigation Team comprised of police officers not involved in the incident (Section 4.1.2), with a Senior Critical Incident Investigator appointed to lead the CIIT.

The officer-in-charge of the investigation into Stephen's death, Detective Sergeant Andrew Tesoriero, was attached to the Corrective Services Investigations Unit (**the CSIU**) as at 8 March 2016. As Stephen was in lawful custody at the time of his death, the responsibility for investigating his death was assigned to the CSIU. This had the practical consequence that Stephen's death was investigated by an independent investigator separate from the Police Local Area Command (as it was then known) where Stephen's death had occurred.

In evidence Detective Sergeant Tesoriero explained that a critical incident investigation typically involves the deployment of more police resources than might ordinarily be deployed for an investigation of a different kind. Further, if Stephen's death had been declared a critical incident, then Detective Sergeant Tesoriero would have been offered a CIIT. Having regard to the particular features of Stephen's case it should also be noted that the Critical Incident Guidelines provide for local Aboriginal protocols to be considered (Section 4.2.3) and for notifications to be made to the Aboriginal Legal Service, Aboriginal Regional Coordinator, and Aboriginal Community Liaison Officer in circumstances where an Aboriginal person dies during a critical incident. Notwithstanding, Detective Sergeant Tesoriero gave evidence that in Stephen's case the Aboriginal Legal Service were notified of his death and attempts were made to notify an Aboriginal Community Liaison Officer.

CONCLUSION: For reasons set out in greater detail below, the burn injury that Stephen sustained was regarded as relatively minor. Although Stephen required admission to a hospital emergency department it was expected that the severity of his injury would have only necessitated an admission of several hours, or overnight admission. On this basis it could not be said that Stephen's injury met the definition of "serious" injury so as to trigger the operation of the Critical Incident Guidelines. Further, Stephen's collapse seven days following his admission was sudden and unexpected. It could not be said that Stephen's death was foreseeable having regard to the events of 8 March 2016, and the circumstances leading up to his hospital admission, alone. This leads to a conclusion that it was appropriate for the events of 8 March 2016 to have not been declared a critical incident.

There is no evidence that the absence of such a declaration compromised the investigation into Stephen's death in any way. For example, if the matter had been declared a critical incident then directly involved officers (such as Sergeant Shaw, Leading Senior Constable Hurst and Constable Simkins) would have been separated to ensure the integrity of their evidence. However, in this case there is nothing to suggest that their evidence was compromised in any way by the absence of any such separation.

Further, a number of witnesses who gave evidence during the inquest agreed that their recollection of events would have been better preserved if their statements had been taken, and interviews conducted, more proximate to the events in question. The deployment of additional resources associated with the formation of a CIIT would likely have allowed for this to occur. However, as many of these witnesses relied upon their own, and other, contemporaneous records there is no indication that the quality and accuracy of their evidence was adversely affected.

Finally, the allocation of responsibility for the investigation of Stephen's death to the CSIU had the unintended, but fortuitous, consequence of an officer-in-charge being appointed who was separate and independent of the police Command which the directly involved officers were attached to. It should also be noted that certain steps were taken to provide notifications that would ordinarily have occurred in a critical incident investigation.

Was Stephen adequately observed by CSNSW officers?

It is not known precisely when Stephen swallowed the set of keys. However the available evidence suggests that this most likely occurred sometime during the morning of 10 March 2016, prior to 11:50am when Stephen was reviewed by Dr Vandenberg. However, what is known is that Stephen was under guard and observation by CSNSW officers at the time as a consequence of having been remanded into custody the previous day. This, then, raises the question of whether Stephen's swallowing of the keys was reflective of some deficiency in the observations made by CSNSW officers.

The guarding of Stephen was assigned to pairs of CSNSW officers who performed their duties in rotating shifts. In evidence, Officer Sharma explained that it was a requirement for one officer to remain in the room with Stephen at all times with the other officer placed just outside the door to the room. Officer Baptista explained that whilst the officer outside the room would not maintain direct and constant line of sight with Stephen, the officer would ensure that Stephen remained in his/her field of view.

This evidence was corroborated principally by Christine Parker the Nurse Unit Manager (**NUM**) for the Burns unit, but also by other hospital staff witnesses who gave evidence during the inquest. NUM Parker explained that it was not uncommon to have custodial patients in the Burns Unit and that observation of these patients occurred, as it did in Stephen's case, by a CSNSW officer being in the patient's room or keeping the patient in their field of view.

Both Officers Baptista and Sharma explained that their primary role was to ensure the security of the hospital and to ensure that Stephen did not abscond from custody. In evidence Officer Sharma demonstrated that even though Stephen may have remained in sight of a CSNSW officer this would not preclude Stephen swallowing a foreign object, such as a set of keys, if he did so quickly and subtly and/or whilst his back was turned to the officer.

CONCLUSION: There is no evidence to suggest that the CSNSW officers tasked with guarding Stephen did not observe him in an appropriate manner. Given that their primary role was to maintain security and ensure that Stephen did not abscond, it could not be said that there was any deficiency in their observations. Evidence from hospital staff provides corroboration that the CSNSW officers maintained observations as required, by being in Stephen's room with him and keeping Stephen in their field of vision. There is no evidence to suggest that Stephen's ability to swallow the keys resulted from a deficiency in observations.

Was Stephen's risk of self-harm appropriately managed by CSNSW?

Dr Vandenberg considered Stephen's swallowing of the keys to be an intentional act of self-harm. In evidence she was asked whether there were any protective factors in place to mitigate Stephen's risk of further self-harm. Dr Vandenberg said that during each of her attendances on Stephen she raised with the relevant CSNSW officers on duty at the time that Stephen was at risk, and requested that this risk be conveyed to other officers on incoming shifts.

Despite this, it became evident that the risk that Stephen faced was not always made known to the CSNSW officers responsible for guarding him. On 28 March 2016 First Class Correctional Officer Michael Karauria, from the Court Escort Security Unit, wrote a report to the General Manager in which he recorded the following: "*Whilst on a hospital escort with [Stephen] a nurse mentioned something about a key. She spoke in a manner I ascertained to be unimportant. I thought it was maybe a house or car key. I was informed at a later date that [Stephen] had swallowed a key and was required to have an x-ray. I thought nothing more of the incident as he was in a hospital*".

Officer Sharma said that he was not told that Stephen had attempted self-harm by swallowing the keys. He also said he was never told that there was a risk that Stephen might harm himself. Officer Baptista said that at handover at 5:30am on 15 March 2016 he was briefed with the fact that Stephen had swallowed a set of keys. However, Officer Baptista said that it was not explained to him that Stephen's actions meant that he was at risk of self-harm. Notwithstanding, Officer Baptista explained further in evidence that the knowledge of Stephen swallowing the keys remained in the back of his mind, and played a direct role in causing him to remove metal cutlery from Stephen during breakfast on the morning of 15 March 2016.

Dr Vandenberg explained in evidence that the fact that Stephen was in custody meant that he was subjected to a higher level of observation compared to a patient who was not in custody. In this regard, Dr Vandenberg noted the following:

> "*The risk of [Stephen] engaging in further episodes of self-harm after 10 March 2016 was mitigated by the presence of two Corrective Services officers who were involved in supervising him and who would have been aware that he had self-harmed. He was also handcuffed.*

Nursing staff on the Burns Unit were also aware that [Stephen] had swallowed the set of keys and were also aware of the need to monitor him for possible self-harm and to ensure that further episodes were to be prevented, for example by the removal of all potentially dangerous objects".

During the course of the inquest the legal representative for CSNSW indicated that a Memorandum of Understanding (**MOU**) between CSNSW and NSW Health was in the process of being prepared. It was indicated that the MOU would provide for the mechanism by which information regarding custodial patients assessed as being at risk of self-harm could be exchanged between CSNSW officers and hospital staff.

CONCLUSION: Despite Dr Vandenberg's expressed intentions, it appears that not all of the CSNSW officers responsible for guarding Stephen were informed that he had swallowed the keys. Those officers that were informed were not provided with further information that Stephen's actions represented intentional self-harm and that he remained at risk of self-harm.

Notwithstanding, by virtue of his custodial status Stephen was subjected to a higher level of frequency that might be afforded to a non-custodial patient who might be at risk of self-harm. Further, it was evident that Officer Baptista, having been told that Stephen had swallowed the keys, used his own initiative in removing objects with which Stephen might harm himself.

In light of the indication given by CSNSW during the course of the inquest regarding an MOU between CSNSW and NSW Health to facilitate the exchange of critical information regarding whether a custodial patient is regarded at risk of self-harm, it is neither necessary nor desirable to make any recommendation in this regard.

Was Stephen provided with an appropriate level of care whilst at Concord Hospital?

Consideration of this issue can be conveniently separated into three questions: whether Stephen was appropriately assessed and managed for the risk of self-harm; whether Stephen was appropriately assessed and managed for the risk of venous thromboembolism; and whether the imaging scans performed on 14 March 2016 were appropriately reviewed.

(a) Was Stephen appropriately assessed and managed for the risk of self-harm?

Dr Vandenberg conducted a lengthy assessment of Stephen on 10 March 2016. Although Dr Vandenberg described Stephen as being "*superficially cooperative*" she found him difficult to engage and found it difficult to obtain direct answers from him. However Dr Vandenberg explained that she was able to recognise that Stephen was quite a traumatised person and had an irritable manner to most of the hospital staff and so the best way to manage him was to be patient and listen, rather than probe him for information. It was in this context, that Stephen told Dr Vandenberg that he had swallowed the keys.

Dr Vandenberg subsequently formulated a plan for Stephen to be commenced on an Alcohol Withdrawal Scale to monitor him for alcohol withdrawal and to be commenced on a regimen of diazepam for agitation, if there was evidence of this. Further, Stephen was also prescribed thiamine and plans were made to obtain as much collateral information as possible about Stephen's past mental health history. Finally, plans were made for daily psychiatric review in order to monitor his risk for self-harm.

In this regard Dr Vandenberg subsequently reviewed Stephen on:

(a) 11 March 2016 with Dr Tyrrell for at least 15 minutes;

(b) briefly for a few minutes at 9:25am on 14 March 2016, but was unable to see him for longer as his burns dressings needed changing; and

(c) finally again on 15 March 2016, although the review was cut short as Inspector Adams and Ms Pittorino had arrived to see Stephen, although plans were made for Dr Vandenberg to review Stephen at a later point in time.

CONCLUSION: Dr Vandenberg was able to forge a therapeutic alliance with Stephen in challenging circumstances on 10 March 2016. This provided the basis for Stephen's disclosure of swallowing the keys. Having formed the view that this represented an act of intentional self-harm, and that Stephen remained at risk of further self-harm, Dr Vandenberg formulated a management plan consisting of daily psychiatric review and communication to CSNSW officers of Stephen's degree of risk. It has already been noted above that Dr Vandenberg's concerns were not always disseminated in full to the relevant CSNSW officers on duty at the time. However, it is evident that an appropriate management plan and regular review system was in place.

(b) Was Stephen appropriately assessed and managed for the risk of venous thromboembolism?

The NSW Health Policy Directive, *Prevention of Venous Thromboembolism* (PD2014_032) (**the Policy Directive**), published on 22 September 2014, was in force as at March 2016. The Policy Directive notes the following in relation to venous thromboembolism (**VTE**):

(a) It involves the formation of a blood clot within the deep veins, most commonly of the legs and pelvis, known as deep venous thrombosis (**DVT**);

(b) These blood clots may became dislodged and then obstruct the pulmonary artery or one of its branches, known as a pulmonary embolism (**PE**);

(c) VTE is a significant preventable adverse event for hospitalised patients;

(d) The incident of developing a VTE has been shown to be 100 times greater among hospitalised patients than those in the community;

(e) Serious adverse outcomes resulting from VTE may occur, including death;

(f) Effective prevention of VTE is achieved through assessment of risk factors and the provision of appropriate prophylaxis, which can be provided in two forms: pharmacological prophylaxis and mechanical prophylaxis;

(g) Pharmacological prophylaxis is achieved through the use of anticoagulant agents such as heparin;

(h) Mechanical prophylaxis is achieved through the use of physical aids such as graduated compression stockings and intermittent pneumatic compression or foot impulse devices.

The Policy Directive also sets out a number of mandatory requirements which include the following:

(a) All adult patients admitted to NSW public hospitals must be assessed for the risk of VTE within 24 hours and regularly as indicated/appropriate; and

(b) Patients identified at risk of VTE are to receive the pharmacological and/or mechanical prophylaxis most appropriate to that risk and their clinical condition.

(c) Attending Medical Officers (or their Delegate) are to ensure regular review of VTE risk is performed during the patient care episode, particularly as clinical condition changes, and that prophylaxis is monitored and adjusted accordingly.

Finally, the Policy Directive provides for the use of the VTE Risk Assessment Tool (**the VTERA Tool**), a two-page document which, when completed, requires a clinician to assess a patient's risk of VTE and allocate a patient into a risk category (Low, Medium, High). The front page of the VTERA Tool directs a clinician to consider a list of 21 VTE risk factors. It also provides for appropriate prophylaxis to be prescribed. Finally, section 7 of the VTERA Tool relevantly provides that "*Patients should be reassessed when clinical condition changes or regularly (every 7 days as a minimum)*".

Dr Ahn reviewed Stephen upon his admission to Concord Hospital on the evening of 8 March 2016. In evidence Dr Ahn agreed that the mandatory provisions of the Policy Directive applied to Stephen and that a VTE risk assessment was required to be performed within 24 hours. However Dr Ahn did not perform this and did not use the VTERA Tool. Dr Ahn explained that he did not do so because he considered Stephen to be what he described as an "*in and out*" patient.

In other words, the relative severity of his burn injury meant that he would likely remain an inpatient for only four hours. Further, Dr Ahn explained that if Stephen had arrived at Concord Hospital during the day he would have been seen and treated in the outpatient clinic. It was only by virtue of his arrival in the evening that he was treated in the ward. It should be noted that the discharge summary from Westmead Hospital prepared by Dr Joanna Koryzna, the registrar who assessed Stephen, records the following: "*I have spoken to Burns Reg Dr Ahn. He has advised for the patient to be transferred to concord [sic] ED for dressings tonight. Following these, he is to be discharged in police custody*".

Dr Ahn explained that although an overnight admission was not usually necessary for the type of injury that Stephen had suffered, given the lateness of the evening, a plan was formulated to keep Stephen at hospital overnight and discharge him the following morning. Dr Ahn explained that it would not be his practice "*to prescribe anticoagulation in such circumstances as patients undergoing this procedure are usually discharged home from hospital on the same day*". Further, Dr Ahn noted that Stephen's admission was "*never planned to be extended or prolonged*" and that "*there was no indication that [Stephen] would have ongoing issues with mobilisation after his initial admission*".

Professor Peter Maitz, the medical director of the Burns Unit and the consultant under whose care Stephen had been admitted, expressed a similar view to that of Dr Ahn. Although he did not personally assess Stephen for any risk of VTE, Professor Maitz explained said that he did not consider that there was a need to commence Stephen on any kind of VTE prophylaxis. This was due to the fact that it was anticipated that Stephen would be discharged within 24 hours, and because Professor Maitz did not consider that Stephen's mobility would be limited to the extent that VTE prophylaxis measures would be required.

In evidence Dr Ahn explained that in forming the view that Stephen's discharge was contingent upon mobilisation, he gave consideration to the overall picture of Stephen as a patient. In this sense, whilst Dr Ahn regarded the burn injury as minor, and unlikely to affect Stephen's mobility, he explained that his intention was to ensure that no risk factors were missed prior to Stephen's discharge. In this context, Dr Ahn explained that VTE was a part of his thinking, and overall assessment of Stephen.

Dr Arridh Shashank, a Senior Resident in the Burns Unit, reviewed Stephen on the morning of 9 March 2016 and noted that his burn had already been debrided and the Biobrane xenograft applied. Dr Shashank noted that there was no sign of infection and that the burn dressing was intact, suggesting that Stephen would be suitable for discharge that day in accordance with the overnight plan to discharge Stephen with outpatient management of his burn injury.

In evidence, Dr Shashank said that he understood burns patients warranting admission typically had associated clinical factors which increased their risk of VTE and because these patients were likely to be less mobile within the unit compared to their home environment.

Accordingly he explained that it was his standard practice to chart pharmacological prophylaxis in the form of heparin as part of a standard set of medications. Dr Shashank further explained that he did so because he did not know whether a patient he reviewed would remain an inpatient or subsequently be discharged. In this way, the patient would continue to be administered heparin up until they were discharged.

However, Dr Shashank did not follow his standard practice on 9 March 2016. This is because he mistakenly believed that heparin had already been charted for Stephen. The basis for Dr Shashank's mistaken belief was Stephen's electronic medical record (**eMR**) which contained a list of the medication that he had been prescribed. The eMR utilised a software package known as Electronic Medical Management (**eMeds**) which contains all information relating to medication charted for a patient. Stephen's eMeds listed heparin as one of the medications that had been charted for him. However, this had actually been charted in error by an after-hours resident who had intended to chart the heparin for another patient. When the error was subsequently detected, the heparin charted for Stephen was cancelled and Steven was never administered heparin.

However, the record of heparin being charted remained on Stephen's eMeds. Dr Shashank saw this but did not see the entry in the eMeds indicating that the heparin had in fact been cancelled. This is because the cancellation entry was located in a column of information headed "*Status*" which could not be seen on the computer monitor that Dr Shashank was using at the time. In other words, the monitor was not sufficiently wide enough to display all of the columns of information contained on the eMR. In order to locate the "*Status*" column, Dr Shashank was required to scroll to information contained on the right hand side of the eMeds. Dr Shashank explained that upon his (erroneous) reading of Stephen's eMeds he formed the view that heparin had already been charted, that therefore there was no need to re-chart it, and that Stephen was on appropriate pharmacological prophylaxis for VTE.

Dr Shashank further explained that prior to 8 March 2016 the Burns Unit (like the rest of Concord Hospital) had used a hardcopy version of the VTERA Tool. However, with the hospital's transition to an eMR, Dr Shashank explained that there was no electronic equivalent of the VTERA Tool. In any event Dr Shashank did not make use of the VTERA Tool, hardcopy or electronic, when he reviewed Stephen on 9 March 2016.

CONCLUSION: Although he did not employ the VTERA Tool, Dr Shashank correctly recognised on 9 March 2016 that Stephen, by virtue of his clinical status and medical history was at risk of VTE. Dr Ahn, in considering that Stephen's limited mobility represented a risk factor for VTE and making Stephen's discharge contingent on mobilisation, reached a similar conclusion the previous evening when he reviewed Stephen on admission. However, Dr Ahn did not chart heparin or prescribe any other form of VTE prophylaxis because he considered that the nature of Stephen's minor burns injury meant that he would be discharged within a short period of time. Indeed, there is no evidence to suggest that Dr Ahn's consideration in this regard was incorrect. The evidence established that Stephen's burn injury was relatively minor and that a patient with an injury of a similar kind would either be treated in an outpatient clinic or discharged within 24 hours.

Therefore, it could not be said that it was inappropriate for Dr Ahn to not have prescribed any VTE prophylaxis for Stephen.

Dr Shashank similarly did not chart heparin for Stephen although, unlike Dr Ahn, it was his intention to do so. Dr Shashank did not carry out his intention because he mistakenly believed that heparin had already been charted. Dr Shashank's mistaken belief was attributable to a technological impediment and not any deficiency in clinical practice. The fact that such a simple technological impediment can adversely impact patient care is a cause for concern. Although the evidence established that Dr Shashank's mistaken interpretation of Stephen's eMeds was an isolated incident, it is not difficult to envisage situations where other mistaken assumptions might be made about whether a particular medication has been prescribed to a patient or not, if such information is not displayed in a clear and accessible form. Therefore, it is necessary that the recommendations below be made.

In making these recommendations, consideration has been given to the submissions advanced by counsel for the Sydney Local Health District (SLHD). It was submitted that the eMeds software system is a state-wide system employed across Local Health Districts in NSW. Therefore, consideration needs to be given to the fact that altering one aspect of the system may adversely impact on another part of the system. Further, any alteration to the system may potentially decrease usability and detract from the flexibility that is required due to the multitude of users of the system.

RECOMMENDATION 1: I recommend to the Chief Executive, Sydney Local Health District that a copy of these findings be provided to the developer of the eMeds software system for consideration in relation to Recommendation 2.

RECOMMENDATION 2: I recommend to the Chief Executive, Sydney Local Health District that, in consultation with the NSW Ministry of Health, consideration be given to requesting that the developer of the eMeds software system ensure that users of the system are readily able to distinguish between medication that is actively being administered to a patient and medication that has been cancelled, irrespective of the on-screen information chosen to be displayed by the user, and without detracting from the functionality and usability of the system.

Dr Ahn's next contact with Stephen was on the evening of 11 March when he was given a handover from the Burns Unit in preparation for a morning ward round the next day. Up to that point, Dr Ahn was unaware that Stephen had not been discharged as planned and was surprised that he remained admitted. On handover, Dr Constant Van Schalkwyk, a Burns Unit registrar, and Dr Shashank explained that Stephen had swallowed a key and had been kept at hospital to wait for the key to pass. They asked Dr Ahn to review Stephen to see if there had been any progression with the passage of the key. Dr Ahn subsequently reviewed Stephen twice on 12 March 2016. At the second review, an x-ray had been performed which revealed no movement of the key. Dr Ahn reviewed Stephen again on 13 March 2016. At this time the key had still not passed and there was no progress on x-ray.

Each time that Dr Ahn saw Stephen on 12 and 13 March 2016 he was noted to be stable, with no deterioration in his symptoms or vital signs. Further, Dr Ahn noted that that "*there was no concern raised by his care team regarding thromboembolic risk and no planned changes for his medication over the weekend*".

In evidence Dr Ahn said that consideration of VTE prophylaxis never entered his mind on either 12 or 13 March 2016, even though he was aware that Stephen's circumstances had changed by virtue of him swallowing the keys. The reason for this was two-fold. Firstly, Dr Ahn said that the only request made of him was to review Stephen in relation to passage of the swallowed keys; the possibility of DVT or PE was never raised at any point. Secondly, Dr Ahn explained that he had a caseload of almost 40 patients and was also conducting emergency surgical cases. Therefore it would not have been possible or practical for him to conduct a full review of every Burns Unit patient, particularly those patients, like Stephen, who had stable vital signs. In this regard Dr Ahn said that in his experience he knew that the Burns Unit team were typically diligent, that he trusted their care of patients, and that he did not think to double check that patients were being managed appropriately.

In evidence Professor Maitz was asked whether, given that Stephen had been admitted under his care, he considered that it would have been appropriate to perform a VTE assessment after it was discovered that Stephen had swallowed the keys. Professor Maitz indicated that it was possible that this was appropriate, but difficult to say. Professor Maitz cited two reasons in coming to this view: firstly, he was of the belief that Stephen had been prescribed pharmacological prophylaxis as part of standard medication prescribed to all Burns Unit inpatients; and secondly he was aware that Stephen's burns injury had almost healed by the time he swallowed the keys and that Stephen was receiving regular physiotherapy and mobilising well. Professor Maitz explained on this basis that he did not consider that VTE prophylaxis measures were required for Stephen, even after his admission was extended. However, Professor Maitz eventually agreed in evidence that once Stephen's anticipated short admission became a more prolonged one it would have been appropriate to perform a DVT assessment.

Having regard to the evidence given by Dr Ahn and Dr Maitz, the question of whether mandating the use of the VTERA Tool came into sharp focus during the course of the inquest. In this regard, the inquest received evidence from Dr Kashmira De Silva, the Director of Medical Services at Concord Hospital. Dr De Silva highlighted a number of measures available to mitigate the risk of VTE for patients:

(a) The hospital has developed a VTE Power Plan, which went live in August 2016 and which forms part of the eMR, an electronic risk assessment tool to assist clinical staff in the assessing the risk of VTE;

(b) Training provided to new junior medical staff in relation to the eMR and VTE Power Plan;

(c) The creation of VTE risk assessment forms for medical and surgical patients, with the latter completed by medical officers for each elective surgery patient prior to surgery;

(d) Annual and ongoing education sessions provided to Junior Medical Officers and Basic Physician Trainees on VTE risk assessment; and

(e) The use of an updated VTERA Tool, including an electronic version for use in eMR, with the update accompanied by an e-learning module.

In evidence Dr De Silva agreed that it was not mandatory for clinicians to use the VTE Power Plan or the VTERA Tool. Dr De Silva explained that this was because there were different means to assess risks without being entirely reliant on completing a mandatory assessment document. Dr De Silva explained that clinician-to-clinician discussion, taking a patient's history, and pre-surgery timeout procedures all constituted examples of VTE risk assessment. Therefore, Dr De Silva explained, clinicians have a responsibility to consider the overall patient management and in this context are engaged in a constant risk assessment process. However, Dr De Silva also acknowledged that in the perhaps rare instances where VTE risk assessment was not being performed by a clinician, the use of a mandatory assessment tool would prompt such thinking.

Balanced against this, Dr De Silva explained that if a patient were assessed on admission as being a low VTE risk, the use of a mandatory assessment tool would not assist in ensuring that a re-assessment was performed when appropriate. In contrast Dr De Silva offered the view that education about the need for VTE assessment and re-assessment would likely lead to an increased uptake in VTE prophylaxis being prescribed by clinicians. Dr De Silva was also asked about the possible use of an alert to remind clinicians to perform a mandatory VTE assessment for patients admitted for 24 hours. Dr De Silva considered that there were potential benefits and deficiencies with such a system: on the one hand, such alerts might prompt a clinician to think in a different direction when their focus might be elsewhere; on the other hand, the use of repeated alerts might create a degree of "*alert fatigue*" causing a clinician to simply ignore repeated alerts.

NUM Parker was taken to the VTERA Tool in evidence and explained that medical officers within the Burns Unit were reminded by nursing staff the complete it, but in practice this did not always occur. However, NUM Parker acknowledged that whilst the VTERA Tool is useful the VTE risk factors listed are not ordinarily applicable to burns patients; indeed other than obesity none of the 20 other risk factors related to Stephen.

CONCLUSION: The question of whether aspects of clinical practice ought to be mandated is a complex one and multifactorial. One argument that is commonly advanced is that clinical practice requires a degree of agility and flexibility and that prescriptive practice should not be a replacement for the exercise of clinical skill and judgment.

In the particular circumstances of Stephen's case the evidence establishes that at least two VTE assessments were performed; the first by Dr Ahn on 8 March 2016 and the second by Dr Shashank on 9 March 2016. Although neither used the VTERA Tool, or any other documentary checklist, an assessment was performed nonetheless as part of the overall management of Stephen. The only reasons why the assessments did not result in the prescription of VTE prophylaxis was because of the anticipated duration of Stephen's admission and a mistaken belief that pharmacological prophylaxis had already been prescribed.

Dr Ahn had reviewed Stephen on 12 and 13 March 2016. Even if it had been mandatory for Dr Ahn to compete the VTERA Tool during either review, it is impossible to know whether it would have resulted in DVT prophylaxis being prescribed to Stephen, and whether it might have materially altered the outcome. However, given that Stephen's vital signs were stable at the time and that only one of the 21 risk factors on the VTERA Tool applied to Stephen, it is most likely that any assessment would not have led to any VTE prophylaxis being prescribed. On the evidence available in Stephen's case this tends to mitigate against the mandated use of the VTERA Tool.

Dr De Silva introduced into evidence a copy of the Grand Rounds session at Concord Hospital from August 2018 which included a presentation on VTE assessment. Statistics contained within the presentation demonstrated that between September 2017 and June 2018 there was no correlation between documented evidence of VTE risk assessment and whether VTE prophylaxis prescribed was appropriate to the level of risk assessed. Whilst there was a variation of up to 24% in relation the former, the latter remained largely unchanged, with a variation of only 9%.

Having regard to the above, it would appear that educating clinicians about the importance of VTE assessment represents the best prospect of increasing uptake in clinical practice. In this regard, it is desirable to make the following recommendation.

RECOMMENDATION 3: I recommend to the Chief Executive, Sydney Local Health District that consideration be given to the circumstances of Stephen's death (with appropriate anonymization, and conditional upon consent being provided by Stephen's family and following appropriate consultation with them) being used as a case study as part of education packages provided to clinical staff regarding venous thromboembolism risk assessment in the context of unexpected extension of a patient's admission duration.

Associate Professor Grabs considered that it was likely that Stephen developed his DVT in the first few days of his admission. However Associate Professor Grabs noted that it was difficult to provide an accurate estimate of when this occurred as the condition is frequently asymptomatic in the initial stages. Further, although Stephen demonstrated some symptoms consistent with DVT in the period between 8 March 2016 and 13 March 2016 (dizziness, reduction in oxygen saturation) they might also have been symptomatic of a differential diagnosis. In evidence Associate Professor Grabs indicated that the other symptoms which Stephen was displaying, such as dizziness and nausea, were non-specific. In his view the only symptom which required explanation was Stephen's elevated heart rate.

In this regard Stephen's Standard Adult General Observation Chart indicated that between 4:45pm on 13 March 2016 to about 9:00pm on 14 March 2016, Stephen's heart rate was noted to be trending upwards from about 75 beats per minute (**bpm**) to just below 120 bpm. It should be noted that a heart rate of over 120 bpm would fall within the Yellow Zone which required consideration whether a clinical review was warranted.

Shortly before 1:00pm on 14 March 2016 Stephen complained of dizziness and nausea after walking to the shower and was noted to be sweating heavily. Stephen complained of similar feelings following his shower around 10:00am on 15 March 2016. The evidence given generally by Dr Shashank, Professor Maitz, Registered Nurse Alyce McNabb (who took Stephen's observations on 14 March 2016) and NUM Parker was that Stephen's symptoms were non-specific and not unusual for a patient in the Burns Unit. NUM Parker explained that whilst the upwards trend in Stephen's heart rate on 13 and 14 March 2016 would cause concern, on its own it would not be sufficient to raise concerns of VTE risk. NUM Parker explained that consideration would be given to other possible symptoms, such as tightness and deep pain it the calf, which would tend to suggest the risk of VTE. NUM Parker also explained that nausea and dizziness were also non-specific symptoms and could be caused by a number of factors such as a high dose of analgesic, showering, wound dressing changes, the body's natural response to the wound healing process, and a patient visualising their burn wound.

In evidence Dr Shashank said that he did not consider Stephen's elevated heart rate to be clinically significant. This was because Stephen had a baseline heart rate of 85 on admission and so the relative difference did not cause concern. Further, he indicated that consideration would need to be given to Stephen's observations as a whole. Professor Maitz similarly considered Stephen's elevated heart rate to be non-specific but agreed in evidence that he considered that it was clinically significant and not escalated to him for review. Whilst agreeing that it could be symptomatic of VTE, he noted that it could also be symptomatic of a number of different clinical conditions.

Associate Professor Grabs said in evidence that he considered that Stephen's condition changed between the afternoon of 14 March 2016 and the morning of 15 March 2016 due to his increased heart rate, drop in blood pressure, sweating, dizziness, nausea, abdominal pain, and increase in blood sugar levels. It was put to Associate Professor Grabs in cross-examination by counsel for the SLHD that Stephen's elevated heart could be accounted for by a number of factors: pain experienced as part of the healing process five days post-burn, abdominal pain, and a disinterested patient being forced to engage with medical staff and participate in a number of investigations. However, Associate Professor Grabs explained that he would not expect these factors to elevate Stephen's heart rate if he was asleep (for some of the 16 hour period after his heart rate first began to increase from about 5:00pm on 13 March 2016).

Notwithstanding, Associate Professor Grabs agreed that shortness of breath, an increase in respiratory rate and a decrease in oxygen saturations would all be indicative signs of a PE.

However, none of these features were present when Stephen was reviewed by a member of the surgical team (prior to a planned abdominal procedure on 15 March 2016) at 3:00pm on 14 March 2016. Although Associate Professor Grabs did not consider the surgical review to amount to a medical review such as might be undertaken by a Burns Unit registrar, he agreed that it would be unlikely that a registrar conducting a review at that time would consider the possibility of DVT as a differential diagnosis.

CONCLUSION: Stephen's upwardly trending heart rate over a period of about 16 hours between 13 and 14 March 2016 was not, on its own, symptomatic of VTE. His other symptoms, often associated with periods of showering, were also non-specific and not uncommon for a patient in the Burns Unit. However, given that Professor Maitz regarded the elevated heart rate at a level just below the Yellow Zone as being clinically significant suggests that it would have been appropriate to escalate Stephen for further review. The failure to do so represented a missed opportunity to, as many of the hospital staff witnesses described, perform an overall assessment of Stephen having regard to his other vital signs and symptoms. Given that Stephen was not at the time displaying other symptoms that were classical for VTE, it is not possible to conclude that the eventual outcome might have been altered. However, escalation for medical review would have been in accordance with optimal clinical practice.

(c) Were the imaging scans on 14 March 2016 appropriately reviewed?

Dr Archer explained that the primary purpose of the CT scan on 14 March 2016 was to locate the keys that Stephen had swallowed and that the possible appearance of PE was an unexpected finding. Dr Archer noted that it is typically uncommon to visualise enough of the pulmonary arteries on a CT abdomen to raise the possibility of PE. Dr Archer further explained that in her view the appearance of a potential PE was very subtle, that she was uncertain whether emboli were actually present, and that it was reasonable for the potential PE not to have been referred to in the preliminary report.

Dr Archer further explained that, due to her caseload, it was not uncommon for her to complete her final report the morning after the CT scan had been performed and after the preliminary report had been prepared. A more timely final report would only have been prepared if it had been communicated to Dr Archer that it was urgently required.

CONCLUSION: The CT scan performed on the afternoon of 14 March 2016 raised the possibility of PE being present. However, given that the primary purpose of the scan was to monitor the passage of the keys it was reasonable for the possible findings not to have been detected by the registrar who prepared the preliminary report. The evidence from Dr Archer establishes that the findings were subtle, attended by an element of uncertainty, and not usually identifiable on a CT scan. The possible presence of PE was therefore a qualitative, subjective finding.

Further, it was not communicated to Dr Archer or anyone else that the final CT report needed to be completed with any degree of urgency. Had this occurred, it is most likely that the final report would have been completed in a more timely manner. However, again it is not possible to reach any conclusion about whether more timely completion would have made any material difference to the eventual outcome.

Acknowledgments

Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to, Ms Michelle England, Counsel Assisting, and her instructing solicitor, Mr James Herrington of the Crown Solicitor's Office. Their assistance during both the preparation for inquest, and during the inquest itself, has been invaluable. I would also like to thank them both for the sensitivity and empathy that they have shown in what has been a particularly distressing matter.

I also thank Detective Sergeant Andrew Tesoriero for his diligent efforts during the investigation into Stephen's death and for compiling the initial brief of evidence. I also acknowledge and thank the legal representatives for the various interested parties for their assistance during the course of the inquest.

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

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

Identity

The person who died was Stephen Kline.

Date of death

Stephen died on 15 March 2016.

Place of death

Stephen died at Concord Repatriation General Hospital, Concord NSW 2139.

Cause of death

The cause of Stephen's death was pulmonary thromboemboli due to deep vein thrombosis on a background of a leg burn wound.

Manner of death

Stephen died of natural causes during an extended period of hospitalisation after suffering the leg burn wound as a consequence of having a taser deployed at him by a NSW Police Force officer.

5. 107266 of 2016

Inquest into the death of RN. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 18th October 2019

Introduction

This is a required inquest pursuant to s23 (a) of the *Coroners Act 2009* ("the Act") as RN died whilst he was a prisoner on remand at Parklea Correctional Centre ("PCC"). RN was 58 years old, the loved father of daughter S and son M, brother of Sm and husband of NK.

On 31 March 2016, a week prior to RN's death he was arrested and charged with a serious assault upon his wife in their family home. It was the first time RN had ever been arrested or had ever been in custody in Australia. At about 9 pm he was taken to Green Valley Police Station (in Liverpool) and the services of a Khmer speaking interpreter were obtained at his request. With the assistance of the interpreter RN participated in a police interview. He was then charged and was refused bail. A Provisional Apprehended Violence Order was served on RN which prohibited him having contact with his wife who by that time was hospitalised.

At about 4 a.m. on 1 April, RN was transferred from the Green Valley police station cells to Amber Laurel Correctional Centre which is operated by Corrective Services NSW ("CSNSW") where he was received by Mr Russell who was a CSNSW staff member in the Court Escort Security Unit ("CESU"). RN was due to appear by Audio Visual Link ("AVL") in the Liverpool Local Court later that day.

Mr Russell was tasked with completing a paper form titled "Inmate Identification and Observation"("IIO"). Information from that form is entered into the CSNSW electronic database which would generate an identification number for RN and all the details on the form would be created and assigned. Mr Russell ticked the box that said RN required an interpreter and wrote that the language was Cantonese. After Mr Russell had processed RN, RN was placed in a cell and later retrieved to attend court by AVL.

Before his expected court appearance RN was interviewed via AVL by Mr Anderson, a solicitor on the legal aid duty roster. RN's sister Sm attended the interview and acted as interpreter. RN's case was mentioned in court without RN appearing in court on the AVL. His case was adjourned to 15 April 2016 without any application for bail being made so it was formally refused. The court was asked to order a Khmer interpreter for 15 April. Apart from seeing his sister on AVL when Mr Anderson spoke with him, RN had no further contact with his family.

RN remained at Amber Laurel. Sm attended but was unable to visit him and left some clothes for RN. On 4 April, RN was transferred to PCC (then under the operation of GEO Australia Pty Ltd ("GEO")) arriving there at about 12.45 pm.

From 9-30 – 10 pm RN underwent reception screening at PCC which involved RN speaking with endorsed enrolled nurse Ms Howlett employed by Justice Health & Forensic Mental Health Network ("JH&FMHN"). When Ms Howlett interviewed RN she had access to the IIO. According to Ms Howlett she asked RN if he wanted her to telephone an interpreter and he declined. She completed two electronic forms called a "Reception Screening Assessment" ("RSA") and a "Health Problem Notification Form ("HPNF") which stated RN was *a "first time prisoner"* and that he spoke *"basic English"*. She also made an appointment for him to see the medical clinic on 5 April on the "Patient Administration System" ("PAS"). An electronic document called a Drug & Alcohol and Mental Health Summary is generated for the CSNSW Case Management File ("CMF"). The RSA remains a confidential JH&FMHN document. After completing the process with Ms Howlett RN was placed in a cell with 2 other inmates. The time was shortly before midnight – it having taken nearly 12 hours from disembarking the prison truck to entering his cell.

On 5 April 2016, an electronic form called "Intake Screening Questionnaire" ("ISQ") was created in anticipation that RN would be screened by CSNSW. However, that did not occur on that day as RN was required to appear in Liverpool Local Court for the first mention of the Application for Apprehended Violence Order which the police had not linked to the criminal charges. RN did not leave PCC to go to court as he was listed to appear by AVL.

It is unclear if RN did in fact appear in court (via AVL) or whether his legal aid solicitor mentioned the matter on his behalf and adjourned the matter to 15 April 2016 to accompany the criminal charges listed on that date. In any event, RN was not screened for the purposes of the ISQ until 6 April.

By this time RN had spent 3 nights at Amber Laurel and 2 nights at Parklea without having telephoned any family member, having only seen and spoken with his sister Sm on AVL when he was briefly interviewed by Mr Anderson 5 days earlier.

CSCNSW Services and Operational assistant Mr Pauu completed the ISQ. He did not use the services of an interpreter. At the time a statement was not obtained from Mr Pauu and since that time, Mr Pauu has died. Mr Bradley was Mr Pauu's supervisor and assessor of the ISQ. He gave evidence about the form.

On 6 April RN was moved from the previous cell to another and at about 1 pm on 7 April he was moved again to another cell which housed 1 other prisoner. This was either shortly before or after his interview with Mr Pauu who says he completed the ISQ at about 1.10 pm. RN then attended a legal visit with a solicitor Mr Munzenreider, who had been retained by RN's sister Sm. Mr Munzenreider attended RN for a short time commencing his visit at 1.50 pm and left the prison at about 2.30 pm. Mr Munzenreider said that he was able to converse with RN without the use of an interpreter. At 3 pm RN was returned to his cell and he and his cellmate were provided dinner and locked in for the night with the anticipation that the cell would be unlocked at 8 am the following morning.

After eating dinner, RN's cellmate had a shower and he said that he saw RN writing something. The cellmate went to sleep and awoke at about 9 pm to go to the bathroom. When he entered the bathroom he saw RN hanging from a sock attached to the shower rail. The cellmate pressed a call button in the cell which, by a system called "Stenofon", alerts the Parklea control room. Every cell has such a button and though it is designed to be used in the event of medical emergencies only, it is in fact used by prisoners for whatever reason they choose. At that time the PCC Control room was staffed by one person during the night. That staff member had the onerous task of monitoring the entire prison by numerous CCTV screens and answering and logging of each and every Stenofon call.

Ms McFarland was on duty that night. She answered RN's cellmate's call about 14 minutes after the button was pressed. As soon as she learned the reason for the call Ms McFarland made an urgent request for officers to attend RN's cell. RN had been deceased for some time as his body was cold. Inside the cell, officers found a letter that RN had written to his family dated 6 April and 7 April. It is clear from that correspondence that RN was considering ending his life on 6 April and determined to do so after his legal visit on 7 April.

Issues in the Inquest

Of particular focus in this inquest is the process of the reception screening to examine whether RN's well-being was properly assessed having regard to the fact that he was a middle aged man with basic English skills and it was his first time in custody in Australia. The nature of the questions asked on the pro forma screening forms and how they were or were not completed and the decision of each screening officer to not request the assistance of an interpreter has also been scrutinised. The second issue arising from RN's death was the response time taken to answer the call made to the control room. At the inquest GEO made numerous admissions in this regard so it is not controversial. As a result of their own investigation it was identified that the call remained unanswered due to only one staff member being allocated duties in the control room which oversees the entire prison. Such staff allocation was inadequate and at the conclusion of that investigation the inquest learned that the control room has since been staffed by two persons, one of whom has sole responsibility for dealing with Stenofon calls so that they are answered and dealt with in a timely fashion.

The third issue identified initially by investigators was the extent to which the PCC cell had been scrutinised to ensure that there were no obviously accessible hanging points. Evidence was subsequently received which shows that this issue has been responded to and is part of an ongoing response. The hanging point used in RN's death has been removed. At the time of RN's death PCC was operated by GEO and the health care provider was JH&FMHN. Since 1 April 2019, PCC has been operated by MTC Broadspectrum Australia ("Broadspectrum") and health care is provided by St Vincent's Health Network Sydney (St Vincent's Correctional Health) ("St Vincent's"). The Inquest also received evidence relating to the extent to which the procedures and policies of CSNSW and JH&FMHN, respectively, are followed and implemented in the Centre.

However, the inquest is principally concerned with the manner of RN's death consistent with the Coroner's obligation to do so under s. 81 of the Act; the approximate time, the cause and the place is not in issue.

RN's Background

RN was born in Cambodia on 9 September 1957. He had 11 brothers and sisters, 5 of whom died during the time of the Khmer Rouge terror regime. One brother and four sisters live in Australia now. RN did not move to Australia until 1994, when he would have been in his mid to late thirties. RN and his wife NK met in Cambodia when he was 32 and they had both children in Cambodia before immigrating to Sydney.

In Sydney both parents worked hard and bought a house together in West Hoxton. RN apparently had a long-term gambling issue which caused friction from time to time in the marriage. In about 2008/9 RN was diagnosed with high blood pressure and high cholesterol and began taking medication. He was otherwise healthy. In 2015, NK began to work at Curtis Island in Qld, which involved being away from home for 4 weeks out of every 5. That same year RN went to Perth for about six weeks and when he returned he and his wife apparently began to have marital issues.

RN thought that his wife was going to leave him which apparently led to the matter for which he was arrested, charged, bail refused and remanded in custody. The letters which RN wrote whilst in prison prior to his death eloquently speak of his regret and his deep love for his wife and children.

The Brief of Evidence and Witnesses

Written statements were obtained during the investigation and are compiled into a brief of evidence together with other documents such as police, health and correctional centre records. The brief of evidence was tendered through the Officer in Charge, Detective Sergeant Joseph Coorey. Some witnesses were called to give evidence in person so that parties who have a relevant interest in those matters had the opportunity to test the evidence in relation to those issues.

The witnesses called included those who completed the forms at Amber Laurel and Parklea correctional centres as well as Ms McFarlane who was the control room operator on the night RN died. Representatives from all stakeholders - CSNSW, GEO Group Australia, JH&FMHN, St Vincent's and Broadspectrum – were called and gave evidence about the policy and monitoring of compliance in relation to the provision of screening services. I also heard evidence from Associate Professor Dean in relation to the screening tool which was used when RN was in custody and the new screening tool which is being implemented by CSNSW so that a prisoner's mental health can be better assessed.

The Events Leading up to RN's Death

RN in custody at the Green Valley Police Station

When RN was arrested at his home he was cautioned and taken to the Green Valley Police Station in Liverpool. Custody Management Records were sent with RN to the Amber Laurel facility to inform CSNSW. Those records show that RN was spoken to by Snr Constable Dudley, the custody manager. RN requested a Khmer interpreter to attend the station and interpret for RN. The interpreter had arrived by 10.45pm at which time the caution and summary of his custodial rights was given and translated to RN.

RN then requested to speak by telephone with his sister "Sm". At about 11 pm a telephone message was left with Sm's daughter for Sm to contact the police station. Sm called at about 11.15 pm and left her mobile number on which she could be contacted. However, there is no record indicating that Sm's mobile phone number was written down or kept to give to RN so he, the Officer in Charge or the Duty Manager could ring her. Between about 11.30 pm and 00.20 am, RN participated in an interview with the police assisted by the interpreter. He was charged at 1.10 am.

The custody management records indicate that prior to the arrival of the Khmer interpreter RN was spoken to by Snr Constable Dudley who recorded in the Custody Management Report that RN did not make any threats of self-harm, he did not appear severely agitated or irrational, and it was his first time in custody. Officer Dudley made comments about a brief assessment of RN that he *"appears fine and well, nil complaints of health"*, in relation to visual assessment he has commented *"nil issues raised. Conversant"*. In relation to a vulnerability assessment he noted that RN was from a non-English speaking background and that he was an Australian citizen/resident.

Details of RN's medical conditions were recorded indicating that RN takes medication for *"High Blood pressure & Cholesterol tablets every morning"* and that it was his first time in custody. A comment was written as follows: *"nil issues. Conversant, on speaking with a copy of Part 9 Summary he has requested a Khmer interpreter"*. It was at that point, that an interpreter was called to come in to the station. Sm gave evidence that after she spoke with the police at the station she made inquiries about where RN could stay if granted bail and by the time she telephoned the police back they told her RN had been transferred to Amber Laurel and that he would appear in Liverpool Local Court that day.

RN's reception at Amber Laurel Correctional Centre and the Performance of an Inadequate Screening Process

RN arrived at Amber Laurel Correctional Centre sometime in the early hours of the morning on 1 April. The police Custody Management Records were also sent with him. Sm's phone number was not recorded on any of the documents sent from the police station.

Mr Adrian Russell was the Court Services Corrections Officer who was tasked with receiving and processing RN. This task included completing a 'New Inmate Lodgement and Special Instruction Sheet' and an 'Inmate Identification and Observation Form' ("IIO"). The Court Services reception and screening is the first step in a prisoner reception screening process for all incoming prisoners in NSW. The IIO is either filled out by Court Services corrections staff at any NSW Court or at two of the centres in Sydney - one is the Sydney Police Centre and the other is Amber Laurel. Those cells are operated by CSNSW.

Mr Russell gave evidence that upon RN's arrival at Amber Laurel he would have firstly been strip searched by two officers, provided clothing and then brought before Mr Russell in company of those two officers. Mr Russell would then start to fill out the IIO which required him to make observations of RN and obtain information from him. The time Mr Russell recorded on the IIO was 04.45 am. The form is a document which founds much of a prisoner's file. It is particularly important for a prisoner who has never been in custody before. The IIO is a six page document with four sections:

Section 1 Personal Description form which includes Emergency Contact Person, Next of Kin, whether an interpreter is required, country of birth, height weight build and hair eye facial hair colour, whether the prisoner is Aboriginal or Torres Strait Islander origin, citizenship status, language spoken at home, religion, address, identifying marks, details of any children, criminal history, whether there are any other current matters including an AVO and whether this is the first incarceration or any concerns about being in a correctional centre and whether the inmate has been informed about the right of appeal for bail to the Supreme Court and finally a privacy provision requiring the inmate to acknowledge receipt of notice and that his private information could be disclosed.

Mr Russell was taken through the 6 page IIO document and the single page document "New Inmate Lodgement & Special Instruction Sheet". He confirmed that the IIO only contained his writing in one place and that he had ticked that RN required an interpreter and the language was Cantonese and that he had ticked the box indicating that the police Case Management Records (from the police station) had been read.

Section 2 Health History which includes questions about **suicidality** as well as drugs, alcohol, methadone, diet and physical disability.

Mr Russell gave evidence that he did not ask RN any questions. The IIO has a written answer to the question "**Any other general medical conditions",** being "High blood pressure & cholesterol". When a person is taken from the police cells to the Amber Laurel Centre a police document called the "Case Management" travels with the inmate. It would appear that that information has been placed on the IIO as a result of an Officer (other than Mr Russell) reading that document.

Section 3 relates to the Officer's **Visual Assessment- Self harm** with a list of nine questions requiring a yes or no box to be ticked as well as another comment box. At the end of the Visual Assessment section the question is asked: "After reading the Police CMR and completing this interview and visual assessment, in your opinion, is the offender at risk of self-harm or suicide". Mr Russell ticked "No". He said he didn't fill out the answers to the previous nine boxes because he didn't think it was required as the answers were all "No" and that on his visual assessment RN "mustn't have seemed upset".

Section 4 relates to **Supporting information** and again has nine "yes" or "no" boxes all of which Mr Russell left blank including as to whether there were any alerts on the CSNSW Offender Inmate Management System ("OIMS"). However before signing the confirmation on the form, Mr Russell did tick two boxes being that Court Staff had been informed of **'at risk factors**' from CMR or IIO, and that the information had been entered on OIMS (including alerts). It is noted that there were none.

Mr Russell then completed the New Inmate Lodgement and Special Instruction Sheet ("NILSIS") whereby he identified that RN required an interpreter and the language was Cantonese. Mr Russell was unable to identify who had filled out the information in relation to items he hadn't written but he did answer "yes" that the IIO had been completed and he indicated on the form that he had informed the Transporting Officer of "At Risk" and other relevant alerts (of which there were none).

Mr Russell joined CSNSW in 2015, and, after graduating from a nine week training programme at a facility known as "Brush Farm", his first employment position was as a "Court Officer" at Amber Laurel. He said he occupied that position for 12 months. Mr Russell gave evidence that at no time did he receive any training from CSNSW about how to approach or complete the IIO form. Since Mr Russell's evidence was completed, the CSNSW has tendered documents pertaining to Mr Russell's nine week training programme that indicates that Mr Russell was present on the day when the IIO Form and the reception screening process was taught to the trainees. Mr Russell has reviewed that material and does not take issue with that evidence. I accept that he was present when that training was given. Accordingly, Mr Russell either forgot that he had received that training because it was four years prior to giving his evidence, or he had graduated without having any understanding of it. Whatever the explanation, it is apparent that Mr Russell's induction at Amber Laurel did not include a refresher about the importance and the requirements of the IIO form.

Whilst I did not scrutinise any part of CSNSW training I do note that the subjects of reception of prisoners and the completion of the IIO are topics covered in the early to middle part of the training. These subjects could perhaps be repeated or refreshed at the end of the programme to ensure that such an important process is not only one of the first things a trainee learns but is also one of the last things to be imprinted in their minds as they start their first round of duties in a prison or reception centre.

There is no issue that Mr Russell demonstrated poor compliance with the applicable policies and training that had been provided to him. Indeed he accepted that, despite the IIO form being quite self-explanatory about what is required of the Officer completing it, he failed to properly do so. In his evidence he suggested that the reason for the incomplete form was because either the prisoner refused to co-operate and answer the questions or he did not understand the questions and required an interpreter.

Given the evidence of RN's co-operation with all other screeners and with the police, I reject that the form was not filled in properly because RN did not co-operate. I accept the evidence that RN had basic English skills and that had he been asked at least some of the questions he would have been able to answer them. Mr Russell did not ask the questions. The reason behind Mr Russell's failure to properly perform his role is beyond the scope of this inquest. At least to Mr Russell's credit he said in his evidence "It should have been filled in in its entirety; I have no excuses as to why it was not".

Counsel Assisting and Ms de Castro Lopo made submissions in relation to a proposed recommendation aimed at ensuring that officers understand the importance of the IIO and know how to complete the form properly.

Ms de Castro Lopo usefully points out that not all officers are sent to the court services and not all officers would be in positions where they would be required to complete the IIO form on a regular basis. She points out that there are many important training modules and it is difficult to prioritise one over the others to be included in a refresher component. She submits that the suggestion of adding an IIO refresher component in the primary training (at Brush Farm) does not take into account experienced officers who are transferred, promoted or who might work overtime at the court services locations.

Given those circumstances there is a need to ensure that any personnel from any pathway who are required to complete the IIO form must be aware of the importance of the task and their training is up-to-date. Ms de Castro Lopo has indicated by letter of 24 October 2019 that CSNSW has an online training programme which I understand specifically includes the Court Services IIO form and procedure. Any officer engaged in tasks involving these duties should be as part of their induction required to, where necessary, undergo a "refresher" by completing that online module.

Mr Russell said that for the entire time he worked in this area at Amber Laurel that he never once used an interpreter, heard of any other officer use an interpreter or indeed ever saw or heard that an interpreter service was available to assist in communicating with the prisoner to complete the IIO. Mr Russell said he was not aware of any telephone number being posted anywhere in the office or any procedure involved in using a telephone interpreter. It seems to have escaped Mr Russell's attention over the 12 months in his position that the telephone number for the 24 hour 7 days a week telephone interpreter service is identified and clearly recorded on the IIO form itself. Mr Russell said that he did not think his rank at that time would have entitled him to use an interpreter even if he had known about them.

Mr Hayhow was the Officer in Charge at Amber Laurel during the time Mr Russell was working there. He gave evidence that he expected that the IIO form would be fully completed. He also said that the form should have been sent back to Mr Russell by the supervisor on duty so that it could be filled out properly.

Mr Hayhow gave evidence that interpreters were used at the centre by officers (regardless of rank) but that there were occasions when he (and other officers) would get the information required to complete the form "anyway they could" so if another prisoner could translate then he would adopt that course rather than troubling the telephone service in the early hours of the morning. In relation to prisoners telephoning family members, Mr Hayhow said that most prisoners are at Amber Laurel 3-4 days and that if they had not telephoned a family member within the first 72 hours, efforts would be made to assist them in this regard. I note that if RN arrived at about 4 am on 1 April and on that basis he should have had a phone call but as it turned out the phone number recorded (if it was at Amber Laurel) was missing a number. It is not known whether RN tried to call any family when he was a prisoner at Amber Laurel.

Counsel assisting submitted that "a culture of inattention to essential detail in the proper screening of inmates had developed" at Amber Laurel. Ms Castro de Lopo submits that the inquest did not investigate any other inmate screenings and accordingly would not make such a finding. I agree but I do note there is a possibility that that there is a cultural misconception that Amber Laurel is perceived as part of the "police cells" even though it is operated by CSNSW. Such a misconception may cause Amber Laurel to be identified as a location at which an adequate intake or screening process is not necessarily required and though the IIO is on the corrections file, it is not necessarily a document about which much care needs to be taken due to the possibility that a prisoner will be granted bail and not proceed to Reception at one of the prisons.

Mr Russell said some prisoners can stay as little as 2 hours and some as long as 2 weeks. Whilst that might be the case, the centre is run by CSNSW, not the police, and though the prisoner might or might not be remanded to a prison after their court appearance, failing to complete the IIO and expecting it will be completed by another staff member during the later Reception Process is not compliant with CSNSW policy. Due to the inadequate conduct of the screening process at Amber Laurel it is unclear whether RN, even if he had the opportunity to, and if he had been able to, would have conveyed to Officer Russell that he was at risk of self-harm.

RN's first Court mention and whether Mr Anderson was aware that RN was at risk of self-harm

RN was booked to appear in court by AVL on 1 April. Sm attended the Liverpool Local Court and on becoming aware that Mr Anderson was going to represent RN she approached him. Sm told Mr Anderson that she was RN's sister and that RN required an interpreter and as she had been an accredited interpreter she could assist him in the interview. Mr Anderson accepted her offer and they both attended the AVL suite and spoke with RN.

Sm says in both her statement and in her evidence that during the legal interview, RN said to her "*I just want to die*" and she replied "*No don't do that.*" She was aware at the time that her emotions had overridden her duty to interpret, and she apologised to Mr Anderson for doing so and said words to the effect of "*He just told me he wanted to commit suicide*. *And I told him not to".*

Mr Anderson has given evidence and he has no recollection of RN or Sm but has provided his file notes. Those notes do not contain any record that RN had expressed that he wanted to end his life. Mr Anderson says that if he was aware of such an indication he would write a file note and raise it in court. There was no such file note and the transcript of Mr Anderson's appearance in court on behalf of RN shows that he did not raise concerns about RN's mental health. A comment made by Mr Anderson in court however suggests that Mr Anderson had experienced some difficulties in communicating with RN which may have been due to Sm seeking to converse with RN rather than strictly interpreting.

Mr Anderson told the court "*I'd need an interpreter your Honour more…more than his sister better in interpreting than his sister. He understands the seriousness of the matter, that much is understood*". It is possible that Mr Anderson did not appreciate that Sm was conveying to him that RN was threatening self-harm as opposed to Sm apologising for engaging in a conversation rather than strictly interpreting, so that the nature of what RN had said was miscommunicated.

It has been suggested Mr Anderson did not lend as much regard as he should have towards the comment due to his workload, however it appears to me that he is well used to being a duty solicitor and it really was a case of a misunderstanding between him and Sm. Mr Anderson said "*I think it very unlikely I would not have reacted unless it was expressed emotionally to me (due to it being) her brother*."

I accept that had Mr Anderson been aware that his client was at risk of self-harm he would have made a file note and would have raised it with the court. The court transcript indicates Mr Anderson had seen on some papers that the language RN spoke was Cantonese but he clarified with the court that RN was Cambodian and that a Khmer interpreter was required for the next mention. That attention to detail indicates to me that as busy as he was Mr Anderson was mindful of ensuring that his client received the correct services. Mr Anderson indicated to the Local Court that there was to be no application for bail and he asked that the matter be adjourned to 15 April 2016. The magistrate asked Mr Anderson to convey the outcome to RN. Accordingly, it would appear that RN did not appear in court by AVL on that day but was made aware he would be next attend in 2 weeks' time.

RN's medical treatment at Amber Laurel Correctional Centre

Sm said that she took RN's clothes and medication to Amber Laurel but was only allowed to leave the medication. The JH&FMHN Records obtained for Amber Laurel show that RN was reviewed in the holding cell by Registered Nurse Ms Robinson at 4 pm on 1 April. She notes that the medication had been brought in by RN's sister.

She obtained his written consent to acquire information about his medical issues and medication from his GP. RN received further medication at his cell door at 10.13 pm that night. He was again reviewed and provided medication at his cell door at 2 pm on 2 April, and again in the clinic on 3 April. Brief reviews on 2 and 3 April note "*no concerns were voiced*" and "*nil issues stated*". I note that though RN was at Amber Laurel and attended to by nurses on these 2 days, there is no evidence suggesting that the nurse commenced a Reception Screening Assessment.

JH&FMHN Assessment at Parklea Correctional Centre

On 4 April 2016 RN was transferred to PCC arriving at about 12.45 pm. A process of reception screening is conducted by both JH&FMHN and by CSNSW. Only RN's health screening was performed on 4 April and it did not commence until shortly after 9.30 pm. However, the IIO which had been finalised incomplete by Mr Russell 3 days previously was on file.

Ms Howlett, who is an endorsed enrolled nurse, completed the Reception Screening Assessment ("RSA") which is recorded as having commenced at 9.34 pm and completed at 10.00 p.m. That form already had some electronically entered information in a section called "Patient Background" under which the field about "Country of birth" was recorded as "unknown", and that "no interpreter was required".

Those fields are derived from the IIO and if there is an error it can only be changed by a process involving the screening assessor completing a special form and sending it to sentence administration. Given that the IIO was barely filled out by Mr Russell, it is not surprising that RN's country of birth is recorded as "unknown" but the record that "No interpreter required" was inconsistent with Mr Russell having ticked twice that one was required, though incorrectly stating Cantonese. There is no evidence that any attempts had been made to correct the fields by a screening officer. I note that Ms Howlett is not a screening officer employed by CSNSW but rather she is employed by JH&FMHN.

As a result of her assessment of RN, at 10.07 pm Ms Howlett completed a form called "Health Problem Notification Form ("HPNF") which was a notification to CSNSW/GEO that RN was an inmate with special needs and that he should be in a two out cell placement because it was his first time in custody and he was Cambodian with limited English. A CSNSW receiving custodial officer, T. Mosokon, acknowledged receipt of that form on 4 April. Ms Howlett said that she felt she was able to adequately communicate with RN. During her half hour with him Ms Howlett weighed and measured RN, took and recorded his vital observations. She obtained details from him about his General Practitioner. She completed the RSA which included conducting the Kessler 10 Test which is a mental health assessment check. She completed a health notification form.

Ms Howlett gave evidence that she was able to communicate with RN, she had asked him whether he would like her to call the interpreter telephone service and he declined. She made a note that if you spoke clearly and slowly he could understand. This is consistent with RN having basic English skills.

Though there is no record of having done so (as there should have been) I accept Ms Howlett's evidence that she asked RN if he wanted her to call a telephone interpreter and that he declined. Ms Howlett's omission to record so was not compliant with the applicable policy.

It is unclear why RN declined an interpreter. He had requested one at the police station. He did not have an interpreter at Amber Laurel. His sister acted as interpreter at the court. It is unclear whether he understood sufficiently or whether he understood enough and did not want to inconvenience any interpreter given the time of night or did not want to experience further delay getting to whatever cell he was being allocated as he had been waiting at PCC reception for over 8 hours to be processed. RN was able to tell Ms Howlett the medications he had for cold sores, high blood pressure and that he had no other major medical conditions, that he was not a drug, alcohol or tobacco user and that he did not take any prescribed or non- prescribed opioids. Ms Howlett indicated on the form that RN was neither intoxicated nor withdrawing.

Ms Howlett administered the Kessler 10 mental health safety test. The test provided a score which indicated that RN may currently **not** be experiencing significant feelings of distress. Ms Howlett commented on the form that RN's presentation was congruent with that score, that it was his first time custody; he had limited English, but that he understands if you speak clearly and slowly. Ms Howlett noted that RN denied any thoughts of self-harm or suicide. He identified he had a sister for support, was a non-smoker, had a history of hypertension, elevated cholesterol and his mood was sad. Ms Howlett was of the opinion that he should be "2 out" (that is, he should be accommodated in a cell with another prisoner in preference to being alone).

Ms Howlett recorded that RN had indicated that he had never been treated for a mental health problem, or tried to hurt himself, or tried to end his life or anyone in his family had. Under patient concerns Ms Howlett recorded that RN was worried about the future as his wife may leave him. Ms Howlett said that in answer to the question *"How do you think you will cope with prison?"* RN replied *"I don't know".*

Of note in the Kessler 10 test there is a series of questions about whether in the last 4 weeks he had felt "depressed, worthless, that everything was an effort and so sad that nothing could cheer him up". To each of those questions RN had answered "*a little of the time*" (which is one of the 4 options available). It is not clear whether this was because he had only had those feelings since he had been arrested or whether some other explanation was available. The form does not record any explanation of this other than the words "*mood sad*" but does record that "*patient denies any thoughts of self-harm suicide*".

It is unclear whether, due to the time of night and the lack of English, RN fully understood the nature and the importance of the assessment Ms Howlett was engaging him in. It may well have been safer, as well as simply prudent, to seek the assistance of at least a phone interpreter and/or refer him for further assessment by a mental health nurse.

Following Ms Howlett's screening a request for information from his doctor was sent and RN's G.P responded on 6 April 2016. The response confirmed RN's medications and the response did not raise anything from his past medical history suggesting an issue with self-harm, depression or suicidal thinking. RN was placed on the JH&FMHN Patient Administration System (PAS) on 4 April for routine follow-up within 7 days by the 'population health' nurse specialty and within 8 days (non-urgent) for the Primary Health Nurse specialty.

At about 1 pm on 7 April 2016, RN attended the primary health nurse at the clinic where his blood pressure and pulse were checked. No note is made of any concerns and the identity of the nurse is not recorded. Since April 2016 the RSA has undergone a review and Associate Prof Dean provided a statement commenting on the current procedure and the proposed procedure.

Screening by GEO Corrections Personnel

On 4 April before RN was assessed by Ms Howlett he saw Mr Petkovic who placed a number of forms in front of him, explained in a nutshell what they were and asked RN to sign them which he did. The forms contained legal language and were like basic contracts whereby the prisoner acknowledges responsibility not to damage property and the like. Mr Petkovic said that he asked RN if he would like an interpreter and RN said that he would. However, Mr Petkovic determined that RN did not need an interpreter so did not organise one. On reflection Mr Petkovic was of the view that he should have ordered one and he had even thought that RN might need an interpreter for the ISQ which was also required to be completed. I am satisfied that RN signed documents at the request of Mr Petkovic and it is unlikely that he understood fully what it was he was signing.

Mr Petkovic suggested that the reception and screening centre is a high-pressure environment with people queuing up. Ms Howlett said that she might process up to 10 prisoners a shift though she said she felt no time pressure to finish RN's assessment for her to finish her shift on time (10 pm). Given that RN was there for 8 hours it seems that prisoners may be processed in circumstances which, due to time constraints, results in at least persons with a basic level of English being disadvantaged by not having an interpreter made available to assist them with such forms.

RN was screened by Corrections Officer Mr Pauu on 6 April 2016. On one of the forms is a phone number for Sm but it does not contain sufficient digits. Either that phone number or another number subsequently provided by RN was called by Mr Pauu, but the number didn't work. Mr Pauu is now deceased and cannot shed light on what number he relied on, but no other number is noted on the available forms. A GEO spokesman, Tony Mannweiler, identified that the deficient phone number resulted in a referral for Offender Services to try and contact a relative on RN's behalf. Unfortunately, RN did not have the opportunity to speak with his sister Sm or any family member before he died. An intake screening questionnaire ("ISQ") was completed by Mr Pauu. The form suggests that the 87 questions were asked and answered between 12.59pm and 1.10pm. Mr Pauu's supervisor, Mr Wayne Bradley, suggests that this must be an error as it would not be possible to ask those questions in that time frame.

The form requires the officer to consider using an interpreter. An interpreter was not used. Question 52 notes that when asked how he was feeling, RN replied "feel a bit sad". No further note is made of what precisely this meant or any exploration of it. RN apparently denied any thoughts of self-harm or to take his own life.

On 6 April 2016 the ISQ was reviewed by GEO Group employee, Karen Morton. She did not detect any indicators of suicide risk in the Questionnaire. She noted RN had limited English. She did not interview him. In her statement Ms Morton said she looks at the following things when assessing whether an inmate is at risk of self-harm: the inmate's profile document (this would have been insubstantial given he had only just come into custody for the first time), the court records (also limited) and the ISQ.

Policies about Screening and Reception of Prisoners

The policy applying to JH&FMHN screening after RN's death is called "Health Assessments in Male and Female Adult Correctional Centres". It notes that the triage of the inmate's immediate health needs is the focus of the initial assessment in the cells. It also suggests that registered nurses working in the police cells would create a Reception Screening Assessment ("RSA").

The policy requires that a Registered or Enrolled Nurse must complete an RSA for all patients entering correctional centres. The policy appears to be silent as to the use of interpreters. Ms Barbara Ball, Acting Nurse Manager Operations from JH&FMHN, annexes the policy at the time of RN's death to her statement.

The policy relating to the use of interpreters is found elsewhere, in a document called 'Health Care Interpreter Services-Culturally and Linguistically Diverse Patients', which was issued in 2013. It variously provides that: (i) if an interpreter isn't available, it has to be logged on the Incident Information Management System ("IIMS"); (ii) if a patient identifies as non-English speaking, or if a language other than English is spoken at home, this requires the services of an interpreter and must be noted on the Health Problem Information Form and as an alert on PAS; and all patients who are not fluent in English must be informed about their right to access a professional health care interpreter at first point of contact and on an ongoing basis.

Both the Health Care Interpreter Service and Health Language Services offer a 24hr/7 day service. Accordingly, when an assessment is carried out after hours such as in RN's case an interpreter should still be used rather than the nurse making a judgment call (as suggested by Ms Ball in her statement). A flowchart in the policy allows that when an interpreter is not available a staff member or patient could be used to interpret suggesting that only questions essential for the patient's health and safety, presumably until a full assessment with the assistance of an interpreter can be completed.

Health staff are encouraged to use their judgment to decide if an interpreter should be used and how they exercise that judgment seems to depend on what the issues to be communicated at the health appointment are. Of course if a practitioner asks a prisoner if they would like an interpreter and the prisoner declines a prisoner has a right to their privacy. However, if the practitioner is unable to elicit sufficient information they should organise an interpreter to at least discuss that issue so that the prisoner understands why an interpreter should be used, regardless of what the prisoner has indicated. To do so would not be a breach of the prisoner's privacy but rather an adoption of best practice so that the practitioner is confident that their purpose is understood by the prisoner.

Associate Professor Dean gave evidence about the implementation of a proposed new screening policy from the from JH&FMHN perspective designed to improve screening for persons who have mental health issues such as depressed mood. Associate Prof Dean considers that the Kessler 10 test may not have been as effective as it was intended to be.

Ms Lucia Boccolini, co-ordinator of the CSNSW Reception Screening and Induction Assessment and Case Management Support Team, gave evidence about the current CSNSW policy, including the requirement that interviews be conducted in a language that the inmate understands (as it is critical to record accurate information) and has provided an extract of the relevant Operations Procedures Manual ("OPM") applying at the time of RN's death, specifically clause 7.15.3.4 of the 'Guidelines for Telephone Interpreting'. The policy includes that interpreters be used *"whenever it is felt that the inmate may be disadvantaged without the services of an interpreter"* or where there is any doubt about their ability to comprehend or express themselves in English.

The fact that from time to time, relatively sophisticated terms are used in the screening process and that it is a very important exchange between the inmate and the prison, it would be prudent to utilise the services of an interpreter when an inmate has basic or limited English Language skills. Apparently about 5% of the NSW prison population have English as a second language which would suggest that most staff members of Reception and screening areas would be, or should be, very proficient in using interpreters so that those prisoners are not disadvantaged. I suspect that best practice is likely compromised at times by the dictates and pressures imposed by the demands of a busy engagement. Whether that was the case for RN is difficult to determine but it seems likely given that it was a process involving at least 8 hours.

I note that after seeing the Registered Nurse in the clinic on 7 April, RN attended the legal interview with the lawyer Mr Munzenreider which had been arranged by Sm. That interview was also held without an interpreter. Mr Munzenreider was with RN for about half an hour and said in his statement that RN spoke in "broken English" but he was confident that RN understood the conversation. He said that RN did not raise anything which suggested that he was at risk of self-harm. It is not clear when RN formed the intention to end his life but it may have been at the least the day prior as that is the date of one of the letters he wrote.

Though it is clear that RN spoke and understood sufficient English it is unclear whether he would have done so to tell someone about how he was feeling which would trigger a full mental health assessment. It is not possible to confidently identify that his language skills were a barrier to him doing so. I do note that Ms Howlett formed the view that RN's relationship with his sister would be a supportive and protective factor and Ms Howlett believed that RN would be able to contact Sm so it would be an effective factor. However, RN was not able to contact Sm and it was only on 6 April that an unsuccessful attempt was made.

RN took his life after a week of incarceration. During that week he had been processed by numerous people without an interpreter, on the first occasion Mr Russell asked no questions of him at all, on the next occasion with Mr Petkovic he was at least asked if he wanted an interpreter but when he said "yes" he was denied an interpreter. Perhaps when he declined Ms Howlett's offer of an interpreter he thought that is what he was meant to do. RN moved cells constantly and he did not have a telephone call with any family member. He did not appear in court even on AVL. I do not think that the entire processes of that week could be described as being conducive to good mental health for a middle aged person who had never been in custody before but at least had English as their only language, let alone a person who had basic or broken English skills.

Hanging Points in Parklea Corrections Centre

Shortly after RN and his cellmate were locked in their cell for the night, the cellmate went to sleep and RN was finishing his goodbye letter to his family. He then went into the bathroom and hung his sock over the shower rail. Since RN's death there have been a number of inquests in relation to hanging points at PCC (and other) Correctional Centres. The shower rails and other identified points have now been removed. Accordingly, this inquest has not focussed on this issue.

Response Time to Attend to a Distress Alarm in 3A Wing

After RN's cellmate woke up and discovered RN deceased, the cellmate pressed the alarm. The alarm is heard in the control room which has monitors showing all areas of the prison which housed at that time a little fewer than 1000 prisoners. Only one person staffed the control room. All cells are equipped with an alarm button. It is a constant challenge to determine which calls are genuine and which are not. At the time of RN's cellmate's alarm, another incident was occurring at another location and the control room operator determined that she needed to watch that incident unfold in case further staff assistance was required. RN's cell alarm was responded to after a delay of about 15 minutes. This issue was adequately investigated by the GEO Group at the time. As a result, overnight control room staffing levels have doubled so that one staff member is solely responsible for answering the alarm calls and keeping the log of Stenofon use.

The evidence indicates that RN was likely deceased for some time when he was eventually responded to. He is described as 'cold to the touch' by several attending staff. He could not be revived. This should not detract from the need to provide as urgent a response as possible in similar tragic situations.

I have heard from the witness who operated the control room that night. However, given the changes made to the response to the Stenofon alarms, it is not an issue which has concerned this inquest.

Parklea Under New Management

Since RN's death the operation of PCC and the provision of health services there have passed from GEO and JH&FMHN, to Broadspectrum and St Vincent's. The overall monitoring of policy compliance is conducted by CSNSW. The use of interpreters is to be encouraged in Broadspectrum's screening and reception processes.

JH&FMHN has a new policy which sets out that an interpreter should be used when the prisoner is "not fluent" in the English language. In other words, unless a patient is fluent in the English language an interpreter should be used. In addition to the same policy, St Vincent's has an extra guide whereby it advises that to assess whether a patient is fluent, one can take into account whether they hesitate or have difficulty in understanding and communicating in English.

Recommendations

Counsel Assisting's proposed recommendations were circulated with his closing submissions. The first set is directed at CSNSW and the second to JH&FMHN.

In relation to CSNSW, Counsel Assisting proposes recommendations directed to Amber Laurel Corrections Centre:

- Recommend that remedial training be provided to officers at Amber Laurel correctional centre involved in completing '*Inmate Identification and Observation*' forms as to the importance and reasons for completing such forms and the use of interpreters in line with CSNSW Custodial Operations Policy and Procedures 11.1 Language Services; and
- Recommend that consideration be given to developing a policy requirement for inmates, who are detained in custody for the first time, and housed at Amber Laurel correctional centre for more than 48 hours prior to movement to a reception centre, to be offered (and, if accepted, provided with) a telephone call to a nominated family member.

In relation to JH&FMHN, counsel assisting proposes:

To the Director, NSW Justice Health and Forensic Mental Health Network:

- That consideration be given to amending the current version of the Justice Health policy '*Health Care Interpreter Services-Culturally and Linguistically Diverse Patients*' to provide guidance as to the need to offer telephone interpreter services to a patient who lacks fluency in the English language. This may include by incorporating the words:

- "Firstly, as a guide, a patient can be said to be not fluent in English if they hesitate or have difficulty in understanding or communicating in English", or such other formulation as is deemed appropriate by Justice Health.

The evidence in this inquest does not readily indicate that such a change is required because Ms Howlett completed a reasonably comprehensive RSA after RN declined the services of an interpreter and she was sufficiently mindful of his basic English and adapted her language to ensure effective communication. Although she did not record that she had offered an interpreter and that he had declined, Ms Howlett did record that his ability to communicate required the assessor to speak clearly and slowly.

Ms Howlett, an experienced screening nurse, appropriately assessed that RN was vulnerable as a middle aged first time prisoner with basic English. She identified the protective factors, his mood and his uncertainty about how he would cope with prison. She booked him in to see the nurse within seven days and she provided in that notification that he should be accommodated in a cell with another person. JH&FMHN submits that if there were any shortcomings in the screening process they were not because RN had basic English but rather possibly due to the shortcomings of the Kessler 10. The mental health screening is greatly changed since then with the implementation of a new mental health screening test.

Mr Bradley submits that St Vincent's guide that a patient's hesitation in responding to a question could demonstrate a lack of fluency of English language is of equivocal assistance and as such does not warrant the change in policy as suggested in the recommendation. On balance I agree with that submission. As Mr Bradley points out, Clause 2.1 states that "health care interpreters are to be engaged in all healthcare situations where communications are essential for patients/clients who are not fluent in English…". The guide, at Clause 2.3, states "to assess if the patient is able to fully understand and communicate in a health care situation. Just because they can manage to give you their personal details and talk about every day topics such as the weather, do not assume they have enough English to cope in a medical situation".

On the basis that it is clear that a RSA process is a "healthcare situation" I am of the view that the policy is probably more helpful to understand the meaning of fluency than whether the patient "hesitates". The policy clearly identifies that an interpreter should be used in circumstances where the patient has basic or less English language skills. Accordingly, I determine that such a recommendation, on the evidence of this inquest, is not required and I decline to make it. I note that Ms Cooper supports Counsel Assisting's proposed recommendations directed at Amber Laurel Corrections Centre. Ms de Castro Lopo submits that the evidence falls short of establishing that the inaptitude of Mr Russell is symptomatic of the culture at Amber Laurel. Given that the screening took place three years ago, I hope she is correct. However, it appears that Mr Russell was not the only staff member who paid disregard to the requirements of the IIO – so too did his supervising officer.

I note that there is no evidence about why an RSA was not commenced while RN was housed there, as I surmised earlier I suspect that staff are influenced by the guaranteed transience of their inmates and if the inmate proceeds in the prison system further screenings are likely to be fully carried out at that stage. I also note that since that time CSNSW has introduced an auditing process designed to identify shortcomings in their processes. Perhaps, though without a specific recommendation, if an audit has not yet occurred at Amber Laurel it should now be performed to ensure that there is no longer the shortcomings in the screening process as there was at the time RN entered the facility.

I have already dealt with the issue of training officers about the importance of completing the IIO and am aware that there is an ongoing process of review and improvement. I thank Ms de Castro Lopo for her assistance in regards to this recommendation. I note that her advice in her letter dated 24 October 2019 that "There is a Course available on the CSNSW Learning Management System – Reception Operations (For 1st Class Correctional Officers)". On that basis, I decline to make the recommendation sought by Counsel Assisting but I do encourage CSNSW to ensure that all Officers who are engaged in the Reception Screening Process, if necessary, to have a "refresher" by undertaking the on-line learning module.

Ms Cooper submitted strong support that an inmate at Amber Laurel is able to make a telephone call within 48 hours. She says "The family believe both a telephone call and the use of interpreters would have reduced RN's sense of isolation and that the family hope that steps are taken to improve these services for future inmates". The isolation of a prisoner, particularly in RN's circumstances should not be underestimated, and whilst the screening procedures by both CSNSW and JH&FMHN are designed, in part to identify prisoners at risk of ill mental health and/or at risk of self-harm, and though those screens are "but a moment in time" they are the primary tool currently utilised.

In many ways making an interpreter available to a person who clearly struggles with English shows a powerful message to the prisoner and that is, someone cares enough about him that they want to make sure that he understands what his rights are, what services are available to him and who he can ask for help. Frankly, they seem to me to be basic human rights for persons who are incarcerated no matter what their cultural or linguistic background. I am fairly certain that RN did not know that he could or did not know how to ask for help. When, after 6 days a telephone call to Sm was attempted but failed he may well have given up. A prisoner should be able to make a telephone call to a family member or friend within 24 hours and 48 hours at the latest.

Ms Janet de Castro Lopo confirmed in writing by email and a later letter both dated 24 October 2019 that *"This process has already been developed at Amber Laurel since this serious incident. Welfare staff from Emu Plains are also used where necessary to assist with inmate welfare calls and issues. Although there is no facility for Offenders to make a phone call unless Welfare Staff have been called to assist, the staff at Amber Laurel will contact Offenders relatives at the Offender's Request".*

Ms de Castro Lopo submits on behalf of the Commissioner that due to this change the recommendation is not required. I disagree. Though the difference may be subtle, I think that a prisoner being able to speak personally to a loved one, particularly in their own language, is a far more protective factor than being told by a prison officer or a welfare officer that contact has been made and a message passed on.

If the recommendation requires infrastructure change so that telephones need to be installed for this purpose then the recommendation should be read as such.

To the Commissioner of Corrective Services NSW

I recommend that consideration be given to developing a policy requirement for inmates, who are detained in custody and housed at Amber Laurel Correctional Centre prior to movement to a reception centre, be provided with a personal telephone call to a nominated family member preferably within 24 hours but certainly no later than 48 hours.

Perhaps an interpreter would have made a saving difference; perhaps a telephone call would have as well. Ultimately, the letter written by RN doesn't speak about his experience in the prison but rather his regret and sorrow of the actions he committed against his wife and ultimately his family. It is unclear how much his experience in the prison system over the preceding seven days impacted upon RN's inability to see a future for himself after realising that his marriage was over and he had lost his cherished family, an experience he had previously suffered whilst a young person in Cambodia due to the terrors of the Khmer Rouge.

Identity

The person who died is known as "RN"

Date of Death

RN died on 7 April 2016

Place of Death

RN died in the bathroom of his cell at Parklea Correctional Centre, Quakers Hill NSW

Cause of death

RN died as a result of asphyxiation by ligature

Manner of death

RN's death was intentional and self-inflicted in circumstances where he was a recent remand prisoner at Parklea Correctional Centre.

6. 110830 of 2016

Inquest into the death of Ossama Al REFAAY. Findings handed down by Deputy State Coroner Ryan at Lidcombe on the 25th October 2019

On 11 April 2016 Ossama Al Refaay died in his cell at Long Bay Correctional Facility where he was on remand for charges of people smuggling. As Mr Al Refaay was in custody, the responsibility for ensuring that he received adequate care and treatment lay with the State. Pursuant to sections 23 and 27 of the Act, an inquest is required when a person dies in custody to assess whether the State has discharged its responsibilities.

Mr Al Refaay's life

Ossama Al Refaay was of Iraqi background and was born on 6 September 1979 or 1981, depending on NSW or Federal police records. He arrived in Australia by boat in June 2001. He had a wife living in Uzbekistan, and was pursuing a spousal visa for her to come to Australia.

In 2005 Mr Al Refaay met Ms Eve Szymanska in Sydney and they formed a relationship. The couple had a daughter who is now aged 11 years. Although the relationship ended about a year after her birth Mr Al Refaay was in regular contact with Ms Szymanska and his daughter, and helped with food and bills. After Mr Al Refaay entered custody in 2015 Ms Symanska did not have any further contact with him. She did however attend each day of this inquest. While he was in custody Mr Al Refaay received visits from friends within the Iraqi community.

Mr Al Refaay was using methylamphetamine and oxycontin during the time of his relationship with Ms Symanska. It is not known to what extent his drug use continued afterwards. On 19 March 2015 Mr Al Refaay was arrested on charges of people smuggling and other offences. He was moved to the hospital complex within Long Bay Correctional Centre on 18 May 2015 for dental treatment, and remained there until his death. At the time of his death Mr Al Refaay was sharing a cell with an inmate BB who described him as a friendly person who spoke often about his family.

Long Bay Hospital and Visitor Centre

Long Bay Hospital is located within Long Bay Correctional Centre, and consists of two areas known as LBH1 and LBH2. LBH1 houses up to 70 inmates who are mental health patients, post surgical patients, and inmates needing aged care. LBH2 is used to house overflow of remand inmates from other gaols, and accommodates up to 250 inmates.

These inmates do not necessarily have ongoing medical issues.

LBH1 and LBH2 share the same Visitor Centre. Visits to inmates are allowed on Thursdays, Fridays, Saturdays and Sundays, and take place in three separate rooms of the Visitor Centre. CS officers are rostered to manage and supervise visits. Each of the three visit rooms has cameras fixed to the ceiling which record constantly and are faced in different directions. As a correctional facility classified as '*maximum security*', LBH is subject to CS policy that a strip search of all inmates be conducted after they have received contact visits.

On 29 January 2016 Mr Al Refaay received a visit from a person who was found to have concealed in his armpits small balloons containing tobacco. When Mr Al Refaay was interviewed he said he was expecting to be passed the tobacco, and it was intended for his own use.

For the following 28 days Mr Al Refaay was only permitted to receive visits on a non-contact basis, that is in a room with a glass screen and metal grille. His visitor was banned from further visits for a period of time. However no alert was entered on Mr Al Refaay's Inmate Profile as a result of the incident. The court heard this was an oversight and that ordinarily this would be expected to happen. The effect would have been that the notation would appear on records used by the Deposition Clerk on visiting days, enabling the Clerk to advise supervising officers that the inmate is at risk of trafficking contraband and may need a higher level of attention during the visit. A further consequence is that the inmate could be considered for targeted cell search.

On 3 April 2016 Mr Al Refaay received one of his regular visits from a Mr Eile Mazloom, who is described in CS records as Mr Al Refaay's friend. By this time Mr Al Refaay was once again being permitted the usual 'contact visits'. During the visit Mr Mazloom's feet were seen to be partly out of his shoes, arousing suspicion of an attempt to pass contraband to Mr Al Refaay. Mr Al Refaay was strip searched after the visit but nothing was found.

The day before he died Mr Refaay received another visit from Mr Mazloom, who was this time in the company of another male AA. The time of the visit was around or soon after 12.30pm on 10 April. On that day ten CS officers were rostered to manage visits as follows: seven to supervise the visits rooms, two to process visitor entry and exit, and one to escort inmates for legal visits. Of the staff rostered to supervise the visits area, one was monitoring the CCTV cameras and another four were directly monitoringthe visits in the three rooms.

CS officers did not record any concerns about Mr Al Refaay's visit from Mr Mazloom and AA. However three months after Mr Al Refaay's death AA was visiting at another correctional centre and was found in the carpark in possession of a small balloon containing strips of the drug buprenorphine.

The night of 10 April 2016

During the evening of 10 April Mr Al Refaay's cell mate BB thought he seemed anxious. Mr Al Refaay told him he'd had a bad visit with his brother. In the early hours of 11 April BB heard Mr Al Refaay say something loudly in his own language, but thought he was praying and went back to sleep. At 3.40am BB awoke and went to use the toilet and found Mr Al Refaay seated on it. He was pale and unresponsive. A plastic bag had been positioned inside the toilet bowl. BB immediately called emergency services, but they could find no signs of life and he was pronounced deceased. Muslim inmates conducted prayers for him later that morning.

What caused Mr Al Refaay's death?

Forensic pathologist Dr Istvan Szentmariay performed an autopsy examination and found the cause of Mr Al Refaay's death to be acute methamphetamine toxicity. His abdominal cavity contained seven small balloons which were located in the small bowel. These were packed with a hard substance. Within the same area Dr Szentmariay identified four other balloons that appeared to have burst.

Subsequent sampling of the seven intact balloons established that five contained vegetable matter (probably tobacco), one contained buprenorphine, and the seventh contained methylamphetamine. The burst balloons and their remnant contents were not tested due to work health and safety risks.

Toxicological analysis of Mr Al Refaay's post mortem blood samples showed very high concentrations of methamphetamine, consistent with the release of methylamphetamine from the ingested material. At the inquest Dr Szentmariay described the level as *'severely high'* and commented that such a level was rarely seen in daily forensic practice. He considered it was reasonable to conclude that at least one of the burst balloons had contained methylamphetamine.

Dr Szentmariay was strongly of the view that Mr Al Refaay had swallowed the balloons, stating that had they been inserted via the rectum it would have been impossible for them to have migrated up the digestive tract to the location where they were found.

In oral evidence to the inquest Dr Szentmariay said that swallowed material generally takes between 8 and 10 hours to reach that part of the small bowel where the balloons were located within Mr Al Refaay. However this process could take longer if the material was, as were these balloons, of a larger size than most foods. Taking this timeframe into account, in his opinion it was feasible that the balloons had been ingested by Mr Al Refaay during the visit he had received the afternoon before his death.

Mr Al Refaay's post mortem urine samples showed the presence of buprenorphine, although his blood sample did not. Dr Szentmariay explained that this drug remains detectable in the blood stream for up to 24 to 48 hours, but for a much longer period in urine. The test results indicated that Mr Al Refaay had ingested the buprenorphine on a separate, probably earlier, occasion to that when he ingested the methylamphetamine.

No other drugs were detected, and there were no external or internal injuries.

The above evidence enables a finding that the cause of Mr Al Refaay's death was acute methamphetamine toxicity. His death was most likely the result of one or more of the ingested balloons which contained methylamphetamine bursting or dissolving internally.

How did Mr Al Refaay obtain the balloons?

It is open to find, based on the medical evidence, that Mr Al Refaay ingested the balloons within the timeframe of the visit he received on 10 April; that is an estimated 12-15 hours before his death. The expert evidence that Mr Al Refaay had swallowed the balloons also strengthens the inference that he obtained them in the course of the visit rather than by some other means: for example, by receiving them within the prison from another inmate or a prison officer. Had he done so there would have been less of an imperative to swallow them. There is a high likelihood that the strip search which routinely follows prison visits would detect contraband concealed on the body, but it would not be capable of revealing goods which had been ingested.

Given this, it was naturally suspected that Mr Mazloom and/or AA may have passed the balloons of drugs and tobacco to Mr Al Refaay during their visit. Both men were separately interviewed and each denied ever having done such a thing.

In his interview Mr Mazloom said that during the 10 April visit he had bought Mr Al Refaay a drink and a packet of chips from a vending machine within the Visiting Centre. He denied using these to transfer anything to him or seeing AA do so. The court heard that visitors are able to buy packets of food from vending machines in the foyer of the Visiting Centre and in the visit rooms. After they are opened the packets are sometimes used to conceal contraband which the visitor has concealed on his or her person. The inmate is then able to transfer the contraband into his mouth under the guise of eating the food. AA said he was unable to remember if he'd seen Mr Mazloom pass anything to him, as he'd been '*fried*' since then.

The evidence tending to support the proposition that Mr Mazloom and/or AA transferred the balloons to Mr Al Refaay is as follows:

- the visit of the two men occurred within the timeframe for Mr Al Refaay's digestion of the balloons
- during the visit Mr Mazloom bought a packet of chips and a drink for Mr Al Refaay, a process well understood to facilitate transfer of contraband

- Mr Al Refaay had previously shown an intention to receive contraband using the visit process (refer paragraph 8 above).
- AA was subsequently involved in an apparent attempt to bring drugs into a correctional centre (refer paragraph 12 above)

Notwithstanding the above, I accept the submission of Counsel Assisting that the evidence is not sufficient to be satisfied that either these two men was responsible for bringing the balloons into the visiting area. Both men denied having done so. It can be inferred that none of the supervising officers observed anything untoward, as no reports ensued. Although CCTV cameras are in operation in the visiting rooms, by the time the relevant footage was requested it had been recorded over due to the then policy of retaining footage for seven days only. Mr Al Refaay and Mr Mazloom had had a number of phone conversations in the weeks leading up to 10 April, but when the recordings of their conversations were listened to they did not contain anything of a suspicious nature. Finally, it was acknowledged by correctional officers that transfer of contraband via the visiting process is by no means the only way inmates can get access to it.

As regards the circumstances of Mr Al Refaay's death, there is some evidence that he was being physically threatened by a fellow inmate or inmates to bring contraband into the gaol. The investigation was not able to produce sufficient evidence that this was the case. Nevertheless it remains a possibility, and further underlines the harm that can ensue when contraband is able to be introduced into the prison environment.

There is no evidence that Mr Al Refaay ingested the balloons with the intention of taking his own life.

The issue of contraband in LBH

The inquest heard evidence from a number of senior CS officers, all of whom acknowledged that the bringing of contraband into LBH is an ongoing problem with serious consequences for the health and welfare of inmates and staff. Just one of its malign effects is the enabling of a black market in goods inside prison with accompanying violence and intimidation. Another is the high risk of serious injury or death which accompanies the methods of concealment needed to avoid detection. The court heard evidence from Terence Murrell, General Manager of Custodial Corrections within CS, that for these reasons the introduction of contraband into prisons was a very significant concern for the Commissioner and the focus of much attention as to how to reduce its incidence.

As regards the scale of the problem at LBH, at the inquest Mr Murrell acknowledged that collectively LBH1 and LBH2 have a relatively high rate of detection of contraband. This he attributed in part to it being a transit and remand centre and therefore housing inmates who are in a less stable state of mind than those who have already been sentenced.

Statistics were provided to the court of the incidence of contraband being detected in LBH, but these did not identify which of the various methods of entry had been utilised. In many cases this information is simply not available. In addition to use of the visit process, known methods include introduction by mail, by means of prison officers and others who provide goods and services to the prison, the use of drones, and items being physically thrown into centres.

As a result it was not possible to be precise about the number of times there had been attempts, successful or otherwise, to introduce contraband into LBH by means of transfer from a visitor. One officer, Senior Correctional Officer Brendan Flanagan, believed there may typically be as many as five such incidents per month but he acknowledged this was an estimate only. He agreed with the proposition of Counsel Assisting, that given the difficulties of surveilling the large numbers of people in the LBH visit rooms (inmates and visitors alike), the most effective preventive approach would be to attempt to detect contraband on the visitors themselves before they had the opportunity to bring it into the visit rooms.

However this approach is problematical. There are many ways in which a visitor might conceal goods on his or her person. By comparison, the measures for detection which CS officers are permitted to take are limited by statutory and privacy considerations. Upon entering the Visiting Centre, visitors are required to put handbags and loose personal items into a locker in the foyer. They must also walk through a metal detector and have shoes and belts screened by an x-ray machine. However small items concealed under clothing or inside the mouth might well escape detection. Nor do CS officers have the powers of police officers to detain and search visitors on suspicion they are carrying contraband.

Mr Murrell acknowledged that targeting visitors to reduce the incidence of visitor-introduced contraband requires a careful approach. Maintaining relationships with family and friends is very important for inmates' welfare, and for their reintegration into the community once released from prison. For this reason there is a need to make the visit environment as humane as it may be, in particular for the sake of children who are visiting. On the other hand, as Senior Correctional Officer Flanagan emphasised in his evidence, CS owes a duty of care to inmates and staff to eliminate as far as possible the risks posed to them by introduction of contraband into the prison environment.

Question of recommendations

With the above in mind, at the close of the evidence three recommendations were proposed by Counsel Assisting, designed to reduce the incidence of visitor-introduced contraband. These appear in italics below.

That consideration be given, in circumstances where there is evidence of an attempt by a visitor

to smuggle contraband to an identifiable inmate, to formalising the process of notification:

- *by requiring notice in writing to be provided to the relevant intelligence officer of that attempt; and*
- *by requiring that an alert notification be placed on the inmate's Inmate Profile Document concerning the attempt.*

As noted in paragraph 9 above, an alert was not placed on Mr Al Refaay's Inmate Profile after his unsuccessful attempt on 29 January 2016 to receive tobacco from a visitor. The evidence was that such a notification would not always occur, in particular where the attempt was unsuccessful. In addition the court heard there is no process, after such incidents, for a written notification of the attempt to be made to LBH's intelligence officer. I accept that both measures would be desirable, in the interests of prompting a higher level of vigilance of inmates in similar circumstances to those of Mr Al Refaay. Submissions made on behalf of the Commissioner of CSNSW indicated his support for this recommendation.

- *That consideration be given to increasing the period of time at Long Bay Hospital within which CCTV footage of the visiting area is retained, from 15 days to 30 days.*

After Mr Al Refaay's death the period of retention of CCTV footage of the visits area was increased from 7 to 15 days. However at the inquest, Senior Investigation Officer Graham Kemp expressed that there are cases, such as that of Mr Al Refaay, where a longer retention period was necessary. Submissions made on behalf of the Commissioner were that the feasibility of this extension will be investigated.

- *That consideration be given to trialling the use of a low dose body scanner for adult visitors visiting inmates at Long Bay Hospital, having due regard for any relevant statutory and privacy considerations.*

This proposal is directing at increasing the prospects of detecting contraband before it is able to reach the visit rooms. Low dose scanners are designed to detect items concealed under clothing. Their reflected waves are reconstructed into a 3D image which does not show human anatomy, but highlights the area of the body where an item has been concealed. Evidence was heard that low-dose scanners are in use in some privately run correctional centres in NSW, but only in relation to inmates. They are also in use for passenger screening at some Australian airports.

There are evident legislative, privacy and resourcing considerations surrounding this proposal. There is also however the potential for it to enable drugs and other contraband to be detected before they have even reached the visit rooms. Submissions made on behalf of the Commissioner undertook to evaluate the success of the scanners being trialled in the privately run facilities and assess whether their use in CSNSW centres is warranted and feasible.

I make all three recommendations, for the consideration of the Commissioner.

In closing, I make the following comments in relation to three issues which were canvassed in evidence at the inquest. These were the prohibition of vending machines, the level of staffing in the Visiting Centre, and whether additional training in use of the existing x-ray machines is required.

In their evidence two senior correctional officers expressed the view that the vending machines in the visit rooms and foyer ought to be removed. They argued this would eliminate one of the methods by which contraband is transferred to inmates via the visits process. In his oral evidence Mr Murrell acknowledged this, but drew attention to the importance of enhancing the visit experience for inmates and families. He also pointed out that there remained other ways by which contraband could be transferred from visitor to inmate during the visit.

The question of whether it would be good policy to remove these vending machines requires balancing the sometimes conflicting imperatives of security and inmate welfare. I note the position put by the Commissioner in response to this issue, that vending machines at LBH will not be entirely removed unless it has been established that food packets are an identified method of transfer. As regards this, the anecdotal evidence of the operational officers at inquest indicated this was a method employed for transfer of contraband. In light of this the Commissioner may wish to consider the evidence of Senior Officer Flanagan, that allowing the vending machines to contain only small packaged goods such as chocolate bars may at least reduce the scope of the problem.

As regards the other two issues, one senior correctional officer mentioned in the course of his evidence that he did not believe he was able to sufficiently recognise suspicious items on the screen of the x-ray machine through which visitors' shoes and belts must pass. He suggested this may be the case with others officers as well. His evidence may prompt the governor of Long Bay Correctional Facility to enquire if officers believe they need remedial training in the use of these machines.

Finally, operational officers who gave evidence commented that at busier visit times (mainly Saturdays and Sundays) they would be assisted with additional resources to supervise inmates and visitors. In his evidence however Mr Murrell stated that staffing levels had been agreed in consultation between management and the relevant unions. The inquest did not hear detailed evidence about the adequacy of staffing levels in the visit rooms so I do not make this the subject of any recommendation but note the comments of operational staff, for the attention of the Commissioner.

Conclusion

On behalf of all at the NSW Coroner's Court, I express sincere sympathy to Ms Symanska and to her daughter for the loss of Mr Al Refaay. I also express my thanks to Mr Aitken, Counsel Assisting the inquest, to Mr Bell of the NSW Crown Solicitor's Office, and to the NSW Department of Communities and Justice, Legal, for their assistance.

Findings required by s81(1)

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

Identity

The person who died is Ossama Al Refaay.

Date of death:

Ossama Al Refaay died on or about 11 April 2016.

Place of death:

Ossama Al Refaay died at Long Bay Correctional Facility, Malabar NSW 2036

Cause of death:

Ossama Al Refaay died as a result of acute methamphetamine toxicity.

Manner of death:

Ossama Al Refaay died as an inmate of Long Bay Hospital, when a balloon or balloons filled with methylamphetamine which he had swallowed burst or dissolved inside his abdomen.

<u>Recommendations</u>

That the Commissioner of Corrective Service New South Wales consider:

- *In circumstances where there is evidence of an attempt by a visitor to smuggle contraband to an identifiable inmate, formalising the process of notification:*
  - *by requiring notice in writing to be provided to the relevant intelligence officer of that attempt; and*
  - *by requiring that an alert notification be placed on the inmate's Inmate Profile Document concerning the attempt.*

- *Increasing the period of time at Long Bay Hospital within which CCTV footage of the visiting area is retained, from 15 days to 30 days.*

- *Trialling the use of a low dose body scanner for adult visitors visiting inmates at Long Bay Hospital, having due regard for any relevant statutory and privacy considerations.*

7. 214323 of 2016

Inquest into the death of L. Findings handed down by Deputy State Coroner Ryan on 30th April 2019 at Lidcombe.

Introduction

Section 81(1) of the *Coroners Act 2009* [the Act] 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 L.

On 14 July 2016 L aged 43 years died at Parklea Correctional Centre. L was on remand awaiting trial on criminal charges. As L was in custody, the responsibility for ensuring that he received adequate care and treatment lay with the State. Pursuant to sections 23 and 27 of the Act an inquest is required when a person dies in custody, to assess whether the State has discharged its responsibilities.

The role of the Coroner

Pursuant to section 81 of the Act a Coroner must make findings as to the date and place of a person's death, and the cause and manner of death. In addition the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

L's life

L was born on 30 January 1973 to parents EAP and CG. He had two older sisters, W and C, and the family lived in a farm house 30 kilometres from Grafton NSW. When L was only 14 years of age his father died, and L left school to get a job. In 1999 L married A, whom he had met through the sport of archery. The couple lived in Grafton and had two children. L worked in the telecommunications industry and A in accounts management.

On 25 September 2015 L entered custody awaiting trial on criminal charges, and died there ten months later. Each day of this inquest was attended by L's wife A supported by her own mother, and L's mother and his sister W. At the close of the evidence they all spoke lovingly of L and it is clear they grieve his loss deeply. They told the court of his generosity as a son, husband and brother and of the love and pride he took in his own children and those of his sisters. In particular it saddens his family to think that L died alone, separated from them.

L's custodial history

On 25 September 2015 L was charged with multiple offences of aggravated sexual and indecent assault of girls under 16 years of age. He was refused bail and was incarcerated in Grafton Correctional Centre. The following month he was moved to Cessnock Correctional Centre, and then on 5 November 2015 to Parklea Correctional Centre [Parklea] which is located in metropolitan Sydney. At his own request L was being held in Special Management Area Placement due to the nature of his charges. A Supreme Court bail review hearing had been listed for 2 August 2016.

This was the second time L had been charged with child sex-related offences. In 2014 he was charged with offences of possessing child abuse material, indecent assault, and firearms offences. He received a sentence of fifteen months imprisonment and was released to parole in June 2015. Three months later he was charged with the further offences referred to above. The court heard that a trial for the new charges was listed for February 2017. L's wife A reported that soon after being charged in 2014 L began to suffer depression and anxiety. His conditions of depression and anxiety did not resolve over his remaining two years, and they played a major part in his death.

Parklea Correctional Centre

From 2009 until 1 April 2019 2009 Parklea was operated by GEO Group Australia Pty Ltd [GEO Group] through a contractual agreement with the NSW Commissioner of Corrective Services. Its operation remained under the oversight of the Commissioner of Corrective Services. The prison has capacity to house up to 800 inmates, a large proportion of whom are on remand awaiting the outcome of criminal charges. Health and psychiatric services for the Parklea inmates are provided by the Justice Health and Forensic Mental Health Network [JHFMHN]; however psychology services for inmates were provided by GEO Group.

Changes to Parklea are forthcoming. First, on 1 April 2019 the operation of Parklea transferred to a new private consortium, MTC/Broadspectrum. Secondly, a new facility is being built and is planned to be in operation by the end of 2019. This will increase Parklea's total inmate population to 1,300. The proposed fit out of the cells in the new facility is of relevance to this inquest and is addressed later in these findings. Parklea was described by a number of witnesses at the inquest as an aging correctional facility, constructed almost 40 years ago. Its inmates are housed in five areas of the jail. L's cell was in Area 2 which could accommodate up to 123 inmates. Area 2 inmates are held in various forms of protective custody and are not able to mix with inmates from the other areas of the jail.

At the time of his death L was housed in a cell with another inmate, GJ. L and GJ had shared this cell for approximately four months. They appeared to have a good relationship and often spoke to each other about their families. Their cell was fitted with a double deck bunk bed, with the uppermost bed occupied by L.

The events of 14 July 2016

On 14 July 2016 L's cell mate GJ was absent from Parklea due to a court commitment, and did not return until later that night. Throughout the day L made a number of phone calls to his wife A. At about 2.15pm he told her he felt depressed and upset that she had formed a new relationship. A tried to reassure him of her support and said she would talk to him the next day, but L told her he was saying goodbye. In accordance with usual routine L was locked into his cell at about 3.15pm.

At 8.50pm two correctional officers escorted GJ back to his cell in Area 2A. GJ entered the cell first and immediately cried out '*Oh, no, no, no'.* The correctional officers followed and saw L hanging from the railing of the top bunk, with his knees almost touching the floor. He had torn lengths from his green bed sheets and plaited them together to fashion a rope. This he had looped three times around his neck and attached to the upper bed railing.

Correctional Officer SL immediately called an alarm. He and his fellow officer then checked L for vital signs but could find none. L's body was limp and cold and he had no pulse. The officers cut the sheet-rope and placed L on the cell floor. When emergency nurses and paramedics arrived a few minutes later they too could find no signs of life. L was pronounced deceased. The post mortem report of forensic pathologist Dr Istvan Szentmariay confirmed that L had died as a result of hanging.

L's psychiatric history in custody

A primary focus of the inquest was the mental health care and treatment L received while in custody at Parklea. It is well documented that prison inmates suffer a disproportionate amount of psychiatric disorder. In addition according to expert psychiatrist Dr Olav Nielssen, who gave evidence at the inquest, almost a quarter of prisoners report symptoms amounting to a diagnosis of a depressive illness or anxiety disorder.

The evidence indicated that L's mental health difficulties started in 2014 when he was charged with criminal offences. He was commenced on the anti depressant citalopram. During his first incarceration he was found to have a '*potentially severe anxiety disorder and/or depression',* and his citalopram medication was continued. To Justice Health clinicians he denied having any current plans to harm himself or to take his own life.

When L re-entered custody in September 2015 he was assessed as needing ongoing psychological and psychiatric care. It was considered however that he presented *'low risk of self harm'*. By this time L was being prescribed the medication quetiapine in addition to his citalopram, to help with persistent sleeping difficulties. He had meetings with psychologists and nursing staff in October, November and December 2015 who recorded his symptoms of anxiety, depression, poor sleep, and loss of motivation.

He was placed on a wait list to see a psychiatrist. Psychiatrist Dr Charles Chan assessed L in Parklea's Justice Health Clinic on 4 February 2016. L told Dr Chan that his family meant everything to him, and that he hadn't seen his children for many months. Dr Chan confirmed a diagnosis of major depression and noted L's ongoing difficulties with insomnia. He increased his dosage of quetiapine, and directed a review in six weeks to assess how L's mood and sleep were responding to the higher dose.

Dr Chan saw L again on 17 March 2016. L was still suffering insomnia and he expressed frustration with his medication and with the inefficiencies of the prison system. Dr Chan decided to cease L's quetiapine and instead prescribe the antidepressant mirtazapine, which has a sedating effect. He maintained the prescription of citalopram, and requested a further review of L to take place in 6-8 weeks.

In fact L never had another face to face psychiatric review. For reasons which are unclear a follow up psychiatric appointment was not immediately fixed. This was noticed on 13 May by mental health nurse clinician Robyn Osborne, who assessed L and directed a psychiatric review. On three occasions in the second half of May a psychiatric appointment for L had to be rescheduled. Then on 2 June L did not attend a psychiatric appointment booked for that day. No reasons have been uncovered for L's non-attendance, or for the need for the May appointments to be rescheduled.

However during April and May L did have meetings with psychologists Nicole Weaver and Andrew Redden, and with Nurse Osborne. At least two of these appointments were arranged by correctional officers who were concerned about L's state of mind. To these mental health clinicians L said he felt his medication was not effective and he voiced frustration that it was taking so long to obtain a psychiatric review. He reported feeling increasingly depressed about the future of his marriage, and his chances of receiving bail. Poor sleep continued to be a problem. On each occasion it is recorded that L denied thoughts of self harm or suicide.

On 27 April, following one of their daily phone calls L's wife A was sufficiently concerned about L that she contacted JH psychologist Andrew Redden. L was interviewed by correctional staff and encouraged to get help if he felt he needed it.

The self harm incident on 27 May and its aftermath

On 27 May L carried out an act of self harm by cutting himself to the chest with a razor blade. L cited rising distress at his family situation and his court proceedings as the cause for his actions.

L's act of self harm triggered a series of processes mandated by Corrective Services protocols. He was placed on what is known as a 'RIT' order. This is made following an assessment by the Risk Intervention Team [RIT], a multidisciplinary team responsible for assessing an inmate's risk of suicide or self harm. The RIT is composed of staff from Corrective Services and Justice Health. Their task is to prepare a management plan with strategies to target the inmate's risk factors.

As part of L's RIT plan he was placed into an assessment cell located within the JH Clinic. Assessment cells have minimal fittings which provide almost no opportunities for hanging points, and have specially designed sheets known as safety blankets that are unable to be torn. Inmates are monitored by means of Closed Circuit television and frequent physical observations. The court heard that, not surprisingly, most inmates find it deeply unpleasant to be in the sterile and isolated environment of the assessment cell despite its physical safety features.

The RIT team assessed L again on 30 May and noted that he was denying any thoughts of suicide or self harm. They determined he could now have '*two-out cell placement*' and be further reviewed on 15 June. An inmate on two-out cell placement shares a normal cell with a selected cell mate, but must not be left alone at any time. The cell mate is to activate the cell alarm if there is any risk the inmate will carry out an act of self harm or suicide.

For L the problem with two-out cell placement was that it made him ineligible to carry out his prison work as a wing sweeper. For many inmates this work is valued because it allows additional time out of the cell, and earns money for privileges. On 6 June L requested that the RIT team review his status and give him normal cell classification once again. The request was denied and L had to wait until the scheduled review on 15 June.

The RIT review on 15 June

On 15 June L was reviewed by a member of the RIT team, Anthony Clarke. Mr Clarke is a Registered Nurse employed by Justice Health. RN Clarke assessed that L could resume normal cell placement. As required by protocol, he discussed his assessment with another member of the RIT team who then co-signed the relevant Notification Form.

RN Clarke's notes of the review are very limited, recording only that L *'denies recent or current self harm of suicidal thoughts'*. At the inquest RN Clarke expressed regret that he had not more fully documented L's review. He described the JH Clinic environment as '*routinely chaotic*' due to its workload and thought it likely this had impeded him from completing proper notes that day. However he told the court about his usual practice when conducting such reviews. This was to carry out a risk assessment based on questioning and observation. RN Clarke was aware of L's desire to resume his work as a sweeper, which he (RN Clarke) regarded as an important safeguard for an inmate's wellbeing. He was certain that he would have documented any concerns had he assessed there to be any.

As a result of the review L was able to return to his shared cell in Area 2A. In the last two weeks of his life he made numerous phone calls to his wife. In many of these he expressed feelings of hurt and sadness and of not being able to carry on. His cell mate GJ stated that L's mood was '*like a roller coaster*', worried and upset about his future one day and happier the next. He said that the night before he died, L was talking to him about his upcoming Supreme Court bail application.

Four days after L's death his wife A received a letter in the mail from him dated 7 July. He asked her not to read it until the day fixed for his bail review. In the letter he expressed hurt that A had someone else in her life. He wrote that if he didn't get bail he could not *'do another nine months of this'* and that *'not being with you and the kids is slowly putting me deeper and deeper into depression as without you and the kids in my life it is not worth living'.*

The cause and manner of L's death

The autopsy report of pathologist Dr Istvan Szentmariay recorded the direct cause of L's death as '*hanging'*. L's family has expressed a preference that the cause of his death be recorded as '*asphyxiation by ligature'*, and this is what I have done.

As for the manner of L's death, the evidence above is more than sufficient to find that L died as a result of an intentional act to end his own life. He had a significant depressive disorder and he was deeply pessimistic about the future of his marriage and the prospect of facing a lengthy time in prison. L took what steps he could while in jail to address his mental health. He actively sought mental health services and did what he could to maintain his work as a sweeper. Sadly his situation overwhelmed him. It was in these circumstances of deep depression and despair that L made the decision to end his life.

The issues at inquest

The manner of a person's death also encompasses the circumstances in which the death occurred. In L's case the circumstances explored at the inquest were L's state of mental health, the contribution it made to his death, and the adequacy of the mental health services he received as an inmate at Parklea. The inquest also examined certain other issues with the aim of considering what might be done to reduce the incidence of suicide hanging deaths in custody. L's death in a state of despair is sadly not uncommon in NSW prisons. The Coroners Court is obliged to examine whether reasonable steps can be taken to reduce the incidence of these terrible events, which impact the lives of so many people. These include not only the families of those who have died, but also those who live and work within the prison system.

In examining what preventive measures might feasibly be taken, the inquest heard evidence about the availability of hanging points in the cells. The inquest also examined certain other issues with the aim of considering what might be done to reduce the incidence of suicide hanging deaths in custody. Parklea and what steps have been taken, and may still be taken, to reduce their presence.

The report of Dr Olav Nielssen

The Court was assisted with expert evidence from Dr Olav Nielssen about L's state of mental health and the adequacy of his mental health care.

Dr Nielssen is well qualified to provide this assistance. He is a consultant psychiatrist with many years' experience providing specialist services for prison inmates. During the years 1993 to 2008 he was a Visiting Psychiatrist for Justice Health, in which role he provided psychiatric services to Parklea inmates for a period of time. Among his current appointments he is a Visiting Psychiatrist at St Vincent's Hospital Sydney and a Clinical Professor of Psychiatry at Macquarie University Faculty of Medicine and Health Sciences.

From his review of the evidence, Dr Nielssen confirmed that around the time of his death L was most likely suffering a major depressive illness, with symptoms of depressed feelings, negative ruminations, suicidal thoughts and poor sleep. L had probably developed this condition in response to being charged with criminal offences in 2014, and it appeared to have become more severe in the months before his death. Dr Nielssen was asked his opinion as to the appropriateness of L's medication while in custody. In his view L was prescribed the appropriate medication for his conditions, namely citalopram for depression and mirtazapine to help address ongoing issues with sleep.

Regarding the medical care L received for his mental health issues, in Dr Nielssen's opinion this was *'of an adequate standard and was appropriate to his reported symptoms'.* He noted that L had a number of appointments with a mental health nurse and with prison psychologists, and two with a specialist psychiatrist. Furthermore the prison health services responded promptly to each sign of suicide risk by arranging mental health treatment and review, and restricting L's opportunities for self harm after the incident on 27 May.

Indeed, Dr Nielssen considered the level of mental health treatment provided to L was *'far better than that received by most prisoners in similar circumstances'.* This statement however must be seen within a context in which, as Dr Nielssen described it:

- there is a disproportionate amount of psychiatric and psychological disorder in the prison population
- mental health care cannot be delivered efficiently in prisons, due to the limited time prisoners are allowed outside their cells
- he has regularly encountered prisoners who have not yet been assessed despite having months of untreated symptoms.

Dr Nielssen was also asked to comment on the fact that L did not receive a psychiatric review after 17 March 2016. In his opinion this ought to have occurred, notwithstanding the Clinic's heavy workload. It would have provided an opportunity to consider whether a different antidepressant might have provided better results for L over time. However Dr Nielssen was not willing to assert that had L received a psychiatric review after 17 March, this may have altered the tragic outcome. In his opinion the triggers for L's depression were largely external, being his family and his court situation. Medication alone was unlikely to be able to alleviate L's mental ill health – recovery would require him to develop a different way of approaching his problems.

Dr Nielssen was also asked whether the decision on 15 June to restore L to normal cell placement was appropriate. He acknowledged that when viewed in hindsight, it was not. Nevertheless from a prospective point of view the decision was '*reasonable and understandable'*. The self harm of 27 May was of a superficial nature, and to his clinicians L consistently denied suicidal plans. He was also keen to resume his work as a wing sweeper, which Dr Nielssen agreed can be a therapeutic activity. For these reasons Dr Nielssen was not willing to conclude that the decision was an unreasonable one.

Conclusions regarding L's mental health care

Considering firstly the appropriateness of L's medication, this was a concern held by L as well as by his family. Nevertheless in Dr Nielssen's view L was receiving the proper medication for his condition. There is no basis to reject this opinion. When considering L's dissatisfaction with his medication moreover, Dr Nielssen's comments need to be borne in mind: that the causes of L's depression lay very much in his situation, and that it was unlikely that medication was capable of removing the stresses imposed by it.

Turning to the adequacy of L's mental health care, it remains unclear why he did not receive further psychiatric review after 17 March. It is also unclear why L did not receive any psychological services in the seven weeks following his self harm incident and his death on 14 July. Nevertheless Dr Nielssen was unwilling to conclude that a greater frequency of psychiatric and psychological services would have led to a better outcome for L, for the reason referred to in paragraph 50 above. Given this evidence I accept the submission of Counsel Assisting, that it is not apparent that any changes to L's care and treatment would have necessarily prevented his death.

As for whether the care and treatment L received was of an adequate standard, this was Dr Nielssen's view albeit one which ought to be seen within the context of his opinion that prison mental health services overall are overstretched and inefficient. I accept Dr Nielssen's opinion regarding L's care and treatment in Parklea.

The adequacy of custodial mental health services generally

The above conclusion ought not be taken as acceptance of the proposition that overall resourcing for prison mental health services is adequate. This issue was outside the scope of the inquest and it is not appropriate to make specific findings about it. Nevertheless in keeping with the preventive role of the Coroners Court, it is appropriate to highlight in a general sense, evidence received at the inquest about the under resourced nature of mental health services within NSW prisons and the risk this presents.

In addition to that of Dr Nielssen the court heard other evidence about the overstretched nature of prison mental health services.

Mr Trevor Perry is Service Director of Custodial Mental Health, Justice Health. At the inquest he commented that the level of resources specifically for custodial mental health services had not matched increases in the NSW prison population. This was a particular challenge for Parklea due to its large proportion of remand and reception prisoners, who require a high level of frontline screening and diagnostic services.

Also tendered in evidence at the inquest was the December 2018 report of the NSW Legislative Council's Committee of Inquiry into the operations of Parklea. Among others the Committee identified as an issue of concern the level of resourcing for mental health services at the prison. Chapter 7 of the report documented evidence of the overall increase in inmates with serious mental health issues, and the insufficiency of clinician numbers to provide timely diagnosis and treatment for these inmates. At paragraph 7.32 the Committee concluded:

'It is very clear to us, based on evidence presented during this inquiry, that while the inmate population has increased markedly, and the correctional system has received substantial resources to address this demand, the Justice Health system has not, and thus struggles to meet the vast tide of inmate's health needs'.

The Committee called for '*substantial investment*' in Justice Health services generally and mental health services and infrastructure specifically, commenting at paragraph 7.41:

' …We can only highlight that adequate investment here will protect individual and public health, will enable the provision of care in the setting to which patients are entitled, and will greatly relieve pressure within the correctional system'.

This led to the Committee's Recommendation 14:

'That the NSW Government, over and above its recent investment in mental health services and infrastructure from 2018-19 …provide sufficient additional resources to the Justice Health and Forensic Mental Health Network to enable it to meet the health needs of the NSW prisoner population, and their mental health needs in particular'.

The Parliamentary Committee's recommendation seems particularly timely, given that Parklea will soon experience a large increase in inmates with the opening of its new facility. The evidence referred to in paragraphs 59-61 gives rise to concern about the capacity of Parklea's mental health services to meet the inevitable increase in demand for care.

What can be done to reduce the incidence of hanging deaths in custody?

Bearing in mind the above, when considering what recommendations if any might fairly arise from the facts in this inquest, the court confined itself to examining whether any measures might be undertaken to reduce the opportunities for inmates to end their lives in the way L did. Written submissions made on behalf of L's family documented nine suicides by hanging at Parklea between 2010 and May 2017. Five of these took place in 2016 and 2017, in each case by means of a rope fashioned from bed linen and anchored to an area within the cell. In all cases the inmate had been cleared for normal cell placement.

These figures highlight that the risk of hanging is present even in the case of inmates who are not identified as '*at risk'*, bearing out Dr Nielssen's observation that suicide in jails is difficult to predict and the importance of minimising opportunities for it.

Suicide mitigation strategies at Parklea: hanging points

There have been attempts to implement suicide mitigation strategies at Parklea. Their primary focus has been to reduce the risk factors posed by the fittings within cells. Hanging points are a well recognised problem in the custodial environment, and have long been a matter of coronial concern. In older correctional centres such as Parklea the risks are heightened because the design of their fittings tends to present greater opportunities for self harm. The evidence at inquest included photographs of the furniture and fittings within L's cell. Even to the layperson it is apparent they offer numerous points from which a ligature can be hung, including open style railings at the side and ends of each bunk, and open slat ladders.

In 2012 the GEO Group undertook work at Parklea which replaced taps, spouts and shower heads with designs offering fewer obvious hanging points. This refurbishment was in response to recommendations made by CSNSW following the hanging death of an inmate TH. At that time GEO Group recorded it was undertaking a more extensive review of the risks posed by other fittings, including curtain rails, shelving and bunk beds.

The 2017 Action Plan

A review by GEO Group in 2017 resulted in the document *'Action Plan – Vulnerable Inmate Management and Suicide Prevention Strategies'.* The stated objectives of the Action Plan were to:

- review and identify the most appropriate and cost effective way to significantly reduce and eliminate obvious hanging points in Parklea's normal placement cells
- implement a funded project to remove obvious hanging points identified within Parklea's normal placement cells.

The Action Plan strategies included removal of fixtures such as shower curtain railings, metal louvres fitted to windows above the cell doors, and metal bars anchoring shelving units to walls. In the 2017 inquest into the death by hanging of another Parklea inmate P, her Honour Magistrate Grahame recommended that urgent funding be provided to implement these strategies.

In the current inquest the court heard that the work recommended in the 2017 Action Plan has largely been completed. This is a positive development, and evidences commitment by those responsible for Parklea inmates to reduce the known risks of hanging deaths. It is also commendable that the 2017 Action Plan recognised that suicide risk is present in normal placement cells, and not just in special cells for *'at risk'* inmates.

However, it will also be noted that the risk posed by bunk bed design did not form any part of the Action Plan strategies.

The report of Perumal Pedavoli Architects

In 2018 CSNSW engaged Perumal Pedavoli Architects [PPA] to identify ligature risk issues in normal placement cells. PPA was asked to review all the cells in Parklea's Areas 1, 2 and 3. The result was a preliminary report titled '*Review of Ligature Points in Existing Cells'*. The PPA team reviewed a wide range of fittings including bunk beds, cell windows, cell desks, door handles, wash basins, and light fittings. Of relevance to this inquest, the bunk beds reviewed by PPA included the same design as that which L had used to end his life. The PPA report confirmed that these beds and others of similar design in use '*present numerous ligature risks due to gaps, openings'.*

However the PPA authors cautioned that looking at individual fittings in isolation from the remainder of the cell environment '*would not result in a safer cell*'. A '*whole of cell'* design solution was needed which would address all the identified major risk items. They commented at Part 7.2 of the report:

'The design of the furniture in the Parklea cells does not lend itself to any form of rectification that would eliminate all ligature risks. Each cell type differs due to retro fitted items installed over the life of the prison. Some issues are simply not able to be fixed without replacement. The cell furniture should be removed and replaced with custom built items designed to current standards'.

The PPA report concluded that further work was needed to address the identified risks at a more specific level. Despite this the inquest heard there are no current plans to commission further consultants to address at a more specific level the issues identified in the PPA report.

The reasons were articulated by Ms Julie Ellis, who is a Director of CS's Governance and Continuance Improvement Division. With reference to the PPA report she commented in the second of her two statements:

'It will be apparent from that high level review that a permanent solution that would reduce significantly (or entirely eliminate) all hanging risk would require complete refits at a significant cost. There are clearly major infrastructure and cost constraints that would require high level government budgetary commitments before that could occur'.

The evidence therefore is that aside from the work being undertaken for the new facility discussed below, no further work is planned to replace or refurbish the fittings and furniture in Parklea cells, or to otherwise address the suicide risks they present.

The new facility at Parklea: proposed fit out

Before moving on to the question of whether recommendations should be made, it is relevant to make some observations about the proposed cell design for the new facility at Parklea. The new facility is expected to become operational later this year and will have capacity to house 400-500 more inmates, increasing total capacity to about 1300 inmates.

At the request of the Coroner the inquest was provided with information about the designs which are proposed for the fit out of the new cells, with the caveat that the designs may be subject to change. Acknowledging this I will not comment on the details of the proposed designs, except to say that when the designs are examined it seems clear that one of the objectives has been to reduce the availability of hanging points in the cells. In the new two inmate cells the proposed beds are not double bunk style, eliminating the need for ladders and safety railings. In the new single inmate cells there is a redesigned double bunk bed which we were advised was to address likely increases in inmate population. The proposed double bunk bed design does not incorporate any open areas in its ladder or upper bunk railing. The designs for both types of cell show shelf units set into the wall without anchoring bars.

It is evident even from the perspective of a layperson that the designs if adopted would reduce many of the risks identified by the PPA authors in the older style cells of Areas 1, 2 and 3.

Question of recommendations

After a careful review of the evidence, Counsel Assisting the inquest proposed that three recommendations be made. Submissions in response to the proposals were received from L's family, and from CSNSW and Justice Health. GEO Group and the Nurses and Midwives' Association declined to make any submissions. The new operator of Parklea, MTC/Braodspectrum, was also invited to respond to the proposals but declined to do so.

The first proposal is that CSNSW and/or the new Parklea operator MTC/Broadspectrum consider reviewing the method by which inmates are called to a Clinic appointment by announcement over the PA system, and that other options be explored as additions or alternatives.

I have noted that in L's final weeks, three of his psychiatric appointments had to be rescheduled and he failed to attend his final one. The inquest was told by GEO Correctional Officer WA, and by Manager Tony Mannweiler that they were aware of instances where inmates had missed appointments due to not hearing the PA notification because of noise levels in the recreational yard. Further, in his statement Mr Trevor Perry said that some protected custody inmates like L may be reluctant to attend the Clinic in answer to a call that identifies them over the PA system.

Submissions on behalf of the Commissioner for CSNSW were that announcements via the PA system were not the primary means by which inmates were notified of Clinic appointments. Inmates were informed of the time of their appointment at the morning muster. Nevertheless the Commissioner undertook to attempt to improve the clarity of the PA announcements.

Through her representatives, L's wife A strongly supported the proposal that there be a review of the above method of calling inmates to a Clinic appointment. In her evidence at the inquest A mentioned L telling her that he had not been able to hear his name being called over the PA system. I adopt this proposal. Given the importance of such appointments and the overstretched nature of prison mental health resources, every effort should be made to minimise impediments to attendance.

The second proposal is that CS and/or MTC Broadspectrum consider examining options for using tear resistant sheets in normal placement cells. Counsel Assisting noted that L appeared to have had little difficulty tearing and twining his standard bed linen into a ligature. The submissions on behalf of the family documented four other instances in 2016 and 2017, in which Parklea inmates had hanged themselves using their bed linen.

The Court heard that the only alternative currently in use, the safety blanket used in assessment cells, is notoriously uncomfortable because it has metallic thread through its fabric. This is what makes it tear resistant. In their submissions L's family supported this proposal. Submissions made on behalf of CSNSW were that the safety blanket was not a viable option for general use because its discomfort would impose hardship on inmates.

It is not proposed that the safety blanket replace existing bedding for normal cell placements. The proposal is that options be explored for an alternative to the existing sheets which would provide greater resistance to tearing. Although Ms Ellis told the inquest she was aware there had been such research over the years she was unaware of the details. This is not a criticism of her evidence, as the specific issue of prison sheets emerged as an issue during the inquest and was not specifically identified before it commenced.

In my view there should be work done to explore and cost an alternative to the standard issue bed linen which is more resistant to tearing. In my opinion this project is justified by the prevalence within the custodial environment of hanging with the use of bed sheets. If there is a viable alternative this would represent a useful suicide mitigation strategy. The third proposal is that consideration be given to replacing the existing bunk beds in Areas 1, 2 and 3 with a design similar to that proposed for the new facility. Counsel Assisting in her submissions acknowledged the likely unfeasibility of replacing all fittings and furniture in Areas 1, 2 and 3. In her submission however replacing the bunk beds should be considered as going some way to addressing the particular risks they presented.

At the inquest further information about the design of existing beds in Areas 1, 2 and 3 was sought and obtained from CSNSW, and tendered as Exhibit 2. This material shows that Areas 1, 2 and 3 contain almost 300 double bunk units. By reference to photographs included with the material it can be seen that 92 of these bunk units are identical to that which L used to end his life. They feature open space railings at the side and at each end of the bunks, and open slat metal ladders. The other approximately 200 bunk beds in use in Areas 1, 2 and 3 are substantially similar, with many visible hanging points. This thumbnail analysis by no means provides a comprehensive assessment of the risk presented by the current bed fittings, but it is sufficient to identify that the number of Parklea inmates who are using bed furniture that has been described as offering numerous ligature points is very significant.

Submissions made on behalf of CSNSW did not support the proposal that consideration be given to replacing the bunk beds in Areas 1, 2 and 3. The submissions highlighted the very substantial practical and financial implications that would be involved. These included:

- the absence of evidence at this stage that bed units designed for a different cell would be able to fit into the existing cells of Areas 1, 2 and 3

- the questionable effectiveness of retrofitting existing cells with new and safer furnishings, noting the comments made by the PPA authors at paragraph 76 above, that such an exercise may not result in a safer cell unless a '*whole of cell'* approach was taken

- the costs of retrofitting the existing cells, which '*may prove no less prohibitive than rebuilding the facility*'. As observed by Ms Ellis in her evidence, such costs would require a high level of government budgetary commitment. Further, CSNSW would need to consider similar measures across its network of NSW correctional facilities

- the practical impediment of finding alternative accommodation for hundreds of Parklea inmates while the refit took place.

With reluctance I have come to the view that however necessary and desirable it is that there be mitigation of the risk presented by the existing bunk beds in Areas 1, 2 and 3, it would not be feasible to make the recommendation sought. The inquest did not hear any evidence as to whether or not the new safer beds are able to be installed in the older cells of Areas 1, 2 and 3. Furthermore the other fittings within the cells would continue to present ligature risks. I also accept there is a probability that the costs involved in eliminating or substantially reducing existing hanging points as recommended by the PPA authors could exceed the cost of a complete rebuild of those areas. These practical and financial impediments appear insuperable.

For the reasons given above I have determined it is not feasible to make the specific recommendation proposed. However the fact remains that a large proportion of Parklea inmates continues to be housed in environments which present significant self harm risks. The issue is well understood and has been so for a number of years. There is a compelling need for those responsible to mitigate this risk by providing accommodation which conforms with current safety standards.

In closing, and on behalf of the coronial team, I offer my sincere and respectful sympathy to L's family. I hope this inquest has answered some of their questions about his very sad death.

I acknowledge the excellent assistance I have received from those assisting the inquest Ms Palianiappan of Counsel and Ms Skinner of NSW Crown Solicitors Office, and from all legal representatives appearing in the inquest. I also thank Detective Sergeant Joseph Coorey for his investigation of the matter and preparation of the coronial brief of evidence.

Findings

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

Identity

The person who died is L.

Date of death:

L died on 14 July 2016.

Place of death:

L died in his cell at Parklea Correctional Centre, Quakers Hill NSW.

Cause of death:

L died as a result of asphyxiation by ligature.

Manner of death:

L's death was intentional and self-inflicted, in circumstances where he was an inmate in Parklea Correctional Centre.

Recommendations pursuant to section 82 of the Act

1. To the Commissioner of Corrective Services NSW and to MTC/Broadspectrum: that consideration be given to reviewing the method by which inmates are called to a Clinic appointment by announcement over the PA system, and that other options be explored as additions or alternatives.

2. To the Commissioner of Corrective Services NSW and to MTC/Broadspectrum: that options for obtaining tear resistant sheets for inmates in normal cell placement be explored and costed as an alternative to the normal bedding issued to inmates.

I close this inquest.

Non-Publication Orders

Pursuant to section 75(2)(b) of the *Coroners Act 2009 (NSW)* I order that there be no publication of the name or identifying information of the deceased, his spouse, their children, his mother and his sister. Initials may be used as pseudonyms.

Pursuant to section 75(5) of the *Coroners Act 2009 (NSW)* I permit publication of the information contained in these findings in accordance with the above restrictions.

8. 218940 of 2016

Inquest into the death of Rebecce Lyn MAHER. Findings handed down by State Coroner O'Sullivan at Lidcombe on the 5th July 2019

Rebecca Maher was born on 4 May 1980 and was a proud Wiradjuri woman. She was 36 years old when she died sometime before 6:00am on 19 July 2016 in a cell at Maitland police station. Her family have confirmed that they would like me to refer to her as Rebecca.

I acknowledge the Aboriginal custodians of the land on which this Court sits and pay my respects to the elders past, present and emerging.

Rebecca died after she was detained by officers of the NSW Police Force ("NSWPF") at Cessnock just after midnight on 19 July 2016 as an intoxicated person, pursuant to the provisions of Part 16 of the *Law Enforcement (Powers and Responsibilities) Act 2002* ("LEPRA"). An autopsy report dated 25 October 2016 records the direct cause of death as "*mixed drug toxicity*", noting high levels of Alprazolam and Methadone detected in Rebecca's system, the combination of which could lead to respiratory depression and failure. Cannabis and non-toxic levels of other benzodiazepine drugs/metabolites and Mirtazapine (an anti-depressant) were also detected.

As Rebecca died while she was in police custody, an inquest is required to be held pursuant to ss. 23 and 27(1)(b) of the *Coroners Act 2009* ("the Act").

The nature of an inquest

The role of a Coroner, as set out in s. 81 of the Act, is to make findings as to the:

a. identity of the deceased;

b. date and place of the person's death;

c. physical or medical cause of death; and

d. manner of death, in other words, the circumstances surrounding the death.

There was no controversy at the inquest about Rebecca's identity, or about the date and place of her death. The focus of the inquest was therefore the cause and manner of Rebecca's death, in particular, the circumstances leading up to her detention as an intoxicated person, what occurred during that detention and the appropriateness of police action while Rebecca was detained.

A secondary purpose of an inquest is to determine whether it is necessary or desirable to make any recommendations in relation to any matter connected with the death, including in relation to matters of public health and safety.

In preparing these findings, I have been greatly assisted by the Statement of Uncontested Facts agreed upon by the parties in advance of the inquest, as well as the submissions of Counsel Assisting. I have also been assisted by submissions prepared on behalf of each of the interested parties.

The Facts

Background

Personal circumstances

Rebecca lived in Raymond Terrace, NSW since she was a teenager. At the time of her death, her residential address was 22 Windsor Street, Raymond Terrace. She had lived there on and off for a number of years. From around mid-2015, Rebecca lived at that residence with her partner, Kieren Jordan.

Rebecca was the daughter of Debbie Small, who is also from the Wiradjuri group from Mudgee area. Rebecca had three brothers, Justin, Aaron and Chris. Rebecca also had four children: Kaine, Joshua, Mia and Beau. Although Rebecca's children were not living with her at the time of her death, it is clear to me that she was always a part their lives and loved them very much.

Debbie, Kaine, Justin, Justin's partner Aretta, Kaine's girlfriend Candus and her mother Barbara all attended the hearing of the inquest, as did Beau's foster parents, Natalie and Aaron. On the final day of the inquest, Natalie read to the Court a moving statement prepared by Debbie and Kaine, which spoke about Rebecca's kind and caring nature throughout her life towards all people that she met. It also spoke about Rebecca's love of her family and her determination to overcome the very significant challenges that she faced. Their attendance at the inquest is a testament to the love that they had for Rebecca and I thank them for their dignity and contribution throughout the inquest.

Rebecca's history with police and medical history

Rebecca had a lengthy history of dealings with police, which commenced in 1995 when she was a juvenile. At the time of her death, Rebecca was on bail for larceny charges from 18 May 2016 and was reporting daily to Raymond Terrace police station.

Rebecca also had a lengthy history of using illicit and prescription drugs from the age of 15 or 16. In November 2000, records show Rebecca reported "*constant*" use of opiates and five accidental overdoses. From at least November 2000, Rebecca was prescribed Methadone by the Hunter/Newcastle Methadone Program ("Pharmacotherapy Service"). Rebecca continued to regularly consume Methadone on prescription until the time of her death, dispensed either by the Pharmacotherapy Service or, while in gaol, by Justice Health.

Rebecca's medical history indicates that she did not consume alcohol often and, when she did, rarely in large quantities. She did regularly smoke large amounts of cigarettes. In November 2000, Rebecca reported being prescribed various medications for "*asthma/bronchitis*" and continued to regularly report issues with those conditions.

Medical records indicate that, between 2000 and 2013, Rebecca tested positive to Hepatitis C. However, despite NSWPF records to the contrary, Rebecca never tested positive to HIV. Rebecca's autopsy report confirmed that she had antibodies to Hepatitis C but was HIV negative.

In 2001, Rebecca reported using benzodiazepines to manage symptoms of heroin withdrawal. Over time, Rebecca reported increasing consumption of benzodiazepines, both prescribed and obtained on the street. From 2008 to early 2015, Rebecca was regularly prescribed Alprazolam (Xanax) and other benzodiazepines. For much of this period, she was also on the Methadone program.

Starting in about July 2011, Rebecca reportedly started "*doctor-shopping*" (as described in relevant records) to obtain benzodiazepines. Medical records indicate that on three, possibly four, occasions, Rebecca was informed of the risk of overdose if she took benzodiazepines while on Methadone. In January 2016, Rebecca reported being hospitalised for "*accidental overdose*" in relation to heroin twice and in relation to benzodiazepines once.

In January 2016, Rebecca was released from gaol and commenced the Methadone program at the Pharmacotherapy Service. From February to June 2016, Rebecca was prescribed Methadone maintenance therapy of 150mg (30mls) daily, and took this dose most days.

In March and May 2016, urine screening of Rebecca indicated the presence of only drugs she was prescribed, Methadone and Mirtazapine. However, Rebecca's last urine screening on 1 June 2016 indicated the presence of Methadone, two benzodiazepines (Oxazepam and Clonazepam) and Olanzapine (a drug used mainly to treat schizophrenia and other mental disorders). Pharmaceutical Benefit Scheme ("PBS") records for Rebecca indicate that she was not obtaining those drugs from prescriptions filled in her name.

On 14 July 2016, Rebecca saw her GP in Newcastle, Dr Julia Gan, and reported feeling unwell. Dr Gan diagnosed Rebecca with asthma, acute bronchitis, anxiety disorder and a need to stop smoking. Dr Gan prescribed Symbicort, Ventolin and Klacid (antibiotics) for the asthma and bronchitis, Axit 30mg (Mirtazapine) for chronic anxiety and depression, and Nicotinell patches.

Events preceding Rebecca's detention

Sunday, 17 July 2016

On the morning of 17 July 2016, Rebecca had a 150mg (30ml) dose of Methadone at the Pharmacotherapy Service.

Around this time, Rebecca and Kieren exchanged text messages that appear to indicate they ended their relationship. Rebecca subsequently began a relationship with DT and spent time with him that day.

On the evening of 17 July 2016, Rebecca and DT checked into a motel in Mayfield. There was evidence before the inquest that, at that time, Rebecca was quite agitated and appeared to be under the influence of a drug but did not smell like she had been drinking alcohol.

Monday, 18 July 2016

At 8:05am on 18 July 2016, Rebecca had a 150mg (30ml) dose of Methadone at the Pharmacotherapy Service. Rebecca also sent text messages and made phone calls that morning, which, Counsel Assisting submitted, indicate that Rebecca was trying to purchase prescription drugs. Rebecca and DT then travelled by public transport from Newcastle to Maitland, and from Maitland to Cessnock.

In Cessnock, Rebecca and DT each had a consultation with a GP, Dr Gunendra Weerabaddana, at Hunter Valley Medical Practice.

Dr Weerabaddana prescribed Rebecca one Alprazolam 2mg tablet twice a day. Alprazolam is a drug used to treat anxiety and associated disorders. Dr Weerabaddana's prescription authorised the dispensing of 50 tablets. At the time of prescribing, Alprazolam was a "*drug of addiction*" under Schedule 8, *Poisons and Therapeutic Goods Act 1966*.

Separately, Dr Weerabaddana gave DT a prescription for Sildenafil (Viagra). DT had previously consulted with Dr Weerabaddana and had been prescribed Alprazolam (2mg x 50 tablets) on 16 June 2016 and 8 July 2016. At 5:20pm, Rebecca and DT had their prescriptions filled at Priceline Pharmacy in Cessnock. Pharmacist Keith Gael dispensed Alprazolam to Rebecca and Verafil (Viagra) to DT. In a statement provided to investigating police, Mr Gael said that he "*noticed that [Rebecca] was unsteady on her feet and that she appeared to be under the effect of a substance and that she was not functioning normally*". He did not detect alcohol on her.

Shortly after Rebecca's death, DT told investigating police that Rebecca opened the bottle of Alprazolam straight away after leaving the pharmacy, which suggests that Rebecca had Alprazolam there and then. There is some question as to the weight to be given to DT's evidence, in light of his extensive history of drug abuse and pre-existing brain damage. However, DT's account in this regard is consistent with evidence of a pharmacy employee and with Rebecca having been dependent on Alprazolam and needing to alleviate withdrawal symptoms.

At about 6:00pm, Rebecca and DT went to Cessnock police station where, on the suggestion of an officer there, Rebecca called Raymond Terrace police station to inform them that she would report on bail at Cessnock.

DT told investigating police that he and Rebecca then went to a house and consumed crystal methamphetamine ("ice") and alcohol. DT also gave oral evidence about this at the inquest, Again, there is a question about how much weight should be given to this evidence. Given there was no ice or alcohol detected in Rebecca's post-mortem blood sample, it is likely that DT was confusing a memory from an earlier occasion or alternatively that he and Rebecca consumed something that he thought was ice but was something else.

At about 9:00pm that evening, Rebecca and DT were seen on South Street in Cessnock. Rebecca asked the passenger of a passing car for money and a lift to Raymond Terrace, and also asked where she was. The passenger described Rebecca as *"…very pale in the face and she was slurring her speech and she was not coherent. She was awkward on her feet and in her movements in general."* She formed the view that Rebecca "*was very much under the influence of something. Whether it was alcohol or drugs or both*".

Events of 19 July 2016

Sergeant Brooks sees Rebecca and DT

Late at night on 18 July 2016, Sergeant Nathan Brooks ("Sgt Brooks") from Cessnock police station was patrolling Cessnock by himself in a police vehicle. Around midnight, he responded to a police radio broadcast of two to four males running into traffic on Wollombi Road near a Seven Eleven service station. When he arrived at the scene, Sgt Brooks drove around for a while looking for those persons.

When Sgt Brooks pulled over across the road from the Seven Eleven, he was approached by the driver of a nearby car who informed him that a girl wearing a pink jumper (presumably Rebecca, who was wearing a pink or orange coloured jumper at the time) had jumped out in front of his car.

Sgt Brooks drove around again and saw Rebecca. Sgt Brooks immediately formed the opinion that Rebecca was intoxicated on the basis that "*[s]he was unsteady on her feet and staggered as she walked*". DT was with Rebecca and it appeared he was trying to get her to sit down.

DT told investigating police and gave evidence at the inquest to the effect that, when they saw police, they "*freaked out*" and he gave Rebecca a pill bottle containing Alprazolam tablets. According to DT, Rebecca indicated that she would hide her bottle of Alprazolam and his bottle in her vagina. He told the inquest that while he believed that was what Rebecca then did, he did not actually see it happen and did not recall whether Rebecca said she had done this.

Sgt Brooks spoke with Rebecca and DT. He then briefly lost sight of them, before seeing what he described in an interview with investigating police as Rebecca "*staggering in the middle of [Wollombi Road] trying to cross the road. A vehicle was forced to slow right down and manoeuvre around her*." Sgt Brooks approached Rebecca and DT again.

Rebecca is detained as an intoxicated person

Sgt Brooks asked Rebecca and DT for identification. DT handed Sgt Brooks his wallet, and Rebecca eventually gave her name and her home address of 22 Windsor Street, Raymond Terrace.

Sgt Brooks then conducted Central Name Index ("CNI") checks on Rebecca and DT. The radio despatcher told Sgt Brooks that Rebecca had failed to report on bail that day. In response to this (incorrect) information, Sgt Brooks called for a caged vehicle so that he could arrest Rebecca.

In addition, the radio despatcher stated that Rebecca may be an illicit drug user and that "*she is HIV and Hep C positive and may inflict self-injury*". This information was recorded against Rebecca's CNI number in the NSWPF database. As noted above, while Rebecca did have antibodies to Hepatitis C, she was HIV negative.

A short time later, a police vehicle staffed by Senior Constable Luke Marks ("SC Marks") and Constable Robert Brown, and a police van staffed by Senior Constable Laurie Coleman ("SC Coleman") and Senior Constable Elizabeth South ("SC South") arrived at Wollombi Road. SC Marks informed Sgt Brooks that Rebecca had reported on bail at Cessnock police station.

A number of officers present at Wollombi Road gave evidence that, at this time, Rebecca alternated between appearing to fall asleep and being responsive. Rebecca was described as slurring her speech and being unsteady on her feet. At times she would stand up and on at least one occasion reportedly attempted to cross the road. It is clear to me that each of the officers formed the view that Rebecca appeared to be seriously intoxicated. Although the officers were unsure of the cause of Rebecca's intoxication, each surmised it to be alcohol or drugs or a combination of the two.

In an interview with investigating police, Sgt Brooks said that DT told him they had been drinking alcohol but denied using anything else. SC South gave a similar account of this conversation during her interview with investigating police. However, in his oral evidence at the inquest, Sgt Brooks said that both DT and Rebecca indicated they had taken drugs earlier that day.

Sgt Brooks decided that SC South and SC Coleman should take Rebecca to Maitland police station to be detained there as an intoxicated person pursuant to s. 206(4) of LEPRA. This provision allows a police officer to take an intoxicated person to an authorised place of detention and detain them there if a responsible person cannot be found to take care of the intoxicated person. There was evidence before the inquest that Sgt Brooks nominated Maitland police station as opposed to the closer Cessnock police station because Maitland had the benefit of a 24 hour custody manager.

Sgt Brooks told the inquest that, in reaching his decision to detain Rebecca as an intoxicated person, he considered releasing Rebecca into DT's care but did not consider him to be a responsible person, as DT was himself intoxicated and had been unable to stop Rebecca from walking out onto the road.

Sgt Brooks said that he did not attempt to have Rebecca taken to her Raymond Terrace home address because he doubted that she lived at that address and assumed there would be no responsible person there. Rebecca had also indicated she was not going anywhere without DT.

At the request of SC South, Rebecca, guided by SC South and SC Coleman, walked to the van and got into the rear of the caged section.

Police do not search Rebecca at Cessnock

Section 208 in Part 16 of LEPRA authorises police to search a person detained as an intoxicated person and to remove any personal belongings found on them.

Sgt Brooks stated that he asked Rebecca and DT whether they had anything in their pockets at the same time he asked for their identification. Sgt Brooks said that DT turned out his pockets but he could not recall whether Rebecca did. He did recall that Rebecca pulled earphones out of her pocket, although no earphones were found in Rebecca's property or clothing after her death.

SC South gave evidence at the inquest that she had originally intended to conduct an ordinary search of Rebecca. However, while SC South was escorting Rebecca to the van, Sgt Brooks said something to SC South which caused her to immediately stop touching Rebecca. Rebecca continued walking to the back of the van. SC South conducted no ordinary search of Rebecca at Cessnock and nor did any other officer.

Sgt Brooks and SC South gave conflicting evidence as to what Sgt Brooks said to SC South while she was escorting Rebecca to the van. SC South told investigating police that Sgt Brooks said to her, "*Did you hear the warnings? … She's got AIDS. Don't search her, just put her in the back of the truck*." SC South told the inquest, "*Sergeant Brooks said something along the lines of 'Just put her in the back of the truck', I from that assumed that he said not to worry about searching her, although I had made my own decision not to search her at that time*". By contrast, Sgt Brooks said he warned SC South that Rebecca had "*HIV and Hep C just be careful*" but denied directing SC South not to search Rebecca. He said that, as a matter of general practice, he does not give directions to escorting police about searches.

SC South and SC Coleman also gave conflicting evidence as to whether SC South asked Rebecca whether she had anything in her pockets. While SC South gave evidence that she performed no more than a "*visual search*" of Rebecca and could not see that she had any pockets, SC Coleman told the Court he heard SC South ask Rebecca whether she had anything in her pockets.

Counsel Assisting submitted that, where there were conflicting factual accounts between SC South and Sgt Brooks and/or SC Coleman, SC South's evidence should be preferred. This was on the basis that she generally presented as a credible witness, who was prepared to make some admissions against her own interests and gave a more nuanced account of events. By contrast, and as will be explored further below, both Sgt Brooks and SC Coleman gave evidence that was not, on occasion, credible.

For the reasons submitted by Counsel Assisting, I do accept the evidence of SC South where it conflicts with the evidence of Sgt Brooks and SC Coleman.

It is clear to me from SC South's evidence that the dominant reason for not searching Rebecca at Cessnock was a perceived health risk of contracting HIV or Hepatitis C from Rebecca. SC South consistently expressed concern that, when she spoke, Rebecca was "*projectile splattering*" such that she thought she might be exposed to an infectious disease. SC South told the inquest that, even if she wore a mask, her eyes would still have been exposed. She said that she was particularly concerned given that, at the time of detaining Rebecca, she thought she might be pregnant. Her evidence was that the only way to avoid the risk of being struck by body fluids from Rebecca would have been to forcibly search her involving two officers, one using their arm to hold Rebecca's head so that it faced away from the officers.

There was also evidence from SC South and Acting Sergeant Greg Hosie ("A/Sgt Hosie") that Rebecca smelled quite strongly as if she had not showered for a few days. As will be explored further below, this may have been relevant to the level of care she received when she reached Maitland police station.

Rebecca and DT enter the van

There was evidence before the inquest that DT picked up a bag from where he and Rebecca had been sitting and, with the consent of police, got into the back of the police van and sat with Rebecca.

SC Coleman and Sgt Brooks gave inconsistent descriptions of the bag collected by DT. Sgt Brooks described a leopard print handbag. This matches the appearance of the handbag that police obtained from DT after Rebecca's death, which contained belongings of both Rebecca and DT. By contrast, SC Coleman described the bag as a reusable shopping bag. He denied seeing a leopard print handbag, but said it was possible that that bag was inside the shopping bag. Counsel Assisting has submitted that this inconsistency does not need to be resolved and I agree.

The evidence was that, at some point around this time, SC South conveyed Sgt Brooks' warning about Rebecca to SC Coleman, although SC Coleman could remember only the reference to HIV.

Rebecca is transported to Maitland police station

SC South and SC Coleman drove Rebecca and DT to Maitland. The trip took between 20 and 30 minutes.

SC South and SC Coleman both gave evidence of hearing Rebecca and DT either arguing or speaking in "*elevated voices*" during the trip. This is consistent with what DT told investigating police. DT said that, during the journey, he asked Rebecca to give him back his bottle of tablets but she refused to do so.

During the journey, SC Coleman telephoned Maitland police station and spoke to the custody manager A/Sgt Hosie. SC Coleman told A/Sgt Hosie that they were conveying to the police station an intoxicated person in a dishevelled state who was HIV positive.

SC South and SC Coleman dropped DT near Maitland railway station and arranged for DT to take Rebecca's bag with him. SC Coleman told the Court that this was because he wished to avoid preparing paperwork caused by entering the bag into police custody. SC South suggested that an additional reason was "*because of the AIDS and all*"; that is, to avoid contracting an infectious disease by handling the bag or its contents.

Rebecca arrives at Maitland police station

CCTV footage indicates that the police van transporting Rebecca arrived at Maitland police station at 1:24am. At 1:25:10am, Rebecca exited the van, stumbling as she did so. She was wearing a pink or orange coloured jumper, three quarter length black pants and shoes.

Rebecca walked through the doorway to the charge room at the end of the van dock corridor, followed by SC South and SC Coleman. At 1:25:26am, Rebecca can be seen to stumble and was held up by SC Coleman.

1:25am – Rebecca is taken to cell 4

At 1:25:39am, Rebecca followed SC Coleman down the van dock corridor to cell 4. The inside of cell 4 was visible to persons in the corridor outside. There were also CCTV cameras in the corridor and one in cell 4. Monitors in the charge room showed the feed from the CCTV cameras.

SC Coleman opened the door to cell 4 and Rebecca entered it. CCTV footage shows Rebecca staggering and falling forward before she pushed herself up and sat on the bench in the cell. SC South and A/Sgt Hosie were standing at or just outside the doorway of cell 4 at this time.

At 1:26:05am, Rebecca removed her shoes at SC South's request, and SC South kicked them out of the cell. SC South threw two blankets onto the floor in the cell. Rebecca pulled the mattress from the wall it was leaning against and spread a blanket out on the mattress. SC South then left the cell.

Warnings, search and opportunity to contact responsible person

At some stage, SC Coleman informed A/Sgt Hosie that Rebecca's CNI check contained a warning as to a risk of self-harm. By this stage, A/Sgt Hosie was also aware of the warning about HIV and Hepatitis C. A whiteboard in the charge room was used to provide information to oncoming police about persons kept in the cells. On that whiteboard, A/Sgt Hosie recorded that Rebecca was being detained as intoxicated and made a notation of "*HIV*" and "*Hepatitis C*". He did not record any other information, including the warning about Rebecca's risk of self-harm, her level of intoxication, or his inability to complete a risk assessment of Rebecca.

A/Sgt Hosie stated in his oral evidence that he did not know why he did not record any further information. He denied that he had been more concerned for the welfare of police than he had for the welfare of Rebecca. However, Counsel Assisting has submitted that this is the only rational inference available. In response, A/Sgt Hosie submitted through his counsel that his actions (in the context of his subjective belief that he was only dealing with an intoxicated person who was "*sleeping it off*" and appeared "*normal*") did not rise to the only inference asserted by Counsel Assisting. In my view it was most likely a combination of both.

It is clear that Rebecca was not searched while at Maitland police station. Both A/Sgt Hosie and SC South provided an account of a conversation where SC South told A/Sgt Hosie that she had not searched Rebecca due to her concerns about contracting an infectious disease, and SC Hosie agreed that it was not necessary in the circumstances.

It is also clear that A/Sgt Hosie did not make attempts to give Rebecca an opportunity to contact a "*responsible person*" after she arrived at Maitland police station, as required under s. 207(2)(a) of LEPRA. A/Sgt Hosie told the inquest that he was not aware of his obligation, as a custody manager, to do so and did not think of making any enquiries.

1:26am – Rebecca asks for food and uses toilet

At around 1:26am, Rebecca asked SC South and then A/Sgt Hosie for some food. SC South responded to the effect that Rebecca would not be fed because she would not be detained for that long. When asked about this at the inquest, SC South stated that the reason she said this was because it was past the cut-off time for provision of a meal. SC South said she was unaware that there was a specific provision of Part 16 LEPRA as to the need to provide intoxicated persons with food and other sustenance appropriate to the person's needs.

The two officers then left the cell and locked Rebecca in. CCTV footage shows Rebecca staggering over to look through the perspex door.

At 1:27am, Rebecca walked over to the toilet. She could not walk in a straight line. The CCTV footage from the camera in cell 4 is limited because the area of the toilet is permanently blacked out for privacy reasons. What can be seen is that Rebecca discarded a piece of toilet paper, dropped the toilet paper roll and struggled to pull up her pants.

The piece of toilet paper Rebecca discarded was discussed by police, who were watching Rebecca on the CCTV monitor in the charge room, as having "*blood on it*". In the police investigation following Rebecca's death, that piece of toilet paper was reported to have on it what appeared to be a bloodstain.

1:29am – Rebecca sits on mattress and slumps forward

CCTV footage shows that, at 1:29am, Rebecca spread one of the blankets out on the mattress then sat down. She rolled up the left leg of her pants.

The quality of the CCTV footage is not good enough to be certain as to exactly what Rebecca did at this point. Counsel Assisting submits that it is possible that Rebecca either retrieved or secured in position a pill bottle. However, on behalf of Rebecca's family, Mr de Mars submitted that I could comfortably conclude that Rebecca did not, at this point, place a pill bottle in the rolled up left leg of her pants, because she would have had to have such a bottle in her hands prior and the CCTV footage show that her hands are empty. The location of the pill bottles is explored in more detail below.

What is clear is that Rebecca sat up on the bed when A/Sgt Hosie came to the door shortly afterwards. They had a conversation through the door, and A/Sgt Hosie returned to the charge room. Rebecca started to slowly slump forward before sitting back upright again. At 1:30am, Rebecca leaned forward, lost her balance and appeared to touch the toilet paper on the floor.

At 1:32am, Rebecca, still sitting on the mattress, leant forward with her arms hanging on the floor and appeared unable to hold herself up before she sat back with her elbows on her knees. She repeated this behaviour a couple more times.

At 1:33am, Rebecca looked as if she was going to fall over onto the floor. In the charge room, A/Sgt Hosie and SC South watched Rebecca on the CCTV monitor. SC South then left the charge room and walked to cell 4. SC South gave evidence that her concern at this point was that Rebecca might fall over and hurt her head, not that she might be losing consciousness.

SC South appeared to speak to Rebecca through the cell door without getting a response. SC South then kicked the cell door and Rebecca sat up. SC South told Rebecca to lie down on the mattress and returned to the charge room.

1:34am – Rebecca lies down on mattress

At 1:34.30am, Rebecca stood up, leant on the mattress and lay down on her right side with her back to the cell CCTV camera. Her right arm was stretched out above her head and her knees were tucked up slightly with her left arm in front of her. Rebecca did not change her position before she died.

Counsel Assisting submitted that the evidence shows that police officers who saw Rebecca on the CCTV monitor screen in the charge room had concerns about her health. SC South gave evidence that she either mentioned to A/Sgt Hosie, or else simply thought to herself, that it looked like Rebecca may have been dead. This was within the hour or so that SC South and SC Coleman remained at the police station after delivering Rebecca.

By 1:34:30am, SC South had returned to the charge room after speaking to Rebecca through the cell door. On more than one occasion, particularly in the early part of Rebecca's detention, A/Sgt Hosie used the zoom function on the CCTV camera for cell 4 to get a close-up view of Rebecca lying on the mattress.

When talking to police investigators on 19 July 2016, SC South said she thought that A/Sgt Hosie had responded to her drawing attention to the fact that Rebecca had not moved and looked as if she may be dead by saying, "*No, I can see her chest rising*". However, in her evidence at the inquest, she said she raised it with SC Coleman.

On the CCTV footage, SC South can be seen to have a series of exchanges with A/Sgt Hosie at around 1:33am. From the gestures made by SC South during the conversation, it appears that at least part of the discussion concerned the reasons she did not conduct a search of Rebecca. SC South is visible in the charge room thereafter, from 1:48:36am to 1:55:10am, and then again from 2:04am to 2:21am, during which periods both A/Sgt Hosie and SC Coleman were also present.

1:55am – Custody Management Record

At around 1:55am, A/Sgt Hosie entered data in the NSWPF computerised custody management record ("CMR") for Rebecca.

There was evidence before the inquest that each CMR has a number of components, including the detained person's details, a brief assessment, a visual assessment, a vulnerability assessment, a questionnaire, and other "*actions*", which relevantly include details of inspections.

The visual assessment, vulnerability assessment and questionnaire are all "*mandatory actions*", which means that, in theory, they must be completed before the CMR can be finalised. However, the inquest heard evidence that it is possible for a custody manager to defer completing the mandatory actions until the point at which the prisoner or detainee was to be released. Each topic or question in the mandatory actions included a section for the custody manager to enter comments.

The NSWPF Custody Management System ("CMS") indicates that A/Sgt Hosie listed the address for Rebecca as her home address of 22 Windsor Street, Raymond Terrace. Against "*ATSI Status – Aboriginal/Torres Strait Islander*", the word "*refused*" appears. The inquest heard evidence that the only options which A/Sgt Hosie could select were "*Yes*", "*No*" and "*Refused*".

The digital record for Detained Person's Details shows that in the field for Next of Kin, the word "*incoherant* [sic]" appears. This does not appear in the printed copy tendered as part of the inquest. A/Sgt Hosie told the inquest that he did not write the word "*incoherant*" in Rebecca's CMR, and that it may have been entered by SC Coleman when he completed the Field Arrest Report. However, there was no field for "*Next of Kin*" in the Field Arrest Report. Further, in the vulnerability assessment section of the CMR, A/Sgt Hosie entered "*Unable to obtain this information due to her intoxicated state*".

A/Sgt Hosie told the Court that, although there were other NSWPF databases he could consult to try to find records of Rebecca's next of kin or someone who could look after Rebecca, he did not give this any consideration. A/Sgt Hosie did not think of making an inquiry as to whether there was anyone at Rebecca's home address who could take care of her that night.

In the visual assessment section, against the topic "*Illness*", A/Sgt Hosie entered the comment, "*Appears to be seriously effected [sic] by intoxicating liquor or drug*". Although scars on Rebecca's left wrist were found on autopsy,P15P A/Sgt Hosie responded to the question, "*Does the person have scars or injuries that suggest previous attempts at self-harm"* with the response *"No".* To the question, "*Does the person appear irrational*", A/Sgt Hosie responded "*No*". In a comment at the end, A/Sgt Hosie wrote, "*Appears to be seriously effected [sic] by intoxicating liquor or drug, seen to be very unsteady on feet*"P158F

In the vulnerability assessment section, A/Sgt Hosie answered four of the six questions "*Not Known"*, including the question "*Is this person Aboriginal or Torres Strait Islander*". As noted above, in the comments for this section, A/Sgt Hosie wrote, "*Unable to obtain this information due to her intoxicated state*".

The inquest heard evidence that the questionnaire in particular is part of a risk assessment process, and is meant to be completed by asking the detainee questions. In this case, the questionnaire, which includes questions in relation to a detainee's health and mental condition, was completed by A/Sgt Hosie without attempting to ask Rebecca any of the questions in it. His evidence was that he did not ask Rebecca any questions because of her level of intoxication.

Counsel Assisting submitted that the requirement to complete the mandatory actions indicate that they are essential to the proper assessment of whether the detainee was in need of medical care. An inability to complete them due to the detainee's condition would necessarily indicate that the detainee was so incapacitated that police were unable to assess whether the detainee was fit to be kept in detention. A/Sgt Hosie's failure to complete the mandatory actions, particularly the questionnaire, was indicative that Rebecca was in a state where she should not have been kept in police detention but instead taken to a hospital.

I accept Counsel Assisting's submissions.

3:00am – Sgt Brooks visits Maitland police station

At around 3.00am, Sgt Brooks arrived at Maitland police station. He spoke with A/Sgt Hosie in the charge room. CCTV footage shows A/Sgt Hosie appearing to mimic Rebecca slumping forward during this conversation. When he was shown this footage at the inquest, Sgt Brooks told the inquest he could not remember "*at all*" what he talked about with A/Sgt Hosie at that point.

Both officers spent a substantial amount of time looking at the CCTV monitor. At about 3:10am, Sgt Brooks conducted a visual inspection of Rebecca from the van dock corridor through the perspex into cell 4. He did not attempt to rouse her. He later said, "*I could see that she was lying on her right side and her stomach was rising and falling*." Counsel for Sgt Brooks submitted that Sgt Brooks observed no abnormal breathing pattern and had no concerns with respect to Rebecca's breathing. He did, however, concede that Sgt Brooks had no medical training with respect to types of breathing patterns that should cause a Custody Manager concern.

Sgt Brooks spent further time in the charge room, mainly speaking with A/g Sgt Hosie. Sgt Brooks was not prepared to speculate in his evidence at the inquest as to the likely topics of conversation with A/Sgt Hosie, and continually responded that he had no recollection of what they talked about.

Counsel Assisting submits, and I accept, that given Sgt Brooks' seniority and experience, and what can be seen in the CCTV footage of the time that he spent with A/Sgt Hosie in the charge room discussing Rebecca, I can be reasonably satisfied that A/Sgt Hosie and Sgt Brooks spent time discussing the general topic of Rebecca's initial detention and her health, including her infection status and the concerns which had earlier been discussed about Rebecca's breathing.

This conclusion is supported by evidence from SC South that she heard SC Coleman say that A/Sgt Hosie had a conversation with Sgt Brooks, in which Sgt Brooks stated that they had to watch Rebecca because her breathing was shallow. Although Sgt Brooks said in his oral evidence that "*there was definitely no discussion*" about Rebecca's health, I note my earlier comments about the credibility of this witness as compared to SC South. I have also taken into account the gestures that Sgt Brooks can be seen to make in the CCTV footage.

Commencing at about 4:43am, Sgt Brooks made entries in police records relating to the events involving Rebecca and DT at Cessnock. Counsel Assisting notes that both sets of entries recorded that Rebecca and DT were "*searched with nothing found*". However, as noted above, Sgt Brooks gave evidence at the inquest that he did not conduct an ordinary search but simply asked Rebecca and DT to turn out their pockets. His evidence was that he had left the searching of Rebecca up to the escorting officers.

I find these two COPS entries to be misleading. They leave the reader with the impression that Rebecca and DT had been searched and nothing was found. A more accurate entry would have been that the pair were asked to turn out their pockets and nothing of interest was seen or seized. On behalf of the family, Mr de Mars submitted that the COPS entries are even more particular in suggesting that a substantive search of Rebecca and DT had been conducted, and that the nature of the entry clearly misrepresents what had occurred. I accept this submission.

Checks conducted on Rebecca

The CMR for Rebecca also comprises a series of additional actions for Inspection. The time and date for each such entry is automatically recorded by the CMS and each entry contains a comment.

The evidence shows, however, that many of the inspection entries made by A/ Sgt Hosie do not correspond with him physically going to cell 4.

Similarly, on a number of occasions where CCTV footage shows that he did go to cell 4 and look into the cell, it is not recorded in Rebecca's CMR. Accordingly, the CMR is not a reliable record of what A/g Sgt Hosie did by way of inspection of Rebecca.

On a number of occasions whilst he was in the charge room, A/Sgt Hosie can be seen to look at the image of Rebecca on the CCTV monitor. A/Sgt Hosie explained to the Court that a number of his inspections of Rebecca were carried out this way. It should also be noted that A/Sgt Hosie relied on the CCTV monitor to conduct inspections of the two other detainees in custody at Maitland police station at the time. However, inspecting prisoners or detainees by looking at them on a CCTV monitor is contrary to the instruction, set out twice, in the Code of Practice for CRIME, to conduct inspections in person.

The CCTV shows that A/Sgt Hosie also conducted six visual checks, which involved him looking through the perspex door into cell 4 from the corridor. During these checks, the lights in the cell were off in Rebecca's cell. They remained off until 5:55:46am. The only source of light was a fluorescent-style night light in the ceiling of the van corridor, outside the cell.

At no point between 1.27am and 5:51am did A/Sgt Hosie or any other officer enter Rebecca's cell and attempt to physically rouse Rebecca to check on her breathing and consciousness level.

Counsel Assisting submitted that there is more than one possible reason why police did not enter Rebecca's cell to physically check on her wellbeing, including:

a) A smell emanating from the cell. Although A/Sgt Hosie denied that this was a reason, the CCTV footage shows him conducting his inspections more than once while covering his mouth and nose with his arm and elbow, seemingly to guard against an unpleasant smell;

b) Lack of knowledge/training. A/Sgt Hosie said he had not been trained to physically attempt to rouse an apparently sleeping intoxicated person to check their level of consciousness. Sgt Brooks and SC Coleman also gave evidence that they were unaware of this requirement; and

c) Lack of concern for Rebecca's welfare relative to concern for welfare of police. Examples of this attitude include: the failure to search Rebecca for fear of contracting an infectious disease; the failure to note on the whiteboard the warnings about Rebecca's risk of self-harm; A/Sgt Hosie's conduct in the charge room in which he mimicked Rebecca's stumbling in the police station as the behaviour of a chimpanzee; and a prevailing sentiment in relation to Rebecca's level of intoxication, which seems to have been to simply "*let her sleep it off*" (that is, to simply accommodate Rebecca and not to care for her).

Counsel for A/Sgt Hosie submitted that the primary reason for police not entering Rebecca's cell was because of their "*collective subjective belief that she was not in danger*". However, Rebecca's family have submitted that, in light of what can be seen on the CCTV footage and other evidence, it is difficult to escape the conclusion that "*distaste*" for the physical state Rebecca was in was a significant factor in the manner in which police dealt with her. I respectfully agree with this submission.

Concerns about Rebecca's breathing

There is evidence to suggest that, from what could be seen on the CCTV monitor of Rebecca lying on the bench on cell 4, police had concerns about her manner of breathing during the first half of her detention.

CCTV footage from the charge room shows several officers, particularly A/Sgt Hosie, spending a relatively long time studying the footage from cell 4. The only movement which was apparent on the monitors, and which therefore could have been the subject of discussion or concern, was a rise and fall in the area of Rebecca's waist and lower back.

The CCTV footage shows that after checking on Rebecca, A/Sgt Hosie had a conversation with A/Sgt Jonathan Cassidy in which he appears to be demonstrating the manner of Rebecca breathing. He can be seen holding his two hands at the left side of his lower torso and making a pushing in movement. A/Sgt Hosie then zoomed in on the monitor screen, and the pair watched Rebecca's breathing on the monitor intently and for an extended period of time.

A/Sgt Cassidy gave evidence that A/Sgt Hosie was expressing concerns about Rebecca due to her breathing, and zoomed in on the monitor. After observing Rebecca on the monitor, A/Sgt Cassidy gave evidence that he was of the view that "*it appeared as though her breathing wasn't normal. You could clearly see her stomach suck in in a sharp motion and was slow to push out*." A/Sgt Hosie denied that A/Sgt Cassidy had said anything to him about Rebecca's manner of breathing. His evidence was that, if A/Sgt Cassidy had said any such thing to him, he would have called an ambulance.

A/Sgt Hosie told the inquest that he either mentioned to another officer, possibly SC Coleman, or thought to himself that he was considering getting Rebecca checked over by an ambulance. However, he said that it was "*just a general consideration because of her intoxicated, dirty state*" and not for a specific reason. He also said it may have been because he had "*noticed the deep breaths*" although he had thought that was "*was just part of her being intoxicated*". SC Coleman said that he raised with A/Sgt Hosie the subject of calling an ambulance, however, A/Sgt Hosie maintained that it was he who raised it.

SC Coleman also gave evidence that he said to A/Sgt Hosie he wouldn't like Rebecca to vomit or choke on her vomit. A/Sgt Hosie denied any recollection of this comment.

Counsel Assisting submitted that a conclusion can be drawn that, at a relatively early stage in Rebecca's detention, A/Sgts Cassidy and Hosie and SC Coleman all had concerns about Rebecca's breathing being abnormal and consideration was given by SC Coleman and/or A/g Sgt Hosie to calling an ambulance. Counsel Assisting further submitted that it reflects poorly on the credit of A/Sgt Hosie that, after being taken to CCTV footage of his apparent conversations with A/Sgt Cassidy and SC Coleman about Rebecca's breathing, during which he made gestures on his torso and his stared intently at the CCTV monitor for extended periods, he did not concede that it is likely he expressed concern to any officer about Rebecca's breathing. I accept these submissions.

5.40am – final recorded inspection of Rebecca

At 5:30.00am, A/Sgt Hosie looked up at the CCTV monitor and then left the charge room in the direction of the muster room. At 5:35.18am, A/Sgt Hosie returned to the charge room and thereafter he moved back and forth from the charge room in the direction of the muster room and back again.

A/Sgt Hosie's final recorded inspection in the CMR is at 5:40am and is accompanied by the comment "*Sighted, sleeping in cell, nil issues*". In this entry, the inspection frequency was also changed from 30 minutes to 60 minutes. While A/Sgt Hosie denied making that change manually, Counsel Assisting submitted that the evidence in relation to the functions of the CMR, which should be accepted, is that the change could only be made manually.

Counsel Assisting submitted that the CCTV footage appears to show that the last movement of Rebecca's waist or lower back was at 5:22:05am. He submitted that it should therefore be concluded that A/Sgt Hosie's final inspection of Rebecca was not only conducted by CCTV monitor, but also that it was not even an attempt at an inspection. By that time, according to what can be seen on the CCTV footage, the movements of Rebecca's waist or lower back had long ceased. Despite this, by 5:40am, A/Sgt Hosie was apparently satisfied that Rebecca did not need close monitoring and, by changing the inspection frequency to 60 minutes, signalled as much to the oncoming custody manager.

Counsel Assisting submitted, and I agree, that it should be concluded that, at least by 5:40am, despite the entries he was making in the CMS, A/Sgt Hosie was not making serious attempts to monitor or inspect Rebecca.

CCTV footage shows that, at 5:51am, A/Sgt Hosie looked at the CCTV monitor in the charge room and then walked down to cell 4. A/Sgt Hosie looked through the perspex at Rebecca and moved his head closer. He knocked on the perspex a number of times. Rebecca did not respond.

At 5:52:32, A/Sgt Hosie walked away in the direction of the muster room and, shortly after, returned to cell 4 with A/Sgt Cassidy.

5:52am – Police enter cell 4

At 5:52.41am, A/Sgt Hosie entered cell 4. He did not touch Rebecca at this stage. A/Sgt Hosie then left the cell and returned at 5:53.14am wearing gloves. A/Sgt Hosie entered the cell and then left again for a brief time. He re-entered the cell again at 5:53.26am. A/Sgt Hosie called out to Rebecca but she did not respond. He touched Rebecca on the shoulder. A/Sgt Cassidy entered the cell.

Both A/Sgts Hosie and Cassidy later said that Rebecca's skin looked purple or blue. A/Sgt Cassidy also saw what appeared to be vomit on the blanket and around Rebecca's mouth and nose. A/Sgt Hosie described seeing phlegm in that position.

A/Sgt Hosie shook Rebecca with two hands but she did not respond. He is reported as saying to other officers that Rebecca was not breathing. By this stage, a third officer, SC Nichols, was standing outside the cell.

At 5.54am, A/Sgts Hosie and Cassidy ran out of the cell. A/Sgt Hosie returned with a defibrillator, although he did not know how to use it. He was shortly followed by several other officers including Inspector Craig Reid ("Insp Reid"), A/Sgt Cassidy and Constables Nicky Taggart and Ryder. At the same time, SC Nichols called "000" from the charge room. It should be noted that it took more than two minutes after A/Sgt Hosie observed from his final visual inspection that he could no longer detect any movement of Rebecca's torso before he actually came into physical contact with Rebecca.

Although this may not sound like much time, the reality is that Rebecca was not breathing and it was a situation that required far more urgency than is apparent from A/Sgt Hosie's actions visible on the CCTV footage. When asked to explain this delay, A/Sgt Hosie's response was "*I don't know how to explain that*".

5:55am – Police attempt to resuscitate Rebecca

At 5:54.53am, Insp Reid entered the cell and put on gloves. He checked Rebecca's pulse and looked for any rise and fall of her chest but found no activity. Insp Reid, assisted by other officers, rolled Rebecca onto her back and commenced CPR at 5:55.42am. Insp Reid told investigating police that he smelt vomit and he and other police officers saw what they thought was vomit or yellow mucus on and around Rebecca's head. At about 6am a defibrillator was used on Rebecca but indicated no shockable rhythm of the heart.

At 6:02.27am, paramedics arrived in the cell and took over attempts at resuscitating Rebecca. However, the evidence of attending paramedics was that there was no electrical current in Rebecca's heart. The paramedics reported "*large amounts of vomit material and fluid regurgitated with each compression*" during CPR, and also noticed dry vomit on and around Rebecca's head and clothes.

At 6:07.29am, paramedics ceased administering CPR to Rebecca and she was pronounced dead.

8:18am – crime scene investigation

At about 8:18am, Detective Senior Constable Sven Gerber and Senior Constable DT Costelloe arrived at Maitland police station to conduct a crime scene investigation. During the course of that investigation, DSC Gerber observed that there was visible fluid around Rebecca's mouth, nose and neck areas and on her hands, which he believed to be vomit. He also noticed that there was red coloured staining on toilet paper sitting on the floor of the cell.

DSC Gerber found two chemist's pill bottles inside the left leg of Rebecca's pants, one with a red cap and one with a white cap. He also found one Alprazolam tablet on Rebecca's back in the area where her bra strap had been.

I am satisfied on the evidence that the bottle with the red cap was the bottle of tablets given by DT to Rebecca at Wollombi Road. When found, this bottle was bloodstained and contained nine Alprazolam tablets and one Clonazepam tablet. I am also satisfied that the bottle with the white cap was the bottle that had been dispensed to Rebecca by Mr Gael at Priceline Pharmacy, Cessnock. When found, this bottle was not bloodstained and contained 19 whole and two half Alprazolam tablets plus two Clonazepam tablets.

12:20pm – notification of death to Rebecca's mother

At around 12:20pm, at Raymond Terrace, an acting sergeant and a leading senior constable personally advised Debbie of her daughter's death. This was more than six hours after Rebecca had been found dead, although it appears that the officers could not initially locate Debbie.

Counsel Assisting submitted the overall delay in notifying Debbie of her daughter's death and the fact that Debbie was not notified by a commissioned officer, as required by the NSWPF Handbook, is a matter of concern. No evidence was given at the inquest to explain this delay.

Further, in the death message conveyed for forwarding to Debbie, Raymond Terrace police were told Rebecca had been "*subject to regular checks by the custody manager*" and accordingly told Debbie that "*Throughout the night Rebecca was regularly checked as per our guidelines*". This information was not only wrong but obscured a material factor contributing to Rebecca's death.

Cause of death

The weight of the expert evidence was that the levels of Alprazolam and Methadone detected in Rebecca's blood sample were both in the toxic and potentially fatal range for each of those two drugs, and that the combination of those substances could also be fatal.

As noted above, the autopsy report records the direct cause of death as "*mixed drug toxicity*". It notes, "*this mix of drugs could act synergistically causing significant sedative/respiratory depression leading to fatal respiratory failure*". The weight of the expert evidence at the inquest, and the written submissions of the parties, supported this finding.

The autopsy report further records the presence of cannabis and non-toxic levels of other benzodiazepine drugs/metabolites and Mirtazapine in Rebecca's system, which may have contributed to Rebecca's overall sedation.

I also note the evidence of Dr John Vinen, expert in emergency medicine, who identified the conditions leading to Rebecca's death as:

(a) decreased level of consciousness;
(b) leading to respiratory depression/possibly partially obstructed airway;
(c) followed by aspiration of gastric contents; and
(d) followed by death.

The autopsy report raised the question of whether vomitus material found in Rebecca's airways had implications for the cause of death or whether it occurred as a result of CPR. However, it appears from the evidence of several police officers involved in resuscitation attempts that vomitus was present around Rebecca's face before police attempted CPR.

The autopsy report does not express a firm conclusion on this issue, but notes that heavily sedated individuals are at a significant risk of aspirating vomit. This was also noted by Dr Vinen, who opined that aspiration of vomitus contributed to Rebecca's death and may have been a major factor in her death.

On behalf of Rebecca's family, Mr de Mars submitted that the cause of death be recorded as "r*espiratory depression after loss of consciousness caused by mixed drug toxicity and possibly aspiration of vomit*". This was supported by Counsel Assisting. Although aspects of this submission were contested by other parties, I am satisfied that it is a fair summary of cause of death.

Issues explored at the inquest

A list of issues was circulated to the interested parties in advance of the inquest outlining the areas of interest for the inquest. The issues can be broadly categorised as follows:

e. The circumstances by which Rebecca obtained and consumed prescription drugs on 18 July 2016;
f. The circumstances and appropriateness of Rebecca's detention and requirements of the relevant legislation;
g. The appropriateness of police actions once Rebecca was detained; and
h. The reason for the six hour delay in notifying Debbie of Rebecca's death.

I will deal with these issues in turn. I note that, in making findings, I have had regard to the principles established by *Brigenshaw v Brigenshaw*.

The drugs

(a) Where did the drugs which Rebecca had consumed come from?

Methadone

As noted above, Rebecca was dosed by the Pharmacotherapy Service at Newcastle at 8.05am on 18 July 2016 with 150mg (30mls) of Methadone. I accept the evidence of Professor Alison Jones (toxicologist) and Dr Hester Wilson (GP) that this dose was within acceptable limits of clinical practice.

I also accept the evidence from Professor Jones, which Dr Wilson agreed with at the inquest, that the level of Methadone found in in Rebecca's blood post-mortem was indicative of her having consumed more Methadone than the 150mg dose she received on the morning of 18 July 2016. It is therefore likely that Rebecca obtained and consumed more Methadone on 18 July 2016 than her dose from the Pharmacotherapy Service earlier that day.

Alprazolam

On the afternoon of 18 July 2016, Rebecca was dispensed a bottle of 50 x 2mg Alprazolam tablets by Mr Gael at Priceline Pharmacy in Cessnock. That bottle was found in the course of the crime scene investigation in the left leg of Rebecca's pants just above the left knee. By that stage, the bottle had 19 whole and two half tablets left in it. I am unable to make a finding from the evidence as to what happened to the balance of 30 pills.

A second bottle containing nine tablets of Alprazolam and one tablet of Clonazepam was also found in Rebecca's left pant leg near the upper thigh. I am satisfied that this was the bottle DT gave to Rebecca when Sgt Brooks approached them. Although DT evidently formed the impression that Rebecca intended to place this bottle in her vagina, he did not see this occur and there is insufficient evidence for me to make a finding in this regard.

I accept Professor Jones' evidence that the concentration of Alprazolam in Rebecca's blood post-mortem indicates that she consumed Alprazolam tablets within the rough period of 9:00pm on 18 July 2016 and the time of her death between 5:20 and 5:50am on 19 July 2016. On the basis of this evidence, Counsel Assisting submitted that the possibility that Rebecca consumed Alprazolam shortly after going into police custody cannot be excluded.

It is not possible to make a finding as to whether Rebecca consumed a tablet or tablets while in the back of the police van which took her and DT to Maitland. Mr Madden (for SC Coleman) and Mr Eurell (for SC South) separately submitted that it was highly unlikely that DT or Rebecca took tablets while in the van. In making this submission, Mr Madden drew my attention to DT's evidence that he and Rebecca "*freaked out*" when they saw police and that he did not see pills or pill bottles in the van, as well as DT's history of being stopped and searched by police. However, both Counsel Assisting and Mr de Mars submitted that this possibility cannot be excluded and that, in the circumstances, there would have been opportunity for Rebecca to consume tablets undetected at that time.

It is also not possible to make a finding from the CCTV footage of Rebecca on the toilet in cell 4 whether she extracted a bottle from her vagina at that time or whether, either while sitting on the toilet or on the mattress, Rebecca consumed a tablet or tablets. On behalf of SC South, Mr Eurell submitted that there is no evidence that Rebecca ingested any drugs or substances after 12:45am or while in police custody. However, Counsel Assisting submitted that both possibilities cannot be excluded, and noted that Rebecca had at some stage apparently placed an Alprazolam tablet underneath the back strap of her bra – consistent with an intention to secrete it but have it available to her. Further, in reply submissions, Counsel Assisting submitted that it seems more probable than not that the pill bottle which had been dispensed to DT was secreted in Rebecca's left pants legging at the time she entered the observation cell. The location of the pill bottles is dealt with further below.

Mirtazapine

Dr Gan, Rebecca's GP, gave Rebecca a prescription for Mirtazapine on 14 July 2016. However, PBS records do not indicate that Mirtazapine was dispensed to Rebecca on that prescription.

Early in the morning of 18 July 2016, DT had Mirtazapine dispensed to him by a pharmacy in Wallsend on a prescription. Three Remeron (Mirtazapine) tablets were found in Rebecca's handbag. The expiry date and batch number on the foils for those tablets are the same as those on the empty Remeron box in DT's property.

I am therefore satisfied that, on 18 July 2016, Rebecca had access to Mirtazapine dispensed to DT this is the likely source of the Mirtazapine found in Rebecca's post-mortem blood sample.

(b) Was it appropriate for Dr Weerabaddana to prescribe Alprazolam to Rebecca?

Dr Weerabaddana gave written and oral evidence in relation to his consultation with Rebecca on 18 July 2016. The consultation on 18 July 2016 was Dr Weerabaddana's first consultation with Rebecca and took around 14 minutes. Rebecca gave a history of significant anxiety and panic attacks, and told Dr Weerabaddana that she was on Alprazolam and had no allergies. She also said that other medications did not work for her anxiety and that she was not suicidal.

Dr Weerabaddana's evidence was that he conducted a physical examination of Rebecca and did not find anything of concern. He did not remember seeing track marks on the cavity of Rebecca's left elbow suggestive of old injecting drug use but said it was possible that he did not examine her arms.

Dr Weerabaddana gave evidence that he explained to Rebecca the addictive and sedative nature of Alprazolam before prescribing 2mg twice a day, and giving her a script for 50 pills with no repeats. He then obtained a phone authority from the Department of Human Services to dispense the medication on the PBS.

Dr Weerabaddana told the Court that he obtained an authority from Rebecca so he could get a patient history from her regular GP before his second consultation with Rebecca. Rebecca advised him that her regular practice was Raymond Terrace Family Practice but said that she could not recall her doctor's name. Dr Weerabaddana did not call Raymond Terrace Family Practice to find out the name of Rebecca's treating GP.

Dr Weerabaddana stated that he was prepared to prescribe Alprazolam to Rebecca without seeing her previous medical records because he was concerned about her getting withdrawal symptoms. He also relied on the fact that the Department of Human Services did not alert him to another recent script for Alprazolam when he sought the phone authority.

Dr Wilson gave evidence that, in her expert opinion, Dr Weerabaddana's prescribing of Alprozalam to Rebecca was not in accordance with professional practice for a GP. This opinion was based on the following factors:

a) It was Dr Weerabaddana's first consultation with Rebecca;

b) The diagnosis of anxiety and panic attacks given by Rebecca was not questioned or verified;

c) There is no patient history to suggest a diagnosis of panic disorder was made. This may have been due to Dr Weerabaddana not appreciating the difference between panic attacks (symptoms) and a panic disorder (diagnosis);

d) Rebecca exhibited many of the attributes that should have alerted a doctor that the patient was high risk: she was an unknown patient, asking for a specific psychoactive drug that is known to cause dependence and who stated that no other drugs had been effective; and

e) Dr Weerabaddana had little understanding of the medical condition of dependency or addiction "*where individuals are not able to change their use despite harm*".

Dr Wilson gave evidence that, ideally, it would have been better for Dr Weerabaddana to direct Rebecca back to her usual doctor or take steps to corroborate information provided by Rebecca and/or obtain further relevant information. Alternatively, Dr Weerabaddana could have prescribed a small amount of Alprazolam or liaised with Rebecca's local pharmacy to arrange staged and/or supervised supply.

As at July 2016, Alprazolam was a Schedule 8 drug under the Poisons and Therapeutic Goods legislation. Accordingly, Dr Weerabaddana would have required an authority from the Pharmaceutical Regulatory Unit at NSW Health to prescribe Alprazolam to Rebecca if, in his opinion, Rebecca was a drug dependent person.

When Dr Weerabaddana prescribed Alprazolam to Rebecca, he was not aware it was a Schedule 8 drug. He gave evidence that he was several years behind in his professional reading due to being busy with establishing his medical practice. Dr Weerabaddana conceded during his oral evidence that, in hindsight, and had he known of Rebecca being prescribed Methadone, he would not have prescribed Alprazolam. He stated that, in retrospect, he was "*overly naïve*" and is now more familiar with "*red flags*" which identify drug dependent persons.

Dr Weerabaddana gave evidence of the education programs he has done since July 2017 in relation to these issues. In her oral evidence, Dr Wilson acknowledged that the content of these courses addresses some of her areas of concerns about Dr Weerabaddana's prescribing of Alprazolam to Rebecca. Dr Weerabaddana also stated that he has not prescribed Alprazolam to anyone since around March 2017.

He told the Court that he does not hesitate to contact previous doctors and other health care professionals "*to get further information from them regarding a patient to support my management and treatment of the patient*", and that he now takes a more holistic approach to the care of drug dependent patients.

I find that, in circumstances where there were signs to alert Dr Weerabaddana to the fact that Rebecca was a drug dependent person and he did not make any attempts to corroborate the information provided by Rebecca and/or obtain further information, his prescribing of Alprazolam to Rebecca in the absence of an authority was highly inappropriate.

Is a referral necessary or desirable?

Counsel Assisting has submitted that the evidence in the inquest warrants further investigation of Dr Weerabaddana's prescription of Alprazolam to Rebecca on 18 July 2016. He recommends that I give a transcript of the evidence to the Medical Council under s. 151A(2) of the *Health Practitioner Regulation National Law*.

In response, Ms Burke submitted, for Dr Weerabaddana, that this recommendation is unwarranted and seemingly punitive. Ms Burke submitted that the circumstances of the evidence referred to by Counsel Assisting does not account for the fact that Dr Weerabaddana's skill, experience and knowledge as a GP as at July 2016 did not provide him with the necessary "*red flags*" to suspect that Rebecca may be a drug dependent person, and that he now undertakes courses and a holistic approach in his practice. She also noted that, had Dr Weerabaddana called the doctor shopping hotline, that hotline would not have disclosed that Rebecca was a drug dependent or addicted person as she did not fit within the criteria.

Ms Burke pointed to Dr Wilson's acknowledgement that it is possible for GPs to miss reading material or be unaware of the doctor shopping hotline, as well as her oral evidence of GPs' natural inclination to accept what a patient is telling them. She cited as significant Dr Wilson's evidence that Alprazolam and other prescribed restricted substances were known risks for patients and "*it is a skill that takes some time to learn as a doctor*".

However, this submission overlooks the fact that, when asked about the depth of her experience as compared to Dr Weerabaddana's, Dr Wilson acknowledged her particular expertise but stated, "*the reality is, if you are worried that someone is going to withdraw, then…it's part of the diagnosis of dependence. …They go together and it's not a highly specialist skill to be thinking that*". It also does not adequately address the fact that Dr Weerabaddana prescribed a Schedule 8 drug without knowing it was a Schedule 8 drug, nor his failure to contact Rebecca's claimed GP in Raymond Terrace before issuing a prescription.

Accordingly, I accept the submissions of Counsel Assisting and propose to give a transcript of the evidence to the Medical Council so that this matter can be investigated further.

(c) Was it appropriate for the pharmacist, Mr Gael, to dispense Alprazolam to Rebecca?

As noted above, Mr Gael gave evidence that, when dispensing Alprazolam to Rebecca at around 5:20pm on 18 July 2016, he noticed that she was unstable on her feet, not functioning properly and apparently under the effect of a substance. One issue explored at the inquest was whether it was appropriate for Mr Gael to dispense a Schedule 8 medication to Rebecca in these circumstances.

Mr Gael gave evidence that, in hindsight, he considered that Rebecca's manner on 18 July 2016 was more likely due to her being "*anxious and requiring that particular medication to address her anxiety or panic*" than being intoxicated. However, he later conceded that his evidence that Rebecca was swaying on her feet was an indication of intoxication.

Mr Gael gave evidence that he would have verified the Alprazolam script supplied by Rebecca by his familiarity with Dr Weerabaddana's handwriting, and that, at 18 July 2016, he did not have any concerns about drugs of addiction prescribed by Dr Weerabaddana. However, he conceded that he "*probably*" had not exercised his independent judgment appropriately in dispensing Alprazolam to Rebecca, given she appeared intoxicated and was not previously known to him.

The inquest heard expert evidence from Mr Jonathan Feather, pharmacologist, to the effect that one action Mr Gael could have taken would have been to contact Dr Weerabaddana and confirm Ms Maher had a therapeutic need for the Alprazolam, and report that Rebecca appeared to be under the effect of a substance. At the inquest, Mr Feather was asked several questions about this conclusion by counsel for Mr Gael based on a series of 13 assumptions. Based on those assumptions, Mr Feather stated that the supply of Alprazolam to Rebecca on 18 July 2016 was probably warranted.

It appears to me that, in light of his observations of Rebecca's behaviour, it would have been prudent for Mr Gael to contact Dr Weerabaddana if practicable (noting that the exchange occurred around 5:20pm on a Monday). However, I agree with Counsel Assisting's submission that, on balance, and in light of Mr Feather's oral evidence at the inquest, Mr Gael's conduct on 18 July 2016 does not require further investigation. Based on his long experience as a pharmacist who regularly dispenses drugs of addiction, Mr Gael decided to dispense a legal prescription. The CCTV footage from the pharmacy shows that Rebecca's motor skills were impaired but she was able to take part in basic transactions such as paying for the medication.

(d) Would the availability of real-time prescription monitoring in NSW have affected Rebecca's access to benzodiazepines during the period leading up to her death?

In her evidence, Dr Wilson expressed the view that a real-time prescription monitoring ("RTPM") service would be extremely useful for practitioners in NSW. This was also the evidence of Dr Weerabaddana.

Dr Wilson noted that the Prescription Shopper Programme ("PSP") operated by the Department of Human Services identifies a limited range of patients, and that Rebecca probably would not have been identified by the PSP.

Counsel Assisting submitted that a RTPM would enable doctors to immediately get more information from a source other than the patient. Such a service would have readily identified that Rebecca was on a Methadone program and therefore a drug dependent person. This would have triggered the requirement for Dr Weerabaddana to obtain an authority from the Department of Human Service before prescribing Alprazolam to her.

The implementation of RTPM in NSW has been the subject of a number of coronial recommendations directed to NSW Health, most recently in March 2019.

On 17 April 2019, a letter was sent to NSW Health requesting an update or submissions on behalf of NSW Health in relation to the implementation of RTPM in NSW, particularly in relation to the timing of the commencement of such a scheme. In a response dated 24 June 2019, NSW Health advised that it continues to support in principle the introduction of RTPM and is involved a national steering committee examining a potential funding model and technical details for a National Data Exchange ("NDE"). The response notes that the architecture of the NDE requires clarity before NSW Health can determine the most effective and efficient approach in implementing any RTPM process. The response from NSW Health does not provide any dates or anticipated timeframes.

In light of recent recommendations made in other inquests, I do not propose to make a recommendation in this regard. However, I emphasise that Rebecca's death further highlights the desirability of RTPM being available to GPs. The present system is flawed and limits the information prescribers can obtain from sources other than the patient.

Circumstances of Rebecca's death

(a) Requirements of relevant legislation

Detention as an intoxicated person

As noted above, Part 16 of LEPRA sets out a series of requirements in relation to the detention of intoxicated persons (s. 206), detention of persons in authorised places of detention (s. 207) and searching of detained persons (s. 208). It includes the following requirements:

i. an intoxicated person who is detained in a police station is required to be given a reasonable opportunity by the custody manager to contact a responsible person; and

j. police detain an intoxicated person temporarily for the purpose of finding a responsible person willing to undertake the care of the person.

I note the following relevant definitions that appear at Part 16 s. 205:

*"'**authorised place of detention'** means:*

(a) a police station,

***'intoxicated person'** means a person who appears to be seriously affected by alcohol or another drug or a combination of drugs.*

***'responsible person'** includes any person who is capable of taking care of an intoxicated person including:*

(a) a friend or family member, or

(b) an official or member of staff of a government or non-government organisation or facility providing welfare or alcohol or other drug rehabilitation services."

As noted above, A/Sgt Hosie's evidence was that he was unaware that the power of detention was one that was to be exercised temporarily in order to find a responsible person.

Counsel Assisting and Mr de Mars submitted that there appeared to be consensus among SC South and A/Sgts Hosie and Cassidy that the power to detain an intoxicated person was to be exercised to allow the person to "*sleep it off*". In his written submissions for SC South and A/Sgt Cassidy, Mr Eurell submitted that this unfairly characterised the evidence, which was to the effect that, in the vast majority of cases, persons who have been detained under s. 206 of LEPRA are released after "*sleeping off*" the effects of alcohol. Mr Eurell submitted that it would be wrong to conflate experience with purpose.

I do not agree with Mr Eurell's submissions and am troubled by the apparently prevailing attitude in relation to allowing intoxicated persons to "*sleep it off*". I accept Counsel Assisting's submission that police involved in exercising powers which relate to the detention of people need to understand the express statutory purpose for the exercise of those powers, and what they should do to achieve that purpose.

Rights of Aboriginal people as "vulnerable persons" under relevant legislation

At the time of Rebecca's death, Division 3 of Part 3 of *Law Enforcement (Rights and Responsibilities) Regulation 2005* ("LEPR Regulation"; now in Part 3 of LEPR Regulation 2016) provided a scheme which ensured that, if a person fell into one of the categories of vulnerable persons as defined in the LEPR Regulation, they were to be put in touch with external assistance. The categories included (and still include) persons who are Aboriginal or Torres Strait Islanders. This scheme is directed to people arrested under Part 9 of LEPRA for offences. The principal support for vulnerable persons is to have a support person or interpreter present when they are questioned or required to undertake an investigative procedure, and the custody manager has a duty to assist the person in exercising their rights as far as practicable, including any right to make a telephone call.

Further, pursuant to cl. 33 of the LEPR Regulation (now cl. 37), the custody manager has an obligation to immediately notify a representative of the Aboriginal Legal Service (NSW/ACT) Limited ("ALS") if an Aboriginal or Torres Strait Islander person is being detained in respect of an offence. However, the premise for this duty is that the person is being detained "*in respect of an offence*". It does not apply to people who are detained under Part 16 of LEPRA as intoxicated.

(b) Should Rebecca have been detained as an intoxicated person or should some other measure/s have been taken and, if so, what other measure/s?

This issue requires consideration of whether Rebecca met the requirements for detention of an intoxicated person under Part 16 of LEPRA. These requirements are as follows:

a. That the person appears to be seriously affected by alcohol or another drug or a combination of drugs;
b. Was found in a public place; and
c. Was in need of physical protection because the person was intoxicated.

I am satisfied that each of these requirements was met in Rebecca's case when she was detained by Sgt Brooks shortly after midnight on 19 July 2016 at Wollombi Road, Cessnock. My reasons for this finding are set out above.

However, as noted above, Rebecca was only to be taken to and detained in an authorised place of detention (here, Maitland police station) if, relevantly:

a. it was necessary to do so temporarily for the purpose of finding a responsible person; or
b. a responsible person could not be found to take care of Rebecca or Rebecca was not willing to be released into the care of a responsible person and it was impracticable to take her home.

I accept Sgt Brooks' evidence as to why he did not consider DT to be a responsible person to take care of Rebecca. I also accept that, based on the information available to Sgt Brooks at the time, it was reasonable for Sgt Brooks to conclude that there was no responsible person at her address in Raymond Terrace into whose care she could be delivered.

However, through their counsel, Rebecca's family submitted that this was not a basis for Sgt Brooks foreclosing consideration of alternative options for Rebecca, and have requested a finding that Sgt Brooks could have made greater efforts to find a responsible person before detaining Rebecca at Maitland police station. In making this submission, Mr de Mars emphasised that, given her long history of police contact, an obvious source of information available to Sgt Brooks would have been Raymond Terrace police. This submission was supported by Counsel Assisting. I accept this submission.

Rebecca's detention as an intoxicated person continued through to the period of her detention at Maitland police station. Counsel Assisting submitted that, given Rebecca's state of intoxication, her behaviour upon her arrival, and the fact that she was unable to participate in the risk assessment because she was "*incoherent*", police should have made arrangements to transfer Rebecca to a hospital. Counsel Assisting supported a submission made on behalf of Rebecca's family that an ambulance should have been called at the point when A/Sgt Hosie determined that Rebecca was too intoxicated for him to administer the questionnaire, and by no later than the time when she was seated on the bench in cell 4 and slumping forwards.

The question of what point at which Rebecca should have been taken to hospital is explored further below. Separately, I note that, regardless of whether it was appropriate to detain Rebecca as an intoxicated person, this is intended to be a temporary measure and A/Sgt Hosie had a duty under s. 206(4) of LEPRA to continue to try to find a responsible person to take care of Rebecca throughout the duration of her time in custody. There was no evidence before the inquest that A/Sgt Hosie made any effort to comply with s. 206(4), despite having access to databases that would have enabled him to identify and locate Debbie.

(c) Are there alternatives to detaining intoxicated people at police stations?

The relevant aim of s. 206(3) and (4) in Part 16 of LEPRA is for intoxicated persons (who meet the criteria for detention) to be delivered into the care of a "*responsible person*", and to only detain such persons at a police station for so long as is necessary to find such a person. The definition of "*responsible person*" is set out above and includes a friend, family member or welfare facility.

There was no evidence before the inquest to indicate that there was a "*welfare facility*" into whose care Rebecca could have been delivered. Accordingly, if police did not identify a friend or family member as a responsible person, the detention of Rebecca would, as a matter of course, be at a police station.

There was no evidence to indicate that Rebecca's mother was not available to care for Rebecca on 18-19 July 2016. However, at no time at Wollombi Road or at Maitland police station did police ask Rebecca whether there was anyone who could take care of her. Apart from the questions asked of Rebecca by Sgt Brooks at Wollombi Road, there was no evidence of police attempts to identify or locate a responsible person into whose care she could be delivered.

All of the involved officers, but notably A/Sgt Hosie, had access to previous CMRs for Rebecca, through which they could have identified Debbie's contact details in a manual search. A/Sgt Hosie's evidence was that he did not consider next of kin, had never conducted a manual search of older CMRs and was not aware that he had an ongoing responsibility to try to identify a responsible person.

Is a recommendation necessary or desirable?

On behalf of Rebecca's family, Mr de Mars made submissions about alternatives to detaining intoxicated persons at police stations. He noted that the second reading speech for Part 16 of LEPRA anticipated that police and other local agencies would develop protocols to allow for the provision of services to intoxicated persons. Mr de Mars noted the absence of any evidence of relevant protocols in Rebecca's case and proposed that I make a recommendation to the effect that NSWPF review the existence of protocols developed for the purposes of Part 16 of LEPRA, with a view to reporting to the Minister for Police on the extent to which they appear to fill the role as envisaged in the second reading speech.

A similar proposition was made in submissions prepared on behalf of SC South and A/Sgt Cassidy. Mr Eurell also submitted that I make an additional recommendation to the following effect:

> *"That the New South Wales Government establishes, within each and every Police District, at least one public hospital as a proclaimed and authorised place of detention as contemplated within the meaning of s. 205 of [LEPRA]."*

In relation to the further recommendation proposed by Mr Eurell, Counsel Assisting submitted that, although it may have merit on its face, the question of using coercion to detain intoxicated persons under LEPRA in public hospitals was not canvassed during the inquest or raised with any witness, and therefore lacks an evidentiary basis. I agree with Counsel Assisting's submissions in this regard.

Counsel Assisting and the Commissioner both made submissions in response to the submission proposed by Mr de Mars.

The Commissioner submitted that, from July 2017, "*Safe Custody – Medical risks*" posters setting out the obligations of a custody manager, including in relation to seeking medical assistance, have been prominently displayed in custody areas. Further, the Commissioner noted Dr Vinen's evidence that the only alternative to detaining an intoxicated person at a police station is to take the person to a hospital or call for ambulance assistance. The Commissioner submitted that any review of the protocols developed for the purposes of Part 16 of LEPRA will not overcome the risks identified by Dr Vinen, and that the family's recommendation should be rejected.

Counsel Assisting submitted that while Mr de Mars' submission about the intention of enacting Part 16 of LEPRA is correct, in this case there was no evidence that there was a government or non-government organisation or facility providing welfare or alcohol or other drug rehabilitation services into whose care Rebecca could have been delivered.

Counsel Assisting proposed an alternative recommendation in relation to this issue. However, this issue was not canvassed in great detail at the inquest and I am not inclined to make a recommendation in this regard.

(d) Should the Aboriginal Legal Service Custody Notification Service be extended to the detention of intoxicated Aboriginal people?

One matter explored during the inquest was whether the Custody Notification Service ("CNS") operated by the ALS, which was established as a result of recommendations arising from the Royal Commission into Aboriginal Deaths in Custody ("RCIADIC"), should be extended to the detention of Aboriginal or Torres Strait Islander persons detained as intoxicated persons.

As set out above, the obligation of police to notify the CNS only arises when an Aboriginal person is in custody for an offence. It does not arise if that person is detained as an intoxicated person under Part 16 of LEPRA. Therefore, on 19 July 2016, even if police had known Rebecca was Aboriginal, they had no statutory obligation to put Rebecca in touch with a lawyer or other person by reason of her being an Aboriginal person.

The CNS is clearly a necessary and valuable resource. The CNS is notified by police whenever an Aboriginal person comes into custody for an offence and an ALS solicitor is able to speak with the person arrested over the phone. Jeremy Styles, an ALS lawyer who has been deeply involved with the CNS since its inception, gave evidence at the inquest that the CNS performs an important welfare function in addition to its legal advice function. Based on his experience, Mr Styles indicated that if a CNS lawyer thought that an Aboriginal person required medical care and conveyed this message to police, police invariably complied. However, Mr Styles also gave evidence that the caseload of the CNS already exceeds its resources, and it has not been funded or designed to assist Aboriginal persons detained as intoxicated persons.

Is a recommendation necessary or desirable?

I am satisfied that it is desirable to recommend that consideration be given to:

a. amending LEPRA to ensure that an Aboriginal person detained under Part 16 of LEPRA as intoxicated is provided with the same access to the CNS as an Aboriginal person held in custody under Part 9 of LEPRA, and that the duty of police to put an Aboriginal person in custody in touch with the CNS is extended to Aboriginal persons detained under Part 16; and
b. ensuring that the CNS is funded to enable it to provide its service to Aboriginal persons detained under Part 16 of LEPRA.

After the hearing of the inquest was complete, the Court received a letter from the Commonwealth Minister for Aboriginal Affairs advising that the Commonwealth "*is currently working with the NSW government on funding options after 31 June 2019 and on potential improvements to the CNS model to ensure it extends to protective custody*".

(e) Why was Rebecca not identified as Aboriginal from her CNI entry? Is the process for identifying the Aboriginality of those detained by police in NSW appropriate and adequate?

It was accepted at the inquest that the officers involved in Rebecca's detention did not know she was Aboriginal. Counsel Assisting submitted that Rebecca was not identified as Aboriginal from her CNI entry for two reasons.

First, in her COPS profile, Rebecca was identified as "*Caucasian*". Second, at the time of her detention, there was no system to ensure that a reference to the fact that a person is Aboriginal or Torres Strait Islander in their COPS profile was also recorded in a person's CMR in the CMS.

In his initial investigation, the senior critical incident investigator reported that he was unaware that Rebecca was Aboriginal for some days after her death. As a result, that officer recommended changes to NSWPF record systems, which have now been made. From October 2018, if a person is brought into custody and, importantly, has previously been recorded in the COPS system as being Aboriginal or Torres Strait Islander, the CMS suggests to the custody manager that that person is Aboriginal or Torres Strait Islander. The custody manager has an opportunity to ask the person to confirm this. If the person is intoxicated and cannot answer, the default answer is "*yes*". The result will be that a person in Rebecca's situation should be now automatically treated as an Aboriginal person in custody.

Actions of police once Rebecca was detained

(a) What searches of Rebecca should have been conducted? Were the reasons why Rebecca was not searched appropriate?

Police had the power, but not a duty, to conduct a search of a person detained as an intoxicated person under Part 16 of LEPRA. Both Counsel Assisting and Mr de Mars submitted that the general purpose of the search power under Part 16 was similar to the search power under Part 9 – specifically, to ensure the person in custody does not have anything which could be used to harm themselves or any other person. I accept this submission.

As I have set out above, it is clear that police did not conduct an intrusive search of Rebecca at either Wollombi Road in Cessnock or Maitland police station. They also did not conduct an ordinary search, beyond possibly asking Rebecca to turn out her pockets and conducting a visual inspection.

I have received different submissions as to the likely location of the pill bottles on Rebecca at the time that she arrived at Maitland police station. This is significant because it impacts the question of whether, had Rebecca been searched at that point or earlier, police would have located one or both of the pill bottles in her possession.

Mr de Mars made compelling submissions that the evidence points to at least one of the pill bottles was located in Rebecca's clothing when she entered the observation cell, noting the completely clean state of the bottle containing Alprazolam ultimately located in her pants leg.

By contrast, Mr Eurell submitted that, prior to Rebecca entering the observation cell, both pill bottles were located in her vagina. Similarly, SC Coleman submitted, through his counsel, that the Court might find that Rebecca hid the bottles in her vagina and that this was the action of someone known to police. These submissions do not account for the fact that only one bottle located in Rebecca's pants appeared to be blood-stained.

Having considered the submissions, I am satisfied that it is likely at least one of the pill bottles was located in Rebecca's pants leg at the time she entered the observation cell at Maitland police station, such that, had a pat down search been conducted at that point, that bottle may well have been located. This in turn may have alerted police to the nature of her intoxication and need for medical assistance. It is certainly clear that, at the time Rebecca lay down on the mattress in cell 4, both pill bottles were in her pants leg, such that a search immediately prior to this point would have revealed them. This is around the same time as CCTV footage from the charge room shows SC South and A/Sgt Hosie having a discussion about the fact that Rebecca had not been searched.

Counsel Assisting submitted that three reasons emerged in the evidence as to why no search was conducted:

k. fear of becoming infected with an infectious disease;

l. a direct order by Sgt Brooks; and

m. agreement by A/g Sgt Hosie with SC South not to search.

Counsel Assisting submitted that reason (a) above, particularly a fear of becoming infected with HIV or Hepatitis C, appeared to be the main reason police did not search Rebecca. He argued that fear of infection should not deter officers from performing an intrusive search where necessary or desirable. He noted that police policy and training includes information on the nil to low risk of occupational transmission of HIV and Hepatitis C. Further, all officers are provided with appropriate personal protective equipment to guard against the risk of contracting infection, and NSWPF Infectious Disease Prevention Guidelines teach police to use standard precautions. Counsel Assisting submitted that, therefore, as a matter of occupational risk, the fears which police had of risking infection with HIV or Hepatitis C were not well-founded and therefore were not an appropriate reason to refrain from conducting a search of Rebecca. He emphasised that Rebecca was not, in fact, HIV positive.

SC South conceded, in submissions prepared on her behalf, that the risk of contracting HIV or Hepatitis C was one of a number of reasons why she did not search Rebecca.

Her counsel submitted that other reasons included her perception that Sgt Brooks had determined that a search was unnecessary, her evaluation of the risks (including that Rebecca presented a low risk of self-harm, did not appear to have anything in her pockets and the potential for escalation if force was used), and the potential consequences for her pregnancy.

Through her counsel, SC South acknowledged that there was a low risk of becoming infected with HIV or Hepatitis C, but submitted that it would be wrong to conclude that there was no risk at all. Mr Eurell submitted that while the likelihood of infection from saliva alone was remote, this may be higher if a person is injured and there is exposed blood. He asserted that such matters become increasingly likely every time police decide to use force (including a search).

A number of officers gave evidence, which was picked up in submissions, that the reason they did not search Rebecca was due to the fact that she was being detained as an intoxicated person (as opposed to being under arrest) and/or the discretionary nature of the search power conferred by s. 208.

In submissions prepared on behalf of the Commissioner, Mr Spartalis accepted that, with the benefit of hindsight, it would have been best practice to search Rebecca. However, he emphasised that an officer charged with the discretion to search should exercise the discretion carefully.

Both Counsel Assisting and Mr de Mars submitted that the fact that a power is discretionary does not justify an omission to search where it is required or desirable in the circumstances, given that the main reason to conduct a search in these circumstances is to locate anything which could be used to harm the person searched or anyone else. As at July 2016, the NSWPF Handbook made clear that there are specific circumstances in which a search of an intoxicated person can assist in ensuring their health and welfare while in custody. At the inquest, A/Sgt Hosie gave evidence that he was unaware of those provisions but accepted that the provisions suggested that Rebecca should have been searched. However, he said that he did not know whether, if he had known of the provisions, he would have insisted that Rebecca be searched.

Mr de Mars further submitted that it was fallacious for parties to somehow seek to distinguish the power to search persons detained as intoxicated from the power to search in relation to persons detained pursuant to Part 9 in relation to an offence, which is also not mandatory. He argued that, as a matter of police practice and procedure, it would be highly unusual and contrary to established practice not to search those going into police custody on either basis. Counsel Assisting submitted that Rebecca's case illustrates that persons detained as intoxicated may have drugs on them that they may try to hide from police, which gives rise to the risk that they will then take such drugs while in police custody. He submitted that, in order guard against this risk, it is desirable that they be searched. Mr de Mars submitted that the reasons for searching a detainee go further than this, and that the identification of the quantity of a drug on a detainee is potentially a highly important piece of information for the police in relation to their assessment of the potential level and type of intoxication that may be involved.

This may in turn have consequences for risk assessment and recourse to acquiring medical attention.

Is a recommendation necessary or desirable?

Counsel Assisting noted that the learnings for the risk of occupational transmission of Hepatitis C and HIV are not simple, and cited conflicting information in police policy and training that may result in confusion for police. Accordingly, he submitted that I should make a recommendation to the NSWPF that it improve its education and training of police officers to provide clear and understandable information as to the risk of infection associated with Hepatitis C and HIV from saliva and the use by police of barriers provided to them to reduce risk of contact from body fluids when searching a person.

In submissions on behalf of the Commissioner, Mr Spartalis noted that, while the Commissioner supports this recommendation, it also has to remain cognisant of its non-delegable duty to its employees and its mandatory obligations to its employees under the *Work Health and Safety Act 2011*. The Commissioner provided evidence of a current review of infectious diseases policies relating to custody to ensure that the policies adequately assist police to perform custody duties.

Counsel Assisting also submitted that I should recommend that NSWPF improve its education and training of police officers as to circumstances which call for persons detained as intoxicated to be searched, in particular circumstances where the person may be intoxicated with prescription drugs and might have such drugs on them when detained. In response, Mr Spartalis submitted that the Commissioner is in favour of training which highlights the necessity for a police officer to properly consider individual circumstances when exercising the discretion to search a person detained under Part 16 of LEPRA. He submitted that the NSWPF will continue to maintain and upgrade its training in response to any issues that arise, such as this inquest, and in response to any legislative changes that occur.

(b) Were the observations made by Police of Rebecca in detention at Maitland police station adequate? If not, why not? How often and by what means should observations be conducted to ensure that an alarm can be raised if a person needs medical care?

Requirements for checking on intoxicated detainees

The requirements for checking on intoxicated detainees in the Code of Practice for CRIME (now merged into the NSWPF Handbook) make detailed provision as to what should be done to look after persons in custody who are:

n. ***Affected by alcohol or drugs,*** including to:

i. Wake, speak to and assess the sobriety of the person at least every 30 minutes (or more frequently if necessary) during the first two to three hours of detention;

ii. Seek urgent medical help if the person cannot be roused or their level of intoxication or consciousness has not changed or is of concern;

iii. Do all assessments in person, not by video; and

iv. Immediately call for medical assistance or send the person to hospital if they are severely affected by alcohol or drugs.

o. ***Sleeping,*** including to:

i. Check the person as often as possible;

ii. Rouse the person and observe their condition if they are snoring, particularly when they are affected by alcohol or drugs; and

iii. Only leave the person asleep if satisfied that they are breathing normally and without apparent distress.

p. ***Unconscious,*** including to:

i. Check the person's condition and be alert to the following signs:

- cannot be roused
- no verbal response; incomprehensible response
- moaning but not speaking
- no eye opening in response to your requests
- no response to speech and simple requests.

The requirement to attempt to rouse the person was supported by Dr Vinen. Dr Vinen said that if a person did not respond to attempts to rouse or did not respond adequately (for example, with rational words like "*go away*" or "*stop hurting me*") but instead simply grunted slightly, then they should straight away be taken to a hospital.

Adequacy of observations/inspections

The evidence about the observations/inspections made of Rebecca at Maitland police station has been addressed above.

I accept the opinion of former Sergeant Piet, a custody management specialist with the NSWPF, that the manner in which A/Sgt Hosie conducted the inspections of Rebecca was not consistent with the requirements of the Code of Practice for CRIME. The expert evidence from Dr Vinen demonstrated the relationship between these inadequacies – and the failure to call an ambulance – and the chances of preventing death of a person in Rebecca's position. Counsel Assisting submitted that, had A/Sgt Hosie conducted his inspections as was required, he would have found, at an early stage, that Rebecca was either unconscious or had very low level of consciousness and called an ambulance. In addition, Mr de Mars submitted, on behalf of the family, that Dr Vinen's evidence makes it plain that had efforts been made to properly observe Rebecca by way of attempts to rouse her, it would have been evident soon after she was lying down (and clearly the case by 2:00am, if not earlier) that her level of consciousness was problematic.

In relation to the appropriate frequency and manner of observations to ensure that necessary alarms can be raised, Counsel Assisting submitted that this question is answered by reference to what is observed of and/or known about the person. In this case, and as set out above, it is evident that Rebecca was so intoxicated that A/Sgt Hosie considered that he was unable to complete the questionnaire, an essential element of proper risk assessment. Counsel Assisting submitted that the critical factor is that the observations need to involve the custody manager physically entering the cell and attempting to rouse the detained person in order to determine whether it is safe to continue to have the person in custody.

A/Sgt Hosie gave evidence that he was not aware of the requirement to inspect intoxicated persons in person (as opposed to monitoring CCTV) and that he had not been trained to attempt to physically rouse an apparently sleeping intoxicated person to check their level of consciousness. Sgt Brooks and SC Coleman were also unaware of this instruction.

Counsel Assisting submitted that the need for custody managers to understand the importance of conducting appropriate inspections is something which cannot be over-emphasised. Counsel for A/Sgt Hosie similarly made submissions of the importance of "*on the job*" education and training for custody managers on this issue. At the inquest, I had before me a "*Safe Custody – Medical Risks*" poster published by NSWPF and a Nemesis message sent to all police that highlighted the importance of custody managers making attempts to physically rouse intoxicated persons who appear to be asleep. I also received evidence about discrepancies between the intensive five-day Custody Managers Course, which deals in detail with safety issues, and the Custody Managers Workshop, which appears to train in little more than using CMS software. Counsel Assisting submitted that there can be no doubt that, the more custody managers who undertake the Custody Manager's Course, the greater the likelihood that intoxicated prisoners will be managed appropriately.

Is a recommendation necessary or desirable?

Counsel Assisting submitted that I should make three recommendations directed to NSWPF in relation to this issue.

First, that all police officers who perform duty as custody manager at police stations undertake the Safe Custody Course, which would include education and training as to:

a. The duty in respect of a person detained under Part 16 of LEPRA to make all reasonable efforts to identify and locate a "*responsible person*"; and
b. Content of the NSWPF poster entitled "*Safe Custody: Medical Risks*" including that, when managing a person detained as intoxicated, it is dangerous and inappropriate to take the approach that the person will or can "*sleep it off*".

In his submissions, Mr Spartalis indicated that the Commissioner supports this recommendation with respect to custody training generally rather than specifically to the "*Safe Custody Course*", subject to resources. Further, the NSWPF accepts that that all officers that conduct custody duties should undertake a form of safe custody training.

Secondly, that the CMS be modified to require the custody manager to record:

a. when making entries for inspections where the detainee is intoxicated:

ii. what occurred when the custody manager attempted to rouse the detainee, and

iii. the custody manager's assessment of the detainee's level of consciousness; and

b. the efforts they have made to identify and locate a "*responsible person*", including consulting previous CMRs.

Mr Spartalis confirmed that the Commissioner supports this recommendation. He also noted the following initiatives undertaken by NSWPF in respect of these issues:

- Nemesis messages disseminated in February and March 2019 that reminded officers of their obligations to rouse, and undertake risk assessment of, intoxicated persons who appear to be sleeping;
- alteration of the CMS to record "*responsible person*" details, in addition to "*next of kin*";
- review and condensing of the safe custody course content to permit more officers to be trained; and
- introduction of a new NSWPF Learning Management System in January 2020 to enhance and increase the education available to officers.

Thirdly, that the circumstances of the death of Rebecca at Maitland police station be considered for use as a case study in training of police officers who are to undertake the duties of a custody manager. Mr Spartalis confirmed that the Commissioner supports this recommendation and resources have already been allocated to undertake the case study.

(c) Can appropriate care be provided for those detained under the intoxicated persons' provisions at police stations? Should a nurse be involved or contactable when a person is in detention as an intoxicated person?

Although police officers may have greater basic first aid training than many people, they are not medically trained. Officers cannot be expected to provide medical care for people detained under Part 16 of LEPRA in a police station.

There was some evidence of police in other jurisdictions employing nursing resources to watch houses, either in person or over the phone.

However, Counsel Assisting submitted that there are difficulties in implementing a similar scheme here, namely the high number of police stations in NSW and the concerns raised by Dr Vinen as to the efficacy of a telephone advice. As noted by Dr Vinen, a nurse in this situation cannot view the detained person and must depend on the police officer to provide an account as to the person's state. These uncertainties made Dr Vinen prefer that the person be taken to a doctor for assessment in a health care setting.

Is a recommendation necessary or desirable?

On the basis of Dr Vinen's evidence, which I accept, it does not appear desirable to make a recommendation in this regard.

I note the submission of Mr de Mars that the efficacy of a regular medical or nursing presence could be considered at larger watch house locations in NSW. On behalf of Rebecca's family, Mr de Mars also submitted that the difficulty of providing a nursing service at a location such as Maitland lends weight to the need for police to be more readily prepared to seek ambulance services or to transport detainees to hospital. Accordingly, he suggested that there may be a place for the development of local area protocols between police and local area health and ambulance services.

This has not been canvassed with any relevant agency and, accordingly, I decline to make a recommendation in this regard.

(d) Should an ambulance have been called before Rebecca died? If so, when should an ambulance have been called?

On the question of what the trigger point was for a person to be taken to hospital, Dr Vinen gave evidence of three basic indicators which occur before the point at which the person has lost consciousness, which are as follows:

- decreased level of consciousness, such that the person "*is either not responding… or responding inappropriately to stimulus, which may include pain*";
- being very unsteady on their feet, for example "*falling over, or sitting down and falling off, you know, chairs or benches or whatever*"; and
- having "*markedly slurred speech, or you know, they can't communicate with you*".

Dr Vinen was shown the CCTV footage of Rebecca's arrival at Maitland police station through to lying on the bench on the observation cell. After watching that footage, he said that, if a person had behaved that way in an emergency waiting room of a hospital, at a bare minimum they would have been put in a bed with side rails, placed under visual observation including testing their level of conscious, and hooked up to heart and blood oxygen monitors.

Dr Vinen said the safe thing to do with Rebecca would have been to have her transferred to an emergency department. What the emergency department of a hospital could provide which a police station could not was:

- airway management – ensuring an airway to ensure adequate ventilation and oxygenation, prevention of aspiration;
- oxygenation – maintaining oxygen levels within the required levels;
- ventilation-maintaining COR2R within the required limits; and
- administration of an opioid antidote. Naloxone, the antidote for opioid overdose, reverses all signs of opioid intoxication.

There was evidence before the Court that both Cessnock Hospital and Maitland Hospital had a 24 hour Emergency Department in operation on 18 and 19 July 2016.

Counsel Assisting submitted that it is open to me to conclude that:

a. When she entered into custody, Rebecca was stumbling, had slurred speech and could not sit upright on the bench in the observation cell. Police should have concluded at that early stage that Rebecca was severely intoxicated;
b. Rebecca's level of intoxication was so high that police were unable to perform the essential components of the risk assessment provided by the CMS to allow them to determine risks to her health;
c. for an extended period of time during the first half of her detention, police had concerns about Rebecca's health, specifically her breathing;
d. in light of the above, police should have caused Rebecca to be taken by ambulance to hospital for urgent medical assessment. If that had occurred, the expert evidence of Dr Vinen suggests that Rebecca would have survived; and
e. the failure of police to organise for Rebecca to be transported to hospital for urgent medical assessment was in breach of applicable requirements of the Code of Practice for CRIME.

Counsel Assisting submitted that the ambulance should have been called no later than when Rebecca slumped forward with her arms hanging towards the floor when seated on the bench on the observation cell. However, he noted that the criteria for calling an ambulance were satisfied when it was clear that Rebecca was stumbling and "*incoherent*". Rebecca was plainly severely intoxicated and, importantly, so much so that police were unable to complete the questionnaire in her CMR.

Counsel Assisting further submitted that it is arguable that if a person is relevantly incoherent, they should not be detained as intoxicated at a police station. Under s 207(2)(a) of LEPRA, such persons must be given a reasonable opportunity by the person in charge to contact a "*responsible person*". If, due to the person's level of intoxication, this function of the legislation cannot be achieved, then the person should not be detained at a police station and instead should be taken to a hospital. I accept and agree with these submissions.

(e) Exploration of Back to Base Pulse Oximetry to ensure an alarm is raised if an intoxicated detainee's blood oxygen saturation drops.

This issue was raised before the hearing of the inquest because of a recommendation made in another inquest concerning this technology. That inquest involved a death in a psychiatric intensive care unit.

Dr Vinen gave evidence as to the purpose and function of this technology, which can be used to detect suicide attempts by high dependency mental health inpatients in real-time. However, Dr Vinen pointed to a number of reasons why the technology might not be suitable in a non-health care setting like a police station and provided a lengthy list of requirements that would need to be met for back to base oximetry monitoring to be conducted for persons detained or held in custody in police stations.

I accept this evidence and am satisfied that this technology would not be practical for use in a police station.

(f) SafeWork NSW referral

Because of the potential for relevant work practices to remain systematically entrenched in the NSWPF, Rebecca's family have raised, through their counsel, a suggestion that I consider referring the circumstances of Rebeca's death to SafeWork NSW for investigation and review. Mr de Mars submitted that the evidence supports a concern that important aspects of the conduct of relevant police indicate there may be a widespread lack of understanding of officers' obligations.

Counsel Assisting submitted that these submissions have some force. By contrast, Mr Spartalis submitted on behalf of the Commissioner that there was no evidence before the inquest to suggest or find systematic failure, or to find that there is potential for police practices at one police station in relation to the exercise of the power under Part 16 of LEPRA for be systematically entrenched at all other Police Area Commands. Mr Spartalis argued that the submissions on behalf of the family in this regard should be rejected.

The submissions on behalf of Rebecca's family do not seek to trigger the institution of criminal proceedings under the *Work Health and Safety Act 2011*. Instead, noting the power of SafeWork NSW to seek enforceable undertakings, Mr de Mars' submissions propose that I forward a copy of these findings and the brief of evidence to SafeWork NSW so that it can determine whether any enforcement or other action in relation to NSWPF is warranted.

Both Counsel Assisting and Mr Spartalis submitted that this submission should be not accepted, as it would not be fair to NSWPF or the individual officers represented at the inquest for this issue to be raised at this late stage.

Counsel Assisting noted that, given the broader public health issues involved, and noting that any person can do so as a matter of practice, I should not consider forwarding the papers to SafeWork NSW.

Mr Spartalis further submitted that, as issues arose for the NSWPF before and during the inquest, the NSWPF responded positively. With one exception, the Commissioner supports the recommendations for change proposed in Counsel Assisting's principal submissions. In other words, in considerable measure, the NSWPF accepts, supports or is in the process of implementing the types of measures for change which would be likely to be the subject of enforceable undertakings flowing from any referral to SafeWork NSW.

I accept Mr Spartalis' submissions in this regard and decline to make a referral to Safework NSW or forward a copy of my findings.

Reason for the delay in notifying Rebecca's mother

Counsel Assisting submitted that the management of notifying Debbie of Rebecca's death was in breach of NSWPF requirements and was disrespectful to Rebecca's family and to the memory of Rebecca herself.

In circumstances where the reason for the delay in notifying Rebecca's mother of her daughter's death is not known, I am unable to make findings in relation to this issue. However, I note my concerns about the manner in which this was handled and extend my condolences to Rebecca's family for any additional pain this may have caused.

Conclusions

Before making my formal findings, I would like to once again acknowledge the dignity of Rebecca's extended family throughout the inquest process and thank them for their participation. It is clear to me that Rebecca was a cherished and much loved member of her family, who continues to be dearly missed. I would also like to extend my thanks to my team for the enormous amount of work they have put into assisting me and to the Critical Investigation Team for their very thorough investigation and assistance at the inquest.

Findings required by s. 81(1)

Formal Findings:

Rebecca Maher died on 19 July 2016 in a cell at Maitland police station in NSW. Rebecca's death occurred accidentally while she was detained by officers of the NSWPF as an intoxicated person, medical attention not having been sought on her behalf. The medical cause of death was respiratory depression after loss of consciousness caused by mixed drug toxicity and possibly aspiration of vomit.

Recommendations

Pursuant to s 82 of the Act, I make the following recommendations:

To the Attorney General of NSW and Commonwealth Minister for Aboriginal Affairs:

1. *That the Attorney General consider amending the Law Enforcement (Powers and Responsibilities) legislation to ensure that an Aboriginal person detained under Part 16 of LEPRA as intoxicated is provided with the same access to the CNS as an Aboriginal person held in custody under Part 9 of LEPRA, and that the duty of police to put an Aboriginal person in custody in touch with the CNS is extended to Aboriginal persons detained under Part 16; and*
2. *That the Commonwealth Minister for Aboriginal Affairs continue to work with the NSW government on funding options and on potential improvements to the ALS CNS model to enable it to provide its service to Aboriginal persons detained under Part 16 of LEPRA.*

To the Commissioner of Police, NSWPF:

1. *That the NSWPF consider improvements to its education and training of police officers to provide clear and understandable information as to the nature of infectious diseases and associated risks.*
2. *That the NSWPF consider improvements to its education and training of police officers as to circumstances which call for persons detained as intoxicated to be searched, in particular circumstances where the person may be intoxicated with prescription drugs and might have such drugs on them when detained.*
3. *That the NSWPF consider the implementation of a requirement that all police officers who perform duty as custody manager at police stations undertake the Safe Custody Course, which would include education and training as to:*
    a. *The duty in respect of a person detained under Part 16 of LEPRA to make all reasonable efforts to identify and locate a "responsible person"; and*
    b. *Content of the NSWPF poster entitled "Safe Custody: Medical Risks" including that, when managing a person detained as intoxicated, it is dangerous and inappropriate to take the approach that the person will or can "sleep it off".*
4. *That the NSWPF consider modification to the CMS to require the custody manager:*
    a. *when making entries for inspections to record, where the detainee is intoxicated, (1) what occurred when the custody manager attempted to rouse the detainee, and (2) the custody manager's assessment of the detainee's level of consciousness; and*
    b. *to record the efforts they have made to identify and locate a "responsible person", including consulting previous CMRs.*
5. *That the NSWPF continue to review the circumstances of the death of Rebecca Maher at Maitland police station as a case study in training of police officers who are to undertake the duties of a custody manager.*

9. 273191 of 2016

Inquest into the death of MA. Findings handed down by Deputy State Coroner Grahame at Lidcombe on the 19th June 2019

MA was 44 years of age at the time of his death. He was at Parklea Correctional Centre in relation to a breach of parole and in relation to fresh charges which were pending. At the time of MA's death Parklea Correctional Centre was privately operated by the GEO Group Australia Pty Ltd (GEO), through a contractual agreement with the Commissioner of Corrective Services. Since 1 April 2019 the prison has been operated by MTC- Broadspectrum. The court was also advised that the primary medical care at the correctional centre which was provided through Justice Health & Forensic Mental Health Network (JH&FMHN) at the time of MA's death, is now be provided by St Vincent's Hospital Sydney Limited (SVHS).

Parklea Gaol is in metropolitan Sydney. The prison has a current capacity to house around 800 inmates. Once new facilities are completed on the site, the capacity will be greatly enlarged.

A revocation of parole warrant in relation to MA had been issued on 31 August 2016. On 8 September 2016 MA was arrested in relation to a number of serious domestic violence offences and he was taken to Belmont Police Station. The parole warrant was executed and bail was refused. MA's balance of parole was recorded as 4 months and 9 days.

Records indicate that after having been held briefly at Belmont Police Station, MA was received into custody at Parklea Correctional Centre on 9 September 2016.

After induction screening MA was housed in area 3A of Parklea Correctional Centre.

On 11 September 2016, not long after 7pm, MA was found by correctional officers hanging by a torn bed sheet, at the back of his cell. He was alone. He was cut down from the hanging position and CPR was commenced. Paramedics were called, but MA could not be revived. He was pronounced dead at 7.30pm. A post mortem examination was conducted on 13 September 2016. The forensic pathologist conducting the examination confirmed that MA's death was caused by hanging. MA was later formally identified by his sister.

The role of the coroner

The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death. In addition, the coroner may make recommendations in relation to matters that may have the capacity to improve public health and safety in the future.

In this case there is no dispute in relation to the identity of MA, or to the date, place or medical cause of his death. For this reason the inquest focused on the manner and circumstances surrounding his death. It was also necessary to consider whether or not his death was in any way avoidable and if so what mechanisms, if any, could be put in place to help prevent similar tragedies occurring.

A finding that a death is self-inflicted should not be made lightly. The evidence should be extremely clear and cogent in relation to intention. However, in this case the steps taken by MA, once he was alone, indicate a clear intention to take his own life.

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. For this reason it is especially important to examine the circumstances of each death in custody and to understand how it occurred. Over the years there have been many hanging deaths in NSW correctional centres. There is a public interest in looking towards finding further ways to reduce this tragic statistic.

Section 81 (1) of the *Coroners Act* 2009 NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of MA.

Scope of the inquest

A number of issues relevant to MA's death were identified prior to the inquest commencing. These issues included, among others, the lack of medication prescribed to MA given his known mental health history, the adequacy of information sharing between JH&FMHN and correctional officers, the decisions made around cell placement and the steps which have subsequently been taken to improve cell architecture at Parklea.

The inquest took place on 20 May 2019. A three volume brief was tendered including statements, recordings, prison and medical records. Four witnesses were called to give brief oral evidence.

Background

MA was born on 4 January 1972. He grew up on the Central Coast of NSW. He was the eldest of three siblings. In 1986 his family moved to Belmont, NSW. After school MA worked in the construction industry and had qualifications in scaffolding, rigging, and as a fork lift and train driver. At around 24 years of age he became involved with a woman who became his long term partner. They had two children together.

The family appear to have had many happy times. However in recent years the relationship was marred by violence and drug use. MA's partner attended the hearing, but did not wish to give evidence. MA had a criminal record and had been in custody before. There appear to have been no recorded suicide attempts on his correctional or medical files.

MA's reception into custody

On 9 September 2016, at about 9.54 pm Registered Nurse (RN) Ephrem Aberra conducted a Reception Screening Assessment (RSA) on MA. The document produced notes that as part of this routine screening process, MA disclosed that he had a history of mental health issues, namely depression and that he was prescribed Escitalopram in the community. MA disclosed that he used methamphetamines (ice) on a daily basis and had last used it "one week ago." A "Kessler 10" test was apparently administered. RN Aberra noted the score as 12/50, indicating that at that time MA was "not experiencing significant feelings of distress." Although MA stated that he was concerned about his mental health issues, RN Aberra also indicated that MA said that he would "cope well in prison". Given the low Kessler score, RN Aberra considered no immediate action was warranted.

RN Aberra states that he would then have created a Request for Information(ROI) form to obtain treatment and medication information from MA's community health care providers for future collection. He also made a referral in the Patient Administration System (PAS) for MA to be placed on the waiting list to be reviewed by the Adult Ambulatory Mental Health Team and the Drug and Alcohol Team. At the time of collecting the initial information, RN Aberra stated that he had access to limited information as the inmate's previous files would have been held elsewhere and it was not RN Aberra's usual practise to request them at the time of the initial screening.

RN Aberra was also tasked to complete the Health Problem Notification Form (HPNF). This document is the main conduit of health information from JH&FMHN to correctional officers and is used to assist in the making of cell placement decisions. This form appears to have been auto-filled as having been completed at 9.51pm, that is prior to the RSA. There is no explanation for this discrepancy. The information on the form is extremely brief. "Normal Cell Placement" is recommended. This designation could mean MA was housed by himself or with another inmate(s) in a normal cell.

The section of the HNPF which is used to alert correctional officers to signs or symptoms that should be reported to JH&FMHN staff adds little valuable information. It states "New reception – previous experience/Hx Mental Health condition/Guarantees own safety." In other words, there is nothing to alert correctional staff to the possibility of suicidal ideation or any particular issue to watch out for. RN Aberra gave evidence at the hearing. Unsurprisingly, after the time which has now elapsed, he had no independent memory of the brief assessment process he had conducted with MA and was thus unable to expand further on his initial impression of MA.

RN Aberra was questioned briefly on the question of ice withdrawal. He had noted on MA's form that MA's last ice use was a week ago. RN Aberra did not appear to be worried about the potential effect of that. He stated "Technically, there's no withdrawal from ice. Once they're off it for a week there shouldn't be - there's no, as such, withdrawal. There might be - often then they might feel distressed for a little while but it is not as bad as the other drugs we normally use – where we use withdrawal management."

It is impossible to know why MA told his cellmate that he had been using consistently for 13 days and yet he apparently told RN Aberra that he had last used a week previously. Whatever the reason, the information recorded by Nurse Aberra did not ring any particular alarms bells. In my view it is likely that MA's use was heavier and more recent that RN Aberra realised. The behaviour outlined in his recent charge sheet indicates that it is likely MA had been on an ice binge, prior to his entry into custody. When questioned RN Aberra felt confident that he had sufficient training in relation to drug and alcohol issues, however it may be that front line medical staff should receive further training in relation to the potential mood effects of ice withdrawal. Anecdotal evidence now suggests high levels of ice use in persons entering custody. It may be that reception staff should be encouraged to be more curious in relation to the possible effects of sudden amphetamine withdrawal, particularly in patients with known mental health issues such as depression.

MA's medication

RN Aberra recorded that MA had been taking an oral dose of Escitalopram (20mg) daily. It appears that he did not have the medication or prescription on him. To receive medication in custody, a patient must be prescribed that medication by a GP or psychiatrist in the correctional centre. In this case RN Aberra did not see any urgent or compelling reason to depart from the normal practise which was to record MA's usual medication and place him on the mental health list to be seen by a psychiatrist who could assess him and if necessary continue the prescription. RN Aberra appears to have understood this may have taken some time. However he stated that if MA had been looking "very unwell" he would have kept him in the clinic and created a HPNF which would keep him in there until he could be cleared by the Mental Health Team or a GP. During the short time MA was in custody he did not receive his medication. There was no evidence before me to indicate whether he had been compliant in the community or what the effect of ceasing his medication may have been.

MA's cell placement

After screening by JH&FMHN staff, an inmate is reviewed by a reception officer. Notwithstanding that a JH&FMHN nurse has recommended normal cell placement, a correctional officer may nevertheless decide that further review should take place. If, for example a correctional officer observes worrying or "abnormal" behaviour then the officer can place the inmate on a Mandatory Notification Form (MNF) which is then reviewed by the Centre's Risk Intervention Team (RIT). This process is known as "placing an inmate on a RIT."

The court was told that on 9 September 2016, Correctional Officer Derrick Brown reviewed the HPNF prepared by RN Aberra in relation to MA. On the basis of information available to him, Mr Brown recorded that MA should be given "normal cell placement". This designation meant that he could be placed with or without a cellmate and would be housed in a "normal cell." This is sometimes called a "white card." Inmates on a "green card" must only be placed with another inmate and cannot be left alone for any length of time.

It is clear from the statement provided by Correctional Officer Brown that he misunderstood the nature of the decision he was called upon to make when he placed the inmate. He states "the placement of inmates as either one-out or two-out cell is the decision of Justice Health staff." This is incorrect and although correctional officers will properly take into account information recorded in the HPNF, decisions relating to cell placement rest with the correctional officer.

MA was placed in area 3A with a cellmate, SW. SW said that MA had been honest about assaults he had recently committed on his partner and spoke candidly of the breakdown of their relationship. MA was reportedly heartbroken about missing his children, whom he loved dearly. SW told the investigation that MA admitted that he had smoked ice for 13 days straight following his release from custody on the last occasion. He had not slept during that time. SW explained that MA was exhibiting withdrawal symptoms and that since arriving had slept all day and night. While he understood that MA was distressed about the long sentence he may be facing, SW stated that he did not realise that MA was suicidal. On the contrary he stated that MA appeared "in good spirits" when SW left for medical treatment on the afternoon of MA's death. In SW's view "it was the drugs that done that."

Photographs tendered in these proceedings show that MA's cell had numerous potential hanging points, including but not limited to the bars to which he ultimately attached his bed linen.

The evening of 11 September 2016

MA and his cell mate were provided with their evening meal around 2.30pm. According to his cell mate SW, MA ate his meal, then showered and shaved. About 3pm the centre was placed in lock down and a final bed count was conducted according to normal routine.

A short time later SW smoked a nicotine patch. SW was asthmatic and the patch triggered an asthma attack about 4.20pm. MA used the cell intercom to call correctional officers to inform them that SW was having chest pains. At 4.22pm Correctional Officers and Justice Health staff attended the cell and transferred SW to the medical clinic for observation and treatment. Prior to removing SW they confirmed that MA had a "white card" which meant that he could be left alone.

Later that evening it appears that SW was well enough to return to his cell. At 7.09pm correctional officers Aimee Flynn and James McCarthy returned SW to his cell. As they opened the door they saw that MA was hanging towards the back of the cell with his face to the wall. He appeared suspended by a torn bed sheet. SW was removed from the area and a CERT call was initiated. Officers cut MA down using a "911" tool and lay him on the floor to commence CPR. He was taken outside the cell, where there was more space and assisted by officers until paramedics arrived at 7.26pm. He was pronounced dead, four minutes later.

What steps have been taken at Parklea Correctional Centre to remove or reduce the risk of inmates hanging themselves?

One of the tragedies of MA's death is that it is not an isolated incident. Hanging points are a longstanding and well recognised problem in the custodial environment. As a result of coronial recommendations back in 2010, Corrective Services NSW (CSNSW) conducted a state-wide survey and audit of the Corrective Services estate for obvious hanging points and "high risk" furniture installations. This resulted in some positive change in relation to "step down cells" in a variety of NSW Gaols, not including Parklea. More recently there have also been some attempts to address suicide mitigation strategies at Parklea Correctional Centre.

A review by GEO in 2017 resulted in the document "Action Plan – vulnerable Inmate and Suicide Protection Strategies" The stated objectives of that review were to identify the most appropriate and cost effective ways to significantly reduce and eliminate hanging points in Parklea's normal placement cells and to implement a funded project to remove obvious hanging points identified in Parklea's normal cell placement. Some of the strategies included removal of fixtures such as shower curtain railings, metal louvres fitted to windows above cell doors and metal bars anchoring shelving units to walls. The plan required the cooperation of CSNSW. The work recommended in 2017 was largely completed but represented a "partial fix".

One of the initiatives was to increase the number of "step down" cells. These cells have reduced hanging points. These additional cells have increased the capacity to transition inmates from safe cells to normal discipline in a more staged approach that is consistent with a policy of least restrictive care but which provides some additional safety for inmates. Other initiatives relate to architectural and furniture changes in some cells, and changes in relation to screening policies for fresh inmates.

In October 2018 CSNSW arranged for Perumal Pedavoli Architects (PPA) to conduct a high- level review of areas 1, 2 and 3 of Parklea Correctional Centre to identify risk issues in normal placement cells. The preliminary report entitled "Review of Ligature Points in Existing Cells – Areas 1, 2 & 3" was produced. A wide range of fittings were reviewed including bunk beds, cell windows, cell desks, door handles, wash basins and light fittings. However, the authors cautioned that looking at individual fittings in isolation from the remainder of the cell environment "would not result in a safer cell." A "whole of cell" design solution was needed.

The report states “the design of the furniture in the Parklea cells does not lend itself to any form of rectification that would eliminate all ligature risks. Each cell type differs due to retro fitted items installed over the life of the prison. Some issues are simply not able to be fixed without replacement. The cell furniture should be removed and replaced with custom built items designed to current standard.” The report concluded that further work was needed to address the identified risks at a more specific level.

The court was provided with a statement from Julie Ellis, Director of Corrective Services Governance and Continuance Improvement Division. Ms Ellis also gave oral evidence. She stated that there has been no decision to commission any further consultants to address the issues raised in the PPA report. She stated “it may be that, as is foreshadowed in the report’s conclusion, a whole of cell design solution might prove more expensive by way of retrofitting than building a new facility. In either case, there are clear budgetary implications surpassing the financial capacity of CSNSW and/or the new operator and whose solutions would require government commitment and budgetary support.”

While some changes have been made to some cells at Parklea, the cell MA died in and others in that area remain unsafe with known hanging points. There appears to be no plan to rectify that situation and no government commitment to make implementation of such a plan possible.

The need for recommendations

I have carefully considered the need for recommendations in this matter. The problem lies with the fact that we are imprisoning people in cells which are known to be unsafe and unsatisfactory. A cost analysis decision appears to have been made that it is just too expensive to remodel every unsafe cell in this state. There is an acceptance at a departmental level that comprehensive change is currently unfeasible. It is in my view entirely unacceptable, however I am sceptical that any recommendation I make will change this regrettable situation. Given the known architectural risks are not being tackled, more must be done to increase other protective strategies.

I note that the contract between CSNSW and MTC-Broadspectrum has been written to provide penalty for unnatural deaths. One hopes this adds additional commercial pressure to the new operator to avoid unsafe cell allocation.

On a review of the evidence, I remain concerned about the possible missed opportunity that occurred on MA’s reception. His cellmate reported that MA had just ceased a major “ice binge”. For reasons which remain unclear this information was not obtained during MA’s initial health screening. I wonder whether it is time to review the training given to induction nurses in relation to the potential mental and mood effects of ceasing amphetamines after heavy use, particularly in an inmate with a known history of depression. However, there appears little utility in making recommendations to GEO, who no longer operate the prison. MTC-Broadspectrum indicated that its medical services at Parklea will be run by a new provider, SVHS.

For this reason, I have decided not to make a formal recommendation in this regard, but given the cooperation MTC-Broadspectrum has shown during the inquest, I request that MTC-Broadspectrum considers alerting its health provider, SVHS to this issue by providing a copy of these findings to it for review.

The other area where a recommendation was considered involved introducing formal protocols to mitigate the risk of placing people with documented mental health histories *alone* in cells known to provide hanging points, prior to a full mental health assessment. CSNSW indicated that recent changes mean that there are now more cells in Areas 1 and 2 where such prisoners could be placed. These cells have been modified to reduce obvious hanging points. This may assist some inmates. The need to consider placing those at possible risk in two-out cells must also be considered. While each cell placement decision must be considered individually, one cannot help but wonder if MA had been placed two-out, at least until he had been screened by a mental health practitioner, he would be alive today. It is certainly clear his suicidal action did not commence until he was left alone.

It is well known that the decision to kill oneself can be sudden and impulsive. I accept it is difficult to predict and I note that neither RN Aberra who screened MA, nor his cell mate thought MA was suicidal. In the gaol environment there are many documented cases of prisoners making this decision when left alone, even for short periods of time. There is a well-known protective value in housing prisoners with a compatible cell mate. With hindsight, MA should have been housed with another inmate in a two-out placement at least until he had been reviewed by a mental health practitioner and re-commenced on medication.

I am aware the Magistrate Elizabeth Ryan recently made a recommendation in the *Inquest into the death of L* aimed at exploring options for obtaining tear resistant sheets for inmates in normal cell placement. I support that recommendation.

The safety issues at Parklea remain. It appears that CSNSW has no current intention or ability to provide the financial backing necessary to alter cells in Area 3, where MA died. MTC-Broadspectrum and SVHS need to manage the suicide risk, as best they can, by careful mental health screening and cell placement decisions. In my view the architecture remains unsatisfactory, with little chance for rectification in the short term. While I make no formal recommendations to the new providers, I hope they will carefully review these findings in a genuine attempt to develop strategies and policies which may create a safer environment for vulnerable prisoners in this troubling context.

Conclusion

MA's tragic death was unforeseen by those entrusted with his care. I accept that his decision to take his own life was likely to have been both sudden and unexpected. Once alone, he appears to have fallen into a state of profound despair. However he was placed in a cell that offered numerous hanging points.

Had he not been able to attach his torn bed sheet to a hanging point in his cell, he may have survived until his cell mate returned. Equally, had he been placed "two-out" until he was seen by a psychiatrist, he may also have been somewhat protected. MA is not the only prisoner to have died in these circumstances.

Finally I offer my sincere condolences to MA's family and friends. His despair in custody is a tragedy and I acknowledge their grief and loss.

I strongly urge that any published report of this death include reference to suicide prevention contact points.

Findings

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

Identity
The person who died was MA

Date of death
MA died on 11 September 2016

Place of death
MA died at Parklea Correctional Centre, Parklea, NSW.

Cause of death
MA died from hanging.

Manner of death
MA's death was intentionally self-inflicted.

10. 329687 of 2016

Inquest into the death of Paul Dennis LAMBERT. Findings handed down by State Coroner O'Sullivan at Coffs Harbour on 15th February 2019.

Paul Lambert was born on 10 August 1980 in Queensland. He was 36 years old when he died on 3 November 2016. The shooting was a culmination of a series of dramatic and tragic events that day. Mr Lambert died after he attempted to kill Dr Angela Jay in Port Macquarie, was involved in a police pursuit and stand-off on the Pacific Highway, and was ultimately shot multiple times by officers of the NSW Police Force at approximately 9:38pm on 3 November 2016. At the time he was shot, he was advancing on a number of police officers with a raised knife. He received gunshot wounds to the upper body and died at the scene.

As Mr Lambert died in the course of a police operation, an inquest is required to be held pursuant to ss. 23(c) and 27(1)(b) of the *Coroners Act 2009* ("the Act").

The nature of an inquest

The role of a Coroner, as set out in s. 81 of the Act, is to make findings as to:

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

There is no controversy about Mr Lambert's identity, or about the date and place of his death. As to the cause of death, the available medical evidence suggests that the cause was three gunshot wounds to the chest and abdomen which, according to forensic pathologist Dr Lyons, would have "rapidly and inevitably lead to death". Accordingly, the focus of the inquest was on the manner of Mr Lambert's death, both in the two weeks leading up to the shooting and the shooting itself. The inquest examined if the death was preventable.

A secondary purpose of an inquest is to determine whether it is necessary or desirable to make any recommendations in relation to any matter connected with the death, including in relation to matters of public health and safety.

The Facts

Mr Lambert (nee Scales) was born in Queensland and was 36 years old when he died. His mother and father separated in 1986, when he was four years old. He had an older sister, who is married with a family. Mr Lambert's father had two boys in a subsequent relationship and two daughters from a previous relationship.

Mr Lambert graduated from St James Practical School in 1998 and completed a tertiary degree in business and finance at Queensland University of Technology/Southern Queensland. Mr Lambert worked in a finance position at a motorcycle dealer in Hervey Bay and when he moved to NSW he found a job in finance at a motorcycle dealer in Kogarah.

Mr Lambert's family attended every day of the inquest hearing, which is a testament to the love they held for him. Through their advocate Mr Evenden, they asked intelligent and reasonable questions of the individual police officers and showed considerable compassion and respect towards them. On the final day of the hearing they read a beautiful statement which illuminated a kinder, gentler and more complex person than the evidence had revealed. I thank them for their presence and contribution.

Mr Lambert's criminal history

Mr Lambert had a history of intimate partner violence. It appears that Mr Lambert engaged in criminal conduct towards many of his previous girlfriends and, between March 2003 and October 2016, he was the subject of 10 interim or full apprehended domestic violence orders ("ADVOs") in respect to five women (including Dr Jay). On three occasions, he was charged and convicted in relation to breach of an ADVO.

The evidence indicates that Mr Lambert repeatedly engaged in controlling, intimidating and sometimes physically violent behaviour towards his partners. He had a pattern of engaging in dramatic behaviour when women tried to end relationships with him. This included threatening to kill himself, inventing elaborate lies about family members dying or claiming that he had cancer or had been sexually abused as a child. Sometimes he would contact family members of romantic partners and make threats of harm or created false identities to stalk partners. He would claim diagnoses of various psychological disorders to excuse his behaviour, implying that he suffered from a dissociative or multiple personality disorder (referring to "bad Paul" or "evil Paul"). At one stage, Mr Lambert claimed to have nine personalities.

On 2 February 2014, Mr Lambert married a woman he had known since 2008. The relationship quickly became troubled but they travelled to the US for holidays and renewed their vows in Orlando, Florida in September 2014.

Mr Lambert returned to Florida in 2014, while he was still married, and began a relationship with a television reporter, Ms Brittany Keil, after meeting her via a dating application. His marriage broke down and he moved to Florida to be with Ms Keil in around March 2015.

Like his past relationships, whenever Ms Keil tried to end the relationship Mr Lambert would invent a major life trauma, for example the death of his father, a history of sexual abuse or diagnoses of a brain tumour and she felt pressured to stay. When Ms Keil finally terminated the relationship, Mr Lambert harassed her and threatened to release private information about her to her employer and other news stations. Ms Keil reported the conduct to police and Mr Lambert was arrested on 11 May 2015 and charged with stalking and extortion. He was deported on 23 June 2015, after spending approximately a month in immigration detention. It appears that Mr Lambert changed his name from Paul Scales to Paul Lambert after he was deported from the US.

When Mr Lambert's wife found out that he had been deported for offences against a woman she went to police in Hervey Bay in Queensland and told them that Mr Lambert had also stalked and intimidated her. She was granted a protection but Mr Lambert breached it on a number of occasions and, on 22 February 2016, he attacked her while they were travelling to a Justice of the Peace to sign divorce documents. During the car ride, Mr Lambert verbally abused his wife, made comments that "*he may as well crash the car*", accelerated the vehicle, then grabbed her neck and punched her in the face. She escaped and Mr Lambert was charged with a number of offences including assault occasioning actual bodily harm.

On 19 July 2016, Mr Lambert was convicted of assault occasioning actual bodily harm and sentenced to nine months imprisonment with immediate release to parole. Convictions were also recorded for driving offences and contravention of the protection order, for which he was sentenced to 12 months' probation and disqualified from driving for two years.

In around May 2016 Mr Lambert had moved into a boarding house in Kogarah and commenced work nearby at a motorcycle dealer. He stayed living and working in NSW after his convictions in breach of his parole and probation orders.

Mr Lambert's parole

It is a condition of every Queensland parole and probation order that offenders cannot leave Queensland (or live or work in another State) without the permission of the Queensland Probation and Parole Service. Breach of parole orders can lead to a suspension of parole by the Probation and Parole Service (depending on the circumstances and the outcome of a risk assessment) and the matter is referred to the Parole Board of Queensland to determine the action to be taken.

Mr Lambert was supervised by a Probation and Parole Service Senior Case Manager, Ms Raewyn Sanson. At his initial risk assessment on 19 July 2016, Mr Lambert requested that the orders be transferred to NSW so that he could live and work there.

He expressed surprise that he was not able to live in Sydney or travel as he pleased and said he was not aware of these conditions of his sentence. His application to transfer his orders to NSW was declined on 27 July 2016. Mr Lambert was told he could return to NSW to collect his belongings from 17-22 August 2016. A further application to transfer his orders was declined on 19 September 2016.

However, Mr Lambert did not return to Queensland and he started actively deceiving his Case Manager, flying back to Brisbane from Sydney for their meetings. On 9 August 2016, Mr Lambert falsely told his Case Manager that he was living on the Sunshine Coast for a few days work at a motorcycle company, staying with his sister, and that he spent the rest of the time in Brisbane residing with his parents. On 20 September 2016, he reported that he was working full-time. It appears that no collateral checks were made with his mother, sister or his employer to verify where he was living and working.

Mr Lambert was directed on 23 August 2016 to attend the Responsible Men program (a program aimed at preventing domestic violence) but he requested to do the program through his own psychologist. Mr Lambert had not undertaken the course by the time of his death. It appears he was not actually seeing a psychologist at the time and no check was made. Mr Lambert called in sick when he was required to report to his Case Manager on 31 October 2016 and did not report on his next scheduled meeting on 3 November 2016, the day he died.

Ms Sanson states that if information was received that Mr Lambert was living and working in NSW it is highly likely that action would have been taken to suspend his parole order and a warrant would have been issued for his arrest. However, Mr Lambert's breach of parole had not been discovered by the time of his death.

Psychological and psychiatric issues and treatment

It does not appear that Mr Lambert was being treated for any mental health issues at the time of his death. An anti-depressant/mood stabiliser, Olanzapine (Zyprexa), was found with his belongings after his death but the drug was not detected in his post-mortem blood. Mr Lambert told his mother and sister and others that a psychologist had diagnosed him with a borderline personality disorder whilst in immigration custody in the US.

Dr John Aloizos started seeing Mr Lambert when he was seven or eight years old and described him as "*always [having] had behavioural issues*". He referred Mr Lambert for psychological treatment at around the age of 10. Dr Aloizos saw Mr Lambert on seven occasions between 2015 and 2016. He initially prescribed Mr Lambert with the anxiety medication Ativan but Mr Lambert told Dr Aloizos that he had been diagnosed with borderline personality disorder in the US and Dr Aloizios issued a mental health plan for Mr Lambert to see clinical psychologist Joey Tai. On 6 August 2015, Dr Aloizios prescribed Mr Lambert with anti-depressants but on 3 November 2015 Mr Lambert indicated that Mr Tai had diagnosed him with bipolar disorder and Dr Aloizios issued a prescription for Olanzapine. Dr Aloizios urged Mr Lambert to see a psychiatrist to no avail.

On 22 July 2015, Mr Lambert had attended psychiatrist Dr Simone Becker. Dr Becker considered that Mr Lambert was suffering from symptoms suggestive of a manic episode with psychotic features and advised him that he required immediate in-patient treatment. Mr Lambert presented himself to the Emergency Department ("ED") at Royal Brisbane Women's Hospital and was assessed by mental health clinicians who determined that he did not require inpatient care. Dr Becker subsequently contacted the ED psychiatrist to express her concerns and referred Mr Lambert to the Mental Health Acute Care Team.

On 7 December 2015, Mr Lambert informed Dr Aloizos that he had stopped taking Olanzapine. Dr Aloizos said in his statement that "*it was obvious to me that Paul had a personality disorder*". On 5 October 2016, Dr Aloizos received a message from his administrative staff that Mr Lambert had requested an extension of his mental health plan. Dr Aloizos completed the extension and gave it to Mr Lambert's mother. He did not see Mr Lambert on this occasion.

On 4 August 2015, Mr Lambert started seeing Mr Tai. He had 17 sessions in total, the last being on 3 May 2016. On the first occasion they met, Mr Lambert provided Mr Tai with a 17 page document outlining his life and mental health issues. Mr Tai diagnosed Mr Lambert with borderline personality disorder and secondary depression, and recommended ongoing psychological intervention.

According to his contemporaneous clinical notes, Mr Tai repeatedly warned Mr Lambert not to contact him outside sessions and told him that he would not respond to any non-administrative message. Mr Lambert would often threaten suicide to gain attention but he also told Mr Tai that he would not have the courage and that he made the threats to manipulate people. Mr Tai told Mr Lambert that he would not respond to suicide threats and that if he felt suicidal he should contact emergency services.

During Mr Lambert's last session with Mr Tai on 3 May 2016, Mr Lambert said he was moving to Sydney. On 27 October 2016, Mr Lambert sent a message to Mr Tai that read:

> *"Hi joey if you have anyone cancel today could you please call me for a phone appointment. I've fallen off the rails again. Been very suicidal and not functioning properly"*

On the same day Mr Lambert made an appointment to see Mr Tai on 3 November 2016. Mr Tai recorded in his notes that he did not respond to Mr Lambert's text message because he had made an appointment and due his policy of not responding to Paul Lambert's regular threats of suicide.

Forensic psychiatrist Dr Kerri Eagle was retained during the coronial investigation to provide a retrospective diagnosis of Mr Lambert (sometimes called a psychiatric autopsy). She opined that Mr Lambert most likely had Bipolar 1 disorder and severe personality disorder with borderline and narcissistic personality traits. Dr Eagle considered that the disorder was longstanding and that it affected had Mr Lambert's relationships from late adolescence/early adulthood.

Dr Eagle's report states that, while Mr Lambert would have benefitted from assessment and ongoing treatment by a psychiatrist, there are no real options for the treatment of entrenched stalking behaviour and legal frameworks have so far proved ineffective.

Relationship with Dr Angela Jay

At the time that she met Mr Lambert, Dr Jay was living in Port Macquarie and doing a rotation at Port Macquarie Hospital as a trainee obstetrician and gynaecologist.

Dr Jay met Mr Lambert via a dating application in around August 2016. The long distance relationship lasted for approximately two months. It was normal and happy at first, with the pair travelling to see each other on weekends, but soured after Dr Jay started to feel overwhelmed and Mr Lambert began engaging in controlling and possessive behaviour.

Towards the end of the relationship, Mr Lambert used the techniques he had used in previous relationships to emotionally manipulate Dr Jay and make her feel unable to reject him, including threatening self-harm and suicide, claiming to have various mental illnesses, lying about deaths in his family, manufacturing crises and stating that he needed help. Mr Lambert also invented a friend called "Dan" and registered a different phone number to text Dr Jay as "Dan" to tell her that "Paul" had attempted suicide . "Dan" used Dr Jay's caring nature and sense of responsibility against her. He told her that she had a duty to look after Paul because she was a doctor and pressured her to reconcile with him, telling her she was heartless and the only person who could keep Paul alive. Dr Jay was aware through her work of the risk of suicide in people with borderline personality disorder. The techniques of manipulation may seem obvious in retrospect but they were subtle and insidious at the time, involving layers of escalating emotional abuse. It led to an erosion of Dr Jay's confidence and self-worth and to her doubting her own judgment and her own behaviour.

On Saturday 29 October 2016, Dr Jay agreed to allow Mr Lambert to accompany her, strictly as a friend, to a school reunion function at the Crowne Plaza in Terrigal. During the night Dr Jay became emotional and confided to a friend that she felt scared of Mr Lambert and that he was emotionally blackmailing her into resuming the relationship. Mr Lambert left the function with Dr Jay's bag, phone and keys and her friends retrieved them for her.

Dr Jay told the inquest that the concerned reaction of her friends helped her to see the relationship in a new light. Dr Jay stayed the night at her sister's house that night and Mr Lambert appeared unannounced a couple of times through the night. He also sent Dr Jay approximately 50 threatening messages and phone calls. Dr Jay's sister urged Dr Jay to go to the police.

The week of 30 October 2016

Dr Jay goes to the police - Gosford Police Station 30 October 2016

On the morning of 30 October 2016, Dr Jay attended Gosford Police Station with her sister. She told Senior Constable ("SC") Bradley Clarkson that she was scared of Mr Lambert and felt that he was emotionally blackmailing her with threats of self-harm. SC Clarkson checked the National Suspects and Offenders System and found what he described as "an extensive history of mental health and officer safety issues". SC Clarkson did not tell Dr Jay what was in the records (and had no power to do so) but suggested to Dr Jay that the information "was more pertinent to self-harm and officer safety". Dr Jay told the inquest that SC Clarkson was kind and made her feel validated. He encouraged her to call police if there were more threats of self-harm or concerns for her safety.

The National Suspects and Offenders System entry for Paul Lambert included warnings about the risk of self-harm and violence towards police, details relating to three expired protection orders relating to past partners, an active protection order in relation to his former wife and Mr Lambert's convictions for attacking his wife in the car. There was nothing on the system which would have alerted SC Clarkson to the fact that Mr Lambert was in breach of his parole (or of the content of his parole and probation conditions).

The COPS entry prepared by SC Clarkson in respect to Dr Jay's visit to Gosford Police Station records that Dr Jay said she did not want to report an offence but wanted to make sure it was reported in case the situation escalated. The matter was recorded as "domestic violence – no offence". Gosford senior officers reviewed the file and ultimately there was a decision to attend Mr Lambert's house in Kogarah and make a welfare check.

Paul Lambert stalks Dr Jay in Port Macquarie and is pulled over by police

On the same day Mr Lambert took leave from work telling his employer he was having issues with his girlfriend. He flew to Port Macquarie and rented a white Corolla hatchback from 1st Class Rentals at the airport telling manager Lee Scott that he was trying to make amends with his girlfriend. Mr Lambert was disqualified from driving but Mr Scott had no access to any system which would have identified his license status. I address a recommendation proposed by Mr Scott below.

At 2:17pm on 30 October 2016, Mr Lambert went to Bunnings at Port Macquarie and bought a utility knife, a hatchet (an axe) and two 30 metre rolls of duct tape. At 4:20pm on 30 October 2016, Mr Lambert was pulled over by SC Justin Cordell for driving 71km in a 50km/h zone. He was found to be disqualified and appropriately issued a Court Attendance Notice ("CAN"). Mr Lambert persuaded SC Cordell that he was unaware that his license was disqualified and SC Cordell noted that he had a good traffic record. Mr Lambert told SC Cordell that he would ask his girlfriend (whom he said was a doctor) to collect the car and return it to the rental company.

He walked away but then returned and sat in the gutter until SC Cordell and his fellow officer left the location... Presumably, Mr Lambert then drove away.

As Counsel Assisting noted in her opening, at the time Mr Lambert was pulled over by Port Macquarie police he was disqualified from driving, in breach of his Queensland parole, had been subject to a complaint by Dr Jay for frightening her (but not an ADVO) and had purchased weapons suggesting violent intentions towards Dr Jay. The weapons may well have been in the car when SC Cordell was speaking to Mr Lambert. The officer in charge Detective Chief Inspector ("DCI") Mark Henney informed the inquest that police have no power to confiscate keys from disqualified drivers. This is a matter outside the scope of this inquest.

Later that night on 30 October 2016 Dr Jay drove back from Gosford to Port Macquarie. Mr Lambert was waiting at her house when she arrived. Dr Jay returned his bags without allowing him into the house. During the conversation, Mr Lambert told her that "Dan" was not a real person and he was just trying to get her attention. He also stated that he was "*the good Paul*" but he could feel "*the bad Paul*" taking over. Dr Jay was frightened and called Port Macquarie police.

About 6:00 or 7:00pm on 30 October 2016 Mr Lambert texted Dr Jay and Dr Jay again called the police. At 7:07pm she sent a message to Mr Lambert:

> *"Don't ever contact me again".*

At 7:30pm she received a message which read:

> *"Angela you need to call the police right now. Get them there. When they are there ring me and I will tell you and them why. I need you to understand that this is my good side right now. That good side wont last long. Especially being rejected Call the police when they are they ring me and put me on speaker Text ok back that you understand I care about your safety".*

At 8.13pm she received a message which read:

> *"Are they there yet? Go to a neighbours house until they do. Im not near by atm I need you to fully understand this is the good side still. I cant keep it long and need positive reinforcement for it to stay for long periods. I know you're scared right now and rightfully so but please know Im doing this for you. OK?"*

At 8.16pm she received a further message:

> *"Ang I need you to be positive with me ok. Encourgae [sic] the good. I know it sounds wacky but its how it happens in me. Your not safe in that house. I have some of the house keys"*.

Dr Jay called the police four times between 7:08pm and 8:16pm as she became increasingly concerned about the messages and, after the last message, went to her neighbour's house. While Dr Jay was waiting she received more messages from Mr Lambert stating he had keys to her house and she realised that some of her keys were in fact missing.

SC Mick Gentle and SC Styles arrived around 9:00pm and took Dr Jay to Port Macquarie Police Station. An interim ADVO was made on her behalf. While Dr Jay was at the station, Mr Lambert called and SC Gentle answered the phone. Mr Lambert hung up but called again. Dr Jay said she overheard Mr Lambert's voice on the phone saying he could not trust "*the other Paul*" as he didn't know what he was capable of. SC Gentle told Mr Lambert that his conduct was terrifying Dr Jay and that he needed to stop. He also told Mr Lambert and that he was taking out an ADVO so he had to stop calling and messaging.

Dr Jay told SC Gentle that Mr Lambert was flying to Brisbane for a parole hearing the next day in order to assist him to serve the ADVO.

In an ideal world, this was an opportunity for NSW authorities to contact Queensland authorities and discover that Mr Lambert was in breach of his parole. However, DCI Henney informed the inquest that the NSW Police Force have no way of knowing the parole conditions of interstate offenders by way of computer inquiry. DCI Henney stated the only way for a police officer to discover an interstate offender's conditions was to contact the Queensland Probation and Parole Service Case Manager directly (an option not available to SC Gentle that night).

In any event, while it is possible that an interstate communication between police and Queensland parole would have led to a warrant being issued for Mr Lambert, it is speculative to find that this necessarily would have occurred before the events of 3 November 2016. I do direct that this finding be provided to Queensland Probation and Parole Service and the Commissioner for the NSW Police Force so that further reflection can take place about how information systems between States could operate more effectively.

After her contact with Port Macquarie police Dr Jay took a number of steps to protect her own safety, some based on the suggestions of SC Gentle and SC Clarkson. She also kept working 24 hour shifts at the Hospital delivering babies and caring for patients. Dr Jay was unable to change her phone number because of its importance to her job.

31 October 2016

The next morning at about 6:30am Mr Lambert sent a text to his mother:

> Mr Lambert: *"Mum I'm in trouble again. I tried to talk to joey [former psychologist Joey Tai] last week but he wasn't available. Could I talk to you jacalyn or Nathan. I almost hurt angela but had enough strength not to. I told her to call the police and she did ive lost the plot and im on the run. Im a mess".*
>
> Mum: "*What can I say … I'm sorry but u need help we can't help u And u knew the outcome and being on the run isn't the answer*"
>
> Mr Lambert: "*I'm psychopath I really am. Could you or Jacalyn call me later when boys have gone to school. I've lost the plot again. Please don't leave me alone*".

Mr Lambert was required to report at the Queensland Probation and Parole Service but called his Case Manager and said he was sick with a head cold. She thought he sounded unwell and said he could report on 3 November 2016.

On the same day, Dr Jay's mother travelled to Port Macquarie to stay with Dr Jay at her house. Dr Jay worked out what keys had been stolen from her keyring by Mr Lambert and removed the locking mechanism from those doors. She also removed a door handle from the downstairs bedroom. She asked her real estate agent to change the locks. She also hid knives in locations around the house. Dr Jay said police called her and told her they were trying to serve the ADVO. She did not hear from Mr Lambert.

The ADVO was never served. Port Macquarie police attempted to serve the ADVO by attending Port Macquarie airport on 31 October 2016 when Mr Lambert was expected to be flying from Port Macquarie to Brisbane for his parole meeting. The ground staff would not tell the police if Mr Lambert was on the plane and told them to contact head office. The two officers informed their supervisor.

31 October 2016

At 10:08am on 31 October 2016 Mr Lambert went to PL Firearms in Port Macquarie and attempted to obtain a gun. The owners Mr Peter Long and Ms Cheryl Long spoke to Mr Lambert. When Mr Lambert was told he needed a license for a gun, he asked for a Taser or capsicum spray (which he was also unable to buy as he was told that Tasers were illegal). He said he wanted protection for a friend who was scared of her ex-boyfriend. Mr Long encouraged him to buy a personal alarm from Jayco and even gave him directions to the Jayco store. Mr Lambert left the store and then returned at about midday and bought a knife, despite Mr Long trying to persuade him to buy a torch instead (these conversations were captured on CCTV footage and extracts were viewed during the inquest). According to DCI Henney, it has not been determined whether the knife bought by Mr Lambert was used in the attack on Dr Jay.

Mr and Mrs Long provided statements to the inquest suggesting a coronial recommendation that weapons sellers be able to opt-in or have voluntary access to an online system that would notify them if anyone seeking to buy a knife has an outstanding ADVO. I have made such a recommendation below.

I note here that Mr and Mrs Long behaved as extremely responsible business owners and citizens. They had no reason to think Mr Lambert was a danger to Dr Jay but they did all they could to encourage him not to buy weapons as it could endanger his safety. Meanwhile, Mr Lambert continued to stalk Dr Jay. At 11:04am on 31 October 2016 Mr Lambert rented a room at the Rotary Lodge at the Port Macquarie Base Hospital under a false name (Brady Jackson), claiming his wife was staying in the hospital. It appears he spent much of the week using the Lodge as a base to stalk Dr Jay.

He told other guests at the Lodge that his wife had a premature baby and spoke about how his wife's doctor was being stalked by a former boyfriend. Ms Patricia Darcy remembered thinking it was odd that "Toby" (as he introduced himself) was more concerned about his wife's doctor than his own wife and baby. She said that "Toby" seemed agitated and was chain smoking.

That night a man matching Mr Lambert's description started chatting to a woman outside Port Macquarie Base Hospital. He told the woman that his wife was in labour inside and persuaded her to let him drive her home to Wauchope. During the drive he put his hand on her knee. She told him that she had a boyfriend and asked him to drop her in the main street.

1 November 2016

The next day – 1 November 2016 – Mr Lambert was seen on CCTV footage at 3:26pm buying and filling a five litre can of petrol when refuelling his car. Earlier that day he had exchanged his white Corolla for a larger X6 Tarago and appeared interested in the luggage area of the Tarago. He returned the Tarago shortly after and reverted to the hatchback stating that the new car was too big (the car was so dirty and full of litter the car rental manager thought he had been sleeping in it). At 11:23am, Mr Lambert sent a text to his sister and brother in law in law stating:

> *"You can call the police this isn't a joke. I won't call again. I have to do this before I change and someone gets hurt. You need to stay away from me im not safe mum too".*

There was no reply to this message. I would like to make very clear that Mr Lambert had a long history of using threats of self-harm and manufactured crises to seek attention. His family had sought professional advice about this on a number of occasions and had been told to ignore these messages. Their actions were entirely appropriate and consistent with their desire to do everything possible to help Mr Lambert.

2 November 2016

On 2 November 2016, Mr Lambert went back to Bunnings and bought a club hammer and a crow bar.

That evening two officer of the NSW Police Force attended Mr Lambert's home in Kogarah. The officers were told that Mr Lambert had not been seen for several days and that he may have been visiting his girlfriend in Port Macquarie. No contact was made with Mr Lambert's family or with Dr Jay and Mr Lambert's Case Manager in Queensland was not aware of the home visit by the police.

Events of 3 November 2016

The attack on Dr Jay

On the morning of 3 November 2016 Dr Jay went to work at the hospital. At about 3:15pm, a neighbour saw a man without a shirt on in Dr Jay's kitchen through the kitchen window. The neighbour saw the same man some time later smoking a cigarette on the back porch of Dr Jay's house.

At about 5:00pm, Dr Jay came home from work. She turned on the TV and reheated some spaghetti bolognese her mother had for made her in the microwave. At around 6:00pm, she went to her bedroom to pack some clothes to stay overnight with her cousin. Mr Lambert emerged from the bedroom walk-in wardrobe and put his hand over her mouth. He was barefoot and bare-chested. He had a knife in his pocket and told her he had taken the knives out of her bedroom drawer (Dr Jay had been keeping a kitchen knife in her bedside table in case Mr Lambert returned). Dr Jay spoke to him briefly and asked to go to the toilet. Mr Lambert let her go but watched her.

After a brief conversation, Dr Jay decided she needed to escape. She ran towards the door but Mr Lambert grabbed her wrist and started stabbing her. Dr Jay received 11 stab wounds to the chest, arms and legs. Mr Lambert also poured petrol over her. This made Dr Jay slippery and she was able to evade Mr Lambert's grasp and run to the neighbours screaming for help.

Dr Jay's neighbours ran to help her and were confronted with a horrific scene. Dr Jay retained consciousness and was able to direct her neighbours to treat her injuries and instruct them about what to tell emergency services. I note that at this time no one knew Mr Lambert had fled the scene and there was some fear the attacker remained nearby. The combination of Dr Jay's medical skills and her neighbours' bravery saved her life.

The neighbours have asked not to be named or otherwise involved in this inquest. I respect their wishes but I commend their bravery and thank them for their efforts. Bystanders play a critical role in preventing deaths from the domestic violence.

An ambulance was called at around 6:27pm and a number of police including Detective Senior Constable ("DSC") Shaun Durbridge attended and canvassed the area for the attacker while Dr Jay was rushed to hospital.

Subsequent crime scene investigations suggested that Mr Lambert had planned the scene for some hours and had items stored in Dr Jay's bedside drawers including duct tape, cable ties and knives. He had also showered and written "*I love Paul*" in condensation on the mirror and stored a fire extinguisher in the bedroom wardrobe.

Dr Eagle states that the attack on Dr Jay was the culmination of a sustained period of stalking and likely prompted by anger and revenge following Dr Jay's rejection. She also states that Mr Lambert may have been in a manic or hypomanic state at the time of the attack which would have impaired his judgment and self-control and increased his propensity for aggressive behaviour.

Dr Jay gave evidence at the inquest and I thank her for her powerful and moving testimony. She was an extraordinary witness and it was a privilege to hear her account. Dr Jay has used her traumatic experience to help others and has become a prominent advocate against domestic violence and she also has assisted patients escaping or enduring violent relationships. Dr Jay said she has been invited to speak about her experiences to police officers undertaking domestic violence training. I commend the Commissioner of NSW Police and the relevant officers for this action. I cannot think of anyone who would not benefit from hearing Dr Jay speak and police officers, in particular, would gain great insight into how to detect the more subtle signs of emotional abuse and the potentially devastating consequences of failing to appreciate those signs.

Events after the attack

After Mr Lambert fled the scene he made a number of communications (presumably from his car):

- At around 7:05pm, he called Dr Jay's phone. Her neighbour answered the phone and then handed it to an ambulance officer. According to the ambulance officer, Mr Lambert said "*how is she*" and *"I didn't mean to do it. I want to talk to her. You know an AVO is not going to stop me. I know where to find her"*.
- At 7:17pm he sent text messages to his mother:
    - Mum: *"so whats next Paul"*
    - Mr Lambert: *"I'm sorry mum I'm taking my life"*
    - Mum: *"And how ru doing that"*
    - Mr Lambert: *"Truck or building"*
    - Mum: *"I'm sorry"*
- At 7:34pm Dr Jay's mother received messages from Mr Lambert on Facebook Messenger, which included screen shots of messages sent to Dr Jay:
    - *"I told the Police to do more. I told them they wouldn't listen. Now he's hurt someone I care about deeply. I hope she is ok. I'm going to kill myself and I'm sure you welcome it. Tell Angela I'm sorry I wasn't strong enough to stop him. He tried to stab her and light her on Fire"*
    - *"he's fighting his way out and I can only hold on so long. I'm not dominant"*
    - *"an AVO isn't enough tell them to do more"*
    - *"I'm sorry you're scared. I'm saying this to protect you"*.
- At 7:35pm, Mr Lambert contacted a Sydney police station and told an officer that he had stabbed his girlfriend and set her alight and was planning to throw himself under a truck on the highway.
- At 7:39pm Mr Lambert's sister called him. He told her the police were chasing him and he was sick of hurting everyone. She told him to seek help from the police or a hospital but he ended the call saying "*goodbye Jacalyn*".
- At 7:44pm Mr Lambert called the Port Macquarie Police Station and informed an officer "*I just tried to kill my girlfriend*". He said he was on a highway and wanted to jump in front of a truck.

- At 7:53pm Lambert spoke to DSC Durbridge who called his mobile phone. Mr Lambert told him to put police guards at the hospital and at Dr Jay's mother and sister's house and during the call he said "*I watched it in my head and I wasn't strong enough to stop it*". Lambert terminated the call.
- DSC Durbridge spoke to Inspector Fuller about engaging police negotiators and Inspector Fuller requested their assistance at 8:00pm.
- At 8:02pm DSC Durbridge called Mr Lambert on his mobile phone. Mr Lambert described stalking Dr Jay over a few days, knocking the locks out of the rear door to enter the house and waiting for an hour and half for Dr Jay to come home. He talked about himself in the third person. Mr Lambert told DSC Durbridge that "he" was going to force sex on Dr Jay, tie her up, strangle her, pour petrol on her and kill her. DSC Durbridge tried to get Lambert to meet with him to no avail.
- At 8:10pm the on-call negotiator declined to assist because of the perceived risk of erratic behaviour while talking to Mr Lambert on a mobile phone whilst driving at high speed.
- At 8:17pm, Mr Lambert tried unsuccessfully to call his former psychologist Mr Tai. It appears the call went to voicemail.
- At 8:18pm and 8:20pm, Mr Lambert he called his estranged wife. This call was recorded by her sister in order to prove that Mr Lambert was in breach of a protection order. During the call, he told his wife that he had stabbed someone and set them on fire and told her to get her mother and sister and keep them safe.

The Pursuit

At 7:05pm it was identified that Mr Lambert had been stopped in Port Macquarie four days earlier and a description of the vehicle was broadcast over the police radio known as VKG. A series of broadcasts followed including that Mr Lambert was wanted for a stabbing and attempted murder, that he was "armed and dangerous" and should be treated with "extreme caution" and that he had previous warning for firearms, suicide and self-harm.

Police located Mr Lambert driving north on the Pacific Highway at around 8:00pm after triangulating his phone. A police pursuit started at about 9:00pm when Mr Lambert failed to stop for Highway Patrol officers SC Craig Myles and SC Logan O'Donahue (in vehicle North 296).

The pursuit was appropriately terminated at 9:14pm but recommenced soon afterwards with SC Damien Buckley as the lead driver in an unmarked police car. During the pursuit Mr Lambert engaged in extremely dangerous driving that put himself, police and other road users at serious risk.

The pursuit ended at around 9:30pm after road spikes were successfully deployed near Bonville by SC Gio Zugajev and SC Rodney Peters. An earlier attempt to use road spikes by Acting Sergeant Wallace Brooks and SC Vicky Bamford had failed after dangerous driving by Mr Lambert.

The stand-off on the Pacific Highway

Mr Lambert exited the car; he was bare-foot and wearing shorts and a jumper. In-car video ("ICV") footage shows him facing the officers and raising the knife above his head before turning and running away towards the median strip.

SC Myles and SC O'Donohue can be seen on the ICV footage running after Mr Lambert and vaulting over a concrete barrier on the median strip. SC Buckley followed.

Other officers engaged in the highway pursuit arrived soon after. Some searched the bushland west of the car, partly as a result of an erroneous broadcast on VKG that Mr Lambert had run towards the west. The responding police vehicles parked on the highway effectively blocked traffic on the northbound side of the highway within five minutes of their arrival.

Meanwhile SC Myles, SC O'Donahue and SC Buckley engaged in a chase north up the southbound side of the highway (in other words they ran on the road towards the oncoming traffic). The lighting was poor and cars narrowly missed the group including two large B-double trucks. I attended the scene at night as part of the inquest and can only imagine how frightening it must have been for those officers to run towards an armed and dangerous man while trucks roared towards them in the darkness.

As they ran, the officers, particularly SC Buckley, urged Mr Lambert to get off the road and to put down his weapon. At one point Mr Lambert yelled "*I've got a knife*" and SC Myles replied "*I've got a gun, put the knife down*".

After about 300-400 metres Mr Lambert stopped and stood facing the officers on the southbound part of the highway. Mr Lambert held the knife and waved it in front of his body. SC Myles and SC Buckley had their guns drawn. SC O'Donahue shone a torch at Mr Lambert's eyes (to blind him and hamper any attempt to attack the officers) and kept his gun in its holster. He also made radio transmissions from the scene.

SC O'Donahue said he radioed for the highway to be closed. This transmission is not recorded on the VKG radio. It is not possible to say whether SC O'Donahue is mistaken about the broadcast, if the broadcast is not audible on the recording, or if the recording did not transmit because the button was not pressed at the right time. I accept SC O'Donaghue's evidence that he believed he had made the broadcast and, in any event, I would not be critical of him given the stress of the difficult and dangerous situation he was in and the real difficulty of making broadcasts while running down a live highway.

SC Buckley, SC Myles and SC O'Donahue continued to call for Mr Lambert to drop the knife and SC Buckley tried to engage him in conversation. SC Buckley tried to steer Mr Lambert off the road and onto the median strip.

All the officers gave evidence at the inquest and their evidence was honest and thoughtful. They answered questions openly and without any defensiveness. SC Buckley was a particularly impressive witness. SC Buckley detailed the various techniques he had used to try and gain rapport with Mr Lambert and to try and de-escalate the situation. For example, SC Buckley described the following interactions with Mr Lambert:

> *"I kept talking to him. I was just saying words to the effect of, 'I don't want to do that brother. I don't, I don't want this to happen. Talk to me.' You know, I said, I asked him, I said, 'What's your name? I'm Damien. What's your name brother? Talk to me. Please talk to me. I'm happy to sort anything out but you've got to put that knife down.'*"

At times SC Buckley seemed to be getting through to Mr Lambert and he became convinced he could get Mr Lambert to surrender. At one key point he was able to persuade Mr Lambert to move off the southbound highway and onto the grass verge in the middle. As this occurred, more officers were arriving on the scene.

A number of police officers present on the highway gave evidence that, during the encounter, Mr Lambert was continually saying words to the effect of "*what do I have to do to make you shoot me*" and "*I want you to kill me*".

Mr Lambert crossed the grass verge and brifen wire onto the northbound part of the highway. By this stage the road was blocked by the vehicles of police officers. Mr Lambert walked backwards away from the police. At various times, and as more officers arrived, he demanded that no officer moved behind him. This was an issue of obvious sensitivity to him and SC Buckley said it was the first time he saw Mr Lambert "flare up" and show signs of aggression.

The stand-off continued with SC Buckley repeatedly trying to engage with Mr Lambert and other officers calling on him to drop the knife. SC Buckley still believes he could have connected with Mr Lambert and ended the stand-off. He said in evidence, believably, that he was prepared to talk all night.

Sergeant Rory McDonnell called for a Taser trained officer when he arrived at the scene. Most of the officers' present at the scene were Highway Patrol Officers and accordingly did not have Tasers. Some of the officers including the Sergeant had Tasers but had left them at the station in their eagerness to reach the scene.

SC Richard Osborne (with SC Tajinder Singh in Coffs Harbour 14) was the only officer who responded to the Taser call.

SC Richard Osborne arrives

SC Richard Osborne arrived with the Taser and saw Mr Lambert holding a knife and the other officers facing him with their weapons drawn. He heard Mr Lambert saying that he only wanted to talk to SC Buckley but did not know that SC Buckley had established a rapport with Mr Lambert. SC Osborne approached Mr Lambert from behind. SC Osborne was not aware that Mr Lambert had an issue with people moving behind him. His plan was to surprise Mr Lambert by firing the Taser at his back. SC Osborne had been trained that the back was a preferred "Taser area or body mass" and that the element of surprise can be an effective method of gaining control and disarming an offender. Unfortunately, this action precipitated the final fatal confrontation.

As SC Osborne approached, SC Myles said "*mate you are going to get Tasered*". In evidence, SC Myles said this comment was partly to focus Mr Lambert's attention on him and partly to give Mr Lambert an opportunity to surrender. Mr Lambert turned and saw SC Osborne. SC Osborne fired the Taser around the same time. The Taser footage depicts Mr Lambert turning and then raising the knife and coming very close to SC Osborne. Many of the officers at the scene thought SC Osborne was about to be stabbed.

The Taser was working properly but was not effective when it was deployed, possibly because the barbs connected with clothing rather than skin (a barb was found in Mr Lambert's jumper and shorts).

Mr Lambert can be seen on the Taser footage to turn to his left, raise the knife over his head and move forward. At that point, the footage goes dark as SC Osborne reloads and a loud bang is audible followed by a cry of pain. It is possible this records the first gun shot. Some of the witnesses, including SC Myles and SC Buckley, state that Mr Lambert buckled or stopped after the first shot but then continued to move forward with the knife towards SC Myles and a number of shots were fired.

Many of the witnesses say that after the Taser was deployed something profound changed in Mr Lambert's demeanour, he stiffened and acted like he was enraged. In a statement prepared for the inquest, Mr Lambert's family stated that this change was something they were familiar with.

The VKG log records "*shots fired, shots fired*" and a request for an ambulance at 9:37pm. There are many different versions of how many shots were heard, what sequence they were in and where pauses may have been. Similarly, there are many different accounts of where each officer was standing. It is not possible nor necessary to resolve each version.

It is tolerably clear that SC Myles discharged his firearm first and there was a pause before Mr Lambert came at him again and he and SC Buckley fired again. A number of officers reported a delay between the first shot and subsequent shots. SC Andrew Harris was standing next to SC Myles. He said Mr Lambert lunged towards him and SC Myles with his arm extended. He stated that Mr Lambert was less than a couple of metres away and he feared for his life, but he did not fire his weapon because he feared SC Osborne was in his line of fire. He heard one shot, saw Mr Lambert stumble and then fall after three to four more shots.

SC Judd Rowsell was facing the officers. He had not drawn his weapon due to fear of cross-fire. He saw Mr Lambert lunge towards SC Myles and heard three to four shots. It took him a moment to compose himself before realising he had not been shot. Only SC Buckley and SC Myles state that they discharged their weapons. The magazines of the remaining officers were not checked but there is no evidence that any other officer discharged a weapon.

SC Buckley said he fired twice. SC Myles said he fired four times. When the weapons were checked, SC Buckley had 13 bullets left in his magazine and SC Myles had 11 bullets (a magazine contains 15 bullets). NSW Police Force ballistics expert, Matthew Bolton, matched four cartridges to SC Myles' pistol and one to SC Buckley's pistol. DCI Henney said in his evidence that cartridges commonly go missing from busy scenes which are attended by multiple officers and emergency services.

Mr Lambert had one entry shot in his back with an upward trajectory. SC Buckley said in evidence that he believes he fired this shot as Mr Lambert moved quickly past him towards SC Myles. On the available forensic and ballistic evidence this seems like the only explanation for the entry wound in Mr Lambert's back.

Response to the shooting

Several police called for an ambulance immediately after shots were fired (VKG suggests this was at 9:37pm). SC Buckley handcuffed Mr Lambert from behind as a safety measure. Shortly afterwards, the handcuffs were removed and a number of officers commenced CPR. SC Rowsell secured the knife and the handcuffs. He also had the presence of mind to take some photos of the scene and some notes on his phone.

Inspector Brendan Gorman (who was the duty officer on scene) states that he identified SC Myles, SC Buckley and SC Osborne as involved officers (for the purposes of the critical incident investigation) and instructed them not to discuss the matter. He instructed Sergeant Rory McDonnell to get the three involved officers to the station.

SC Bamford states she saw SC Myles cradling the offender. SC Myles confirmed he shot Mr Lambert and SC Buckley said "*so did I*". SC Bamford states she took SC Myles away and asked another officer to support SC Myles. SC Singh drove SC Osborne back to the station almost immediately after the incident. Sergeant McDonnell transported SC Myles and Buckley back to Coffs Harbour police station some time later.

Critical Incident Procedures

A critical incident was declared and it was decided that SC Myles, SC Buckley and SC Osborne were "involved officers".

Those officers had their appointments seized, were subject to breath tests and drug tests (after a slight delay) and subject to a verbal direction by Superintendent Holohan not to discuss their evidence. SC Buckley and SC Osborne were interviewed on 9 November 2016 and SC Myles on 10 November 2016.

Note discovered post death

A search of Mr Lambert's rental car revealed Mr Lambert's passport, driver's license, traffic infringements, disqualified driver CAN and cash. Mobile phones were also located with a backpack and an amount of clothing. An undated note signed by Mr Lambert was located in the backpack. The note provided for his funeral and stated:

> *"Free of what I do cause and subject people too. I'm toxic and not worth shit. I try and do the right thing, try to be a good person but that person is not enough for some and too much for others … Your all now at peace and free to live happy lives without me fucking it up and being a toxic blight on this world and to you all".*

Issues explored at the inquest

A list of issues was circulated to the interested parties, outlining the broad areas of interest for the inquest as follows:

- the manner and cause of Mr Lambert's death on 3 November 2016;
- were there alternatives to lethal force available to the officers who discharged their firearms;
- to what extent was Mr Lambert motivated by suicidal intent in his interactions with police on the Pacific Highway;
- with the benefit of hindsight and reflection, could any steps have been taken by the police officers on the Pacific Highway that may have led to a different and better outcome for Mr Lambert; and
- with the benefit of hindsight and reflection, was there any particular form of intervention with Mr Lambert in the two weeks prior to his death that had a realistic prospect of changing the tragic course of events.

I will deal with these issues in turn.

Were there alternatives to lethal force available to the officers who discharged their firearms?

I do not consider that there was any available alternative to lethal force when Mr Lambert was shot. When the first shot was fired, Mr Lambert was moving towards SC Myles with a raised knife, having previously threatened SC Osborne and, of course, having earlier almost killed Dr Jay. An attempt to disarm him with a Taser (ie non-lethal force) had failed. Mr Lambert had refused repeated directions from the police to surrender and put down the knife. He had also shown a reckless disregard for his own safety with extremely dangerous driving and requests to be shot.

It is unecessary to say exactly how close Mr Lambert was to SC Myles or how fast he was moving when shots were fired as perceptions are inevitably different and affected by stress and the speed of the unfolding and dynamic situation.

I accept without reservation that SC Myles had an honest and reasonable belief that his life was in danger and that SC Buckley had an honest and reasonable belief that SC Myles' life was in danger when they discharged their firearms. Both officers were honest witnesses who clearly remain deeply affected by the death. SC Myles was completely overcome with emotion when he recounted the moment at which he discharged his firearm. SC Buckley said he reflects on the death every day and desperately wishes that there could have been a different outcome and that he could have "*sent Paul home*" to his family. He even said he wishes he could have "*swapped spots*" with Mr Lambert. Firing shots was clearly a last resort.

I further do not consider that steps could have been taken at an earlier time to de-escalate the stand-off and prevent the death. All the officers, but SC Buckley in particular, did everything they could to negotiate with and to disarm Mr Lambert without resorting to force. I accept Dr Eagle's conclusion that there was nothing else the officers could have reasonably done, in the circumstances, to avoid the outcome.

To what extent was Mr Lambert motivated by suicidal intent?

Somewhat unusually, in this inquest the family have asked me to find that Mr Lambert had homicidal intent (or at least violent intent) when he was killed. The representatives for the Commissioner of Police, NSW Police Force and the individual officers have submitted that I should find that Mr Lambert was suicidal.

It is not necessary for me to make a finding about Mr Lambert's motivation and, on reflection, I do not consider that I have sufficient evidence to do so. It is certainly the case that Mr Lambert had made repeated threats of suicide in texts and phone calls during the pursuit, his behaviour at the scene suggested he wanted to be killed, either by dangerous driving during the pursuit or by police at the scene, and the undated note found in his car indicates some suicidal intent.

I also consider it is significant that Mr Lambert was "provoked" by SC Osborne moving behind him, given his repeated demands to police to keep in front, and that the Taser shot led to a loss of control, a circumstance that seemed to enrage Mr Lambert like it had when Dr Jay attempted to flee. At that point, witnesses describe a change in demeanour more like homicidal or violent rage than suicidal intent.

Mr Lambert's psyche was clearly extremely complex. Dr Eagle was unavailable to give oral evidence at the inquest and she was not aware of the family's insights into Mr Lambert's behaviour so I do not have the benefit of her opinion with all the available evidence. In the circumstances, I decline to make a finding about Mr Lambert's motivation in charging at SC Myles.

With the benefit of hindsight and reflection, could any steps have been taken by the police officers on the Pacific Highway that may have led to a different and better outcome for Mr Lambert?

This question is inherently speculative but it is designed to be constructive so that lessons can be learned for future application in dangerous situations where life is at risk. Fatal police shootings have a devastating impact. The loss of life in such circumstances is harrowing for the family of the deceased. The trauma to the police is also intense and enduring and was very noticeable in this case. Mr Evenden for the family made detailed and compelling submissions about a number of aspects of the police operation and how the death may have been prevented. He also persuasively argued that the NSW Police Force need to be proactive in exploring different mechanisms to defuse situations with armed offenders including investigating the use of shields and methods used in different Australian States and overseas.

Counsel Assisting submitted that it was unfair, even in hindsight, to apply a counsel of perfection to the officers' conduct. I accept this submission and will endeavour to be realistic when assessing the conduct of police in what was described as "a dark, dynamic and dangerous situation".

I agree with Counsel Assisting and Mr Evenden that, ideally, the Pacific Highway would have been closed sooner and that more officers on the scene should have been armed with Tasers. The live highway posed considerable danger to Mr Lambert, the police and the public as road users. It also no doubt spiked the adrenaline of those involved and hampered the ability for calm judgment. However, I do not accept Mr Evenden's submission that the pursuing police needed to close the highway (or request it be done) before they gave chase on foot. It was appropriate in the specific circumstances of this case, indeed very brave, of the officers to give immediate chase in order to apprehend an armed and extremely dangerous offender. This is not a case where there is ambiguity about the potential danger of Mr Lambert to the public; he attempted murder three hours earlier and, in fact, had made further threats to Dr Jay and his wife during the pursuit. In any event, the northbound highway was blocked within five minutes by responding police cars.

Inspector Gorman, the senior officer on the scene, very responsibly accepted that his first step on arrival should have been to take steps to close the highway but said in effect he was distracted by the stand-off and his desire to take more immediate action at the scene. I am not critical of Inspector Gorman for this and no doubt this experience will inform his practice in the future.

Inspector Gorman said that his plan on arrival was to establish a secure inner and outer perimeter and to contact specialist services including negotiators. As he walked to his car to make these calls he heard the first shot fired. If Inspector Gorman had been able to complete his plan, the situation may, possibly, have had a better outcome. Similarly, if SC Buckley had more time to keep talking to Mr Lambert, it is certainly possible that he may have persuaded him to surrender. With the benefit of hindsight, Inspector Gorman said he would have facilitated continued negotiation by SC Buckley and not used a Taser operator.

I understand fully why Mr Lambert's family feel that the use of the Taser precipitated the tragic outcome and accordingly why they submit this should not have occurred. But I also find that SC Osborne acted in a manner entirely consistent with his training. He understood that he was being called out to use the Taser and made an assessment that immediate action was necessary when he arrived on the scene and saw Mr Lambert (wanted for attempted murder) facing armed police and refusing directions to put his knife down. He did not know that Inspector Gorman was on the north side of the highway. SC Osborne acted quickly and put his own life in danger trying to immobilize Mr Lambert and to preserve Mr Lambert's life.

Even with the benefit of hindsight, it cannot be said with any confidence that a better outcome would have occurred if SC Osborne had reported to Inspector Gorman and a prolonged negotiation had occurred instead. The outcome may still have been Mr Lambert lunging towards police, and possibly causing injuries to those officers. SC Buckley gave evidence that he was planning to crash tackle Mr Lambert if the opportunity presented and stated, "*I would have been laying in a box right now had I done that*".

On the other hand, if the Taser had worked, Mr Lambert's life would have been spared and the officers would have avoided the trauma of his death.

I do not consider that the use of trained negotiators during the highway pursuit or at the scene was likely to make a difference. Dr Eagle reviewed the tapes of DSC Durbridge's calls to Mr Lambert and the statements of the individual officers. She commended the use of techniques by the officers to create rapport, provide hope and offer options. Dr Eagle was unable to suggest anything else that could have been attempted that might have led to a better outcome.

There may well be lessons from an operational perspective that can be drawn from this incident particularly relating to command and co-ordination of a dynamic, fast-moving scene, establishing a proper perimeter and communications between officers in person and over radio. Further, the risk of cross-fire was acute in the ultimate confrontation, some officers didn't fire for fear of wounding another officer and Mr Lambert was shot in the back. On the evidence, however, it appeared that risk was unavoidable.

Sergeant Jonathan Healy, Operational Safety Instructor, from the Weapons, Tactics, Policy and Review Unit attended each day of the inquest and said he was not aware of anything that could have been improved with the benefit of hindsight. I make no recommendation but would urge the Weapons, Tactics, Policy and Review Unit to reflect on the lessons that may be drawn, and on the family's submissions in particular, and consider if this incident could be effectively integrated in some way into training exercises.

With the benefit of hindsight and reflection, was there any particular form of intervention with Mr Lambert in the two weeks prior to his death that had a realistic prospect of changing the tragic course of events?

Sadly, the inquest has not identified any possible intervention in the final two weeks of Mr Lambert's life that could have prevented the tragic outcome. The only realistic way of preventing the attack on Dr Jay and the ensuing events on the Pacific Highway was for Mr Lambert to choose desist or to be arrested or otherwise contained.

Dr Eagle considered Mr Lambert's disorder capable of treatment but only with motivation to change, compliance with appropriate mood stabilising medication and regular sessions with an engaged and skilled psychiatrist. None of these factors were present in November 2016.

An ADVO would not have stopped Mr Lambert. The evidence suggests that he thought an order was in place at the time.

Dr Jay had no responsibility to protect herself but she took every conceivable step to protect her own safety including staying with relatives, alerting her neighbours, changing locks, repeatedly seeking police assistance and completely disengaging with Mr Lambert.

The best possible prospect of intervention was detection of Mr Lambert's breach of parole by living in NSW from July 2016 to November 2016. If a warrant had been issued for Mr Lambert's arrest it is highly likely that his encounters with the NSW Police Force in October and November 2016 would have led to his arrest and, possibly, psychiatric treatment. An examination of the Queensland parole system is not suitable for this inquiry but I direct that a copy of the transcript of the inquest and of these findings be forwarded to the Queensland Probation and Parole.

Is it necessary or desirable to make a recommendation?

During the inquest, Mr Evenden asked a number of police witnesses about evidence given by Police Commissioner Fuller to Portfolio Committee No. 4, Legal Affairs, NSW Parliament Budget Estimates 2018-2019 the week before the inquest on 31 October 2018, which is publically available on *Hansard:*

> *Mr FULLER: Assistant Commissioner Mark Walton, who is the commander of the Central Metropolitan Region, is our spokesperson for mental health. I talk to him regularly about these issues. There is a new tactical model in North America-I think it is Chicago. You would have heard us talk before, Mr Shoebridge, around contain, negotiate-which is very much based on a bricks-and-mortar approach that you have someone in a room, in a house or in a building and you can contain, negotiate with them in there and then you safely negotiate a better outcome.* ***In the Topic matter is out in the open, it obviously makes it much, much more challenging to contain, negotiate.***

> ***They have trialled and-I believe successfully-put in place some different tactics around using different types of shields to better contain, negotiate people in open environments.*** *I have asked Mr Walton to progress--quickly, expeditiously-if this is something we could use in New South Wales. The answer is 'yes' and that is one example."*

Sergeant Healey of the Weapons, Tactics, Policy and Review Unit gave evidence but he was not aware of the trials of different tactical initiatives or different types of shields. No further information was provided by the NSW Police Force on request but the representatives for the Commissioner of the NSW Police Force have indicated that there is support for the following recommendation:

> *"That NSW Police Force continue to review other tactical options of a non-lethal nature for dealing with offenders armed with a knife, including the use of shields, in order to minimise the likelihood of serious harm in the event of a police response that requires an offender to be disarmed."*

I am very grateful for two suggested recommendations from two Port Macquarie business owners.

Mr and Mrs Long have asked that licensed weapons dealers be able to check if a person buying a knife has an outstanding apprehended violence order ("AVO") or ADVO as is currently the situation in respect of firearms. AVO and ADVO defendants are not able to purchase firearms. I think the recommendation is desirable. I understand, as DCI Henney observed in his evidence, that knives are sold in supermarkets, fishing shops and Bunnings and that this recommendation will not prevent a determined killer. However, any information sharing that takes place between police and weapons dealers about attempts to buy lethal weapons by AVO and ADVO defendants is desirable for public safety. Privacy issues are less fraught because the facility already exists for licensed dealers with respect to firearms. I recommend that the suggestion be considered by the Commissioner of the NSW Police Force.

Mr Scott of First Class Rentals gave evidence that his rental company was not notified by police that Mr Lambert had been detected speeding and driving while disqualified and stated that, if alerted, he would have cancelled the hire contract and placed an alert on the company computer system. Mr Scott also said that he fears that rental cars are often used to commit crimes such a drug running by disqualified drivers. Mr Scott suggested that rental companies be able to check the license status of drivers as they are apparently able to do in Western Australia.

Roads and Maritime Services ("RMS") were notified prior to the inquest of the matters raised by Mr Scott and were invited to make submissions as to a possible recommendation that the Minister of Transport for NSW consider implementing a system similar to the Western Australian system in NSW.

RMS have advised that there are initiatives presently being undertaken at RMS, including the Digital Driver License system whereby an electronic version of a NSW license is available via an application (as in a web "app").

Once implemented, this system will allow rental car companies to identify whether a NSW license is active, expired or suspended (including out of state disqualifications which lead to NSW licence cancellation if properly notified to the RMS). In the circumstances, I do not consider that a recommendation as proposed by Mr Scott is necessary. I should note that I am very grateful to Mr Scott for his evidence to the inquest and commend him on his highly responsible conduct of his business.

I note one final matter. SC Buckley gave evidence that he was instructed to take notes as part of his critical incident direction but he did not do so on legal advice. He was not interviewed until six days after the shooting despite making himself available and cancelling prepaid travel arrangements so that he could be available. He clearly experienced some stress waiting for the interview. DCI Henney was asked about the timing of the interview but could not recall the reason for it. It would have been desirable for the interview with SC Buckley to have been done sooner, both for an account of the events closer to the time and for his own healing. There may be many sound reasons why this did not occur but they were not available to the inquest. One useful approach might be for critical incident investigation teams to record why officers are interviewed on a relevant date and what measures were undertaken to ensure the witnesses did not discuss the matter with other officers in the interim. This is not formal recommendation but I trust the NSW Police Force representatives will bring my comments to the attention of relevant parties.

Concluding remarks

Dr Jay and SC Buckley are not here today but their evidence was so compelling and important. I consider that their insights and wisdom would be an enormous benefit to the continuing education of police and, if they are willing, I encourage the Commissioner of Police to involve them in training.

I would like to thank my team. I have had the great benefit of being assisted by Kirsten Edwards, my Counsel Assisting and Alana McCarthy and Clare Skinner from the Crown Solicitor's Office. They have worked so carefully and thoughtfully in the months leading up to this inquest and the months following the hearing. I am most grateful.

I would like to thanks the Critical Investigation Team for their assistance.

Finally, I offer my condolences to Paul's family who have attended this inquest every day. I thank them for showing such courage and dignity.

Findings required by s. 81(1)

Pursuant to s. 81 of the *Coroners Act 2009*, I make the following findings:

Paul Lambert died on 3 November 2016 on the Pacific Highway, near Bonville in NSW. Mr Lambert was shot multiple times by an officer or officers of the NSW Police Force in circumstances where he was advancing towards a police officer with a raised knife. The shooting followed an attempt by Mr Lambert on the same day to murder his former girlfriend and a subsequent police pursuit and stand-off with police on the Pacific Highway. The medical cause of death was the combined effect of gunshot wounds to the chest and abdomen.

Recommendations

Pursuant to s. 82 of the *Coroners Act 2009*, Coroners may make recommendations connected with a death.

I make the following recommendations:

To the Commissioner of NSW Police Force:

1. *That the NSW Police Force continue to review other tactical options of a non-lethal nature for dealing with offenders armed with a knife, including the use of shields, in order to minimise the likelihood of serious harm in the event of a police response that requires an offender to be disarmed.*

2. *That the NSW Police Force consider the implementation of an information sharing system to allow licensed weapons dealers to check if a person buying a knife has an outstanding apprehended violence order or apprehended domestic violence order.*

11. 334771 of 2016

Inquest into the death of Bryce James DOYLE. Findings handed down by State Coroner O'Sullivan at Dubbo on the 21st February 2019.

The *Coroners Act 2009* (NSW) in s. 81(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 Bryce James Doyle, a young man who was only 22 when he died. Bryce was much loved by his large family, many of whom have come to Court so that they can learn about the circumstances of his death, and to pay their respects.

I was very pleased to learn about Bryce towards the end of the inquest, by hearing the statement of family members, and a beautiful message from one cousin that was read out. Bryce was very close to many members of his extended family, which is evident given their presence at this inquest. During some of his early school years, Bryce lived with his grandparents. His grandfather who attended the hearing, remembers that time fondly.

Bryce's family remember him as a "good kid, with a naughty and mischievous side". He loved school. He also loved jumping on the trampoline, playing video games and playing soccer. Bryce loved his sisters Tehana and Alisha, as well as his nieces and his own children. His family remember him as a happy person, who was always the life of the party. He had many friends and would do anything he could to help out others.

I extend my condolences to all of Bryce's family, particularly to his mother, father, sisters and grandfather, and to the cousins, aunts and uncles who attended Court and to all those family and friends who were not able to attend the inquest. I am truly sorry for your loss.

The Inquest:

In the circumstances of Bryce's death, an inquest is mandatory pursuant to s. 23(c) and s. 27(1)(b) of the *Coroner's Act* (the Act), which at the relevant time, required an inquest to be held where a person has died "as a result of, or in the course of, a police operation".

Section 81 of the Act requires a Coroner to make a finding as to the identity, date and place of death, medical cause of death, and the manner of death. Cause refers to the physical cause of death. Manner refers to the circumstances leading up to and surrounding the death.

There is no issue in this inquest in relation to Bryce's identity, the time of his death, the place and date, or the medical cause of death. The real issue concerns the manner of his death, or in other words, the circumstances leading up to the collision that caused him to suffer fatal injuries.

The actions of the police officer in pursuit of Bryce, Senior Constable Collier, have necessarily been the focus of this inquest. That is not to imply wrongdoing. It is extremely important that where civilians suffer a loss of life after being in contact with police officers, there is public scrutiny of the actions of officers, so that the NSW Police Force has an opportunity to learn lessons, and so that the public has confidence that the actions of police are subject to scrutiny. It is a reflection of the strength of our institutions and our legal system, that this review takes place.

The Evidence:

At 9.46am on 8 November 2016, Senior Constable Marley-Jo Collier, a member of the Highway Patrol Unit, was travelling east in a fully marked highway patrol vehicle (Western 214) along the Mitchell Highway, when she detected a blue Commodore travelling west on the Mitchell Highway between Dubbo and Narromine.

The speed limit in the area is 110 kilometres per hour. The radar in the police vehicle showed the Commodore to be travelling at a speed of 142km per hour, which went down to 134km per hour when it was 'locked on' by S/C Collier.

The blue Commodore was being driven by Bryce Doyle, who was on his way to the Narromine Local Court to appear for charges of driving without a licence. Bryce was not known to S/C Collier and she could not see the number plate on the back of his vehicle to allow her to check the details of the registered owner. At no time between the time she saw Bryce and his death did she know that he was the driver of the Commodore.

By 2016, police vehicles had been fitted with in car video (ICV) that provides a video and audio record of their own movement. Once the ICV is activated by an officer, as it was in this case, it back captures 30 seconds of footage and continues to record until it is turned off. As a result, the Court has objective evidence as to what Senior Constable Collier did next.

At 9.46.21, just one second after Senior Constable Collier recorded the blue Commodore's speed of 134km per hour on the radar, she activated the warning lights of Western 214 and pulled over to the left of the highway. She allowed one car to pass her and then executed a U-turn with the intention of following the Commodore and pulling the driver over for the speeding offence. It took approximately 16 seconds to execute that U-turn, and Constable Collier could not see the blue Commodore immediately after she started travelling west on the Mitchell Highway, towards Narromine.

The ICV recording shows the following:

- At 9.47.00, Western 214 passed two vehicles travelling east on the Mitchell Highway, at a speed of 190km per hour.
- At 9.47.08 the sirens of Western 214 were activated (warning lights also still activated)
- Between 9.47.00 and 9.49.45, Western 214 travelled towards Narromine at varying speeds and passed numerous vehicles travelling towards Dubbo.
- From 9.47.00 until 9.49.33 (when Western 214 entered the 50km zone on the approach to Narromine), Western 214 passed approximately 10 vehicles travelling east.
- From 9.47.00 until 9.49.33, Western 214 overtook at least 5 vehicles.
- The highest speed of Western 214 during the period Senior Constable Collier was following the Commodore was 204km per hour at 9.48.28.
- The in-car video indicates that she travelled at speeds of between 149 and 204km per hour, at an average of 186km per hour.

In spite of that significant speed, Senior Constable Collier did not gain significant ground on the blue Commodore. As she explained in her recorded interview with police on 9 November 2016, she "just kept a visual of the back… it was just a blip in the distance".

The conditions on the day were fine but overcast. The traffic conditions were light.

At the approach to Narromine, the speed limit on the Mitchell Highway reduces, first from 110 to 80 km per hour and then down to 50km per hour. When Senior Constable Collier entered the 80km per hour zone, she was travelling at 200km per hour. In the 50km per hour zone, S/C Collier was travelling at a speed of between 178-191 kilometres per hour.

Bryce entered the intersection of the Mitchell Highway and Manildra Street travelling west at high speed, and clipped the front nearside corner of a white Toyota Corolla sedan, which was making a right hand turn, east onto the Mitchell Highway, from Manildra Street. That caused Bryce to lose control of the Commodore and collide with a large gum tree on the southern side of the Mitchell Highway. The front end of the vehicle was torn away, exposing Bryce to the excessive force of the impact and causing him to suffer multiple injuries to his head and body, including severe closed head injuries, skull fracture and spinal injuries. Bryce would have died instantly on impact.

Senior Constable Collier was not close enough to the blue Commodore to witness the collision, other than to observe the dust thrown up as a result of it. An eye witness, Cameron Gall, estimated that Senior Constable Collier arrived on the scene about 30 seconds to one minute after the crash. At 9.49.45 on the ICV a dust cloud is seen in the distance, and the police vehicle arrives on the scene of the collision at 9.49.53. At 9.50.26 on the ICV the lights and sirens on Western 214 are deactivated.

After realising that the blue Commodore had hit a tree, Senior Constable Collier pulled over, notified police radio of the crash, requested ambulance and the Fire Brigade and remained at the scene until other police arrived. She did all that she could do to check if the driver of the Commodore needed assistance. Senior Constable Collier was subsequently taken to Narromine Hospital by ambulance for a check-up and to undergo compulsory drug and alcohol testing, which subsequently proved that she had a negative reading.

Members of the NSW Police Force Crash Investigation Unit (CIU) attended and examined the scene. The death of Bryce Doyle was declared a Critical Incident by Police and necessitated an investigation by an experienced officer, who is independent to any officer involved in the accident. The Officer in Charge of this Inquest, Detective Sergeant Andrew Mclean, had not met Senior Constable Collier prior to the investigation and worked at another Local Area Command. All relevant witnesses were interviewed, expert reports obtained and a brief of evidence prepared.

Toxicology results taken after Bryce passed away show that he had a quantity of amphetamine and methylamphetamine in his blood at the time of his death. An expert toxicologist, Dr Judith Perl, has provided a report confirming that the quantity and type of drugs in his system are likely to have impaired his driving, due to over-stimulation of the central nervous system by methylamphetamine. The acute effects of high doses of methylamphetamine can result in driving behaviours including speeding, overtaking and risk taking, all of which Bryce engaged in prior to the collision. That evidence is not meant to criticise Bryce, who was no doubt a young man with so much potential, but it is relevant in determining why he drove the way he did in the lead up to the collision. It is another tragic reminder of the impact of methylamphetamine, known as “ice”, on our young people and the broader community.

The NSW Police Force Safe Driving Policy and “pursuits”:

Police pursuits and other police activities on the road are governed by the policies and procedures of the NSW Police Force. In certain circumstances, police officers are permitted to disregard the road rules, including by exceeding speed limits, but they must do so within the boundaries of the policies that guide them. Where a “pursuit” of a vehicle occurs, there are strict rules governing what Police must do and who they must notify.

Part 7 of the NSW Police Force Safe Driving Policy (SDP) contains a definition of police pursuit as follows:

7-1 **PURSUIT**: A pursuit, regardless of speed, commences at the time you decide to pursue a vehicle that has ignored a direction to stop.

7-1-1 It is an attempt by a police officer in a motor vehicle to stop and apprehend the occupant(s) of a moving vehicle, regardless of speed or distance, when the driver of the other vehicle is attempting to avoid apprehension or appears to be ignoring police attempts to stop them.

When involved in a pursuit, the responsible officer must inform the DOI (Duty Operations Inspector at Sydney Radio Operations Group), and the VKG (the NSW Police Force Radio Operations Centres) Shift Coordinator of the pursuit and provide certain information, including the location and direction of travel, the reason for the pursuit and the description and number of occupants.

Expert evidence was called in the inquest from Sergeant Kris Cooper, a member of the Traffic and Highway Patrol Command, Policy Unit, who is highly experienced and who conducted a review of the evidentiary material in the inquest that was relevant to the NSW Police Force Pursuit Policy and Safe Driving Policy.

According to Sergeant Cooper, the rationale for requiring police to 'call in' a pursuit is because it is important to have a 'cool head' away from the scene to give advice. Senior Constable Collier also understood this rationale. Both Sergeant Cooper and Senior Constable Collier were familiar with term "red mist", which describes the psychological state reached when a person is full of adrenalin, and faced with a highly charged incident that affects the ability to make objective, sound decisions. Having someone away from the scene to give guidance is an important safeguard against this.

Was there a "pursuit" in this case?

Senior Constable Collier gave evidence that she was of the opinion that she was not in a "pursuit" for the purposes of the SDP in place at the time. That was for two reasons: first, she thought that to be in pursuit required her to have closed the distance on Bryce more than she had, and second, because although she did give the driver of the Commodore a direction to stop, she was not sure whether they were aware of it and had deliberately disobeyed it. That is, she was not close enough to Mr Doyle and did not know whether Mr Doyle had seen her. In her interview of 9 November 2016, Senior Constable Collier estimates that the closest she came to the blue Commodore was a distance of between 600 metres and one kilometre. In oral evidence, she said that she since had timed the distance using the odometer in her car and she calculated that she was 1.2 km behind the Commodore at the time of the collision.

Sergeant Cooper provided expert opinion that in fact, Senior Constable Collier was in pursuit at some time after she executed the u-turn and decided to follow the blue Commodore, although he was not able to determine the exact location where the pursuit commenced. Sergeant Cooper found that Senior Constable Collier failed to comply with the requirements of the SDP in relation to the pursuit, and that her non-compliance appears to have arisen from her failure to properly identify that a pursuit as defined under the SDP had commenced.

On the objective evidence, I find that Senior Collier was in "pursuit" for the purposes of the SDP. The definition of "pursuit" in the SDP requires that an officer give a direction to a vehicle to stop, and then form a view that the direction "appears" to be ignored by the young person. Senior Constable Collier acknowledged that she gave the direction to stop.

Although I accept her evidence that she was not fully satisfied that the driver of the Commodore had noticed and ignored the direction, it is obvious in hindsight that he had done. I have formed this view because Senior Constable Collier activated the lights on her vehicle almost immediately after she noted the Commodore speeding, she activated the sirens 47 seconds after that, and then travelled at speeds of up to 204 kms per hour and was not able to catch up to the Commodore. Since she locked on the radar at 134 kms per hour and could not then catch up, Bryce must have increased his pace. Further, if Senior Constable Collier could see the Commodore, even as a "blip in the distance" then he was likely to have been able to see the warning lights of the fully marked police car in his rear vision mirror.

Clearly, even as the situation unfolded, Senior Constable Collier struggled with the question of whether she was in pursuit during the time she was following Bryce. In her 9 November 2016 interview with police, she said (from A 254):

I guess I, I was questioning whether I should call in the pursuit. But then I thought, I've got nothing besides the speed and the vehicle. I've got no rego, I'm not within a distance of him to call a pursuit. At that stage I was just trying to catch up. But, you know, when he failed to stop I, I was thinking to myself, should I be letting radio know…what's goin' on.. just even to advise them … but I'm not in pursuit. Yeah, but, and, to I was, I was so fixated on, on getting' him.

Senior Constable Collier's comment that she "was so fixated" is understandable, but it is also good evidence of why pursuits should be called in. Senior Constable Collier was not correct that a pursuit depends on the distance between vehicles. Paragraph 7-1-1 of the SDP clearly states that:

"It is an attempt by a police officer in a motor vehicle to stop and apprehend the occupant(s) of a moving vehicle, **regardless of speed or distance**, when the driver of the other vehicle is attempting to avoid apprehension or appears to be ignoring police attempts to stop them". However, the fact that par 7-1 and 7-1-1 are separated in the policy may have contributed to her confusion.

The second reason why Senior Constable Collier did not know whether the definition of pursuit was met was because she wasn't sure if the driver of the Commodore had seen her. I can appreciate why, given the way in which definition of pursuit is written in the SDP, this would cause some confusion.

Sergeant Cooper agreed that the SDP should be as clear as possible to give guidance to police faced with the difficult decision of whether to pursue and if so, how long to continue. I propose to recommend an amendment to the SDP, for the consideration of the NSW Police Commissioner, to see if this can be clarified.

Officers such as Senior Constable Collier are in situations of high stress when they make the difficult decision to pursue a driver who may have ignored a direction to stop. I accept that Senior Constable Collier was a witness who was honest and she was attempting to exercise her duties appropriately. She was clearly deeply upset by the death of Bryce and her involvement on the day.

I commend her for the frank evidence she gave and for the way in which she communicated her empathy with Bryce's family.

Findings required by s. 81(1):

The identity of the deceased

The deceased person was Bryce James Doyle.

Date of death

Bryce Doyle died on 8 November 2016.

Place of death

He died at Narromine in NSW.

Cause of death

The death was caused by massive injuries to the head and body, including severe closed head injuries, skull fracture and spinal injuries.

Manner of death

The death was caused by accident or misadventure, in that Bryce Doyle lost control of a car that he was driving while he was trying to avoid a police pursuit, and struck a tree.

Recommendation:

To the Commissioner of Police, NSW Police Force

That the Commissioner give consideration to the following:

With respect to the Pursuit Guidelines in Part 7 of the Safe Driving Policy:

a) the first 2 paragraphs of 7-1 and 7-1-1 be combined, to avoid doubt as to what the definition of pursuit is;

b) a section is included to advise officers that if they are in doubt as to whether or not an offending vehicle has ignored a direction to stop, they should inform the DOI, or the VKG shift coordinator of their actions, and provide the information outlined in paragraph 7-5-1.

12. 350477 of 2016

Inquest into the death of Celal KIZILDAG. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 13th February 2019.

On 21 November 2016 Celal Kizildag was involved in a motor vehicle collision from which he suffered fatal injuries. Tragically, Celal was only 22 years old at the time. A short time before the collision there had been a chance encounter between Celal and four police officers who were driving in another vehicle. As a result of the chance encounter the police officers followed the motorcycle that Celal was riding for a brief period and eventually came across the collision scene where Celal's motorcycle had impacted another vehicle.

Why was an inquest held?

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

Due to the circumstances surrounding Celal's death, he was regarded as having died in the course of a police operation. This meant that, according to the relevant section of the Act which applied at the time, an inquest into Celal's death was mandatory. Inquests are mandatory for these types of deaths to ensure that there is an independent and transparent investigation of the circumstances of the death, and the relevant conduct of any of involved police officers.

Celal's life

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

Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Celal's important life. It is hoped that the brief words below do so in a meaningful and respectful way.

Celal's parents, Kemal and Emine, arrived in Australia from Turkey in about 1994. Celal's mother was pregnant at the time and Celal was born a few months after their arrival. Celal's sisters, Rukiye and then Burcu, were born a short time later. Initially Celal's family lived in the Liverpool area in Sydney, before later moving to Regents Park when Celal was about eight years old.

By all accounts, Celal enjoyed a close relationship with his family and in particular with his sister, Rukiye. There is no doubt that Celal is greatly missed and that his passing has devastated his family. To lose a son and a brother at any time is an occasion for much sorrow; but to lose a young man approaching the prime of his life is truly tragic.

Background to the events of 21 November 2016

Approximately six months prior to November 2016 Celal's sister, Rukiye Yusuf, observed a number of changes in Celal's behaviour. She noticed that Celal began associating with a different group of friends, that he lost weight, and that he was often seen to be "*fidgety*". During this same six month period, Celal acquired a motorcycle, even though he did not hold a motorcycle licence. After acquiring the motorcycle Celal's parents often spoke to him to express their view that the motorcycle was too big and dangerous for him to handle.

About two weeks before November 2016 Rukiye noticed that Celal had also acquired a small safe which he kept in his bedroom. Although Rukiye never saw Celal place anything in the safe, she heard him using it and noticed a strange smell coming from it, leading her to believe that Celal stored illicit drugs inside the safe. At around this time Rukiye also noticed that Celal had more money than usual, which in turn made her believe that Celal was involved in selling illicit drugs.

What happened on 21 November 2016?

On Monday 21 November 2016 Senior Constables Craig Norman, Officer 1, Daniel Dring, and Constable Michael John were performing duties with the NSW Police Public Order Riot Squad. In the morning, they left their headquarters in Homebush in order to conduct high visibility patrols in a black Toyota Landcruiser (**the Landcruiser**). Senior Constable Norman was the driver of the vehicle with Officer 1 seated in the front passenger seat, Senior Constable Dring seated in the rear driver's side seat, and Constable John seated in the rear passenger's side seat.

After leaving Homebush the Landcruiser conducted patrols in Sydney city, North Sydney and the Inner West before the four police officers drove back to Homebush for a lunch break. Following this, the four officers left in the Landcruiser again to conduct patrols in the south western region of Sydney, with each of the officers occupying the same seating positions as they had before lunch. At about 1:55pm on Celal rode his Suzuki GSX-R600 motorcycle (**the Suzuki**) to the Speedway service station at 23-27 Amy Street, Regents Park. The service station is located at the end of a series of retail shops and services that line both sides of Amy Street as it leads towards Regent Park station.

CCTV footage shows that the Suzuki bore a licence plate PCP44, however the last digit of the licence plate was obscured by a piece of black material (which was later discovered to be tape).

After parking the Suzuki Celal walked across the street where he remained for a short time before later returning to the Suzuki at 2:13pm and filled it with petrol from a bowser. Celal went into the service station shop and spoke briefly to the owner, Mamdouh Hayek, who he knew. Mr Hayek expressed some surprise that Celal was riding a motorcycle and asked him whether it was dangerous to ride. Celal replied by telling Mr Hayek that his (Celal's) parents had told him that it was dangerous and not to ride it, and that he had already fallen off the motorcycle twice. At about 2:22pm, after speaking briefly with a person in a car which was stopped at the service station, Celal got on the Suzuki to exit the service station. He turned right onto Amy Street and rode away from the station.

Kingsland Road, Regents Park

A short time later the Landcruiser was travelling along Kingsland Road, Regents Park at a speed of about 45 km/hour heading towards Bankstown. Senior Constable Norman saw the Suzuki slowly pull out from the right hand side of the road and then travel in the same direction as the Landcruiser along Kingsland Road. Senior Constable Norman noted that "*as [the Suzuki] pulled out, it kind of wobbled and looked a bit like not a normal rider. It looked a bit weird*". Officer 1 saw the Suzuki as well and also described it "*wobbly*", forming the view that the rider (Celal) may not have been a confident rider or that the motorcycle might have been too big for the rider. Shortly after the Suzuki pulled out, Senior Constable Norman saw that it "*then just took off*" towards the intersection with Kibo Road. As the Landcruiser followed the Suzuki, it also increased its speed.

As both the Landcruiser and the Suzuki travelled along Kingsland Road, Senior Constable Norman estimated that the Suzuki was about 200 to 300 metres ahead. Halfway along Kingsland Road, the Suzuki turned left onto Kibo Road, with the Landcruiser following. As the Suzuki slowed down to turn the corner, Senior Constable Norman saw Celal turn around and look back at the Landcruiser several times and "*then suddenly saw him take off really quickly*". At the same time Senior Constable Normal heard the Suzuki revving its engine. Constable John also heard the revving sound and heard Senior Constable Norman remark words to the effect of, "*Look at this*". Constable John looked through the front windscreen and saw a motorcycle "*a long way in front of us at the end of the street*" with no other vehicles in between. Senior Constable Dring also looked through the windscreen and recognised the model of the Suzuki as he had previously owned a similar model.

Kibo Road, Regents Park

After turning onto Kibo Road Senior Constable Norman estimated that the Suzuki was about 400 or 500 metres ahead of the Landcruiser, and passing over a crest at the intersection of Kibo Road and Phillips Avenue. The Landcruiser continued along Kibo Road and when it reached the crest, Senior Constable Norman saw the Suzuki for only two or three seconds before it turned right onto Clucas Road and went out of view.

Senior Constable Norman estimated that the Suzuki was travelling over 100km/hour as it approached the intersection with Clucas Road, and (whilst he did not check the speedometer at the time) that the Landcruiser was travelling more than 60km/hour but no more than 100 km/hour.

Senior Constable Norman later explained that whilst travelling along Kibo Road his intention was probably to catch up to the Suzuki but explained that he "*wasn't quite sure what we were dealing with*" and that "*at no time was there ever a conversation [with the other police officers] of putting lights and sirens on at all*".

Clucas Road, Regents Park

The Landcruiser continued down Kibo Road and also turned right onto Clucas Road. Senior Constable Dring said that he saw the Suzuki ahead of the Landcruiser, travelling at the designated speed limit, and that Celal turned to look backwards several times. After about 100 metres Senior Constable Dring saw the Suzuki accelerate "*harshly and took off*" at an unknown speed. Officer 1 also said that the Suzuki "*absolute [sic] gunned it*" with the motorcycle putting "*a lot of distance between us*". As this occurred Senior Constable Dring heard Senior Constable Norman remark, "*He's going now*" and Officer 1 say, "*Did anyone catch the rego*". Senior Constable Dring tried to identify the Suzuki's licence plate but was unable to do so.

The Suzuki continued to the end of Clucas Road, which intersects with Amy Street. When the Suzuki reached the intersection the Landcruiser was about 300 metres behind it. Senior Constable Dring later explained that the Landcruiser "*continued travelling at the same speed on Clucas Road. We did not activate our light or sirens".*

Amy Street, Regents Park

When the Landcruiser reached the Amy Street intersection, it stopped for couple of seconds whilst waiting for a gap in the traffic travelling in both directions before making a right hand turn. After turning onto Amy Street, there is a slight incline up to a crest at a point between the intersections with Larcombe Street and Yukka Road, some 370 metres away. The Suzuki could not be seen along the section of Amy Street approaching the crest. After turning on to Amy Street, Officer 1 said to Senior Constable Norman "*He's gone…don't worry about him*".

After turning onto Amy Street, Senior Constable Norman noted that "*there were cars and traffic on both sides going up and down the street*". Both Senior Constables Norman and Dring described the Landcruiser as being "*stuck*" behind traffic on Amy Street.

Pedestrian crossing on Amy Street, Regents Park

At around this time, Nadin El Mched was standing outside her house on 44A Amy Street which is located near the corner of Amy Street and Edwin Street. To the right of this corner, towards Regents Park station, is a marked pedestrian crossing on a raised traffic island.

Ms El Mched turned to the right and saw the Suzuki travelling "*really fast*" and "*faster than the speed limit*" down Amy Street towards the pedestrian crossing.

Rachael Nicholls was driving a blue Mitsubishi ASX (**the Mitsubishi**) along Amy Street at about 2:20pm at a speed of about 40 km/hour when she approached the pedestrian crossing. Ms Nicholls saw a pedestrian standing on the left side of the road at the crossing, so she slowed her vehicle and came to a complete stop to allow the pedestrian to cross.

Michael Oldfield was standing at the pedestrian crossing, waiting to cross. He saw the Mitsubishi stop about one to two metres from the crossing. As he walked out onto the crossing, Mr Oldfield heard the sound of a motorcycle revving and described it as "*sounding like it was redlining*". Mr Oldfield turned to his right and saw the Suzuki travelling on Amy Street. Mr Oldfield saw the Suzuki change gears and its front wheel lift, before the back wheel locked up resulting in the Suzuki "*going a bit sideways*". It appeared to Mr Oldfield that the motorcycle was going too fast and having difficulty stopping. As Mr Oldfield continued to walk across he heard a loud bang and saw Celal land in the gutter past the crossing with the Suzuki on top of him.

About two seconds after stopping the Mitsubishi Ms Nicholls heard a loud revving sound from behind her vehicle. As she looked in her rear view mirror to identify the source of the sound Ms Nicholls felt what she described as a "*big jolt*" as something struck the Mitsubishi. The impact caused the Mitsubishi to move forward even though Ms Nicholls had applied the brake. Ms Nicholls placed her vehicle in park, and as she did so she looked to her left and saw Celal slide past on the ground, followed by his motorcycle, which landed on top of him.

When the Landcruiser passed over the crest on Amy Street Senior Constable Norman saw the Mitsubishi stopped on the road with many people milling around on the left, just past the Mitsubishi. The distance from the crest to the site where the Suzuki collided with the Mitsubishi (**the collision site**) is about 400 metres. The Landcruiser continued travelling down Amy Street towards the collision site, arriving a short time later.

On approach it became apparent to the police officers in the Landcruiser that a collision had occurred. Senior Constable Norman activated the warning lights of the Landcruiser about 100 metres from the collision site. Upon arrival Constable John saw the Mitsubishi stopped at a pedestrian crossing and debris from the collision in the surrounding area, including the Suzuki which was lying in the gutter near the crossing. Constable John also saw that Celal was not wearing a helmet (which appeared to have come off and was lying on the street) and had a wound to his head, with further injury to his legs. Constable John saw Celal attempt to stand up, only to fall down.

Senior Constable Norman and Senior Constable Dring ran over to Celal to help him. They tried to keep Celal still as he complained of pain in his legs and groin. Meanwhile, Officer 1 called for ambulance assistance whilst Constable John diverted traffic away from Amy Street and the collision site.

Celal informed the police officers that he had asthma and could not breathe. Senior Constable Dring saw that Celal was wearing a shoulder bag across his chest. As the bag obstructing the attempts of the police officers to provide first aid to Celal, Senior Constable Dring told Celal he was going to cut the bag strap so that he could remove it. He did so and eventually removed the bag from Celal's grip. Senior Constable Dring opened the bag and saw a wallet with a driver's licence, which he removed and gave to Officer 1 so that an identification check could be performed. Senior Constable Dring also saw that there were three or four clear resealable plastic bags containing a brown coloured crystal powder-like substance, with one bag containing green vegetable matter, inside the shoulder bag.

Senior Constable Dring also noticed that a large number of smaller plastic resealable bags (about 50 to 100) had fallen out of one of Celal's trouser pockets.

Medical treatment at the collision site

A call was made to NSW Ambulance at 2:25pm. Paramedics from a road ambulance arrived on scene at about 2:36pm. Celal was found to be semi-conscious and hypotensive (low blood pressure) with poor saturation of peripheral oxygen. The paramedics also saw that Celal had a notable pneumothorax (collapsed lung) with a penetrating wound to the hip. Urgent assistance, including a medical team, was requested.

A medical retrieval team arrived via air ambulance at the scene a short time late at 2:53pm. A rapid lung ultrasound was performed which confirmed a left pneumothorax. Celal was noted to have a GCS (Glasgow Coma Scale) score of 13 which soon dropped to 3 following examination. Celal was also found to have a haematoma to his forehead, abrasions to his arms and legs, a penetrating wound to his right lower spinal area and bleeding through this wound. It was noted that Celal's oxygen saturations were dropping and so he was ventilated which improved the saturations. A thoracostomy was performed and packed red blood cells were commenced.

A short time later no pulse could be found so cardiopulmonary resuscitation (**CPR**) was commenced with ongoing ventilation. Within four minutes there was a return of spontaneous circulation and Celal was loaded into a road ambulance for urgent transport to hospital. The ambulance arrived at Westmead Hospital at 3:49pm and Celal was taken to the emergency department.

Medical treatment at hospital

Celal was later taken to the operating theatre where a laparotomy, and packing of the abdomen were performed for pelvic stabilisation. No intra-abdominal injuries were identified. Subsequent scans showed that Celal had suffered fractures of the frontal bone of the skull, cervical and lumbar spine, and right side of the pelvis, with bilateral pneumothorax, and large retroperitoneal haematoma. Celal was taken to the intensive care unit where he remained intubated and on inotropic support overnight.

A second laparotomy took place at around 2:30pm the following day to remove the packing. These were removed without difficulty and it was noted that there was no active bleeding from the pelvis. About 15 or 20 minutes into the procedure, the surgeons were planning to place drains and close, at which point Celal experienced a sudden loss of blood pressure. CPR was immediately commenced, and continued for 22 minutes. Following massive transfusion of blood there was an eventual return of cardiac output. However Celal later went into cardiorespiratory arrest again at 4:18pm and a transoesophageal echocardiography showed an enlargement of the right ventricle of the heart with a clot in the pulmonary artery. CPR continued with minimal effect and Celal was later pronounced deceased at 4:30pm.

What was the cause of Celal's death?

Celal was later taken to the Department of Forensic Medicine at Glebe where Dr Lorraine Du Toit-Prinsloo, forensic pathologist, performed a postmortem examination on 24 November 2016. Following external examination Dr Du Toit-Prinsloo noted that Celal had numerous superficial lacerations and abrasions on his head, arms, back and lower legs. Dr Du Toit-Prinsloo also noted that postmortem imaging showed features of subgaleal swelling, bilateral pneumothoraces, surgical packing in a laparotomy wound, fractures of the right pelvis and a fracture of the left tibial plateau.

Toxicological analysis revealed the presence of amphetamine and methylamphetamine at low/ton- toxic levels, together with the presence of ketamine and lignocaine, also at non-toxic levels. Ultimately Dr Du Toit-Prinsloo concluded that the causes of Celal's death was multiple injuries.

Investigations conducted following the collision

The collision scene was later examined by Leading Senior Constable Trent Wheeler, an investigator from the NSW Police Metropolitan Crash Investigation Unit. Leading Senior Constable Wheeler concluded that:

a) the Mitsubishi was stationary immediately prior to the pedestrian crossing;

b) the rear tyre of the Suzuki locked momentarily as it approached the rear of the Mitsubishi causing it to "*move in a lazy S style*";

c) Celal let go the handle bars just prior to impact;

d) the offside of the Suzuki impacted with the rear nearside of the Mitsubishi in a "*side swiping style collision*" causing Celal to lose control;

e) the Suzuki slid along the road surface before the front type impacted with a traffic island adjacent to the pedestrian crossing; and

f) the Suzuki travelled over the traffic island and came to rest in within the southern kerb and footpath.

The Suzuki was later examined by an officer from the NSW Police Engineering Unit and it was found to have no mechanical fault or defect which may have contributed to the collision.

Did a police pursuit occur on 21 November 2016?

The NSW Police Force Safe Driving Policy (**the Policy**) governs the conduct, role and responsibilities of police officers involved in the pursuit of a civilian vehicle. Part 7 of Version 8.2 of the Policy (which was in force at the time of Celal's death) defines a pursuit in this way:

PURSUIT: A pursuit, regardless of speed, commences at the time you decide to pursue a vehicle that has ignored a direction to stop.

It is an attempt by a police officer to stop and apprehend the occupant(s) of a moving vehicle, regardless of speed or distance, 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.

Having regard to the definition provided by the Policy, the initial question to be answered is whether any of the police officers in the Landcruiser on 21 November 2016 issued Celal with a direction to stop. If the answer to this question is in the affirmative, then the next question to answer is whether Celal ignored such a direction.

There is no evidence to suggest that any of the four police officers in the Landcruiser issued Celal with a verbal direction to stop. Therefore, the only means by which such a direction could have been given is if the Landcruiser activated its warning devices (lights and sirens). Each of the four police officers in the Landcruiser were either interviewed or provided statements in which they stated that the Landcruiser's warning devices were not activated until after the collision at the pedestrian crossing on Amy Street.

Specifically, Constable John said that from the time that he first saw the motorcycle he "*did not hear or see anyone activate the lights and sirens in our vehicle. We did not attempt to stop the motorbike rider at any time. I did not see us get close enough to the motorbike at any time to attempt to stop it*". Further, whilst Officer 1 agreed that the police officers "*probably*" would have attempted to pull over the Suzuki they did not do so "*because the distances were so long and the fact that we, we couldn't even see [Celal] for the majority of our driving…we only saw the, the streets he turned into…there was no point in even trying to like even activate [the warning devices] or anything, he wouldn't have seen them…it sort of happened so quick*".

There is no evidence to suggest that Part 5 of the Policy applied to the events of 21 November 2016.

The version of events from the police officers in the Landcruiser regarding non-activation of the Landcruiser's warning devices is corroborated by evidence provided by a number of civilian witnesses. Ms Nicholls said that the Landcruiser arrived "*very quickly*" after the impact and that its lights were on. However, Ms Nicholls said that she did not hear any sirens from police vehicles before the impact. Mr Oldfield said that the Landcruiser arrived on scene "*about a minute after the collision*" and that he did not hear any siren before the impact occurred. Further, Mr Oldfield said that he was "*pretty sure*" that the Landcruiser did not have its warning lights activated and that they were only activated after it arrived on scene. Ms Mched also said that she did not see any flashing lights or hear any sirens on the Landcruiser when it arrived. Finally, Stephen Dixon was outside his home at 79 Amy Street on 21 November 2016 when he saw the Suzuki "*flying*" and "*going very quick*". Mr Dixon subsequently saw the Landcruiser driving past "*a lot long [sic] maybe a few minutes after*" but did not associate it with the Suzuki because of the gap in time between the two vehicles. Each of these accounts is consistent with Senior Constable Norman's recollection that the warning lights were only activated shortly before (around 100 metres) the Landcruiser arrived at the collision site.

CCTV footage taken from a retail shop at 44 Amy Street and from an Auburn Council camera shows events consistent with the description given by the civilian witnesses. The footage shows the wheels of the Suzuki locking up, smoke emanating from the rear wheel, indicative of harsh braking or gears changing, Celal releasing his hold on the handlebars and then the Suzuki impacting with the Mitsubishi. The footage also shows the Landcruiser stopping at the scene about 20 seconds later following the collision and then activating its warning lights.

Conclusion: The accounts provided by the four police officers in the Landcruiser, the civilian witnesses at the collision scene, and the independent CCTV footage all establish that the Landcruiser's warning devices were not activated at any time prior to the collision. The evidence establishes that the warning lights (but not the siren) of the Landcruiser were only activated shortly before it stopped at the collision site. Therefore, there is no evidence that the warning devices of the Landcruiser were used to issue Celal with a direction to stop. There is also no evidence to suggest that Celal was issued, by any other method, with a direction to stop. This means that a pursuit, as defined by the Policy, did not take place on 21 November 2016.

Did the conduct of any police officer contribute to Celal's death?

Although the evidence establishes that the Policy did not apply to the actions of the police officers on 21 November 2016 it is still necessary to independently examine their conduct distinct from the application of any aspect of the Policy. In this regard the primary question to be answered is whether the actions of any police officer contributed to the manner in which Celal rode the Suzuki in the manner that he did, ultimately resulting in the fatal collision on Amy Street.

Clause 8-6-1 of the Policy is relevant to this question. It provides that it permissible for a police vehicle to "*reduce the distance to an offending vehicle without informing VKG of a response code or activating warning devices. However police must take reasonable care and it must be reasonable that warning devices are not used*". Although there is no offence to suggest that the police officers in the Landcruiser considered that Celal may have committed any offence, and therefore regarded as an "*offending vehicle*", it is evident that their interest in ascertaining more information about the Suzuki was heightened given Celal's manner of riding.

There is no doubt that at various times as the Suzuki and Landcruiser travelled along Kingsland Road, Kibo Road, Clucas Road and Amy Street both vehicles travelled in excess of the speed limit. In an attempt to provide an independent measurement of the speed that both vehicles travelled, CCTV footage from cameras installed at certain points along the path of vehicles was examined. Calculations were then performed measuring the time taken for both vehicles to travel between certain points shown in the footage. These calculations, performed by the Forensic Imaging Section of the NSW Police Forensic Crime Scene Facility, indicated the following:

a) when depicted in the CCTV footage outside 45 Kibo Road, the Suzuki was travelling with an average speed of not less than 99 km/hour and the Landcruiser was travelling with an average speed of not less than 85 km/hour;

b) when depicted outside 26 Clucas Road, the motorcycle was travelling with an average speed of not less than 111 km/hour and the Landcruiser was travelling with an average speed of not less than 84 km/hour; and

c) when depicted outside 140 Amy Street (when both vehicles were in the initial stages of acceleration at a point approximately 500 metres from the collision site), the motorcycle was travelling with an average speed of not less than 59 km/hour and the Landcruiser was travelling with an average speed of not less than 41 km/hour.

The above evidence demonstrates that the Landcruiser was travelling in excess of the designated speed limit on Kibo Road and Clucas Road, but not on Amy Street. This appears to be consistent with the evidence of the four police officers that the Suzuki remained in sight of the Landcruiser whilst travelling along Kibo Road and Clucas Road, but that it was not sighted after the Landcruiser turned onto Amy Street until the latter reached the collision site.

On 2 December 2016 and 9 May 2017 the officer-in-charge of the investigation, Detective Sergeant Sedgwick, conducted a physical reconstruction of the path taken by the Landcruiser on 21 November 2016. The reconstruction involved driving at the speeds that it was estimated that the Landcruiser had travelled (around 85-90km/hour) on that day, and in similar traffic and weather conditions. Detective Sergeant Sedgwick noted that Kibo and Clucas Roads were relatively wide with minimal traffic and, accordingly, the speed of the Landcruiser would not have posed a risk to members of the community. Detective Sergeant further noted that travelling at a similar speed on Amy Street would have posed a risk as it was narrower in width with high traffic flow.

It is evident that, by travelling in excess of the speed limit, the Landcruiser was endeavouring to maintain sight of, and contact with, the Suzuki. Although not explicitly stated by any of the four police officers, it appears from the evidence that one reason for doing so was to close the distance between the Landcruiser and the Suzuki in order ascertain the licence plate of the Suzuki. However, this is not to suggest that the conduct of any of the police officers, or the manner of driving of the Landcruiser affected Celal's control of the Suzuki in any direct way. Rather, the speed that the Suzuki was travelling and the manner in which it was being ridden by Celal appears to have been directly affected by other factors concerning his past history.

Firstly, there is considerable evidence establishing that Celal was involved in the supply of illicit drugs in the period preceding his death. The contents of the shoulder bag that Celal was wearing were later inspected at Auburn police station and logged as exhibits. Amongst other items, it was noted that the bag contained a set of scales, $500 cash, paraphernalia for the use of illicit drugs, and plastic bags containing different coloured rock material and green vegetable matter. The various rock material was subsequently analysed and found to contain 3,4-methylenedioxymethylamphetamine, methylamphetamine, and a methylenedioxy-substituted substance.

Further, after being notified of the collision, Celal's family members later attended the scene. Whilst there, Celal's sister, Ceylan Kanat, was approached by two young males not previously known to her, who told her that Celal's house had been broken into. Ceylan later returned to the family home at Regents Park and saw evidence of a break in. She noticed that a safe that had previously been in Celal's room had been removed, and that a window to Celal's car had been broken.

Investigating police later went to Celal's home on 24 November 2016. With the assistance of an interpreter, Celal's mother told the police that she had recently found what she believed were illicit drugs in Celal's room. Celal's sister, Burcu, also told police that she was aware that Celal had been involved in the sale of illicit drugs. Burcu provided police with a Samsung mobile phone which was previously used by Celal. When the phone was subsequently analysed police discovered a number of text messages indicating that Celal had previously been involved in supplying illicit drugs.

Secondly, at the time of the collision, Celal did not hold, and had never previously held, a motorcycle licence.

Thirdly, the toxicology results from the autopsy revealed the presence of narcotics in Celal's system indicative of illicit drug use proximate to the events of 21 November 2016. It may be inferred from this that the effects of drug use most likely contributed to Celal's decision-making process, his subsequent actions after he sighted the Landcruiser on Kingsland Road, and his ability to safely control the Suzuki in circumstances where it was travelling in excess of the speed limit.

Finally, the CCTV footage from the Speedway service station and subsequent examination of the Suzuki reveals that Celal had made attempts to conceal the full licence plate number of the Suzuki.

Conclusion: The evidence establishes that even before sighting the Landcruiser on Kingsland Road, Celal had taken steps to avoid coming under the attention of law enforcement authorities by obscuring part of the licence plate number of the Suzuki. Celal's motivation for taking such steps appears to be related to one of the following factors, or a combination of one or more of them: (a) his suspected previous involvement in the sale of illicit drugs; (b) the contents of the shoulder bag which he was wearing which pertained to illicit drug use and supply; and (c) his status as a person without a valid licence to ride a motorcycle.

The above factors, coupled with the likely effects of the narcotics that were later found in Celal's system, contributed to his decision to accelerate away at speed from the Landcruiser. It is most likely that Celal did so because of a belief that the police officers in the Landcruiser were seeking to stop him because of one or more of the above factors, or that if they did stop Celal they would discover one or more of the above factors. Regardless of either outcome, Celal's actions in riding away from the Landcruiser and then travelling in excess of the speed limit were consistent with an intention to avoid being stopped and its possible consequences.

Although the Landcruiser also travelled in excess of the speed limit during certain periods there is no evidence to suggest that it did so in a way which placed members of the public at risk of harm. There is no evidence of the Landcruiser being driven in a dangerous manner; indeed, the Landcruiser appropriately stopped at the intersection of Clucas Road and Amy Street to allow traffic to safely pass before continuing on. Further, the evidence establishes that the Landcruiser was not within Celal's rear view at any time whilst the Suzuki travelled along Amy Street. Indeed, the evidence establishes that the Landcruiser was travelling with the flow of traffic on Amy Street and it can be therefore be inferred it was travelling at the designated speed limit. On this basis, the evidence establishes that the Landcruiser was driven with reasonable care on 21 November 2016. Further, the evidence also establishes that it was reasonable for the Landcruiser's warning devices to not have been activated: (a) given the distance between it and the Suzuki, which only increased after the Suzuki was first sighted; and (b) having regard to the logical view expressed by Officer 1 that there would be no utility in doing so as they Suzuki was too far ahead to even be aware of them.

It therefore appears that: (a) the excessive speed that the Suzuki was travelling; (b) Celal's inability to manoeuvre the Suzuki in order to avoid an impact with Mitsubishi stopped at the pedestrian crossing; and (c) his inexperience in handling a motorcycle of the size and power of the Suzuki in circumstances where he had previously fallen off it, were the direct contributing factors to the collision.

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

Before turning to the findings that I am required to make, I would like to acknowledge the efforts of Mr Michael Dalla-Pozza, Counsel Assisting, and his instructing solicitors, Mr James Loosley and Ms Jessica Murty of the Crown Solicitor's Office. Their assistance during both the preparation for inquest, and during the inquest itself, has been enormous. I also thank Detective Sergeant Nicholas Sedgwick for his efforts during investigation into Celal's death and for compiling the comprehensive initial brief of evidence.

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

Identity

The person who died was Celal Kizildag.

Date of death

Celal died on 22 November 2016.

Place of death

Celal died at Westmead Hospital, Westmead NSW 2145.

Cause of death

The cause of Celal's death was multiple injuries.

Manner of death

The multiple injuries were sustained in a collision on 21 November 2016 involving a motorcycle that Celal was riding and another motor vehicle.

13. 361528 of 2016

Inquest into the death of GD. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 3rd April 2019.

This is an inquest into the death of GD who died at Cataract Dam in Appin, NSW. A preliminary question is whether the inquest is mandatory by virtue of the operation of sections 23 and 27 of the *Coroners Act 2009* ("the Act") which provide that an inquest is mandatory "if it appears to the coroner that the person has died (or that there is reasonable cause to suspect that the person has died)… as a result of police operations".

Whilst an initial focus of the coronial investigation was the adequacy of the police response, it does not appear that there was any deficiency or omission in the police operation. As such, I determine that the present inquest is not mandatory as GD's death was not the "result of" a police operation.

The role of a Coroner, as set out in section 81 of 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.

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.

Interested parties

In the present case, GD's family, the NSW Commissioner of Police and WaterNSW (the operator of Cataract Dam) are interested parties of this inquest. GD's family did not attend the inquest but I take this opportunity to pass on my sincere condolences to them.

The evidence

GD

GD was born on 14 October 1954 (he was 62 years old at the time of his death). He was the youngest of four children and is described by his siblings as a loving and close brother with whom everyone got along.

Mr and Mrs GD married in April 1985 and they have two children. The accounts of those that knew him best paint GD as a generous and kind man, a good husband and father and loving brother. These are all matters that make his loss all the more tragic.

Chronology of events

GD was experiencing some level of anxiety in the months before his death. He had retired, he and his wife were building a new house south of Sydney and they were wanting to sell their current home. GD's General Practitioner, Dr Visvalingam, thought that GD had always had an anxious personality, however, noted that this appeared to have increased in the months before his death. To treat this anxiety, Dr Visvalingam prescribed GD Sertraline on 26 July 2016.

On 12 November 2016, GD reported to his doctor that he had taken Sertraline for a few days, but had then stopped using it, had not slept for 2 days and that his anxiety about the sale of his home had gotten worse (he believed his house may have been infected by termites). Dr Visvalingam recommended he re-start Sertraline and also prescribed him Valium.

On 19 November 2016, GD again attended Dr Visvalingam's surgery and reported suicidal thoughts, but with no intent or plan. Dr Visvalingam increased GD's dosage of Valium, and attempted to organise an appointment for him with a psychiatrist (which did not occur). On 22 November 2016, Dr Visvalingam referred GD to Campbelltown Hospital for a mental health assessment.

On 22 November 2016 GD attended Campbelltown Hospital as arranged. He disclosed thoughts of ending his life by jumping off a cliff. He appears to have told at least one clinician that he had located the site at which he would jump, however, during a mental health assessment later that evening, he denied any active plan or suicidal intent. A plan was formed to admit GD to the PECC unit as a voluntary patient, to which GD initially agreed, however in the early hours of 23 November 2016 he requested to be discharged, saying he would rather engage with community-based services.

The medical records indicate that he denied suicidal ideation at the point of discharge. GD was referred to the Community Mental Health Emergency Team for follow up and was told to attend his GP for a medication review, to implement a plan to cease Sertraline and commence Venlafaxine.

GD attended Dr Visvalingam later that morning, who gave him a prescription for Venlafaxine (Eflexor).

Community mental health made contact with GD, however he declined to see them, saying that he had already seen Dr Visvalingam and was feeling well. The records indicate that Mr and Mrs GD knew they could call that service if needed.

On the morning of Thursday 1 December 2016, GD left his home at some time after 10:30am, leaving a note to his wife telling her that he had gone to get a haircut. Where he was between that time and the time he was first noticed to be at Cataract Dam is unclear on the evidence. As noted below, the next time he was seen was at around 1.15 or 1.30pm, at Cataract Dam.

Cataract Dam is in Appin and is managed by WaterNSW. The dam spans the Cataract River and the dam wall is approximately 243 metres long. The precise height between the top of the wall and the river on the downstream side is not directly in evidence but the photographs reveal it to be considerable (the drop is estimated by one witness, Ms Softley, as being 100 metres to a metal walkway which runs across the face of the wall and a further 30 metre drop to the valley floor; by another witness, Senior Constable Caton, as being 40- 50 metres and a third witness, Ms Berendt, describes it as being "significantly more than the height of a double story home). The wall is sloped (with its base being thicker than its top).

The public has access to the dam and there is a car park near the top of the wall (on the same side of the river as Baden Powell Road, the road which provides public access to the dam). On that side of the river (that is, the car park side), there is a bitumen track or roadway (ordinarily closed off by gates) leading to the river and the base of the dam wall. This provides access to a metal walkway which traverses the length of the dam wall near the bottom of it. On the opposite side of the river to where the car park is, there is another access road from the top of the dam wall leading to its base.

There is a walkway across the top of the dam wall to which the public was, at the time of GD's death, permitted access. In the middle of the walkway there is a small structure, known as the crest house, which is used to house some of the dam equipment. The walkway is separated from the edge of the dam wall (on the downstream side) by what one witness describes as a stone "parapet" that is 900mm high (I will refer to this structure as the "pedestrian barrier"). There is a small ledge (about a metre wide) on the outside of the pedestrian barrier before the dam edge.

At around 1.15 or 1.30pm, two employees of WaterNSW, Ben Coughlin and Kate Lenertz and two consultants from Extent Heritage, Ruth Berendt and Corinne Softley were performing work at Cataract Dam. They saw GD standing on the ledge on the outside of the pedestrian barrier. Although it was a warm day he was wearing long trousers and a jumper.

Mr Coughlin called out to GD requesting him to come back to the other side of the fence (away from the edge of the dam wall). He is said by Ms Softley to have done so in a very polite manner. GD did not respond but flicked his hand in a gesture which Mr Coughlin interpreted as signifying for him to go away. Mr Coughlin formed the view that he was "agitated, nervous and incoherent". Mr Coughlin also notes that he had to yell because of the sound of the water being released over the dam wall. Ms Berendt (who, by chance, had had some training in suicide prevention- having completed a Lifeline Australia course in 2010) then attempted to engage in conversation with GD. She too was unable to get any real response from him.

At this time, GD paced up and down then sat down with his legs over the edge. Mr Berendt saw him come away from the edge towards the pedestrian barrier before returning to the vicinity of the ledge on at least three occasions.

Mr Coughlin says that he did not approach closer than 50 metres to GD at any point, although Ms Lenertz estimates that he and Ms Berendt were standing about 30 metres away from GD when they were talking to him. Mr Coughlin and Ms Berendt tried to engage in conversation with GD for around 15-20 minutes before Ms Lenertz suggested to Mr Coughlin to stop in case he aggravated him. Whilst Mr Coughlin and Ms Berendt were trying to engage GD, Ms Lenertz telephoned police (she says at around 1:36 pm although the Computer Aided Dispatch records indicate that the call occurred at 1:42pm). It is possible that this difference is attributable to the difficulties the operator had in hearing Ms Lenertz due to poor phone reception.

The communications officer who had taken Ms Lenertz' call created a Priority 2 "Urgent" CAD incident, with the incident type recorded as "self-harm" at 1:42pm. At 1:42:21, the CAD incident was presented to the dispatcher and to all operational police vehicles attached to Campbelltown LAC which were patrolling and which had their Mobile Data Terminals and Mobile Police CAD system activated. Less than a minute later, the job was broadcast by the dispatcher over the radio for Campbelltown cars to respond. The dispatcher notified the Duty Operations Inspector (Chief Inspector Smith) and the Rescue Coordinator of the incident at 1.43pm. At 1:43:24 the dispatcher also notified the NSW Ambulance Service of the incident via the Computer Aided Dispatch System. The Police Air Wing (Polair) was also added to the incident at 1:46:14.

At approximately 1:43pm, Ms Lenertz also contacted Glenn Capararo, her husband and another employee of WaterNSW, to ask who the Primary Incident Notification Officer ("PINO") at WaterNSW was for that day.

Mr Capararo (who himself was a PINO, although not on duty) then contacted Rod Ruming, who was one of the two PINOs on duty that day. Mr Ruming was the second on call PINO, the primary PINO was Ms Knowles. Mr Capararo says that he contacted Mr Ruming first because he was a dam and water specialist. Mr Capararo agreed to act as incident manager until he could handover to Ms Knowles.

Mr Capararo also suggested to Ms Lenertz that the WaterNSW employees and consultants should stay away from GD to avoid upsetting him. He then asked her to ensure that the public were kept away from the dam wall and arranged for security guards to attend the dam to assist with closing off the gate and moving the public out of the area.

In response to Ms Lenertz' call, police car call sign CT 15 (with Senior Constable Grant Wortmeyer driving and Senior Constable Michael Caton as passenger) acknowledged the job at 1:42pm and proceeded to Cataract Dam.

At around 1:54pm, the Duty Operations Inspector, Inspector Paul Smith, viewed the Computer Aided Dispatch job that had been created as a result of Ms Lenertz' call. Senior Constable Wortmeyer and Senior Constable Caton arrived at Cataract Dam at 1.59pm.

After a brief conversation with the WaterNSW employees and heritage consultants who were present, Senior Constable Wortmeyer walked towards GD, who, by this time, was sitting with his legs over the dam wall. Senior Constable Wortmeyer tried unsuccessfully to engage him in conversation. GD stood up and made hand signals to indicate that he wanted Senior Constable Grant Wortmeyer to go back.

Senior Constable Wortmeyer says that he was between 40 and 45 metres away from GD and that he had marked the ground with his foot so as to ensure that he did not get any closer. This distance is consistent with the estimates of the distance between Senior Constable Wortmeyer and GD given by Senior Constable Caton and later by Senior Constable Mealing.

At this time, Senior Constable Wortmeyer requested the water be switched off as he had been experiencing difficulty in hearing what GD was saying. In his directed interview, Senior Constable Wortmeyer expressed considerable frustration at the fact that this did not occur when he asked for it to be done.

At 2:03 pm, Senior Constable Mealing and Senior Constable Evans, travelling in general duties vehicle call sign CT 16, arrived at Cataract Dam. They too attempted to engage GD in conversation. Senior Constable Evans appears to have had the most success in this regard (in that she was able to persuade him to take a drink of water and GD made eye contact with her) but, even so, it appears that she was not ultimately able to establish any real rapport with him. Senior Constable Mealing offered GD his phone in case there was anyone he wanted to call and also asked him if he wanted water or cigarettes. Senior Constable Caton also asked GD whether there was anyone he could telephone for him or anything he could do for him.

Senior Constable Evans says she got to a distance of about 15-20 metres away from GD at the time when she was having the comparatively greater success in engaging him in conversation. This appears to have been the closest any of the police ever approached to GD.

Whilst police were attempting to engage with him, GD was pacing along the ledge and sitting on it with his feet over the edge of the wall. At some point, GD lay down on the ledge with (at various points) an arm and one leg hanging over the edge.

Also at 2:03pm, Leading Senior Constable Keith Toby, who was rostered on as the mobile Supervisor at the Campbelltown LAC, attended the scene in a single officer police car (call sign CT 14). As he had poor telephone reception at the car park, at 2:12pm, he drove back to the top of the hill on the road leading to the dam in an attempt to get better reception. At around 2:15, he was able to get through to the Duty Officer, Chief Inspector Grady.

Meanwhile, by 2.06pm, the security that Mr Capararo had called for had arrived, had shut the front gate across the road leading to the dam and had arranged for the public to be escorted from the site.

At some point between around 2:00pm to 2.15pm, WaterNSW Maintenance Team Leader, Mark Mallitt, was contacted by Mr Ruming regarding switching the water off at the dam. Mr Capararo delegated to Mr Mallitt the authority of "site controller", which gave him the authority to switch the water off. Mr Mallitt immediately left his office in Campbelltown to travel to Cataract Dam in order to do so.

At 2:22pm, in his role of Duty Operations Inspector, Inspector Paul Smith telephoned the Police Rescue Base at Zetland to see whether police rescue were available to respond if required. (The Rescue Coordinator had already been made aware of the incident by the Computed Aided Dispatch at 1.43pm). Senior Constable Bolitho and Senior Constable Perrett of the Rescue and Bomb Disposal Unit were dispatched from performing duties in the St Mary's area to attend.

Chief Inspector Grady telephoned the Duty Operations Inspector, Inspector Smith, at around 2:25 pm to request the deployment of negotiators. Inspector Smith was already aware of the incident as he had been made a recipient of the Computer Aided Dispatch incident at 1.43pm and had viewed it at 1.54pm. Inspector Smith called Sergeant Murphy of the Police Negotiations Unit (based in Sydney) at 2.26pm. The on call negotiator was Detective Sergeant Gilbody, who was on a rest day at her home. Sergeant Murphy contacted her at 2.37pm and requested her to attend. Detective Sergeant Gilbody left home for Cataract Dam shortly afterwards and notified police that she was responding in an urgent duty capacity by 2:48pm.

A Polair helicopter arrived at the scene at 2:23pm. They flew over the dam wall but gave it a "really wide berth".

Meanwhile, at around 2:13 pm, NSW Ambulance officer Inspector David Kynaston arrived at Cataract Dam. After being briefed by police, he approached to within about 15 metres of GD and attempted to speak to him. GD waved him away and Inspector Kynaston stepped back to join the police officers. Using his mobile phone, Mr Kynaston filmed around 10 minutes of footage of GD pacing and then lying down on the wall. This footage seems to capture towards the latter part of the incident.

Meanwhile, Mr Mallitt arrived at the entrance of the Dam at around 2:30pm and was admitted by the security guard who was at the entrance gate. He drove about one kilometre down the road leading to the car park, where he encountered a police vehicle preventing access to the dam wall, and a police officer standing beside the vehicle (who must have been Leading Senior Constable Toby). Mr Mallitt says that Leading Senior Constable Toby confirmed that another police officer had requested that the water be shut off and Mr Mallit responded that he had the authority to do so. Leading Senior Constable Toby then said he needed to check with the police at the dam wall and get confirmation before he could allow Mr Mallitt to walk down to the dam and turn the water off. Mr Mallitt noted that Leading Senior Constable Toby had poor reception.

At around 3:00pm, Senior Constable Wortmeyer broke into GD'ss vehicle, later joined by Senior Constable Caton. They located his wallet and drivers licence inside, which was how GD was identified. Senior Constable Wortmeyer and Senior Constable Caton walked back to the car park and went to a point overlooking the dam wall.

At around 3:03pm, Senior Constables Perrett and Bolitho arrived at Cataract Dam. They walked onto the dam wall, had a conversation with a male police officer who was on the wall (who was presumably Senior Constable Mealing) and then returned to their vehicle to obtain the rescue equipment that might be needed. At around 3:07, Chief Inspector Grady also arrived at Cataract Dam. She estimates that police were about 20 metres away from GD at the time she arrived. She made a radio call to Leading Senior Constable Toby for the water to be switched off in anticipation of the police negotiators arriving.

Consistently with Chief Inspector Grady's instructions, at around 3.15pm, Senior Constable Toby told Mr Mallitt he could turn the water off. At 15:18:26 GD went over the edge of the dam wall. He is described as having "rolled" over the edge.

Tragically, the Police Negotiator, Detective Sergeant Gilbody, arrived a matter of seconds after GD had gone over the edge (at 15:18:52).

After he had been requested by Leading Senior Constable Toby to switch the water off, Mr Mallitt drove two or three minutes to the dam wall. However by the time he arrived to do so, GD had already rolled off the edge. Mr Mallitt was told, however, that police still wanted the water turned off, so he drove to the bottom of the dam wall to the pump station, walked up a set of stairs to the pump station, and turned the flow of water off.

After GD had rolled off the wall, Senior Constable Wortmeyer and Senior Constable Caton drove down the bitumen track leading to the base of the dam wall on the car park side of the river. Senior Constable Evans and Inspector Kynaston ran down behind them and Mr Coughlin accompanied them down.

Senior Constable Bolitho had walked down the service road on the opposite side of the river from the car park to the dam wall which led close to where GD was lying. He was the first person to reach GD (at about 3:25pm). Senior Constable Bolitho checked GD for signs of life and observed his breathing to be laboured and noisy. He placed GD in the recovery position and called for urgent medical assistance.

Senior Constable Bolitho indicated to Senior Constable Perrett, who was standing on the top of the dam wall that GD was still breathing. Senior Constable Perrett obtained equipment from the truck and brought it down to Senior Constable Bolitho and the ambulance staff. Senior Constable Wortmeyer, Senior Constable Caton and Inspector Kynaston met at the bottom of the wall, walked along the metal walkway at the base of the dam and arrived at a ledge that was about 6 meters above where GD was lying. From there, they could see that GD was still breathing.

Senior Constable Mealing remained at the top of the wall with Chief Inspector Grady due to the fact that the telephone reception was better there. After they reached GD, Inspector Kynaston said that he needed to get his kit bags from the ambulance. Senior Constable Evans collected a bag from the ambulance and then used a waterway vehicle to drive back down to the base of the wall. This turned out to be the wrong kit bag, so Senior Constable Evans gave Mr Coughlin the keys and asked him to retrieve the correct kit bag from the ambulance, which he did.

Inspector Kynaston called for an intensive care car, a primary care car and an Ambulance Medical Helicopter. He moved GD onto his back and placed him on a stokes litter. A cervical collar, oxygen mask and cannula were applied. Once the medical helicopter arrived, a doctor and a paramedic were winched down to GD and treatment continued under the doctor's authority. Unfortunately, these efforts were unsuccessful, and GD was pronounced deceased at 16:45.

Did GD deliberately roll off the edge of the dam?

GD was suffering from serious anxiety in the lead up to his death. He had articulated on a number of occasions that he had suicidal thoughts. He had been hospitalised but he was discharged after asserting he had no plan. The access to the dam has clear signs to the public to not proceed onto the ledge. GD did and despite the intervention of a number of people he proceeded to stay there for quite a long period during which he was clearly contemplating the drop.

It may be that GD lay down and rolled off the edge because it was too confronting for him to have jumped off and/or because of the nature of the curve of the wall and the walkway below he might have been concerned that his attempt may not succeed if he jumped. It is not possible to know precisely what he was thinking but I am of the view that the evidence is clear and cogent that he acted deliberately, propelling himself off the ledge at the top of the dam so that he would end his life.

Was the police response adequate?

(i) the timeliness of securing the attendance of a negotiator

Pursuant to the procedures in the Duty Operations Inspector Handbook, it was the role of the Duty Operations Inspector, (in this case, Inspector Smith), to call out negotiators.

As noted above, Inspector Smith was added to the Computer Aided Dispatch incident once it was created at 1:43pm. This was in accordance with the standard practice for any "Serious, Unusual or Newsworthy" ("SUN") incidents which may require the deployment of scarce resources (such as negotiators) or reporting to the NSW Police Executive.

Though Duty Operations Inspector Smith became aware of the incident at 1:54pm, he did not make arrangements to call negotiators until he had been telephoned by Chief Inspector Grady at 2:25pm. However, this too was consistent with the role of the Duty Operations Inspector as outlined in the Duty Operations Inspector Handbook. Inspector Smith explains that the rationale behind these procedures is to ensure that valuable resources such as police negotiators are allocated appropriately, by having police officers at the scene conduct an initial risk assessment and ascertain whether the situation can be resolved through the use of conventional methods, without the need to involve a specialist unit. Inspector Smith goes on to note that on a monthly basis police attend hundreds of suicide and self-harm threats and that, proportionally, negotiators are only called to a small number of these incidents.

Whilst the Duty Officer (Chief Inspector Grady) was not telephoned in relation to the incident until 2:15pm, this appears to be readily explicable by the need for the first attending police to assess the situation and by the subsequent difficulties that Leading Senior Constable Toby, the supervisor at the scene, had with his telephone reception when he attempted to call her. Inspector Smith's reaction once he received the call from Chief Inspector Grady was rapid (he called Sergeant Murphy at Police negotiators a minute later).

Whilst there was a short delay between the time Sergeant Murphy was called and the time Detective Sergeant Gilbody was first contacted (from 2:26pm until 2:37pm), this appears explicable by the need for Inspector Smith to explain the situation to Sergeant Murphy and then by Sergeant Murphy needing to locate Detective Sergeant Gilbody (who was on a rest day). Similarly, the delay between Detective Sergeant Gilbody being called by Sergeant Murphy (at 2:37) and her telling police that she was responding (at 2:48) is not significant and may be explained by the need for Sergeant Murphy to explain the situation to Detective Sergeant Gilbody and for Detective Sergeant Gilbody to get ready to leave her home. Moreover, the time that Detective Sergeant Gilbody indicated to police that she was responding is not necessarily evidence of the time she left her home. Overall, there is no reason to doubt that Detective Sergeant Gilbody responded to the situation urgently (as she says in her statement that she did).

More generally, I note that the response of the dispatchers was reviewed by Chief Inspector Stafford who expresses the opinion that they acted to a satisfactory level and in accordance with the relevant Standard Operating Procedures. I accept that the relevant policies were complied with. In particular, the dispatchers notified the Duty Operations Inspector of the incident promptly (at 13:43) in case negotiators were required.

In short, although the timing of Ms Gilbody's arrival relative to GD rolling off the wall was almost unbelievably tragic, it does not appear to have been the result of any deficiency on the part of the police response.

(ii) the water not being switched off

Although Senior Constable Wortmeyer asked for the water to be switched off at an early stage, it was not ultimately until after GD had rolled over the ledge that this was done. This appears to be largely attributable to the actions of Leading Senior Constable Toby in holding up Mr Mallitt who had attended to switch the water off at about 2:30pm.

Whilst it may be speculated that, had the water been switched off at an earlier stage, police may have been able to better engage GD, it may also be that it could have been a trigger for him to jump or roll. I think that it was entirely reasonable for Leading Senior Constable Toby to await the direction of Chief Inspector Grady.

Further, none of the police who had the opportunity to engage with GD were trained negotiators and GD did not appear to have been willing to engage with them (as noted above, he had waved away each of the police officers who had attempted to engage him in conversation). It is, in any event, a matter of mere speculation as to whether turning off the water would have made any difference to the outcome. It is worth noting, in this regard, Mr Coughlin's opinion that GD, had he wished to speak to him, could easily have done so by raising his voice. GD was unwilling to engage with the police.

(iii) The attempts made by police to engage with GD

It appears to be the case that all of the police who were present did their best to engage and develop a rapport with GD in as safe and sensitive a way as reasonably possible (noting again that none of these officers were trained as negotiators). They appear to have been acutely conscious of the effect that their presence may have had on GD and seem to have kept a distance which gave due regard to this fact.

The only officer who approached GD more closely than 40-45 metres appears to have been Senior Constable Evans; her actions in this regard seem to have been justified by her relatively better rapport with GD. Other steps taken by police (offering GD water and cigarettes, to call someone on his behalf or, in the case of Senior Constable Mealing, to allow GD to use his private telephone to call whoever he wished) displayed a high degree of sensitivity and compassion.

(iv) training given to police about dealing with persons who may be mentally ill

All police involved had done at least some training in dealing with a mentally unwell person (with Senior Constable Caton and Detective Sergeant Gilbody having done a more intensive four day course).

Were the safety measures in place regarding access to the dam wall adequate?

Members of the public had free access to the walkway across the top of the dam. Signage was in place along the low pedestrian wall prohibiting access to the ledge. GD deliberately entered the ledge. If he had accidentally fallen or rolled from the dam, whether it was a safe area may have been an issue for this inquest.

Thankfully, there have been a limited number of suicides at Cataract Dam. The height of the wall or pedestrian barrier seems to be relatively low making the edge of the dam easily accessible. It certainly does not appear that GD had any difficulty at all in traversing it. However, as Mr Magaharan alludes to in his statements, the dam is over 100 years old and there are a number of relevant heritage considerations and issues of the broader public access to such an amenity.

Mr Magaharan has noted that the height of the pedestrian barrier, although conforming to standards when constructed, would not conform to contemporary standards. Contemporary standards are said to require the pedestrian barrier to be of a height of between 1100-1200mm.

Such a small addition to the height of the barrier may not, as Mr Magaharan goes on to point out, provide much in the way of additional protection against a person determined to climb over it. As an interim measure following GD's death, Mr Magaharan reports that WaterNSW have temporarily prevented the public from accessing the walkway on the top of the dam wall by the erection of temporary pedestrian barriers 1.8 metres high. In his evidence, Mr Magaharan said that full public access is now available to the centre of the dam.

No final decision has been made either in relation to raising the height of the pedestrian barrier (whether to comply with contemporary standards or to such a greater height as might be thought effective to prevent or discourage members of the public from deliberately accessing the edge of the dam wall) or in relation to permanently restricting the public from accessing the walkway on the top of the dam wall. Both of these matters will be the subject of recommendations made to the Board as part of a project which Mr Magaharan refers to as the "Barrier and Fencing Upgrade Project". The recommendation that is likely to be made to the Board is that WaterNSW increase the height of the wall to 1200mm (however this is said to be subject to further technical and expert advice). It is anticipated that the Board will consider these recommendations at a meeting to be held in June 2019 (although that date is said to be subject to change). Implementing the works as a result of the recommendations is estimated to take a period of three years (which is again subject to change).

In addition, the board for WaterNSW is currently reviewing the Public Access Standards for Land and Recreation Activities; a draft of this standard became available in March. Mr Magaharan suggests that it is currently the intention of WaterNSW to obtain further technical and expert advice in this regard. Given that GD did not die accidentally there is, in the circumstances of this inquest, no evidence which supports any recommendation to WaterNSW about the safety or extent of public access to this Cataract Dam site.

Formal Finding:

GD died on 1 December 2016 at Cataract Dam, Baden Powell Drive, Appin, New South Wales, as a result of multiple blunt force injuries from deliberately rolling from the top of the wall of the dam.

14. 24726 of 2017

Inquest into the death of Kenneth HELLYER. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 3rd April 2019.

This inquest concerns the death Mr Kenneth Hellyer who died aged 74. At the time of his death he was serving a custodial sentence at Long Bay Correctional Centre Aged Care Rehabilitation Unit.

Mr Hellyer was in lawful custody at the time of his death. Accordingly, an inquest is required to be held pursuant to sections 23 (d) (ii) and 27 (1) (b) of the Coroners Act.

Pursuant to section 81 of the Act a coroner is required to make findings as to;

a) The identity of the deceased
b) The date of their death
c) The place of their death, and
d) The manner and cause of the person's death.

Under section 82 of the Act, the coroner also has the power to make recommendations concerning matters of public health and safety arising out of the death in question.

Mr Hellyer's personal history

Mr Hellyer was born to his father Charles and mother Phillis and was the second youngest of four brothers. During his early life the family lived in Concord West before moving to Toongabbie. After leaving school Mr Hellyer completed an apprenticeship as a baker. He later managed local service stations before owning and operating a tip truck. He married and had three daughters. After his father passed away he moved with two of his daughters to the Central Coast to live with his mother. After his mother's passing he began living in a caravan park until his current incarceration.

Mr Hellyer's custodial history

Mr Hellyer first entered NSW corrective services custody on 10 March 2010. He was 67 years old and it was his first time in custody. He was transferred to the Metropolitan Remand and Reception Centre (MRRC). On 13 August 2010 Mr Hellyer was sentenced at the Gosford District Court for 3 counts of aggravated sexual assault (victim under 16) and 1 count of aggravated sexual assault (victim under 10). He received a total sentence 14 ½ years with a 9 ½ year non-parole period. His earliest release date was 9 September 2019.

During his time in custody Mr Hellyer was subject to 77 movements between several hospitals and correctional centres.

Mr Hellyer's medical status

Mr Hellyer's medical history included a childhood rheumatic fever. Prior to his incarceration he had a history of heavy alcohol and tobacco use. He had osteoarthritis, basal cell carcinoma, chronic obstructive airway disease, gastro-oesophageal reflux disease, monoclonal B cell lymphocytosis. While in custody he was seen by the general practitioner, haematologist, respiratory physician, gastroenterologist and an oncologist.

In January 2016 that Mr Hellyer was diagnosed with metastatic carcinoma of unknown primary with bilateral lung metastases and abdominal lymphadenopathy. Mr Hellyer's cancer was inoperable and incurable. On 9 May 2016 he commenced palliative chemotherapy; however he developed bone marrow hypoplasia which necessitated the cessation of chemotherapy treatment.

In June 2016 Mr Hellyer was transferred to the Kevin Waller Unit at the Long Bay complex. On 15 September 2016 Doctor Sim completed an end of life care plan in consultation with Mr Hellyer. The plan indicated 'No Cardiopulmonary Resuscitation."

On 15 November 2016 due to his deteriorating health Mr Hellyer was transferred to Long Bay Hospital, Aged Care Rehabilitation Unit. Mr Hellyer continued to deteriorate and on 21 December 2016 he entered end of life nursing care. On 23 January 2016 Mr Hellyer's brother Jeffrey made a request for a family visit which occurred the following day by which time Mr Hellyer was unconscious. Within an hour of the family's arrival, Mr Hellyer died. He was pronounced life extinct on 24 January 2017 at 1.18pm.

Cause of Mr Hellyer's death

On 30 January 2017, Dr Rebecca Irvine conducted an autopsy upon Mr Hellyer. Dr Irvine issued a report recording Mr Hellyer's cause of death as complications of metastatic adenocarcinoma of unknown primary. There is no controversy in relation to the cause of Mr Hellyer's death.

Other issues

Mr Hellyer's brother Jeffrey has queried whether Mr Hellyer was adequately cared for following his diagnosis particularly pain management. Jeffrey makes complaint that if it was not for his telephone call on 23 January 2017 he would not have been aware of Mr Hellyer's deteriorating health.

The Department of Corrective Service files have been tendered as has the NSW Justice Health records. I have assessed the information contained in that material. In relation to the management of Mr Hellyer's health, having reviewed the file it appears that his care and treatment were adequate and appropriate.

The family raises the issue as to whether, when a prisoner becomes incapacitated to contact their family member and/or enters palliative care Corrective Services should be required to contact the emergency family or friend nominated by the prisoner. I note there is no such document contained in the file tendered.

The records of 21 December 2016 indicate that Mr Hellyer was unable to walk and was bedridden and required full time nursing care. He had entered palliative care for end of life expectancy.

The records indicate that on 26 October 2016 Mr Hellyer's sister-in-law Judith telephoned inquiring about him, her particular concern was that he had not written or phoned. She was advised that he was mobile. Judith was advised that he would be informed of her telephone call.

On 12 November 2016 Mr Hellyer's brother Jeffrey and his sister- in-law Yvonne visited him.

There is no record in either the Justice Health or the Corrective Services material indicating that any family member had been contacted and informed of Mr Hellyer's declining health. Given Mr Hellyer's apparent inability to make telephone calls or write letters and by that stage lack of mobility had it not been for a family member making a telephone call to inquire how he was, they would have missed the opportunity to visit him before he died.

The issue is whether the Department of Corrective Services should advise a prisoner's next of kin of that situation. The Department advises that as Mr Hellyer's transfer to Long Bay Hospital did not involve an emergency and did not involve a hospital outside the Long Bay Prison complex, such a transfer is one that did not invoke their policy to contact the Emergency Contact Person. There are concerns that if the Department did contact a family member that they would not be at liberty to divulge private health information but such concerns would not arise if the information was to inform the family of the fact of transfer and the location to which the prisoner is transferred and a suggestion that further contact be made by that family member to Justice Health.

Likewise there appears to be no policy in place requiring Justice Health to notify the Emergency Contact Person of the impending death of an inmate. Justice Health was not a party to these proceedings nor have they responded to correspondence sent by the Advocate assisting me about this issue. The Department of Corrective Services is supportive of such a recommendation. I am of the view that where a patient is transferred to a hospital whether it is a prison hospital or an outside hospital, the prisoners Emergency Contact person should be notified.

Conclusion

Findings

Identity

The person who died was Kenneth Hellyer.

Place of death

Mr Hellyer died at Long Bay's Aged Care Rehabilitation Unit, Long Bay Hospital

Date of death

Mr Hellyer died on 24 January 2017.

Cause of death

The cause of death was complications of metastatic adenocarcinoma of unknown primary.

Manner of Death

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

RECOMMENDATION

To Minister of Corrections and to the Minister of Health:

That Corrective Services and Justice Health Forensic Mental Health Network, liaise to consider implementing a policy to ensure that a prisoner's Emergency Contact Person/ Next of Kin are notified when that prisoner enters any palliative care arrangement or where their end of life is imminent so that if JH&FMHN staff do not inform the Emergency Contact Person/Next of Kin directly they do inform CSNSW, so that a Services and Programs Officer (SAPO) or if out of hours, CSNSW a staff member contact the Emergency Contact person/Next of Kin.

15. 43731 of 2017

Inquest into the death of Xavier Connor BURKE. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 25th July 2019.

In the early hours of the morning on 10 February 2017 Xavier Burke was fatally injured when the vehicle that he was driving collided with a B-double. The collision occurred just north of the bridge at Macksville, after the vehicle that Xavier had been driving had been pursued by a police vehicle for almost 30 minutes and over a distance of approximately 60 kilometres.

Xavier was driving his father's vehicle, which he had taken from the family home some hours earlier. Xavier was only 15 years old at the time, alone in the vehicle that he was driving, and had never received any driving lessons.

Why was an inquest held?

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

Due to the circumstances surrounding Xavier's death, he was regarded as having died in the course of a police operation. This meant that, according to the relevant section of the Act which applied at the time, an inquest into Xavier's death was mandatory. Inquests are mandatory for these types of deaths to ensure that there is an independent and transparent investigation of the circumstances of the death, and the relevant conduct of any involved police officers. Such an investigation serves to provide assurance to the community at large that the wide powers bestowed on police officers have been exercised in an appropriate manner and with due consideration to the safety of those who might be adversely affected by the use of such powers.

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

Xavier's life

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

Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Xavier's important life. It is hoped that the brief words below do so in a meaningful and respectful way.

Xavier was born on 21 August 2001. He was the only son of John and Marina Burke and had a younger sister. At the time of his death, Xavier was a Year 10 student at Melville High School in Kempsey, where he was peer leader for his year and in the top academic class. Xavier was also a gifted sportsman, having played in the State high school softball championships. By all accounts Xavier had a close circle of friends and was popular and well-liked.

From a young age Xavier had a fascination with cars. He spoke often of them and was well-known to be looking forward to obtaining his licence. Xavier also had a love of music and had shown considerable aptitude as a talented pianist.

There can be no doubt that Xavier is deeply missed by his parents, sister, family, and friends. It is most distressing to know that Xavier was lost at such a young age, with his potential still unfulfilled, and in such tragic circumstances.

What happened on 9 and 10 February 2017?

On the morning of 9 February 2017 Xavier spoke to his friends about taking his father's white 2002 dual cab Ford Courier 4WD utility (**the Courier**), with registration BC-38-CB, out for a joyride later that evening. Xavier's father had only bought the Courier recently. At the time, Xavier did not hold a driver's licence and had never received any formal driving lessons. During the day Xavier and his friends formulated a plan which involved Xavier waiting until his parents were asleep, taking the keys to the Courier, and then rolling it down the driveway of his home so that it could be driven away without waking his parents. Xavier and his friends had previously made similar plans to go out on joyrides on earlier occasions

At 9:59pm a member of the public reported to police that they had witnessed a white 4WD utility smash through a locked gate at a truck yard near 33 Bloomfield Street, South Kempsey. A broadcast was made over police radio (also known as **VKG**) for any available police to attend the location.

At the time Senior Constable Grant Osborn and Constable Aaron Wilson, were conducting patrols in a marked police vehicle with call sign Kempsey 22 (**WK22**). They acknowledged the job and proceeded to Bloomfield Street. Initial enquiries suggested that the stolen vehicle was believed to be a white dual cab Nissan Navara with registration BR-75-GN. At 11:02pm a VKG broadcast was made indicating that unconfirmed information suggested that the stolen vehicle was in fact a white Toyota Hilux (**the Hilux**).

Sergeant Damien Goddard and Senior Constable Robert Davison were on duty at Kempsey police station during the evening. Upon hearing the VKG broadcast in relation to the Hilux, Sergeant Goddard decided to conduct a patrol of the Crescent Head area. This was because he was aware that there had been a number of recent break and enter offences committed recently around Crescent Head, as it was known to be popular with tourists who often left their property unsecured, and because another police highway patrol car was already patrolling the Kempsey area. As a result, the area was often targeted by offenders seeking to commit property-related offences.

Sergeant Goddard asked Senior Constable Davison to accompany him on the patrol and they left Kempsey police station in a marked Holden Commodore with call sign West Kempsey 13 (**WK13**). Sergeant Goddard and Senior Constable Davison patrolled the Crescent Head area up until around midnight, encountering little traffic and finding nothing of relevance. They returned to Kempsey police station and attended to paperwork.

After leaving Bloomfield Street Senior Constable Osborn and Constable Wilson attended to two further jobs both relating to vehicle fires which had appeared to have been deliberately lit, and then abandoned, by unknown persons. The first job was at 12:32am in Kemp Street, West Kempsey whilst the second job was at 1:18am in Armidale Road, Greenhill.

According to the plan which had been formulated earlier in the day, Xavier left his home in Kundabung sometime after about 11:30pm. During the journey to Frederickton Xavier told his friends that if he was pulled over by the police that "*he would tell everyone to get out and he would just try and get away from them like, escape the police chase*".

At about 1:00am the group attempted to pick up another friend. After being unable to do so the group left and drove to a quarry located west of Kempsey at the intersection of Gowings Hill Road and Pipers Creek Road. After arriving, all of the youths got out of the Courier and walked around the quarry for an unknown period of time. Whilst doing so they observed some lights near where the Courier had been parked. After waiting for about 10 minutes the group made their way back to the Courier, and saw that the lights had gone. They then drove back towards South Kempsey.

It appears that a member of the public saw Xavier and his friends at the quarry and made a report of the sighting to the police to Kempsey police station, which was received by Senior Constable Davison. Upon hearing the report Sergeant Goddard decided to investigate it, believing that it may be connected to the report of the stolen Hilux. Sergeant Goddard again asked Senior Constable Davison to accompany him.

They left Kempsey police station in WK13 and advised VKG at about 1:23am: "*…we're just making our way out to, uh, the quarry at 501 Gowings Hill Road at Dondingalong and just had a call at the station, uh, at Fort Lakes of the Hilux act, acting suss. It might be the one from earlier*". At the time he left the station Sergeant Goddard was wearing Body Worn Video (**BWV**) recording equipment.

The following exchange then took place between the VKG despatcher and Sergeant Goddard:

VKG despatcher: *Copy that. And, um, before I create the job, you're going out there, Kempsey 13, there are four POI's out there? What were they doing?*

Sergeant Goddard: *Yeah…a white Hilux just acting suspicious. It's possibly the stolen Hilux from earlier tonight.*

As a result the following job was created on the police Computer Aided Despatch (**CAD**) system: "POI'S ACTSUS IN A WHITE TOYOTA HILUX POSSIBLY STOLEN FROM EARLIER TONIGHT".

A short time later the following exchange took place over VKG:

VKG despatcher: *I only got to the channel at 1 o'clock this morning. Um, I don't know anything about any stolen white Toyota Hilux. Have you got a rego?*

Sergeant Goddard: *Yeah the rego is Bravo-Romeo-7-5-Golf-November and it was stolen about, uh, 9 o'clock tonight.*

Senior Constable Osborn and Constable Wilson heard the broadcast and informed VKG that they were going to make their way to Gowings Hill Road from the west with the intention of intercepting the Hilux. Meanwhile, WK13 made its way to Gowings Hill Road where Sergeant Goddard and Senior Constable Davison saw the Courier travelling east in the opposite direction. Sergeant Goddard estimated that the Courier was travelling well over the designated 80 kilometre per hour speed limit at time. He activated his BWV, performed a u-turn and commenced following after the Courier along Gowings Hill Road.

The Courier continued along Gowings Hill Road, and then turned into Middleton Street when the warning lights of WK13 were activated. The Courier proceeded along Middleton Street and turned right onto West Street. After travelling a short distance, the Courier pulled over and all the occupants, except for Xavier, exited the vehicle and began to quickly walk away. WK13 also pulled over. Senior Constable Davison exited the police vehicle and began following after the young persons, telling them to stop.

Moments later, the Courier began to drive away. Sergeant Goddard called out for Senior Constable Davison to return to the police vehicle. When Senior Constable Davison did so, Sergeant Goddard also drove off, following after the Courier.

He advised VKG at 1:35am that a pursuit had commenced and provided the registration details of the Courier as being BC-38-CB. A pursuit was initiated and the lights and sirens of WK13 were activated. WK13 followed after the Courier along West Street before it turned onto South Street and then Macleay Valley Way. As the pursuit crossed Middleton Street, the VKG despatcher sought clarification in relation to the two registration details that had been provided (BR-75-GN and BC-38-CB). WK13 confirmed that it was in pursuit of registration BC-38-CB. The following exchange then occurred:

VKG despatcher: *Copy that. What was the original offence?*

Sergeant Goddard: *Uh, this is relating to kids acting suss. Um, and we've just sort of just come in.*

The pursuit continued through East Kempsey where, prior to crossing the Kempsey bridge, the Courier briefly crossed to the incorrect side of the road. This prompted the following broadcast to VKG: "*…he's just travelled…incorrect side of the road, uh, back on correct side. Zero traffic…Speed is 1-2-0 in a 50 zone, 0 traffic*". Following this, the pursuit continued to head north towards Frederickton.

Senior Constable Davison could not tell how fast the Courier was travelling but knew that it was over the speed limit. He saw no other traffic on the road as the pursuit entered Frederickton. At this point Senior Constable Davison saw the Courier briefly cross to the incorrect side of the road as it negotiated a sharp left-hand turn, before returning to its own lane. This was conveyed to VKG as follows: "*He just crossed on the incorrect side of the roadway again, um, in Frederickton. He's slowed down. His speed's now 1-1-0 in the 50 zone. Still zero traffic. He's back on the correct side of the road now*".

WK13 also advised VKG that there were "*two heads on board*" and that the weather was fine with zero traffic. The VKG despatcher made a broadcast that the pursuit was waiting for an available highway patrol vehicle that was equipped with tyre deflation devices (commonly referred to as **spikes**) on board, as WK13 advised that they were not equipped with spikes (although this was actually incorrect as WK13 was so equipped).

As the pursuit continued along Macleay Valley Way approaching Christmas Creek just outside of Frederickton, the following exchange occurred:

VKG despatcher: *Just confirming Bravo-Charlie-3-8-Charlie Bravo. And uh…*

Sergeant Goddard: *That's correct, radio. White Hilux.*

VKG despatcher: *White Toyota Hilux. Yeah I got here that it's a 2002 white Ford Courier to a John Bourke [sic] of 286 Silo Road Kundabung.*

Shortly afterwards, the VKG despatcher enquired over VKG with a number of other police vehicles (with call signs Mid North Coast 10, Port Macquarie 14, and Coffs Clarence 10) as to whether any suitable officer was able to monitor the pursuit. Chief Inspector Brendan Gorman was the operational Duty Officer for the Coffs/Clarence Local Area Command (**LAC**) and was attending to another matter in the Woolgoolga area in Coffs Clarence 10 (**Coffs 10**), some 140 kilometres from the location of the pursuit. He heard the request from the VKG despatcher for an officer to monitor the pursuit and so acknowledged the broadcast. However, it appears that this was initially overlooked as WK13 continued to provide information regarding the pursuit. Notwithstanding, Chief Inspector Gorman commenced to travel south at speed along the Pacific Highway towards the pursuit.

As the pursuit proceeded along Macleay Valley Way, WK13 advised that the Courier was travelling at an approximate speed of 140 kilometres per hour in a 100 kilometres per hour zone, and then a 110 kilometres per hour in a 50 kilometres per hour zone. WK13 also advised that the Courier briefly crossed to the incorrect side of the road in Frederickton and again as the pursuit approached the Pacific Highway at about 1:42am.

At about 1:45am VKG again broadcast that they were standing by for any vehicle north of the pursuit with spikes on board. Chief Inspector Gorman made a request over police radio for any Traffic and Highway Patrol vehicles in the Coffs/Clarence LAC to respond, with the intention for vehicles north of the pursuit to deploy road spikes. However, there was no answer to this call. Instead, Chief Inspector Gorman indicated that his vehicle contained road spikes but that he was still some distance north of the pursuit.

Shortly after passing through Frederickton the Courier made its way onto the Pacific Highway, still headed northbound, and still followed by WK13. Once the pursuit reached the Pacific Highway, Sergeant Goddard handed the radio handset in WK13 to Senior Constable Davison who started providing information to VKG. At about 1:47am, WK13 advised VKG that the pursuit had passed "*the occasional truck*" and had passed a total of about five B-double trucks also travelling northbound. Whilst travelling along the Pacific Highway, WK13 maintained visual contact with the Courier, and was approximately four seconds behind it.

As the pursuit headed north, Sergeant Goddard estimated that the Courier was travelling between 140 and 150 kilometres per hour (in a 110 kilometres per hour zone). Sergeant Goddard also noted that the Courier was driving within its lane and that the driver did not appear to be driving erratically.

Senior Constable Peter Shelton was rostered to work general duties at Nambucca Heads between 3:30pm on 9 February 2017 and 1:30am on 10 February 2017. Shortly before finishing his shift, Senior Constable Shelton heard the broadcasts over VKG regarding the pursuit and the request for available vehicles equipped with spikes. Senior Constable Shelton called Macksville police station to enquire if his offsider was still there but was informed he had gone home for the night.

Instead, Senior Constable Shelton decided to recall himself to duty and proceeded to travel from Nambucca Heads to Macksville in a vehicle with call sign Nambucca Heads 29 (**NH29**), a fully marked Toyota Hilux police truck with a pod.

As the pursuit approached the Clybucca rest area Senior Constable Shelton made this broadcast: "*Mate, I've knocked off but I just qued [sic] it back up if, uh, [WK13] wants me to start making my way back down there to, uh, there's no spikes here anyway. There [sic] only in the boss's truck and nobody's trained, well, I'm not trained*". This was a reference to the fact that although Senior Constable Shelton had previously been trained in the deployment of spikes his accreditation had since lapsed.

Senior Constable Shelton made his way south with the warning lights of NH29 activated, and stopped at a set of roadworks in North Macksville. There, he spoke to some road workers and asked them to stop northbound traffic, in the hope that the Courier would get caught in an area called Wrights Corner, where there was a wire centre divider. After doing so, he made this broadcast: "*…just for your information, mate, about, uh, 6 to 7 ks north of Macksville, there's road works. There's, uh, just past the blokes they got, they got the, um, traffic lights there doing night road works. Just asked them to stop all northbound traffic so hopefully there's no…congestion up the…if he keeps comin*'".

After proceeding through the roadworks, Senior Constable Shelton drove south over the Macksville bridge. He pulled up beside a B-double truck which was stopped in the northbound lane on the southern side of the bridge. Senior Constable Shelton informed the driver of the truck that there was a pursuit approaching and asked the driver if he could wait there and stop a southbound truck. Senior Constable Shelton said, "*Mate, if you see the, if you see the lights and sirens coming again, just move onto the bridge so we can block him in*".

The truck driver agreed to do so and Senior Constable Shelton proceeded south through Macksville. As he did so, he made a request over police radio to be informed when the pursuit proceeded past the Scotts Head turnoff at Warrell Creek. He then advised: "*…just had a quick chat between truckies on the Macksville bridge there, um, one guy heading northbound is going to stop on the bridge and he's going to stop the southbound bloke on the bridge so he won't be goin' north of Macksville*".

At a point just after Eungai Rail, and just before Macksville, the pursuit encountered some roadwork, causing the Courier to slow to a speed of about 40 kilometres per hour as it got caught behind a truck. However, the Courier soon overtook the truck, increased its speed to 110 kilometres per hour, and proceeded towards Macksville.

At a point somewhere before Warrell Creek the Pacific Highway reverted from a dual lane carriageway to a single lane carriageway and became what Senior Constable Davison described as "*bendy*" with "*a few winds in the road*". At this point, Senior Constable Davison saw the Courier, although he could not recall whether the Courier crossed any unbroken line road markings in order to do so.

As this was occurring, Senior Constable Shelton saw the Courier drive past in the opposite direction, followed a few seconds later by WK13. Senior Constable Shelton performed a u-turn and followed after both vehicles. When he reached the Macksville bridge he saw the truck still in the same location, stopped south of the bridge.

Sergeant Goddard later lost sight of the Courier at some point on the approach to Macksville. However, when he arrived at the Macksville bridge he saw that there was a B-double parked at the northbound entrance to the bridge with two other vehicles parked behind it, but no vehicles in the southbound lane. Sergeant Goddard saw the Courier cross to the incorrect side of the road, and travel over a rise before it went out of sight. WK13 followed over the bridge and slowed down in order to determine whether the Courier may have made a left turn towards Bowraville. At this time, Sergeant Goddard lost sight of the Courier for about 30 to 60 seconds. Around this time Sergeant Goddard made the following broadcast: "*…we're just entering Macksville now. So it's 130 over 50 now radio. We've backed off and he's overtaken another truck. He's heading towards the, um, Macksville bridge. He's just gone on to the Macksville Bridge. We're about 500 metres ride [sic]. The trucks didn't work on the bridge. He's continuing northbound*".

From the northern side of the Macksville bridge, the road curves sharply to the right, just after a turnoff towards Bowraville. The road then continues in a generally straight line along an east-west alignment. At the time roadwork was being performed on a new freeway overpass which intersected above the road, just past Newee Creek, and about two kilometres north of the Macksville bridge. As part of the roadworks a temporary diversion in the road had been constructed, requiring motorists to follow the road to the right and then curve left to re-join the road.

After deciding to continue past Macksville bridge, WK13 travelled along a sweeping right hand bend. Sergeant Goddard saw some tail lights in the distance and assumed that it was the Courier. At this time Sergeant Goddard estimated that whilst WK13 was still attempting to catch up to the Courier it was at least "*a couple of hundred metres*" behind the Courier and described it as "*a fair gap*".

Damien Moylan was driving a Western Star 4800 FXB B-double, federal registration VV-13-JX. At 9:00pm on 9 February 2017 he left the Lytton depot with two trailers loaded with timber, heading south towards Melbourne. As he travelled through Nambucca Heads sometime between 1:30am and 2:00am Mr Moylan saw a police vehicle ahead of him turn on its warning devices and accelerate away. At about the same time Mr Moylan heard on his UHF radio other truck drivers reporting that police were pursuing a vehicle travelling north on the Pacific Highway. Mr Moylan heard some of the other drivers comment that that the pursued vehicle was "*driving like a fucking maniac*" and that some drivers were talking about slowing down on the Macksville bridge so that the highway could be blocked.

By this time Mr Moylan was only a few kilometres north of the Macksville bridge. Having heard the comments made over the radio, and being aware that he was approaching roadworks, he slowed his speed down to 60 kilometres per hour.

As Mr Moylan entered the roadworks he saw the Courier being followed by WK13 along a sweeping left hand bend. Mr Moylan described WK13 as being "*a fair distance back from [the Courier] and holding the same distance*". As the Courier took the bend, at a point where it was underneath the overpass that was being built, Mr Moylan saw it cross the centre line into his lane. Mr Moylan believed that the Courier would correct itself and drive past. However, to be careful, Mr Moylan moved the prime mover into the left of his lane. Instead, the Courier did not brake or slow down and remained on the incorrect side of the road. Mr Moylan continued to move his vehicle further left to the point where if he continued to do so it would have left the road. Moments later the Courier collided head on with the front of the B-double.

The collision caused catastrophic damage to the front of the Courier and significant damage to the front of the prime mover. WK13 and NH29 arrived on the scene a short time later. The respective police officers exited their vehicles and checked on the welfare of the drivers of the Courier and the B-double. It became apparent upon inspection of the cabin of the Courier, and the damage that it had sustained, that the driver and any passengers had sustained non-survivable injuries. A call was subsequently made for NSW Fire and Rescue to attend the scene.

After arriving at the collision site, Chief Inspector Gorman made arrangements to secure and log the scene, and contacted the Duty Operations Inspector, the Local Area Commander and the Crash Investigation Unit. He also made arrangements for Sergeant Goddard and Senior Constable Davison to be breath tested, which returned negative results. As the incident was deemed to be a critical incident (involving the death of a person in the course of a police operation) arrangements were subsequently made for the matter to be investigated in accordance with NSW Police Force critical incident protocols.

A blood sample was later taken from Mr Moylan and analysed. Concentrations of pseudoephedrine (a decongestant) and chlorpheniramine (an antihistamine) were detected in therapeutic concentrations, along with a concentration of modafinil. Mr Moylan later told police that he had taken two tablets of Demazin for hayfever with his evening meal and then again at about 9:00pm. It is accepted that the ingestion of Demazin accounts for the presence of the pseudoephedrine and chlorpheniramine. Expert opinion was sought from Dr Judith Perl, a clinical forensic pharmacologist, who explained that pseudoephedrine and modafinil have no impairing effects on psychomotor skills at therapeutic doses. Dr Perl also noted that whilst chlorpheniramine has sedative effects, not all users experience sedation when ingesting a therapeutic dose. Ultimately, Dr Perl opined that it was highly unlikely that Mr Moylan's driving ability would have been impaired at the time of the conclusion.

What was the cause of Xavier's death?

Xavier was later taken to the Department of Forensic Medicine at Newcastle where a postmortem examination was performed by Professor Tim Lyons on 14 February 2017. The examination revealed that Xavier had sustained a massive head injury, bilateral haemopneumothorax, pelvic fracture, right femoral shaft fracture, and left tibia and fibula fractures.

In an autopsy report dated 3 March 2017 Professor Lyons opined that "*the nature of these injuries was that they would have immediately led to death*". Professor Lyons ultimately concluded that the cause of death was multiple injuries.

What issues did the inquest examine?

Prior to the inquest a list of issues for consideration at the inquest was circulated to the interested parties. That list included the following:

a) Was the conduct of Sergeant Damien Goddard and Senior Constable Robert Davison in initiating and continuing a pursuit of Xavier in compliance with the NSW Police Force Safe Driving Policy?

b) Were the actions of the officers monitoring the pursuit – i.e. Newcastle VKG Supervisor, Sergeant David Stevens, Duty Operations Inspector Paul Smith and a Duty Officer from the Coffs Clarence Command, Inspector Brendan Gorman – in compliance with the SDP?

c) Even if the Safe Driving Policy was followed, does a review of the circumstances of this case suggest that options other than the pursuit should have been considered or employed (e.g. road spikes, or termination of the pursuit)?

d) Why were road spikes not available in the Macksville area and should they be?

e) Was the information provided to Xavier's parents in their two telephone calls to Kempsey Police Station (sometime after 2:00am on 10 February 2017) adequate and appropriate?

Each of these issues is considered in further detail below.

Did Sergeant Goddard and Senior Constable Davison comply with the Safe Driving Policy?

The NSW Police Force Safe Driving Policy (**the Policy**) governs the conduct, role and responsibilities of police officers involved in the pursuit of a civilian vehicle. Following Xavier's death, Sergeant Kris Cooper of the Traffic and Policy Section of the NSW Police Force Traffic & Highway Patrol Command, conducted an internal police review to determine if the Policy had been complied with. Part 7 of Version 8.2 of the Policy (published in July 2016 and which was in force at the time of Xavier's death) defines a pursuit in this way:

PURSUIT: A pursuit, regardless of speed, commences at the time you decide to pursue a vehicle that has ignored a direction to stop.

It is an attempt by a police officer to stop and apprehend the occupant(s) of a moving vehicle, regardless of speed or distance, 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.

There is no dispute that at the time WK13 commenced following after the Courier, after the four young persons had exited it, a pursuit as defined by the Policy commenced. The pursuit continued up until the point that the collision between the Courier and the B-double occurred.

Was there a reasonable basis to believe that an offence had been committed and that the driver of the Courier was attempting to evade apprehension?

Consideration of whether Sergeant Goddard and Senior Constable Davison complied with the Policy focused on a number of specific aspects of it, namely sections 7-2-1 and 7-2-9.

Section 7-2-9 of the Policy provides:

When engaging in a pursuit, you should ensure that there is reasonable cause to believe that the person being pursued has committed, or has attempted to commit, an offence and the offender is attempting to evade apprehension.

After hearing the initial broadcast at about 10:00pm of the Hilux stolen from Bloomfield Street Sergeant Goddard left Kempsey police station to conduct a patrol of the Crescent Head area. After patrolling the area without success, Sergeant Goddard returned to Kempsey police station. He subsequently heard another VKG broadcast made at 1:30am. In his broadcast he made reference to four persons of interest acting suspiciously and that the vehicle sighted was possibly the Hilux which had been stolen at about 10:00pm earlier that evening.

In evidence Sergeant Goddard said that before he left the police station he knew that the vehicle sighted at the quarry was a white 4 door dual cab Toyota Hilux and that he had taken down the vehicle's registration details (BR-75-GN) on a Post-it note which he stuck on the inside of WK13. Shortly after the pursuit commenced at about 1:35am, Sergeant Goddard advised VKG that the registration of the vehicle that he was pursuing was BC-38-CB. As the pursuit reached the intersection of Middleton Street and Macleay Valley Way the VKG despatcher sought clarification of the registration of the pursued vehicle, given that two different registration details had been provided by Sergeant Goddard up to that point in time. Sergeant Goddard confirmed over VKG that WK13 was in pursuit of a vehicle with registration BC-38-CB. In evidence Senior Constable Davison indicated that upon WK13 performing a u-turn and following after the Courier on Middleton Street he immediately recognised that the Courier's registration did not match that of the Hilux, prompting him to broadcast to VKG, "*Disregard, wrong vehicle*". By this, Senior Constable Davison sought to convey to VKG that the vehicle which WK13 was following was not the same vehicle reported stolen from Bloomfield Street.

It is clear from the above, that a short time after the pursuit commenced, and before the pursuit reached East Kempsey and crossed the Kempsey bridge, Sergeant Goddard was in possession of information which suggested, on its face, that the Courier was not the vehicle which had been stolen from Bloomfield Street. This is because the registration details of the Courier were clearly different to that of the Hilux. Further, at a point where the pursuit was between Kempsey and Frederickton, the VKG despatcher again sought confirmation of the registration details of the Courier. When these details were again confirmed by Sergeant Goddard to be BC-38-CB, the VKG despatcher indicated that the registration details were matched to a 2002 Ford Courier. This again meant that at this point, Sergeant Goddard was in possession of information which further suggested that the Courier was not the vehicle which had been stolen from Bloomfield Street.

Given the above, the question which arises is upon what basis did Sergeant Goddard have reasonable cause to believe that the driver of the Courier had committed, or attempted to commit, a criminal offence, as required by section 7-2-9 of the Policy? In evidence, Sergeant Goddard made reference to the following factors which he was aware of from his general policing experience and from his specific policing experience in the area, and which he took into account in forming such a belief:

a) that there was a high crime rate in Kempsey and that some of these crimes related to breaking into, and entering, property, and vehicle theft;

b) that it was not unusual for the owner of a vehicle which had been stolen during the night to not be aware of the theft until the following morning and, consequently, no stolen vehicle report would be made until the morning;

c) the fact that earlier in the evening two reports had been made of vehicles which had been set alight and abandoned, and that offenders were likely to target a particular area and commit a number of offences in that area;

d) the fact that there had been a report of four persons acting suspiciously at the quarry which was "*in the middle of nowhere*";

e) that the location where the four young persons exited the Courier was in an area where many known offenders lived, with Sergeant Goddard being aware of a specific pair of known offenders consisting of a father and son whose family, Sergeant Goddard believed, lived somewhere along Middleton Street;

f) the fact that the Courier was a dual cab utility which matched the description of the stolen Hilux; and

g) after being informed by VKG that the Courier was registered to an address in Kundabung, the fact that the Courier was driving north, away from the registered address.

In evidence Sergeant Goddard was asked why he thought the driver of the Courier sped away. He provided two answers with his first referring to a belief that the driver was an adult who had been working with young persons to commit offences, and that there was stolen property still inside the vehicle; and with his second answer relating to his belief that the Courier was stolen.

Examination of the VKG transcript reveals that although Sergeant Goddard made reference to his belief that the vehicle sighted at the quarry might be the stolen Hilux, no reference was made to any belief that the driver (or occupants) of the Courier might have been involved in a break and enter offence, as Sergeant Goddard indicated in evidence. After the pursuit commenced, Sergeant Goddard had a second opportunity to indicate that this was his belief when the VKG despatcher posed the question, "*What was the original offence?*". Again Sergeant Goddard made no reference to any break and enter offence (or any vehicle offence, for that matter) and instead replied, "*This is relating to kids acting suss*". Sergeant Goddard had a third opportunity to indicate his belief when Chief Inspector Gorman made an enquiry about the original offence. When asked to repeat the original offence, Sergeant Goddard replied, "*Uh, failed to stop. He's stopped the car, let three kids out then took off on us*".

By this stage the pursuit was about six kilometres away from Macksville.

Sergeant Goddard also explained in evidence that he was unaware of what a Courier looked like, believing that it was a type of delivery van, and not a utility. This evidence is corroborated by the BWV recording which captures Sergeant Goddard asking Senior Constable Davison, "*Does that look like a Ford Courier to you?*", moments after the VKG despatcher broadcast the registration BC-38- CB was matched to a Ford Courier as the pursuit approached Frederickton. However, in evidence Sergeant Goddard agreed that he could see the registration of the Courier and that he could see what type of vehicle it was, namely a dual cab utility. He agreed in evidence that it was possible that the vehicle was not in fact a Toyota and when asked if it was possible for him to see that it was not a Hilux, he said that his focus was on the registration and the description of the vehicle.

Further, as the pursuit approached the Clybucca rest area, Senior Constable Davison commented, "*It's a Ford so it's not that Hilux*". This comment provides evidence that by this point Senior Constable Davison had confirmed in his own mind (if any further confirmation was needed) that the vehicle that WK13 was pursuing was not the one reported as stolen from Bloomfield Street. Like Sergeant Goddard, in evidence Senior Constable Davison said that he believed that the Courier had been stolen when the pursuit commenced. He said that he based this belief on the earlier reports relating to the stolen Hilux and two burnt out vehicles, despite acknowledging that there was no direct information connecting the Courier with either matter. However, Senior Constable Davison sought to explain that in his experience it was common for police to locate burnt out vehicles which were only reported as being stolen by their owners the next morning, although he was unable to say how commonly or frequently these incidents occurred.

Despite Senior Constable making his comment which was of critical importance to consideration of section 7-2-9 of the Policy, it did not elicit any response from Sergeant Goddard.

Conclusion: The evidence establishes that from an early point in the pursuit, and before the pursuit had reached Macleay Valley Way Sergeant Goddard was in possession of information, by virtue of two conflicting registration details, which indicated that the vehicle that he was pursuing was not the stolen Hilux. The evidence also establishes that before the pursuit reached Frederickton, further information provided over VKG confirmed this fact. This meant that by this point, there was no reasonable basis for Sergeant Goddard to conclude that the vehicle he was pursuing was in fact the vehicle which had been stolen from Bloomfield Street.

In order for Sergeant Goddard to form a belief that the vehicle that he was following had in fact been stolen, he would have had to reason that it was (a) an entirely different vehicle to the Hilux (but one which, notwithstanding, matched the description and colour of the Hilux), or (b) the Hilux but that it had different registration plates affixed to it. However, there was no direct evidence available to allow Sergeant Goddard to form a reasonable belief in relation to the particular vehicle being an entirely different one to the Hilux, and yet also being stolen. Instead, his belief was formed based on a number of general factors related to his general policing experience, and specific policing experience in the area, and police reports relating to other alleged criminal activity earlier in the evening. There was, however, no direct evidence connecting the vehicle which was being pursued to the earlier reports of criminal activity. More relevantly, there was no evidence to allow a conclusion to be reached as the precise nature of any offence that might have been committed other than to make a general assumption that it similarly related to property theft. Equally there was no direct evidence to allow Sergeant Goddard form a reasonable belief that the different registration plates had been affixed to the Hilux.

Again, this belief was based on the same factors relating to the first belief described above.

It is evident from a reading of the VKG transcript that when the question as to what was the original offence was posed to Sergeant Goddard he had difficulty articulating a consistent response. Sergeant Goddard's first response made reference to the possible stolen Hilux. However his second and third response related only to "kids acting suss" and the Courier failing to stop, with no specific mention made of vehicle theft, property offences, or any other offence. These responses are consistent with the information available to Sergeant Goddard from VKG and also from his own observations. In other words, whilst Sergeant Goddard may have initially had a reasonable basis to believe that the Courier was in fact the vehicle stolen from Bloomfield Street (or was possibly a separate stolen vehicle), as the pursuit continued the possibility of such a belief remaining reasonably open to Sergeant Goddard gradually diminished. By the time the pursuit reached the Clybucca rest area, and upon hearing Senior Constable Davison comment that the Courier was not the stolen Hilux, this fact should have been abundantly clear. Further enquires of the kind later made by Chief Inspector Gorman as to the history of the Courier, and information about its owner, were required at this point in time. These enquiries were not made by either Sergeant Goddard or Senior Constable Davison.

It also became evident in the course of Sergeant Goddard's evidence that there appeared to be some conflation of the dual requirements of section 7-2-9 of the Policy. That is, the fact that the Courier had initially failed to stop was taken to be a justification both for the fact that an offence had been committed, and that the driver was attempting to avoid apprehension. Whilst the mere fact of a pursuit permits a conclusion to be drawn that the person being pursued is attempting to avoid apprehension, this raises a potentially difficulty in the sense that pursuit may become its own justification. It is for this reason that clarification of the offence which gives rise to the first requirement of section 7-2-9 is of critical importance.

The variation in responses provided by Sergeant Goddard highlights another issue, namely that despite the VKG operator (known as Communications Operators pursuant to the Policy) seeking to confirm the originating offence so as to comply with section 7-2-9 of the Policy, that offence was not clearly articulated. Therefore, having regard to the above, the following recommendation is necessary.

Recommendation 1: I recommend to the NSW Commissioner of Police that consideration be given to providing further training to Communications Operators to ensure that appropriate enquiries are made of involved police to clearly identify the offence that a person has committed, or attempted to commit, which has caused a pursuit to be initiated.

Did the need to pursue outweigh the degree of risk?

Section 7-2-1 of the Policy provides:

The decision to initiate and/or continue a pursuit requires weighing the need to immediately apprehend the offender, against the degree of risk to the community and police as a result of the pursuit.

Section 7-2-5 provides:

During any pursuit activity all involved police must continually re-assess the pursuit within the framework set out at paragraph 7-2-2.

The above provisions of the Policy required Sergeant Goddard and Senior Constable Davison to take into consideration a number of factors in making, in essence, a continuous risk assessment for as long as the pursuit continued. In other words, they needed to assess whether the risk (and potential risk) that that the pursuit posed to the driver of the Courier, themselves and other involved police officers, and members of the community outweighed the need to continue the pursuit in order to immediately apprehend the driver of the Courier. Each factor relevant to this risk assessment process is considered individually below.

Data collected following the pursuit established that, in total, the pursuit lasted 29 minutes 18 seconds, travelled a distance of 59.5 kilometres, and that WK13 travelled at an average speed of 121.84 kilometres per hour.

Senior Constable Davison explained that the roadway was *"dual carriage so there wasn't much traffic…wasn't a threat of danger at that stage, there's pretty good road there…the traffic was light, maybe the odd occasional truck*".

Whilst on the Pacific Highway approaching the Clybucca rest area, Sergeant Goddard saw what he thought was a flash from the cabin of the Courier. In evidence Sergeant Goddard said that he was unsure if it was the flash from a mobile phone or other personal electronic device, or whether it might have been the reflection from the headlights of WK13 off the rear view mirror of the Courier. However, the contemporaneous recording from the BWV reveals that seeing the flash caused Sergeant Goddard to remark, "*I think old mate was filming that*", indicating that his belief at the time was that the driver of the Courier was using a mobile phone (or other personal electronic device) whilst driving. In evidence Sergeant Goddard agreed that as a general matter, a person is not permitted to use a device for filming whist driving a vehicle.

Subsequent investigation revealed, from Xavier's friends and from an examination of the Courier following the collision, that Xavier was in possession of an iPod Touch and wifi modem in the Courier and was posting messages to his friends on social media during the pursuit. It appears that this occurred at about the time that Sergeant Goddard made his comment in relation to filming.

As the pursuit approached the Clybucca rest area, Sergeant Goddard remarked to Senior Constable Davison, "*He can't drive*", referring to the driver of the Courier. In evidence when asked what he meant by this Sergeant Goddard sought to explain that it was simply a flippant comment. Sergeant Goddard then said that he could not recall what he meant at the time. However, he agreed with Counsel Assisting that the situation he was in at the time was not the one where flippant comments ought to have been made.

During his interview, Senior Constable Davison was asked whether, at any time during the pursuit, he formed the opinion that it was dangerous and should be stopped.

Senior Constable Davison said in evidence that he did not consider that the pursuit ought to be terminated, nor did he discuss the possibility of pursuit termination with Sergeant Goddard. In evidence Senior Constable Davison was asked what he considered his role, as the escort, to be during the pursuit.

He explained that his role was to be an observer and to call the pursuit to VKG so that Sergeant Goddard could concentrate on driving. When asked if he considered his role to involve some communication with Sergeant Goddard about what he was observing, Senior Constable Davison expressed some degree of ambivalence.

Further, he acknowledged that any assessment which he might have performed pursuant to sections 7-2-2 and 7-2-5 of the Policy was not communicated to Sergeant Goddard.

Finally, apart from the observations made by the two pursuing police officers, there is also evidence from an independent witness. Robert Bradford was driving home from Coffs Harbour and approached the Macksville bridge at about 2:00am. Just before driving onto the bridge he saw the Courier overtake another vehicle and "*fly past [him] at high speed*". The manner that the Courier was being driven prompted Mr Bradford to make a social media post the following day which read: "*…last night from Coffs Harbour coming over the Macksville bridge at about 2 o'clock idiot [sic] nearly wipes me out on bridge overtaking a truck…*".

Conclusion: It was submitted by counsel for both Sergeant Goddard and Senior Constable Davison that each factor relevant to the assessment which both police officers were required to perform during the pursuit should be examined not in isolation but, rather, in context. On behalf of Senior Constable Davison it was submitted that part of that context involves a consideration that policing is a dangerous and unpredictable job. On behalf of Sergeant Goddard it was submitted that he brought his considerable policing experiencing, including his involvement in more than 100 previous pursuits, to bear in the risk assessment he was required to perform.

However, when that type of contextual evaluation is performed the conclusion that must be reached is that the combination of factors relevant to the assessment which Sergeant Goddard and Senior Constable Davison were required to perform meant that the pursuit ought to have been terminated. The point of termination was at least by the time that the pursuit reached Warrell Creek and certainly by the time that the pursuit crossed over the Macksville bridge.

A number of factors are relevant to this assessment:

- Sergeant Goddard's explanation that his comment of, "He can't drive" was only a flippant remark cannot be reconciled against the position he took in his evidence where he sought to emphasise that he was performing a considered assessment and that the pursuit that he was involved in was not the occasion for such remarks to be made.
- Given the contemporaneity of Sergeant's Goddard comment in relation to filming, it should also be concluded that Sergeant Goddard believed that the driver of the Courier was using an electronic device of some kind whilst driving.
- Sergeant Goddard explained in evidence that he expected Inspector Gorman to be available with the spikes around the Macksville area even though he was provided with no confirmation regarding this.

By the time the pursuit proceeded past the Macksville bridge it would have been evident to the pursuing officers that the planned blocking of the Macksville bridge, in the hope that it would force the Courier to stop and possibly allow police to engage the driver in a foot pursuit, had been unsuccessful.

Further, apart from termination the only remaining viable option left at that time for resolution of the pursuit was a vague plan relating to the deployment of spikes north of Nambucca Heads, a distance of at least 20 kilometres away, by Chief Inspector Gorman (discussed further below).

This additional information should only have served to reinforce the conclusion that the pursuit ought to have been terminated by this point.

One further matter which arises is the fact that, as noted above, Senior Constable Davison seems not to have appreciated that as an escort, his role was more than that of a mere observer. As an involved officer he clearly was required to perform the same process of continual assessment that Sergeant Goddard was required to perform. For this reason the following the following recommendations are necessary.

Recommendation 2: I recommend to the NSW Commissioner of Police that consideration be given to making clear in Part 7 of the Safe Driving Policy that all escorts are "involved officers" for the purposes of section 7-2-5.

Recommendation 3: I recommend to the NSW Commissioner of Police that consideration be given to providing clarification during standard police driver training that all escorts are "involved officers" for the purposes of section 7-2-5.

Were the actions of the officers monitoring the pursuit in compliance with the Safe Driving Policy?

Section 7-5-4 of the Policy sets out the command structure for a pursuit response. It identifies the Duty Operations Inspector (**DOI**), VKG Shift Coordinator, and the Duty Officer/Supervisor as being part of this structure. Further, sections 7-5-6 (for the DOI and VKG Shift Coordinator) and 7-5-7 (for the Duty Officer/Supervisor) provide for specific duties for the officers performing such pursuit monitoring. In the case of Xavier's pursuit the monitoring roles were fulfilled by the following officers:

a) Duty Operations Inspector: Chief Inspector Paul Smith;

b) VKG Shift Coordinator: Sergeant David Stevens; and

c) Duty Officer/ Supervisor: Chief Inspector Brendan Gorman.

Section 7-5-6 of the Policy required Chief Inspector Smith and Sergeant Stevens to perform a number of duties including monitoring the pursuit to ensure that the most appropriate driver and vehicles were used, and consider the need to approve and assign additional backup and support vehicles. Section 7-5-7 of the Policy required Chief Inspector Gorman to obtain the offence that was reported as the cause of the pursuit, and to monitor the pursuit and make determinations as to whether it should continue based on local knowledge of the area, the actual or potential danger, and knowledge of the attitude and ability of the police driver engaged in the pursuit.

Further, both section 7-5-6 and 7-5-7 required the monitoring officers to terminate the pursuit in accordance with section 7-6 of the policy, which governs termination of the pursuit, if the criteria provide by that section were met.

During the pursuit the VKG despatcher made attempts to enquire whether the Duty Officer at Mid North Coast and Port Macquarie were available to monitor the pursuit. When it became apparent that these officers were unavailable to monitor the pursuit, Sergeant Goddard suggested that Chief Inspector Gorman might be available. A subsequent enquiry made by the VKG despatcher resulted in Chief Inspector Gorman performing the Duty Officer monitoring role.

When Chief Inspector Gorman began monitoring the pursuit he was in Woogoolga attending to another job, some 140 kilometres from Kempsey. In evidence Chief Inspector Gorman explained that he had some familiarity with Macleay Valley Way as he knew it to be the old Pacific Highway. Chief Inspector Gorman also said that he knew the area around Warrell Creek and knew that there were road works north of Warrell Creek but did not know the extent of them and so the area from Warrell Creek to Nambucca Heads was less familiar to him.

Chief Inspector Gorman said that he was aware that some of the roads between Nambucca Heads and Kempsey were subject to roadworks at the time. However, he explained that he was not aware of the extent of the roadworks, or the impact that they had on the road. Being also unfamiliar with the local area, Chief Inspector Gorman asked how close the pursuit was to the nearest town. He was informed that the pursuit was 18 kilometres from Macksville and that it was nearing the turn off to Stuarts Point.

It is clear that after he commenced monitoring the pursuit, Chief Inspector Gorman sought information over VKG to ensure that Section 7-2-9 of the Policy was complied with. As the pursuit passed Eungai Rail, Chief Inspector Gorman enquired over VKG, "*What's he wanted for?*", referring to the driver of the Courier. Due to other radio communication that was occurring at the time, Chief Inspector Gorman was not provided with a response to his enquiry. Sometime later, when the pursuit was near Albert Drive and about six kilometres from Macksville, Chief Inspector Gorman made a second attempt to ascertain the initiating offence by asking over VKG, "*Coffs Clarence 10…the original offence*". This prompted the VKG despatcher to enquire, "*Kempsey 13, can you repeat the original offence*". The response provided by Sergeant Goddard was, "*Uh, failed to stop. He's stopped the car, let three kids out then took off on us*". This in turn prompted Chief Inspector Gorman to ask, "*What's the history on the vehicle with, uh, history and links to the driver, the owner?*". The VKG despatcher advised that there was "*nothing on the vehicle checks*", meaning that it was not associated with any criminal activity, and that checks were being conducted to determine whether anything adverse was known about the owner of the Courier. At this time a broadcast was made by Kempsey 22 indicating that they would attempt to contact the vehicle owner in order to determine if the Courier was, in fact, stolen.

In evidence, Chief Inspector Gorman agreed that if it had been thought that the Courier had been stolen he expected to be told that. He agreed that such a belief was never communicated to him and that the only offence referred to in response to his direct request to identify the original offence was a failure to stop. In evidence, Chief Inspector Gorman said that despite this he still took into account other pieces of information that he was aware of, namely that it was not unusual for a stolen car to not be reported as being stolen by its owners until the following morning, that the Courier matched the description of the stolen Hilux, and that the fact that a pursuit was taking place suggested that the driver had a "*guilty mind*".

After becoming aware that the attempted block on Macksville Bridge was unsuccessful, Chief Inspector Gorman said in evidence that he formed the view that the pursuit should be terminated in accordance with section 7-6 of the Policy. It should be noted that this was the first occasion that Chief Inspector Gorman expressed this view, with no reference being made to it in his statement made on 10 February 2017. Chief Inspector Gorman explained that he was of the view that the pursuit should have been terminated.

Despite forming this view about termination of the pursuit, Chief Inspector Gorman did not make any VKG broadcast. This is because at that particular time the VKG despatcher was making several broadcasts in relation to two unrelated incidents occurring in the Grafton area that required local police involvement. Chief Inspector Gorman explained in evidence that he used his radio in an attempt to broadcast a direction to terminate the pursuit but was unable to do so because of the radio traffic that was occurring at the time.

Some police radios are equipped with what is known as a smart push-to-talk function. Using this function requires a double press of a radio button to allow a user to override radio communication that may be occurring at the time in order to broadcast an urgent communication. On the available evidence it is unclear whether the radio fitted to the vehicle that Chief Inspector Gorman was driving was capable of performing the push-to-talk function. The evidence established that at the relevant time police vehicles could have been equipped with radios from two different manufacturers, one of which featured the smart push-to-talk function, and one of which did not. However, Chief Inspector Gorman explained that he whilst at the time he believed that such a capacity was available to police radios in general, he did not attempt to use the function for several reasons: given the stressful situation that he was in he did not think to use it, he had never attempted to use the function before, and he was therefore not in the habit of doing so.

Conclusion: Chief Inspector Gorman reached a view at critical point that the pursuit should be terminated. This was a view that was reasonably open to him on the information that was available to him at the time, and pursuit to his role as the Duty Officer monitoring the pursuit. It is evident that if a Duty Officer performing such a role reaches such a view, then the need to communicate this view immediately is of paramount importance. This is because if the view is reached that the pursued driver, pursuing police officers and members of the public are placed at unnecessary risk, any communication regarding termination of the pursuit should be conveyed immediately so as to minimise that risk.

In the circumstances of this pursuit, the view that Chief Inspector Gorman reached unfortunately coincided with a time when there were other communications broadcast over VKG which prevented Chief Inspector Gorman from making a broadcast to terminate the pursuit. Although a function existed on some police radio models at that time which allowed for an urgent communication to override other active broadcasts, it is unclear on the available evidence whether the radio which Chief Inspector Gorman was using was capable of this function. Even if it was capable, the evidence establishes that Chief Inspector Gorman would most likely not have used the function as it was one which he did not routinely use. It is therefore necessary to make the following recommendation below.

Recommendation 4: I recommend to the NSW Commissioner of Police that consideration be given to any measure that can be taken to make the smart push-to-talk function on police radios more broadly available, and to communicate to police officers the availability of that function.

Sergeant David Stevens was the VKG Shift Coordinator on 10 February 2017. He was notified over police radio that a pursuit had commenced and began monitoring it. He said that at the start of the pursuit he understood that the initial offence related to a failure by the Courier to stop, and that there was a possibility of criminal offences due to the fact that persons had decamped from the vehicle and there were reports of suspicious activity in the area where they decamped.

Sergeant Stevens explained that at no time during the pursuit did he consider that any danger to the occupants of the Courier, the pursuing officers, or the public outweighed the need for the offenders to be immediately apprehended. He explained that this was "*primarily based on the fact that there was very little traffic on the road at this time and the majority of the pursuit was on dual carriageway*".

Sergeant Stevens explained that in his view there was a need to immediately apprehend the occupant(s) of the Courier on the basis that an assumption could fairly be made that they had been involved in some kind of criminal activity and there was therefore a need to prevent the commission of possible further offences. Sergeant Stevens also noted that there was a possibility that the Courier contained stolen property, or that the Courier itself had been stolen, but not yet reported as such by its owner. Sergeant Stevens agreed that checks performed during the pursuit revealed that no report had been made that the Courier was stolen, but explained that whilst this was one consideration, another consideration which he took into account was the fact that the young persons had decamped from it in South Kempsey. Ultimately Sergeant Stevens said that he did not consider that the degree of risk to the community and the police as a result of the pursuit outweighed the need to immediately apprehend the alleged offender(s).

Section 7-5-5 of the Policy requires that the DOI is to be advised of a pursuit where it has continued for more than five minutes. In this case, the pursuit had been ongoing for approximately 15 minutes before Sergeant Stevens asked Sergeant Peter Jeans to notify the DOI at the time, Chief Inspector Paul Smith.

Sergeant Stevens said that this was the first opportunity that he had to notify Chief Inspector Smith due to the fact that he was unable to leave the position where he was monitoring the pursuit. He explained that at the time the cordless phone in the VKG Operations Newcastle, which would have allowed him to call Chief Inspector Smith directly from the position he had occupied next the VKG despatcher's terminal, was broken. However, the evidence establishes that this situation has since been corrected and that a cordless phone is now available so that such notification calls to the DOI can be made without delay.

As the pursuit continued Sergeant Stevens asked the despatcher to make requests for Highway Patrol vehicles, and General Duties vehicles equipped with road spikes, to assist. However, information received indicated that there were no such vehicles in the vicinity able to assist. Sergeant Stevens also made a request for a Duty Officer or alternate supervisor who may be able to monitor the pursuit and was advised that no Duty Officer was rostered on at the time for the Mid North Coast LAC.

Chief Inspector Smith described the role of the DOI in a pursuit as being one of a safety net. He explained that as he was approximately 400 kilometres away from the pursuit in Sydney at the time his task was to put together, what he described as a "*word picture*" in his mind. He said that he was not familiar with the section of the Pacific Highway where the pursuit was taking place. However, he did not consider this to necessarily make his role more difficult as he explained that he was reliant on the quality of information provided.

Conclusion: The actions of the senior officers monitoring the pursuit were in compliance with the Policy. Each of the three monitoring officers gave appropriate and careful attention to the factors which were required to be considered in the assessment process required by the Policy regarding continuation of the pursuit. The evidences establishes that whilst each officer was monitoring the pursuit remotely and was therefore primarily dependent on the information provided over VKG, the clarity of information provided did not create any instances of non-compliance with the Policy.

Although the DOI on duty at the time was not notified of the pursuit after it had continued for more than five minutes, as the Policy required, a notification was eventually made. The evidence establishes that the delayed notification was not due to any oversight by the VKG despatcher or Sergeant Stevens but rather due to the unavailability of a phone which allowed Sergeant Stevens to remain at the VKG terminal where he was monitoring the pursuit whilst still being able to make a notification call to Chief Inspector Smith. This technological deficiency has since been corrected so as to mitigate the possibility of any delayed notification occurring again. Importantly in the present case, there is no evidence to suggest the delay in notification of about ten minutes adversely affected the conduct of the pursuit in any way. During this time the pursuit was still being actively monitored by two other senior officers.

Should other options have been considered or employed?

The evidence establishes that there were four options available for the pursuit to be resolved:

i. The driver of the Courier to voluntarily stop the vehicle, or be forced to do so by lack of petrol, and then surrender or attempt to flee;

ii. For the pursuit to be terminated in accordance with section 7-6 of the Policy;

iii. For road spikes to be used; and

iv. For a blockade to be used on the Macksville bridge.

The evidence establishes that at the relevant time the only spikes available were in WK13, in Chief Inspector Gorman's vehicle and in the supervisor's vehicle at Nambucca Heads. Given that WK13 was pursuing the Courier, there was no opportunity for spikes to be deployed from that vehicle. In evidence Chief Inspector Gorman explained that as he travelled south he began to formulate a plan as to where the spikes in his vehicle could be deployed. It should be noted that although Chief Inspector Gorman had previously been accredited in the deployment of spikes, he was not aware that his accreditation had expired at the time of the pursuit. As he was unfamiliar with the Pacific Highway north of the pursuit, he considered that a location on the dual carriageway north of Nambucca Heads would be suitable as it contained long stretches of straight road where spikes could deployed safely to reduce the risk to other road users. It should be noted that although Chief Inspector Gorman explained that this was a plan which he formulated in his own mind as he travelled south, it was never conveyed over VKG. When asked in evidence if he gave any consideration to the time that it would take to reach the location and deploy the spikes, Chief Inspector Gorman said that it remained a viable plan in his mind.

Senior Constable Shelton had previously been trained in the deployment of spikes but was aware that his accreditation had expired some six to eight months prior to February 2017. At the time was aware that spikes were located in the supervisor's vehicle and said in evidence that he "*seriously considered*" using that vehicle and "*cop the backlash later*". However he eventually decided against this course of action, meaning that the only police officer able to deploy spikes was Chief Inspector Gorman.

Conclusion: Appropriate enquiries were made over VKG to identify police vehicles which were equipped with spikes and police officers who were trained and possessing current accreditation to deploy them.

The enquiries revealed that only Chief Inspector Gorman was in a suitably equipped vehicle and believed himself to be capable of deploying the spikes. Although Chief Inspector Gorman had formulated a plan to deploy the spikes in an area north of Nambucca heads, this plan was not actively discussed over VKG. At the relevant time it appears that attention was instead concentrated on the plan to attempt to use trucks to block the Macksville bridge.

The proposed area of deployment was at least 15 kilometres from Macksville. Further, as the pursuit passed through Macksville Chief Inspector Gorman had reached the vicinity of Urunga, some 30 kilometres to the north. Given these factors it would appear that the option of using the spikes was not a viable one. The proposed plan for deployment plan had not been actively considered by any police officer other than Chief Inspector Gorman, no significant steps had been taken towards its implementation other than Chief Inspector travelling south wards the pursuit, and it was uncertain whether Chief Inspector Gorman would even reach the proposed area of deployment in time.

At 1:59am Senior Constable Shelton broadcast over VKG that he had been in contact with truck drivers in the vicinity and requested that they park on the Macksville Bridge. In evidence Senior Constable Shelton said that he had not previously aware of trucks ever being used to block a pursuit, and had never personally employed that tactic before. In evidence Senior Constable Shelton said that he did consider whether the plan posed a danger to the truck drivers. However, he explained that he thought that the approach to the Macksville Bridge afforded a good view of the bridge, and that there was adequate distance for the Courier to stop upon the driver sighting the blocked bridge. However, Senior Constable Shelton acknowledged that whilst he was aware that the Courier was travelling at speed on the Pacific Highway, he was unsure at what speed it was travelling on the approach to the Macksville Bridge.

The use of the trucks to block the Macksville Bridge was raised with each of the monitoring officers. In evidence Chief Inspector Gorman agreed that he heard Senior Constable Shelton's broadcast in relation to arranging for trucks to block the Macksville Bridge. Chief Inspector Gorman said that he did not want this to happen as he considered it to be what he described as a "*dangerous tactic*" in the sense of using civilian vehicles to attempt to stop a vehicle travelling at high speed. Although he indicated that he did not want the block to occur, Chief Inspector Gorman explained that he did not communicate this over VKG because at the time it was difficult for him to use his radio whilst driving at speed in an attempt to reach the pursuit.

Sergeant Stevens explained that he did not instigate the request to block the bridge. Further, Sergeant Stevens explained that because the pursuit had almost reached Macksville by the time Senior Constable Shelton made his broadcast, there was insufficient time to advise any truck driver to not follow this course of action, even if he had wanted to do so. In evidence Sergeant Stevens described the use of the trucks (and any other non-police vehicle) to block a pursued vehicle as being "*unconventional*" but said that in his view there was nothing within the Policy which suggested that such vehicles could not be so used.

When asked about the ability to use non-police vehicles in a road block, Chief Inspector Smith referred to the provisions of the *Law Enforcement (Powers and Responsibilities) Act 2002* (**LEPRA**). Section 37 of LEPRA provides:

(1) For the purposes of this Act, the following are vehicle roadblock powers:

(a) the power to establish a roadblock (consisting of any appropriate form of barrier or obstruction preventing or limiting the passage of vehicles) on any specified road, road related area or other public place or school,

(b) the power to stop vehicles at a roadblock.

(2) A senior police officer may authorise another police officer to exercise any or all of the roadblock powers in respect of any specified vehicle (or class of vehicles) on a road, road related area or other public place or school if the senior police officer suspects on reasonable grounds that:

(a) The vehicle (or a vehicle of the specified class of vehicles) is being, or was, or may have been, used in or in connection with the commission of an indictable offence and the exercise of the powers may provide evidence of the commission of the offence, or

(b) Circumstances exist on or in the vicinity of that road, road related area, place or school that are likely to give rise to a serious risk to public safety and the exercise of the powers may lessen the risk.

Further section 37(3) provides:

A police officer may exercise vehicle roadblock powers without obtaining authorisation by a senior police officer if the police officer suspects on reasonable grounds that it is necessary to exercise the powers and that the seriousness and urgency of the circumstances required the powers to be exercised without obtaining the authorisation.

Section 3 of LEPRA defines a senior police officer to be a Police Area Commander, a Police District Commander, a Duty Officer for a police station, or any other police officer of the rank of Inspector or above. It does not appear that the term "*specified vehicle*" is defined anywhere within LEPRA.

Despite monitoring the pursuit, Chief Inspector Smith had no recollection of being told about the plan to block the Macksville Bridge. He explained that he may have missed the audio communication at the time the plan was being discussed.

In evidence Sergeant Cooper agreed that the safety considerations which underpin section 7-5-1 of the Policy as it relates to police vehicles applies equally in relation to non-police vehicles. Sergeant Cooper said that he was unfamiliar with non-police vehicles being used by police officers for the purposes of a road block, and expressed the view that such a situation would be unorthodox and highly unusual.

Conclusion: By the time the pursuit passed the Macksville bridge, there appeared to be no remaining, or at least actively considered, viable options to bring the pursuit to a resolution short of termination in accordance with section 7-6 of the Policy, or the driver of the Courier deciding to stop voluntarily or due to some unforeseen factor such as lack of fuel. Apart from Chief Inspector Gorman no other police officer had formed the view that section 7-6 of the Policy had been triggered. There was also no information to suggest that the driver of the Courier was likely to stop, either voluntarily or due to some unforeseen factor. Further, by this time the planned blocking of the Macksville Bridge had been unsuccessful and Chief Inspector Gorman's plan to deploy spikes did not appear to be a viable option or, at least, an option which had been carefully explored.

In the present case, by the time the pursuit passed the Macksville Bridge and where any remaining resolution options had either been exhausted or were unlikely to be utilised, consideration ought to have been given to whether the pursuit should have been terminated. It is therefore necessary to make the following recommendation.

Recommendation 5: I recommend to the NSW Commissioner of Police that consideration be given to amending section 7-6-2 of the Safe Driving Policy.

It would appear that section 37 of LEPRA arguably provides for non-police vehicles to be used as part of a roadblock. Section 37 makes reference only to a barrier or obstruction, without identifying what object (such as a vehicle) can be used to form such a barrier or obstruction except to note that it must be of an appropriate form. It is evident from the evidence of the monitoring officers that the provisions of both the Policy and LEPRA may be widely interpreted so far as the use of non-police vehicles in a road block during a pursuit is concerned. Given the potential for adverse outcomes to a pursued driver, pursuing police officers and members of the community who may be directly involved in such action such the possibility for such wide interpretation is undesirable. The following recommendations are therefore necessary.

Recommendation 6: I recommend to the NSW Commissioner of Police that consideration be given to explicitly addressing the use of non-police vehicles (including heavy vehicles) as a road block during a pursuit, either in the Safe Driving Policy, or in another appropriate policy document or guideline, or by an appropriate direction to police officers.

Recommendation 7: I recommend to the NSW Commissioner of Police that consideration be given to including in the standard police driver training an instruction regarding the use of non-police vehicles (including heavy vehicles) by police officers as a road block during a pursuit.

Why were road spikes not available in the Macksville area?

In evidence Sergeant Cooper was asked if he thought it was surprising that there were no spikes available at the relevant time; he replied that he thought it was problematic.

He was asked whether he was aware of any steps made to make spikes more widely available in Macksville and its surrounding areas. He indicated that there are provisions to allow spikes to be fitted to any police vehicle for deployment and that the Mid North Coast command has actively encouraged the certification of officers capable of deploying spikes.

Sergeant Cooper indicated that the command has about 50 officers certified to deploy spikes, with that number representing approximately one third of the officers within the command. Further, he explained that, without being able to quote exact numbers, this percentage of certified officers represented an improvement over the figures that existed in February 2017. Finally, Sergeant Cooper indicated that the question of certification remains a matter of discretion for each individual command, and that he was not aware of the issue being problematic within the Mid North Coast command.

Conclusion: At the relevant time it appears that the unavailability of police vehicles equipped with spikes and police officers who were accredited to deploy them was due to the fact that the pursuit was occurring in the very early hours of the morning. There is no evidence to suggest that the unavailability of spikes and suitably trained officers was reflective of any systemic issue. To the contrary the available evidence establishes that since 2017 there has been an increase in the percentage of suitably accredited officers capable of deploying spikes. Further, there is no evidence to suggest that the percentage of accreditation is deficient in any way.

Was the information provided to Xavier's parents adequate and appropriate?

Shortly after the pursuit had passed Albert Drive and was about six kilometres from Macksville, and at about the time that Chief Inspector Gorman asked whether the history of the Courier and the driver had been checked, Constable Wilson broadcast that he (and Senior Constable Osborne) would make efforts to contact the owner of the Courier in order to verify whether it had been stolen. In order to do this, Constable Wilson needed to return to Kempsey police station in order to interrogate electronic police records.

Upon returning, Senior Constable Renee Bennett (who was on duty at the station at the time) informed them that she was unable to find the Courier's registration details to allow contact to be made with its owner. Constable Wilson explained that, at around the same time, he heard over VKG that Senior Constable Davison had requested the attendance of NSW Fire and Rescue. This led Constable Wilson to assume that there had been a collision of some sort, without knowing any further details.

Constable Wilson was subsequently able to locate the registration details from the police CAD and subsequently identified the owner as John Burke from Kundabung. Constable Wilson noted that the vehicle had not been reported stolen. After locating a phone number for Mr Burke Constable Wilson called and left a message for Mr Burke to contact Kempsey police station. In evidence Constable Wilson estimated that this occurred sometime between 10 and 20 minutes after he returned to the station.

He explained that at that time he had only heard, from the VKG broadcast in the background, the request for NSW Fire and Rescue attendance, and had only made the assumption that there had been a collision. Out of precaution, and in order to rule out the possibility that Mr Burke had been the victim of a home invasion, Constable Wilson decided to drive to Mr Burke's home address.

After Constable Wilson left the station, Senior Constable Bennett received a call from Mr Burke, who enquired about the location of his vehicle. Mr Burke said that his son Xavier was not at home and that he believed Xavier had taken the vehicle without his knowledge. Senior Constable Bennett explained that the vehicle had been located in South Kempsey with a number of youths occupying it and that she would contact Mr Burke with any further information. Mr Burke said that once Xavier returned home he would bring Xavier into the police station so that police could speak to him about taking the car without his parents' knowledge. At the end of the call Senior Constable Bennett called Constable Wilson and told him not to attend Mr Burke's address to speak to him. In evidence Constable Wilson explained that Kundabung was approximately 30 kilometres from Kempsey. After receiving Senior Constable Bennett's call it took him about 10 to 15 minutes to drive back, arriving at about 2:25am or 2:30am.

Constable Wilson returned to Kempsey police station and called Mr Burke who told him that his son, Xavier, and his vehicle were both missing, and asked what was happening. Constable Wilson said that he could only say that the utility had been stopped at South Kempsey and that some persons had decamped from it. In evidence Constable Wilson said that he recalled Mr Burke telling him that Xavier was due at school at 8:00am and that, when Xavier returned home, he would bring Xavier to the police station before school. Constable Wilson indicated in evidence that at the time of this conversation he thought that it was the Courier that was involved in the pursuit and was concerned that it was involved in the collision which he assumed had occurred. However, in evidence Constable Wilson explained that at that time he was unable to obtain any more information about the Courier.

Shortly after the call ended, Constable Wilson updated the police CAD at 2:32am with this entry: "SPOKE TO VEH OWNER – THE OWNER IS IN KUNDABUNG – THE VEH IS MISSING & HIS SON IS NOT THERE – I'VE RECALLED A VALLEY OFFICER – ANY FURTHER GD'S NEEDED?".

A short time later, Mr and Mrs Burke called Constable Wilson. He told them that the utility had been seen near the quarry at Dondingalong with four persons inside.

In evidence, Constable Wilson explained that by the time of this second call he had formed the belief, from what he had heard on VKG, that the driver of the Courier had been fatally injured in the collision. However in evidence he explained that it was not his role to say anything further, and that, in the case of a critical incident it was not policy for him to deliver such information over the phone.

The NSW Police Handbook relevantly provides:

Advice to relatives

…

Ensure next of kin are advised personally of a death at the first opportunity. Police should only phone next of kin to inform them of the death in exceptional circumstances and with the approval of the senior officer on duty.

Additionally, a death should only be notified to the next of kin upon confirmation of the deceased. Where the deceased identity is unconfirmed, police should contact the potential next of kin and explain why they think the deceased is related to them and that there is a requirement to establish the identity of the deceased.

At about 7:30am on 10 February 2017 Superintendent Paul Fehon, Chief Inspector Aldridge, and Detective Sergeant Vandermaat attended Mr Burke's home address in Kundaburg. After Mr Burke confirmed that he was the owner of the Courier, Superintendent Fehon advised that the Courier had been involved in a collision with a B-double near Macksville. Mr Burke asked if Xavier was in the Courier and Superintendent Fehon advised that police had confirmed that there was one deceased person in the vehicle but unsure of who else was in the vehicle.

Mrs Burke called at this time and spoke to Superintendent Fehon, asking for information about the location of the accident. Arrangements were made for Mr and Mrs Burke to attend Kempsey police station where they were later told that a police pursuit had occurred earlier that morning and that the Courier had collided with a B-double. Due to the substantial impact damage, police had been unable to determine who was in the Courier but had confirmed that there was one deceased person in the vehicle. Mr and Mrs Burke later attended Macksville Hospital at about 9:30am where they identified Xavier.

Conclusion: Constable Wilson made appropriate enquiries to ascertain the owner of the Courier, and to ensure that the owner had not been the victim of any criminal offence. It is evident that by the time Constable Wilson spoke to Mr Burke the collision had already occurred. However, at that time Constable Wilson was only in possession of unconfirmed information (which he had overheard over VKG) that led him to infer that a collision had occurred. Although Constable Wilson had reached a belief by the time of his second call with Mr Burke that a collision had in fact occurred and that it was likely that the driver of the Courier had been fatally injured it would not have been appropriate to convey this to Mr Burke at the time. This is because Constable Wilson had not had his belief confirmed and, even if he had, the NSW Police Handbook provided that such information should only be conveyed in person except in exceptional circumstances and only with the approval of the senior officer on duty. The evidence does not establish that either situation applied to the events of 10 February 2017.

Once the details and circumstances of the collision had been confirmed senior police officers took appropriate steps to contact Xavier's parents in person, provide information that was available at the time, and make arrangements for Xavier to be identified.

Findings

Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Joanna Davidson, Counsel Assisting, and her instructing solicitor, Ms Jennifer Hoy of the Crown Solicitor's Office. Their assistance during both the preparation for inquest, and during the inquest itself, has been enormous. I also thank and commend Detective Chief Inspector Neil Stephens and Detective Sergeant David Frith for conducting a thorough, detailed and independent investigation into Xavier's death and for compiling a comprehensive initial brief of evidence. I thank all of them for the sensitivity and empathy that they have shown in what has been a particularly distressing matter.

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

Identity
The person who died was Xavier Burke.

Date of death
Xavier died on 10 February 2017.

Place of death
Xavier died at Macksville NSW 2447.

Cause of death
The cause of Xavier's death was multiple injuries.

Manner of death
Xavier died when a vehicle that he was driving, and which was being pursued by a police vehicle in the course of a police operation, crossed to the incorrect side of the road and collided with a B-double.

16. 76874 of 2017

Inquest into the death of Ryan John Keith AUTON. Findings handed down by State Coroner O'Sullivan at Lidcombe on the 30th April 2019.

Ryan John Auton was only 18 years old when he died on 10 March 2017 as a result of multiple blunt force injuries sustained in a collision between the Nissan Skyline he was driving and a large school bus carrying primary school children.

Shortly after 7am on the morning of 10 March 2017, Ryan's mother, Tracey Auton, woke him up and cooked him breakfast, reminding him that he was running late for TAFE, which started at 8am. Ryan left his home at Yellow Rock at around 7.20am in his silver coloured Nissan Skyline, and dropped his girlfriend off at Springwood Railway Station 10 minutes later, before heading on to TAFE in Richmond.

That morning, Senior Constable Robert Wright, attached to Traffic and Highway Patrol Command, was working in the Hawkesbury Police Area Command and was performing stationary speed enforcement duties in an unmarked Highway Patrol vehicle parked 1.5 kilometres towards Angus Banks on the Driftway at Londonderry.

At about 7.57am, Senior Constable Wright identified the Nissan Skyline driven by Ryan travelling East at 108 km/h in an 80 km/h zone, and he pulled out from the curb and commenced to follow behind. Senior Constable Wright did not activate lights and sirens, but sped up significantly to try to close the gap between him and the Nissan Skyline, so that he could affect a traffic stop.

Only 26 seconds after Senior Constable Wright had pulled away from the curb to commence following the Nissan Skyline, Ryan drove his car through the intersection against a stop sign, and collided with a school bus travelling north on Londonderry road. The bus, which had right of way, entered the intersection before the Nissan and the front of the bus was almost clear of the intersection when the front of the Nissan collided heavily with the rear door area of the bus.

Ryan suffered major injuries and despite the assistance of emergency services, he did not survive them. The medical cause of Ryan's death was massive blunt force injuries sustained in the collision. Although a number of the children on the bus suffered physical injuries, mercifully none of them were seriously hurt.

Ryan lived with his parents and younger sister at Yellow Rock. I read the transcript of interviews between Police and Ryan's parents, Tracey and Colin Auton, and his girlfriend. It is clear that Ryan was very much loved and will be dearly missed. I learnt of a young man who was full of promise, who was very close to his family, girlfriend and friends.

Ryan attended Ellison Public School at Springwood and then Winmalee High School. He obtained an apprenticeship at Marsupial Landscape Management and then Citywide Landscape Australia and he attended TAFE once a week to learn landscaping and horticulture.

Ryan loved cars and was very excited to purchase a Nissan Skyline, which his father described as his "dream car". He was a competent and confident driver, but his father was forever telling him to slow down. There were no drugs or alcohol in Ryan's system at the time of the crash and he was fully licensed, so it is speed that is the significant causative factor in the crash. It is an absolute tragedy that this young, vibrant man, who was just beginning his journey in life and was so full of promise and love, has died.

The Inquest:

In the circumstances of Ryan's death, an inquest is mandatory pursuant to s. 23(c) and s. 27(1)(b) of the *Coroner's Act*, which at the relevant time required an inquest to be held where a person has died "as a result of, or in the course of, a police operation".

Having a public inquest is particularly important when someone dies in a situation where the police are involved. First, opening the circumstances up to public scrutiny can be an important safeguard for the community against the misuse of police powers. Second, it is an opportunity to reassure the community that police are subject to scrutiny. Third, it can foster confidence in police officers themselves, the NSW Police Force as an institution and the strength of the rules that govern their behaviour.

Section 81 requires this Court to make a finding as to the identity, date and place of a person's death and the cause and manner of their death. Cause refers to the physical cause of death. Manner refers to the circumstances leading up to and surrounding the death. Section 82 of the Act empowers the Court to make any recommendations that are considered "necessary or desirable" in relation to Ryan's death.

There is no issue in this inquest in relation to Ryan's identity, the time of his death, the place and date, or the medical cause of death. The real issue concerns the manner of Ryan's death, or in other words, the circumstances leading up to the collision that ended his life and the appropriateness of the actions of a police officer attempting to fulfil his traffic enforcement duties.

The Evidence:

At about 7.57am, Senior Constable Wright, who is attached to Traffic and Highway Patrol Command, was working in the Hawkesbury Police Area Command and was performing stationary speed enforcement duties in an unmarked Highway Patrol vehicle parked 1.5 kilometres towards Angus Banks on the Driftway at Londonderry. The police vehicle was parked and facing in an easterly direction allowing traffic to be monitored in both directions.

Senior Constable Wright had been in place for a few minutes when he noticed a silver Nissan Skyline moving east that he thought was clearly exceeding the 80 km/h speed limit. He released a radar beam and locked the radar on the Nissan Skyline at 108 km/h. As a result, Senior Constable Wright moved off from his position on the curb and followed the Nissan.

Senior Constable Wright was the sole occupant of the police car and he had been trained to engage in high speed and urgent driving duties. He gave evidence that he did not activate the lights and sirens on his patrol car, but sped up significantly to try to close the gap between him and the Nissan Skyline, so that he could affect a traffic stop.

I had the benefit of objective evidence in the form of an in-car video ("ICV") in the police vehicle driven by Senior Constable Wright. The footage depicts Senior Constable Wright pulling away from the northern shoulder of the Driftway into light traffic. The police vehicle is recorded on the ICV passing two civilian vehicles, the first at 139km/h, and the second at 173km/h. The highest speed reached by Senior Constable Wright was 192 km/h, but that speed was sustained momentarily before Senior Constable Wright began to slow down on his approach to the intersection.

The ICV shows that at a distance of approximately 200 metres from the intersection, Senior Constable Wright's vehicle passed over the 'stop sign ahead' markings on the road surface and was reducing speed, but he was still travelling at 179km/h in the lead up to the collision. He had not caught up to Ryan's car, which was speeding into the intersection. From the time Senior Constable Wright began to pull away from his stationary position at 7.57.05, to the time the bus moved through the intersection at 7.57.31 is only 26 seconds. That was a very short period of time to make any decisions.

The Fatal Incident:

As the Nissan Skyline driven by Ryan was travelling east on the Driftway, a school bus driven by Mr Satendra Sharndill was travelling north on Londonderry road. Although Ryan faced a stop sign as he approached the intersection, he made no attempt to slow down his Nissan and continued at speed, with the intention of driving east on the Driftway. The bus, which had right of way, entered the intersection before the Nissan and the front of the bus was almost clear of the intersection when the front of the Nissan collided heavily with the rear door area of the bus. Mr Sharndill did not see the Nissan before the accident.

As a result of the collision, Ryan suffered major injuries and despite the assistance of emergency service, he did not survive. There were fifteen school students on board the bus, five of whom suffered injuries, but none of them major. The bus driver, who was heroic in his actions to make sure children were bought to safety, was in shock, but not physically harmed.

The intersection between Driftway and Londonderry road is located in the rural area of Londonderry. Both roads are single lane bitumen roads with painted line markings and are straight and flat for 1 to 1.5 kilometres before and after the intersection. They are sign posted as 80km/h. Londonderry Road is situated north south, while the Driftway is situated east west. As I have indicated above, drivers on Londonderry Road have the right of way at the intersection, whilst the Driftway is controlled by stop signs and stop line markings.

Constable Gabrielle Drummond, attached to the Metropolitan Crash Investigation Unit, examined the scene on the date of the collision, including the debris and road marks. She provided an expert opinion that the absence of tyre marks leading up to the collision indicates that the drivers of both the bus and the Nissan did not attempt to brake before the collision.

A detailed report was provided by Crime Scene Officer Simon Parker, a member of the Forensic Services Group, Collision Reconstruction. He found that the Holden Commodore driven by Senior Constable Wright was travelling approximately 184 km/hr and the Nissan Skyline was travelling approximately 164 km/h along the Driftway, approximately 250 metres prior to the intersection with Londonderry road. This expert opinion was based on the CCTV provided by a resident of the Londonderry area. Crime Scene Officer Parker calculated the impact speed of the Nissan into the side of the bus as being between approximately 139 to 150 km/h, based on the dash camera footage supplied by the driver of a car in the area, who was a former serving police officer.

Crime Scene Officer Parker summarised the collision as:

A catastrophic t-bone style collision resulting from the Nissan failing to stop at the stop sign and colliding with the central portion of the near side of the bus. The collision caused the bus to rotate anti-clockwise, travelling into the path of oncoming traffic before it started to rotate in a clockwise direction coming to rest 70 metres from the impact location at approximately 90 degrees across the road surface blocking both traffic directions.

It will be obvious from what I have said about the bus driver having right of way, and not seeing the Nissan Skyline before the collision, that his driving could not be faulted. At the time of the collision, Ryan held a provisional P2 license and the Nissan he was driving was fully registered. Toxicology reports show that Ryan did not have any drugs or alcohol in his system at the time of driving. It appears to be his speed and inattention that resulted in the accident. That is not meant as any personal criticism of Ryan, but this terrible accident is a reminder of what a deadly combination cars and speed are, and how important it is for young, inexperienced drivers to learn that lesson.

Autopsy Report

Dr Kendall Bailey performed an autopsy and her report is in evidence. Dr Bailey found that Ryan died as a result of multiple blunt force injuries.

Appropriateness of the actions of Police

Senior Constable Wright gave evidence that he was intending to catch up to Ryan to try to stop him to speak to him about exceeding the speed limit. He explained that he did not activate the lights and sirens because "[b]basically I wanted to try to catch up to him, get him into a position to stop him, before I activated the lights, basically not to sort of spook him".

Senior Constable Wright gave evidence that he tends to get himself set up into a position to stop the driver before activating lights and sirens.

An issue arose in this inquest as to the appropriateness of the actions of Senior Constable Wright, and whether they were in accordance with the Safe Driving Policy, which governs and guides the actions of police on our public roads. The Court had the benefit of an expert report prepared by Acting Senior Sergeant Kris Cooper of the Traffic Policy Section, Traffic and Highway Command. Acting Senior Sergeant Cooper reviewed the available brief material, attended each day of Court and provided valuable written and oral evidence.

In particular, my attention was drawn to sections of the Safe Driving Policy which cover what police can and should do when they are involved in "pursuits", or in another category of driving referred to as "urgent duty".

The definition of pursuit includes the following:

7-1 PURSUIT: A pursuit, regardless of speed, commenced at the time you decide to pursue a vehicle that has ignored a direction to stop.

I accept the evidence of Acting Senior Sergeant Cooper that Senior Constable Wright was not engaged in a "pursuit" for the purposes of the Safe Driver Policy. Since Senior Constable Wright did not get the opportunity to give Ryan a direction to stop, he was unable to form any view that such a direction had been ignored and the definition of pursuit is not satisfied.

Even when not engaged in a pursuit, a police vehicle can travel excessive speed in order to execute a traffic stop or to close the distance to a vehicle. That is a type of "Urgent duty", which is defined in part 6-2-1 of the Safe Driving Policy as "Duty which has become pressing or demanding prompt action".

Ordinarily a police officer engaged in urgent duty must activate warning devices on their vehicle and notify the VKG radio. There is, however, an exception to that requirement in certain circumstances if the Police officer is engaging in a traffic stop, takes reasonable care and it is reasonable in the circumstances not to activate warning devices.

Part 8-6 of the Safe Driver Policy deals with traffic stops. It provides as follows:

It is permissible for police to perform traffic stops … or reduce the distance to an offending vehicle without informing VKG of a response code or activating warning devices. However police must take reasonable care and it must be reasonable that warning devices are not used.

After reviewing the circumstances of this incident, Acting Senior Sergeant Cooper expressed the opinion that Senior Constable Wright's actions in attempting a traffic stop and closing the distance without the use of warning devices was not reasonable in the circumstances and therefore not in compliance with the Safe Driving Policy.

This was because the reasonableness of his actions had to be considered in the totality of the circumstances. The Driftway and its intersection with Londonderry Road is a cross section where vehicles come into conflict. In the absence of warning devices or markings there was nothing on or about the police vehicle to provide any advance warning to other vehicles on the road of its speed or actions whilst approaching the intersection. Acting Senior Sergeant Cooper did not alter his view during cross examination by Counsel for Senior Constable Wright.

On the other hand, Senior Constable Wright gave evidence as to why he considered that his actions were reasonable. He stated that, consistent with the footage in the ICV, at all times he was following the Nissan Skyline he was in full control of his vehicle. Senior Constable Wright thought he was in full compliance with the Safe Driving Policy and he made a calculated and reasoned decision to attempt to close the distance. For example, he gave evidence that the reason he could pass each car in front of him safely was the distance between them. It was also the view of the Officer in Charge of the investigation into Ryan's death, Detective Sergeant Kylie Evans, that Senior Constable Wright had executed his duties in adherence to the Safe Driving Policy regarding traffic stops.

Senior Constable Wright did not believe that Ryan had seen him pull out from the curb or commence following behind him. That was based on a number of factors, including first, that it took him a number of seconds to pull out from the curb and he had to let two vehicles pass in front before he could commence following Ryan. Second, his Highway patrol vehicle is unmarked, and was not displaying warning lights or sirens. Although members of the public might recognise an unmarked patrol car parked stationary as a police car, Ryan was travelling in front of the car and there was nothing to reveal it as a police car. Third, drivers tend to hit the brakes if they do recognise it, and that is not what Ryan did. In his police interview, Senior Constable Wright estimated being 100-130 metres behind the Nissan after he turned the car around to follow it and that he was about 100 metres from the site at the time of the collision. In oral evidence, he corrected that and said that he thought he was more likely to be 200 metres behind at the time of the collision.

I accept that it is possible that Ryan did not see Constable Wright's vehicle parked stationary as he sped past it at 108km/h and he may not have recognised it as a police vehicle. It is possible that he may not have known that he was being followed at any time leading up to the collision. On the other hand, it is clear that Ryan's vehicle sped up considerably after he was followed by Senior Constable Wright.

The highest speed reached by Ryan was approximately 164km/h when he was approximately 250m before the intersection. Even travelling at up to 192km/h, Senior Constable Wright was unable to catch up to Ryan. It is feasible that Ryan recognised the unmarked highway patrol vehicle as a Police sedan and then saw it momentarily in his rear view mirror, or at least was worried that it would pursue him for doing the wrong thing.

Ultimately, I am unable to determine whether or not Ryan knew that he was being followed by a Police officer shortly before his collision, and it is not necessary for me to do so for the purposes of determining manner of death, or the appropriateness of the police actions. I accept the evidence of Senior Constable Wright that for the 26 seconds he was following Ryan, he did not believe that he had been seen.

Senior Constable Wright is a very experienced officer who attested in 1996 and has been in highway patrol for 20 years, since 1999. He has been engaged in countless urgent duty incidents and had never been involved in a fatality. I had the benefit of both a detailed police interview that Senior Constable Wright participated in on the day of the accident, and his oral evidence. I found Senior Constable Wright to be a credible and honest witness, who was doing his best to assist the Court to understand his actions. The evidence he gave in Court was sincere and thoughtful.

Although the Safe Driving Policy is there for the guidance of police officers, inevitably it allows for the individual officer/s to exercise considerable discretion when they make decisions, often under considerable pressure and with very little time to second guess their actions. I am satisfied that at the time he was closing the gap with Ryan's Nissan Skyline, Senior Constable Wright was attempting to comply with the Policy and to fulfil his duties in professional manner.

On careful reflection, I agree with Acting Senior Sergeant Cooper that there has been a breach of the Safe Driving Policy, because it was not reasonable in all circumstances for Senior Constable Wright to close the gap with the Nissan Skyline without activating the warning devices of his highway patrol vehicle. In coming to that conclusion, I rely on the written and oral evidence of Acting Senior Sergeant Cooper and take into account the speeds reached by Senior Constable Wright over the 26 seconds, the fact he was approaching an intersection and the number of other cars on the road. However, I also agree with Acting Senior Sergeant Cooper that this breach was not causative of the accident. For the reasons outlined above, I do not suggest that Senior Constable Wright should be subject to any personal criticism and I commend him for his credibility and openness when giving evidence and his years of service.

Safety issues at the Causeway intersection

I was grateful to receive information as to the state of the intersection and the efforts made immediately prior to Ryan's death to upgrade the safety features. Since there has already been significant work done in that regard, it is not necessary for me to make further recommendations relating to this.

Since the Driftway and its intersection with Londonderry Road is a place where vehicles have previously been the subject of serious collisions, an investigation commissioned by Hawkesbury City Council led to advanced safety measures being implemented prior to Ryan's death. They included advanced stop warning signs, pavement markings and central medial islands and associated line markings.

A road safety nomination incorporating the installation of vehicle activated signs on both east and west approaches to the Driftway was proposed, and that strategy was implemented in the afternoon of 9 March 2017, a day before Ryan's death. After Ryan's accident a further investigation was undertaken to determine whether there were any further safety measures required.

I received a statement from Mr Manjur Rahmen, the Network Development Leader employed by the Roads and Maritime Services ("RMS") as well as a statement from Christopher Amit, the Manager of Design and Mapping Services at the Hawkesbury City Council, and they are satisfied that no further action has is appropriate or necessary.

Recommendations

During the course of the inquest, it became clear that there is still some ambiguity in the way in which sections of the Safe Driving Policy are interpreted by police officers charged with the duty of implementing it in real life situations. One example was that Senior Constable Wright did not realise that Part 8-6 of the Safe Driving Policy dealing with traffic stops, should be read as being subject to Part 6, the urgent duty provisions. It appears from the questioning of Senior Constable Wright by his own Counsel, that this was a surprise to him and not consistent with how he thought the Policy should be read.

Further, Senior Constable Wright had a different view of what was reasonable with respect to the use of warning devices for a traffic stop, than did Acting Senior Sergeant Cooper, although both had sound reasons for their opinions. Police officers will always have to have some measure of discretion in interpreting the Safe Driving Policy, but the Policy and instruction should be as clear as possible. Otherwise, even the most professional and conscientious Police officers are left open to making genuine mistakes which they are later held accountable for.

I understand that the Safe Driving Policy is to be amended by the NSW Police Force soon and a revised version will be in place, although the exact timing is not known. I expect that the revisions will take into account the findings at numerous coronial inquests, as well as the expertise available to Police from their own officers.

To this end, at the end of the oral evidence Counsel Assisting suggested a number of recommendations that the NSW Police Force has had an opportunity to consider, and I received a written response to the original draft distributed. I have taken into account the submissions made on behalf of the NSW Police Force and have modified the original draft of these recommendations. I acknowledge the expertise of the NSW Police Force to help design the best solutions to the challenges that arise from the interpretation and implementation of the Safe Driving Policy.

Findings required by s. 81(1)

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

The identity of the deceased

The deceased person was Ryan John Auton.

Date of death

Ryan died on 10 March 2017.

Place of death

Ryan died at Londonderry in New South Wales.

Cause of death

The death was caused by multiple blunt force injuries.

Manner of death

Ryan died after a vehicle he was driving, which was being followed by a police car, went through an intersection against a stop sign and collided with a bus that had right of way. The resultant collision caused Ryan to suffer multiple blunt force injuries that were not survivable.

Recommendations

1. To the Commissioner of Police, NSW Police Force:

a) That that the NSW Police Force should ensure that police officers receive appropriate instruction prior to the release of the revised Safe Driving Policy by whatever delivery education method is deemed most effective, taking into account the view of police officers themselves as to what they find most beneficial.

b) That the NSW Police Force give consideration to how police officers involved in a critical incident that results in a death can be advised of any breach of the Safe Driving Policy and offered remedial training, in a timely period after the incident.

17. 81862 of 2017

Inquest into the death of Dawn Shirley Jacobs. Findings handed down by Deputy State Coroner Linden at Lismore on the 2nd July 2019.

Due to the presence of police at the circumstances leading up to the death of the deceased it was deemed to be a critical incident.

From a practical perspective police had been called by concerned parties due to the deceased being on the wrong side of the balcony in a block of home units. Police had just arrived and alighted from the police vehicle when the deceased let go of the railing and fell to her death. There can be no criticism of the police in this matter.

The deceased admission to and discharge from the mental health facility at Lismore Base Hospital

The deceased was admitted to Lismore Base Hospital as an involuntary patient on 1March 2017 and discharged on 7 March 2017.The issues raised were:

1. The adequacy of the care received by the deceased during her admission.
2. The appropriateness of the decision to discharge her on 7 March and the adequateness of her discharge plan.
3. The adequacy of her follow-up care received following her discharge and in particular
4. The adequacy of the hospital response following the phone call made by the deceased's sister to Andrew Thomas, Clinical Nurse specialist on the 14th March 2017.

Reports were obtained from two specialist psychiatrists, namely, Dr Anthony Samuels and A/Prof Christopher Ryan. There was consensus that the deceased's condition was difficult to manage with Obsessive Compulsive Disorder (OCD) being definite and other serious mental health conditions present.

The experts were of one mind that the care at the hospital was adequate. Their opinions differed as to the decision to release her and the adequacy of the follow up arrangement.

Dr Samuels was of the view that it was premature to release her and A/Prof Ryan was of the view that it was appropriate to release her.

Dr Samuels was further of the view that the after discharge plan was minimal in particular the after discharge arrangement could have been more extensive. A/Prof Ryan was satisfied with those aspects. The deceased was keen to return to her flat and her husband had indicated that he would arrange to take her home to Tasmania.

There had been no expressions of self-harm and the experts agreed that it can be impossible to predict future self-harm.

Dr Owens, one of the treating doctors, writes regarding his opinion on 7 March 2017, the date of discharge *"I did not consider that Ms Shirley Jacobs met the criteria for ongoing involuntary care given that she appeared willing and able to undertake follow-up psychiatric care in the community, and she had no suicidal ideation or thoughts of self-harm"*

Further treating Dr Siefken stated *"I had no concerns in relation to the discharge plan. Dawns thought patterns associated with her OCD appeared treatment resistant but did not present as a risk of self-harm that required ongoing involuntary inpatient treatment. She had returned to eating and drinking and had expressed a strong desire to go home. As had previously occurred treatment of her longstanding OCD was able to take place in the community as an outpatient."*

A/Prof Ryan was in agreement with this summation.

He stated that the decision to discharge the deceased was both reasonable and appropriate. Dr Samuels was of the view that the deceased could have been detained longer. The deceased with her OCD was a compulsive cleaner of her hands, continuingly refused to eat or drink and was suspicious of people including her sister but had never expressed suicidal ideation or thoughts of self-harm.

Her sister phoned on14 March and spoke to Andrew Thomas, clinical Nurse Specialist at the hospital to inform him that the deceased was again not eating and was reclusive. This was reported to the Acute Care team who were charged with the deceased's ongoing care. The acute care team were due to have contact with the deceased on 16 March, the day after her death.

Given the history I am satisfied that this was an adequate response in the circumstances

In summation I confirm no criticism of the police and am satisfied that the deceased received adequate care as an involuntary patient at Lismore Base Hospital and I am satisfied that her discharge and after discharge care plan were reasonable in the circumstances

No recommendations are needed

Formal Finding:

I find that Dawn Shirley-Jacobs died on the 15th March 2017 at Lismore Base Hospital of multiple injuries sustained following a fall from a balcony self-inflicted with a view to taking her own life.

18. 96394 of 2017

Inquest into the death of Terry Carl AH-SEE. Findings handed down by Deputy State Coroner Ryan

Terry Carl Ah-See aged 35 years died in Bathurst on 29 March 2017. At about 1pm he was travelling in a car which had been reported stolen earlier that day. The car was sighted by a police officer who commenced a police pursuit when his direction to pull over was not complied with. The pursuit was joined moments later by an unmarked police car.

The pursuit lasted little more than a minute. It culminated in a horrific single car crash when the car in which Mr Ah-See was travelling and which was being driven at high speed left the road, became airborne, landed heavily and rolled a number of times.

Mr Ah-See and the other man in the car Frederick Doolan were violently ejected in the course of the crash. Emergency services were immediately called, but Mr Ah-See had suffered severe injuries and he died shortly afterwards in Bathurst Base Hospital. Mr Doolan received minor injuries.

The autopsy report of pathologist Dr Allan Cala found that Mr Ah-See had died of multiple injuries. He had suffered fractures to his skull, ribs and hip, and a subarachnoid haemorrhage to his brain.

Toxicological analysis of Mr Ah-See's post mortem blood samples detected cannabis, fentanyl, methylamphetamine, midazolam and oxycodone. Expert toxicologist Dr Judith Perl assessed the concentration of methylamphetamine to be '*very significant'*. In her opinion it would have been expected to impair the ability of Mr Ah-See to control a car.

The inquest

This is a mandatory inquest pursuant to sections 23(1)(c) and 27(1)(b) of the *Coroners Act* 2009 *(NSW)* [the Act] as in force in March 2017. At that time an inquest was mandated when a person died '*as the result of, or in the course of, police operations*'. A police pursuit falls within the scope of '*police operations'* pursuant to section 23(1)(c). Inquests are mandatory for these types of deaths to ensure there is an independent and transparent investigation of the circumstances of the death, and the conduct of any involved police officers.

The issues examined at the inquest were:

- was Mr Ah-See the driver of the car when it crashed

- were the involved police officers aware that the likely driver was drug-affected?

- was some other step appropriate than conducting a police pursuit?

- in conducting the pursuit did either Senior Constable Elliot or Leading Senior Constable Cooper breach any of the requirements of the NSW Police Force Safe Driving Policy at it existed at that time?

Mr Ah-See's life

Mr Ah-See is an Indigenous man who was born on 25 August 1981 and grew up in Wellington NSW. His de facto partner is Catherine Pitt and they had two children together, Levi and Sharon. Terry also had older children from earlier relationships.

For many years Mr Ah-See struggled with problems of drug addiction which continued up to the day of his death. Catherine described last seeing him two days before the crash and noticing that he was drug-affected and looking like he had not slept for many days.

Each day of the inquest Mr Ah-See's mother Sharon and his partner Catherine attended, together with other family members. At the close of the evidence, on behalf of the family Mrs Ah-See spoke movingly about her memories of her son. He was proud of his partner and children, and deeply attached to his brother Dwayne and to his mother. Sharon spoke of herself and her son as being '*one of the same spirit'*. It was clear that despite the struggles Terry had in his life he was much loved by his family, and they grieve his loss deeply.

The events leading up to the crash

The car in which Mr Ah-See was travelling was a blue Hyundai SUV. It was unregistered. At the time of Mr Ah-See's death it was owned by Ms Jenna Symons, but this change of ownership had not been recorded. On police records the car was recorded as belonging to a previous owner who was a suspended driver.

At 10am on 29 March Ms Symons contacted police to report that her Hyundai had been stolen. Police attended her home at about 11.55am. Ms Symons told police that at 2.30am that morning Mr Ah-See and another man had come to her home. Both appeared to her to be drug-affected and she told them to leave. The next morning she noticed that her car and its keys were missing.

Two men later confirmed to police that they had been in the Hyundai with Mr Ah- See on the morning of 29 March. They are Spencer Morgan and his cousin Frederick Doolan. Mr Doolan recalls that at around midday Mr Morgan was driving the car, with Mr Ah-See in the front passenger seat and himself in the back seat. Mr Doolan told police that Spencer Morgan and Mr Ah-See '*both looked high, off their rocket'.*

SC Elliot's interactions with the Hyundai

Just before 1pm, Senior Constable Wade Elliot was patrolling streets in South Bathurst in a fully marked Highway Patrol police car, which was designated 'Western 240'. The Hyundai drove past him in the opposite direction. SC Elliot's automatic numberplate recognition system informed him that the Hyundai was unregistered and that its owner on the record was a suspended driver.

Senior Constable Elliot decided to try to intercept the Hyundai. He was aware that a colleague, Leading Senior Constable Daniel Cooper, was patrolling nearby in an unmarked police car designated 'Western 243'. As SC Elliot followed the Hyundai he spoke to LSC Cooper on what is known as a radio back channel to tell him of his intention. SC Elliot then turned on the lights and siren of his car, thus automatically activating his in-car video system. From this point onwards, video footage from SC Elliot's in-car system is available and was shown at the inquest.

SC Elliot said that his purpose in activating his lights and siren was to notify the Hyundai's driver to stop the car. He followed the Hyundai into Currawong Street where it pulled into a driveway. SC Elliot pulled up behind and began to get out of his car. However the Hyundai suddenly reversed, turned, and drove off in the opposite direction of Currawong Street.

SC Elliot followed, broadcasting to the police VKG radio: '*Western 240 urgent in pursuit'*. At the inquest he said it was at this point that he regarded himself as engaged in a police pursuit of the Hyundai. By activating lights and siren and pulling up behind the Hyundai he had signaled the driver to stop, which the driver had ignored by taking off. SC Elliot considered these constituted proper grounds to commence a pursuit within the terms of Part 7.1 of the NSW Police Force's Safe Driving Policy [the SDP], further described below.

SC Elliot followed the Hyundai as it drove through various suburban streets of the area and eventually turned into Alfred Street. There the Hyundai pulled over onto the nature strip. Mr Morgan, who had been the driver, opened the driver's door and ran towards the rear of a nearby property.

SC Elliot got out of his car and started to chase Mr Morgan on foot, yelling out to him to stop. Suddenly behind him he heard the Hyundai's engine revving. He turned to see the Hyundai driving away down Alfred Street. He could not see who was driving but as will be explained below, the evidence indicates that when Mr Morgan got out of the Hyundai Mr Ah-See replaced him in the driver's seat.

As SC Elliot returned to his police car he saw the Hyundai turn left out of Alfred Street and into Lloyd's Road. At the same time he noticed LSC Cooper's unmarked car driving down Lloyd's Road in the opposite direction to the Hyundai. Once back in his car SC Elliot heard LSC Cooper broadcast on VKG the words: '*Western 243 urgent'*. This he interpreted as LSC Cooper notifying that he had made contact with the Hyundai and had engaged in the police pursuit.

At the inquest SC Elliot said that at this point he considered he was no longer personally engaged in the pursuit because he could no longer see where the Hyundai was. However in his view the pursuit as an enterprise was continuing. This was because no one had broadcast a termination of it, and he was aware that LSC Cooper was now actively pursuing the Hyundai. He said that had he not heard LSC Cooper's broadcast, he might have considered telling VKG that he was terminating the pursuit. Further, although he regarded his own role in the pursuit as suspended, his intention was to keep searching for the Hyundai. He said that if he saw it again he would have considered broadcasting to VKG that he was re-engaging.

SC Elliot told the court that at the time, he did not have time to consider the question whether the pursuit by LSC Cooper was a separate pursuit or simply a continuation of the one he himself had initiated.

In fact SC Elliot did not see the Hyundai again until after the crash. Moments after hearing LSC Cooper broadcast '*Western 243 Urgent'*, he heard LSC Cooper telling the VKG operator his location, then the words: '*He's come a gutsa'.* This was only 62 seconds after SC Elliot had first notified VKG of his pursuit.

SC Elliot immediately made his way to the crash scene.

LSC Cooper's interactions with the Hyundai

When LSC Cooper first saw the Hyundai it was exiting Alfred Street into Lloyd's Road. LSC Cooper could see SC Elliot's police car stationary on Alfred Street with its driver's door open and its lights still activated. He assumed correctly that SC Elliot was out of his car.

LSC Cooper immediately turned his car and followed the Hyundai down Lloyd's Road. He activated his own lights and siren, and told the VKG operator: '*Western 243 Urgent'*. By this he intended to signify that he was engaged in pursuit.

LSC Cooper told the court that he believed he was continuing an existing pursuit. He had not heard any VKG notification that the pursuit had terminated. Nor was he aware that the Hyundai had stopped in Alfred Street prior to his own sighting of it. Since SC Elliot's car was stationary, and to his knowledge no other police cars were involved in the pursuit, he considered that he had taken over from SC Elliot in the role of primary pursuit car.

LSC Cooper's pursuit of the Hyundai lasted less than twenty seconds. As the Hyundai drove down Lloyd's Road its speed increased dramatically. This can be inferred from a viewing of LSC Cooper's own in-car video footage. This shows his police car's speed accelerating to almost 130 kph. The screen meanwhile shows the Hyundai ahead, pulling away.

At this time the screen also shows a white van ahead of the Hyundai, driving in the same direction. After the crash its driver Mr Hayden James confirmed that he had seen the Hyundai coming up behind him, and a police car further behind with lights and siren on. The Hyundai crossed to the wrong side of the road and overtook the van.

Just as this happened LSC Cooper's in-car video screen shows that LSC Cooper reduced his own speed fairly rapidly. He said he had formed the intention to communicate a termination of the pursuit.

The tragic events of the crash intervened. Just after overtaking the van and crossing the railway tracks the Hyundai shot up in the air, becoming airborne. On landing it left the road and hit a ditch, then flipped a number of times. Mr Ah- See and Mr Doolan were ejected from the car and onto the grass verge.

The police officers were immediately on the scene, followed by emergency services. Witnesses described Mr Ah-See as unconscious and bleeding heavily. Mr Doolan was sitting on the grass verge, injured but conscious. He indicated to LSC Cooper that it was Mr Ah-See who had been driving the Hyundai.

Mr Ah-See and Mr Doolan were taken to Bathurst Base Hospital. Despite the efforts of Emergency staff Mr Ah-See died at 2.53pm.

Later that evening in hospital Mr Doolan spoke to police about the crash. He said that in Alfred Street Mr Ah-See had moved from the front passenger seat to the driver seat and had driven off. In the back seat Mr Doolan had tried to get out but the child lock on his door was on. He estimated the car was being driven at least 150 kph. He said to Mr Ah-See '*slow down, there's an intersection'* and '*pull over, pull over'*, but he didn't respond.

I turn now to consider the issues examined at the inquest.

Was Terry Ah-See the driver of the car at the time of the crash?

The evidence is sufficient to establish that Terry Ah-See was driving the car at the time of the crash. This is based on what Mr Doolan told police on the night of the incident, summarised above. His account that the driver was Terry Ah- See receives some support from what Mr Morgan told police, namely that when he got out of the car in Alfred Street Mr Ah-See was in the front passenger seat and Mr Doolan in the back seat.

Were the police officers aware that the car was being driven by a drug- affected person?

The evidence shows that no police radio broadcast was generated when the Hyundai was reported stolen. Further, no information was broadcast that the person suspected of taking it was drug-affected.

The court heard that in ordinary circumstances, these events of themselves would not warrant a VKG broadcast.

The two involved officers were unaware of the above information when they commenced their pursuit of the Hyundai.

Should the involved police officers have considered or taken other action in preference to a police pursuit?

Addressing this issue requires considering whether the involved officers complied with NSW Police Force's Safe Driving Policy [the SDP]. The applicable version of the SDP at the time of Mr Ah-See's death had come into force in July 2016. It has since received minor revisions, none of which are relevant to the specific issues of this inquest.

Part 7 of the 2016 SDP specifically governed pursuits. It defined a pursuit as follows:

PURSUIT: A pursuit regardless of speed commences at the time you decide to pursue a vehicle that has ignored a direction to stop.

The decision to initiate and/or continue a pursuit *'requires weighing the need to immediately apprehend the offender, against the degree of risk to the community and police as a result of the pursuit':* Part 7.2.1.

According to Part 7.1.2, 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'.*

The SDP made clear that a pursuit may be conducted by a primary response vehicle and a secondary response vehicle. At 7.5.2 the SDP also noted that a secondary response vehicle could take over the role of the primary response one.

Part 7.6 set out the circumstances in which a pursuit must be terminated. The SDP did not provide a definition of a termination, instead setting out the following in quote marks at 7.1.3:

7.1.3 : TERMINATION: 'All vehicles cease to pursue, stop following and return to the legal speed limit. Turn off all warning devices as soon as possible and when safe'.

It did however define re-initiation of a pursuit:

7.1.4 : RE-INITIATION: Re-initiation is where a pursuit of a motor vehicle that has been terminated by any police officer, including the driver involved in the pursuit, is then engaged in a second or subsequent pursuit.

At the close of evidence it was submitted by Counsel Assisting that in the circumstances the two police officers faced, there was unlikely to have been a practicable alternative to conducting a police pursuit. SC Elliot had a proper basis to intercept the Hyundai. He had been informed that it was unregistered and that its last registered owner was suspended from driving. He activated his lights and siren and pulled up behind the Hyundai in Currawong Street. On the evidence, SC Elliot was entitled to conclude that when the driver took off he was disobeying a direction to stop. I accept the submissions of Counsel Assisting on this point.

I accept the evidence of SC Elliot's decision to proceed was a proper one given that the prevailing circumstances presented a relatively low risk of danger to police and public.

At the inquest SC Cooper was questioned as to whether he ought to have called a termination of the pursuit. He replied that he had seriously considered doing this. He had no time to do so however, as the crash happened within seconds.

Given the speed with which events then unfolded, there could not be any reasonable criticism of his failure to call a termination of the pursuit.

Did the involved police officers otherwise comply with the SDP?

Both police officers met SDP requirements that they be suitably classified as drivers permitted to engage in a pursuit, and that they be driving vehicles that were permitted to be used for activities such as pursuits.

A focus of interest in the inquest was whether the incident should properly be regarded as two pursuits, or as a single pursuit conducted in two phases. In other words, were SC Elliot and LSC Cooper engaged in a single police pursuit in the course of which LSC Cooper took over the role of primary response vehicle? Or should the events properly be understood as a re-initiation by LSC Cooper of a pursuit which SC Elliot had terminated?

As noted above, re-initiation is defined at 7.1.4 as *'where a pursuit … that has been terminated by any police officer ... is then engaged in a second or subsequent pursuit'.*

Determining the issue was complicated by the manner in which the incident was followed up within NSW Police. After the crash the Duty Operations Officer, Inspector Ward, completed two separate 'Police Pursuit' forms for the incident, each with its own Pursuit Number. In the first form he described the actions of SC Elliot in commencing the pursuit, chasing Mr Morgan on foot, and observing the Hyundai driving off. In the second Pursuit Form he provided the following description:

'Pursuit re-engaged

Pursuit initiated which crashed as(sic) short time later…'

It appears the Duty Operations Officer believed that SC Elliot had terminated the pursuit itself, and that LSC Cooper had re-initiated it when he commenced to follow the Hyundai.

This is contrary to the way in which the two involved officers understood the situation. I have noted at paragraph 27 above LSC Cooper's evidence that he considered he was continuing the pursuit initiated by SC Elliot. For his part SC Elliot believed that the pursuit as an enterprise was ongoing, even though his individual role in it was suspended because he had lost sight of the Hyundai.

His belief that the pursuit itself was ongoing was based on two factors: first, he was aware that LSC Cooper was now in active pursuit of the Hyundai, and secondly he himself intended to go in search of it.

I should note that nowhere in the SDP is it provided that losing sight of a vehicle that has been under pursuit mandates termination of it. On the contrary, according to Part 7.1.2:

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.

Inferentially where a police vehicle loses sight of an offending vehicle but attempts to remain in contact with it, the pursuit is not to be regarded as terminated, provided none of the other factors mandating termination are present. This does not seem to have been the understanding of the Duty Operations Officer, who as noted considered the pursuit to have been terminated by SC Elliot.

At the close of evidence Counsel Assisting and Counsel for the NSW Commissioner of Police both submitted, on the basis of the evidence and policy documents, that this was in reality a single pursuit which was conducted in two phases.

I accept the SDP evidences an intention that a pursuit be regarded as continuing notwithstanding that a responding officer has lost sight of the vehicle being pursued, provided the officer is attempting to remain in contact with it. The evidence establishes that this was what SC Eliot was doing.

Supporting this interpretation, there had been no broadcast termination of the pursuit. Nor had there been any change in prevailing circumstances such as might lead to a conclusion that the danger to the public outweighed the need for immediate apprehension of the Hyundai. Also relevant is the extremely short space of time within which the entire incident took place. For a pursuit which lasted a total of 62 seconds, without any significant change in circumstances, there would be an artificiality in insisting on an interpretation of commencement, termination and re-initiation.

I conclude that the conduct of this pursuit did not involve any breach of the provisions of the SDP. Nor on the evidence is there is any basis for criticism of the conduct of the two involved police officers for initiating the pursuit, or for the manner of their own driving while engaged in the pursuit.

Are any recommendations necessary and desirable?

Notwithstanding the above conclusion, the question remains whether the circumstances give rise to any need for improvement in the way the SDP is drafted or implemented.

I have noted that the facts demonstrated a lack of consensus as to whether SC Eliot's actions ought to be understood as a termination of the pursuit. This may be attributed to the fact that the SDP does not provide a definition of termination. Part 7.6, headed 'Termination of Pursuit', does not contain a definition, instead listing the factors that mandate a termination. Nor is the wording provided at Part 7.1.3 a definition but rather a form of words, perhaps intended to be used by a VKG dispatcher, instructing all vehicles to stop following and return to the legal speed limit. This interpretation of the purpose of Part 7.1.3 is supported by its use of quote marks.

The facts established in the 2018 NSW inquest into the death of Senior Constable Geoffrey Richardson also exemplify the lack of clarity as to what constitutes termination of a pursuit. Factually that matter too involved a pursuit being conducted by more than one police vehicle. One police officer broadcast that his car was disengaging, while the second police vehicle, having lost sight of the car under pursuit, continued to follow its dust trails. Its driver told the inquest he considered that he was still in pursuit, an understanding which accords with the terms of Part 7.1.2 (see paragraph 41 above). Despite this the evidence of the VKG dispatcher was that she believed the pursuit *as a whole* had been terminated when the first police vehicle indicated its own disengagement from it. With reference to the second police vehicle the dispatcher gave further evidence that when an officer indicated he or she had lost sight of a vehicle this was generally understood to mean that the pursuit had been terminated. This evidence was corroborated by the VKG Shift Coordinator on duty that night [refer par 62 of the *Findings into the death of Geoffrey Richardson*, delivered 6 July 2018].

The above evidence prompted Deputy State Coroner Lee to make a number of recommendations. One of these was that the NSW Commissioner of Police consider ensuring that the SDP provide an unequivocal definition of the term *'termination'* as it related to pursuits. His Honour recommended further that the SDP provide a clear indication of whether and in what circumstances losing sight of a pursued vehicle amounted to termination of a pursuit; and that it develop consistent language and instructions to be used in relation to when a pursuit is terminated (noting the evidence of the dispatcher and VKG Shift Coordinator that notification of a loss of sight of the vehicle is often taken to mean notification of termination of the pursuit).

In the present inquest it was submitted on behalf of the NSW Commissioner that there was no requirement to define what a termination was.

The officers involved had a practical understanding of what they were doing, and did not misunderstand their roles. To make recommendations similar to those in the Richardson case would risk making the SDP overly prescriptive, potentially causing further ambiguity and confusion in implementation. It was further submitted that it was most unusual for a pursuit to be interrupted as this one had been.

It is acknowledged that an overly prescriptive SDP would not be beneficial to police or to the community, and that in the present inquest the lack of clarity about what constitutes termination did not give rise to any breaches of the SDP. Nevertheless in my view it would be of benefit for this issue to be addressed. The ambiguity identified was found to be of direct relevance to the manner of Sergeant Richardson's death. In the present inquest it was reflected in the conflict between the understanding held of the events by the Duty Operations Manager, and that which is reflected in these findings. Further, SC Elliot's actions in discontinuing his personal involvement in the pursuit but intending to resume a role do not appear to be contemplated within the terms of the SDP, however reasonable they were in the circumstances.

As to the submission that it is unusual for a pursuit to be interrupted in this manner, the circumstances in the Richardson matter might suggest otherwise.

Having carefully considered the position put on behalf of the Commissioner, I have nevertheless decided that it is necessary and desirable to make certain recommendations regarding the drafting of the SDP. Those representing the Commissioner advised that the SDP is currently under review, although no information was available as to its terms or when it would be complete. There is thus an opportunity for the review team to consider the recommendations I make.

A note about the manner of death

In the submission of Counsel Assisting, the court would appropriately find on the evidence that Mr Ah-See died in a single car accident when he lost control of the car he was driving, while he was being pursued by police.

Those representing the Commissioner of Police took issue with this description of the manner of death, arguing it implied that Mr Ah-See drove in such a dangerous manner because he was being pursued by police. The evidence, it was argued, did not permit a finding as to what had motivated Mr Ah-See to accelerate so dangerously and lose control of the car in the moments before the crash.

I agree the evidence does not enable the court to find that Mr Ah-See drove in the manner he did because he was being pursued by police. We will never know what was in his mind in the moments before his death. Nor did Mr Doolan refer to words or conduct on the part of Mr Ah-See in those last moments from which it might be inferred that his manner of driving was linked to the fact of the pursuit.

Findings required by s81(1)

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

Identity

The person who died is Terry Ah-See.

Date of death

Terry Ah-See died on 29 March 2017.

Place of death:

Terry Ah-See died on Lloyd's Road, South Bathurst NSW.

Cause of death

The cause of Terry Ah-See's death is multiple injuries sustained in a car crash.

Manner of death

Terry Ah-See died in a single car accident when he lost control of the car he was driving, while he was being pursued by police.

Recommendations

I repeat with minor modifications the relevant recommendations made by Deputy State Coroner Lee in the Richardson inquest, as follows:

To the NSW Commissioner of Police:

That consideration be given to reviewing the current version of the NSW Police Force Safe Driving Policy to ensure that it provides:

1. an unequivocal definition of the term '*termination'* as it relates to pursuits

2. a clear indication of whether, and in what circumstances, a loss of vision of the vehicle under pursuit amounts to a termination of a pursuit

3. consistency in language and instructions when police officers communicate, or are directed, that a pursuit is terminated.

19. 225920 of 2017

Inquest into the death of AB. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 3rd April 2019.

This is an inquest into the death of AB, who died on 22 July 2017 at Lithgow Correctional Centre.

AB was in lawful custody at the time of his death. Accordingly, an inquest is required to be held pursuant to sections 23 (d) (ii) and 27 (1) (b) of the Coroners Act.

Pursuant to section 81 of the Act a coroner is required to make findings as to;

a) The identity of the deceased
b) The date of their death
c) The place of their death, and
d) The manner and cause of the person's death.

Under section 82 of the Act, the coroner also has the power to make recommendations concerning matters of public health and safety arising out of the death in question.

BACKGROUND

AB was born on 3 January 1961 in Gunnedah, New South Wales. He attended Warialda High School where he completed schooling to year 10. He had a brother S, although he had apparently not been in contact with him for over 15 years. He was married to VB for 33 years, and had three children, C, T and K. Prior to going into custody, he resided with his family in Toormina, New South Wales. AB was employed in a variety of roles throughout his life, including the management of a clothing store, operating a convenience store, a manager of a dairy farm and a mortician.

INCARCERATION

On 19 February 1999, AB was convicted and sentenced to 2 years imprisonment, non-parole period of 18 months for offences relating to the indecent assault of a person under the age of 16 years. These were AB's first criminal convictions. He served his sentence in various Correctional Centres, including Cessnock, Long Bay, Bathurst and Kirkconnell, before his release to parole on 18 August 2000.

In March 2004, AB was charged with failing to comply with his reporting obligations under the Child Protection Act when he failed to advise police of his new address and motor vehicle. He was sentenced to a two year suspended sentence.

On 15 January 2014, AB was charged with child sexual offences for which he was ultimately convicted and sentenced at the time of his death. These offences occurred between 2003 and 2005. On 27 September 2016 he was found guilty of the offences by a jury.
On 10 April 2017, he was convicted and sentenced to an aggregate sentence of 10 years and 6 months, with a non-parole period of 7 years. His earliest date of release on parole was 26 September 2023. On 2 July 2017, AB was charged with a further 20 offences relating to child sexual assault matters in Gunnedah between 1983 and 1984. The first court mention date for those matters was to be 28 August 2017.

HEALTH AND TREATMENT WHILST IN CUSTODY

After entering custody on 26 September 2016 AB had been housed at Grafton Correctional Centre, Parklea Correctional Centre, and lastly Lithgow Correctional Centre on 9 June 2017.

AB was in good physical health. He denied using prohibited drugs and stated that he only consumed alcohol in moderation. He was on anti-hypertensive medication Metoprolol, as well as Meloxicam to treat arthritis. He was also being issued with paracetamol daily. Medical records and psychological reports suggest that AB had not indicated any suicidal ideation during his incarceration, but he did suffer from anxiety, stress and a depressed mood due to being away from his family and more recently the new pending charges.

Upon his transfer to Lithgow on 9 June, AB was placed into a protection unit (known as a Special Management Area) due to the nature of his charges. This was a unit where inmates who were vulnerable could be accommodated.

On 11 June, Correctives received information from another inmate that AB had revealed the nature of his charges and was at risk of being assaulted. In order to manage this risk in the short term, staff had AB locked in his cell before transferring him to unit 5.2, which was a segregation unit within Lithgow Correctional Centre.

On 12 June, AB was seen by Justice Health nursing staff who noted bruising on his right eyebrow, and it was believed that he was assaulted prior to being placed in segregation. He did not disclose the details of the assault to nursing staff and declined to make a police report, but during a phone call made to his son C on 12 June, he mentioned that he was assaulted in the protection yard after someone found out about the nature of his charges.

AB was seen by psychologist Rebecca Prodinger on 30 June 2017. He told her he was having family stressors, difficulties adjusting to segregation, and felt as though he was being treated unfairly by being placed in segregation due to the nature of his offences. It was explained that he was in segregation for his own protection, and he was provided with supportive counselling and coping strategies. A suicide/self-harm assessment was conducted. AB did not reveal any past or current self-harm thoughts or intent. On 3 July 2017, AB was served with court attendance notices relating to the new charges involving the commission of offences in 1983 and 1984. On 6 July Dr Prodinger followed up with AB from his visit the previous week. He was reported as being more responsive to coping skills and engaging in friendly conversation with correctional officers in his cell. There were

no indications to Dr Prodinger that AB presented a risk of self-harm. Dr Prodinger advised AB that he would be followed up with again in two weeks.

AB was subjected to a review of his classification. He was classified as Protection Limited Association (or PRLA). Lithgow is not a jail of classification for offenders who were managed as PRLA inmates, and so a transfer to Junee Correctional Centre was ratified on 5 July 2017. AB was unhappy with the impending transfer due to the distance his family would have to travel to visit him. He expressed his dissatisfaction with friends over the telephone, and also with Correctives Officers. He was provided with information about how he could lodge an appeal against his placement.

On 10 July 2017, AB was moved from the 5.2 unit to the 5.1 unit due to overcrowding. 5.1 was also a segregation unit, but was predominantly used to house Extreme Threat Inmates. However, it was not uncommon for inmates to be moved between 5.1 and 5.2 units due to overcrowding. It should also be noted that the Institutional Violence Intervention Unit Program that was in operation at unit 5.1 is no longer being used at Lithgow Correctional Centre, and so this distinction between Unit 5.2 and unit 5.1 is no longer relevant. AB was housed on his own in cell 219.

On 13 July, a referral was received by Psychology from Justice Health in relation to AB. It was a self-referral with AB reporting that he was feeling lonely and depressed in segregation and was having trouble sleeping. Dr Prodinger discussed this referral with Senior Psychologist Jenny Mackie. Given that AB was on a low priority service line, it was decided that she would keep her appointment for the following week.

On 21 July, Dr Prodinger attempted to see AB for their planned follow-up meeting at approximately 1pm. She was informed that he had moved to unit 5.1 and at the time she attended there were no interview room available to meet with him. Dr Prodinger was also informed that AB was scheduled to be moved to Junee Correctional Centre the following day. Given that she was not made aware of any deterioration in his mental state or behaviour, she made a note under his referral that he should follow up by psychology at Junee. There is no record about whether this information was passed onto AB.

At about 2:25pm that same day, AB was seen by Corrective Services staff as they issued the evening meal. At this time, he requested to be provided with plastic bags to pack his belongings for his transfer to Junee in the morning. These were provided to him. The Corrective Services Officer thought that AB appeared to be in good health and was last seen preparing his meal as the cell door was secured.

That was the last time that AB was seen alive. Security checks were conducted during the evening of the cells within unit 5.1, but these checks did not involve an officer physically sighting each inmate, rather only ensuring the cell doors were secure. At about 8:35am on Saturday the 22nd of July 2017, a head count was being conducted of inmates within the 5.1 Unit. An officer opened the observation flap to cell 219 and saw the back of AB's head. The Officer called AB's name and received no response, so he called out for assistance from other Correctional Officers. They opened

the cell door and saw AB with his back to the inner grill door, with a ligature fashioned from torn bed sheets tied around his neck. The ligature was tied below one of the horizontal bars on the internal grill door and looped over the frame of the grill door, allowing him to suspend his body weight from the ligature.

The ligature was cut by Correctives Officers and AB's body was lowered to the floor. CPR was commenced. Further staff from the Immediate Action Team and the Clinical Response Team arrived and AB was moved to the day room of the 5.1 Unit to allow better access for resuscitation. This was continued until 8:46am, when AB was pronounced life extinct. Officers located seven handwritten letters on the table in AB's cell. The first was placed on top of the pile and addressed "to whom it may concern". The other six were addressed to his wife, his three children, and two of his friends. From the letters, it is apparent that AB intended to take his own life, and the primary reason for doing so appears to be the separation from his children and an inability to cope with the prospect of several years in prison.

INVESTIGATON FOLLOWING DEATH

An autopsy was conducted by Pathologist Dr David Cala on 27 July 2017 and he has provided a report dated 14 September 2017. Dr Cala concluded that the direct cause of death was neck compression, due to hanging.

The toxicology report showed paracetamol in his blood at 260mg/L, which is considered toxic and potentially within the fatal range. AB was being issued with 1 gram of paracetamol daily, and it is believed that he must have been saving them over the last 10 days by pretending to Justice Health staff that he had swallowed them each day as required.

AB's forearms had several superficial lacerations where he had apparently cut himself with broken shaving razor which was found in his cell.

Transcripts of AB's phone conversations whilst in custody were provided by police. AB did not say anything that would indicate that he was contemplating self-harm or that he was at risk of self-harm.

CONCLUSION

I have scrutinised the circumstances leading up to AB being placed in the unit pending his transfer to Junee. There is no suggestion that his placement or pending transfer were inappropriate. AB was provided with psychological support and though he was not unfortunately seen following his recent self-referral request, the explanation for that has been satisfactorily explained. I am satisfied that suitable arrangements were made for AB to see a psychologist upon his arrival in Junee.

The evidence enables me to make the required findings. This is not a case where I would make any recommendations to the Department of Corrective Services or Justice Health.

Identity

The person who died was AB.

Place of death

AB died at Lithgow Correctional Centre.

Date of death

AB died on 22 July 2017.

Cause of death

The cause of death was hanging.

Manner of Death

AB suicided whilst serving a custodial sentence.

20. 228552 of 2017.

Inquest into the death of Danukul MOKMOOL. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 5th August 2019.

This is an inquest into the death of a 30 year old man, Danukul Mokmool, who was shot dead by police on the concourse of Central Railway Station at Eddy Avenue in Sydney on 26 July 2017.

As Mr Mokmool died as a result of a police operation, an inquest is mandatory and is required to be held before a senior coroner pursuant to sections 23 and 27 of the *Coroners Act 2009*. An examination of Mr Mokmool's death involves an investigation and scrutiny of the circumstances which led to the incident, the role of the police officers, their resort to lethal force and whether such use complies with the NSW Police Force's standards, policies and rules.

The purpose of an inquest is to determine the date, place, manner and cause of a person's death, and I have a statutory obligation to record those matters. In looking at manner and cause of death, a coroner may examine not only the physical and immediate cause but also the factors that may have caused or contributed to the circumstances of the death.

A secondary, but equally important function of the coroner is governed by section 82 of the Act, which empowers a coroner to make any recommendations that are considered "necessary or desirable" in relation to the death, including on matters of public safety.

The ultimate purpose of an inquest is to answer two questions:

How and why did these people died; and is there anything that can reasonably be done to prevent someone else from dying in a similar manner in the future?

An inquest is not designed to apportion blame. Unlike civil or criminal law, it is an inquisitorial process. The aim is to obtain a frank and full account of what happened in the lead up to Mr Mokmool's death, and to determine whether there are lessons to be learnt so that lives can be saved in the future.

Knowing that, witnesses are encouraged to be as honest, self-reflective and open as they can be.

Personal Background

Mr Mokmool was born on 13 July 1987 in Thailand. Shortly after his birth his parents separated. In 1988, his mother Supaporn Chomphoo immigrated to Australia whilst Mr Mokmool remained in Thailand in the care of grandmother and aunt. In 1993, when Mr Mokmool was 6 years of age, he came to Australia to live with his mother and her husband, Ly Minh Huynh, in Cabramatta. When he was 12 years of age, his brother, Charlie Huynh, was born.

In 2003, Mr Mokmool's school counsellor referred him to Liverpool and Fairfield Mental Health Service for psychiatric assessment and counselling due to difficulties managing his anger. Mr Mokmool left school when he was 15 years old, after which he had a number of ongoing problems including difficulties with mental health, maintaining employment, using illegal drugs. In 2006, at age 18, Mr Mokmool was imprisoned for five years. By 2017, Mr Mokmool was on a methadone programme and apparently abstaining from illegal drugs, however he suffered from social isolation and ongoing unresolved mental health problems, in particular psychosis manifesting as paranoid delusions and anxiety.

At the time of his death Mr Mokmool lived with his family in Heckenberg. He lived there with his mother, his stepfather, Ly Minh Huynh, his brother Charlie and his aunt, Siraphat Chomphoo. There is evidence from Mr Mokmool's family that Mr Mokmool had a longstanding history of having paranoid beliefs that his family members were going to kill him. He sought the assistance of mental health professionals to address these beliefs and, at times, sought protection from the police. He last worked in about March 2017. He was employed in a relative's business, but left due to his beliefs that he was going to be harmed. On 17 July 2017, Mr Mokmool commenced a technology course at Granville TAFE. He was interested in videos and recording music and had set up a studio in his bedroom.

Brief Description of the Events of 26 July 2017

On the afternoon of 26 July 2017, Mr Mokmool and Charlie were at home. Their mother had left for Thailand a couple of days before to visit her ailing father. Charlie saw Mr Mokmool taking out the garbage and went to assist him by moving a small iron bar, which had been sitting on the lid of one of the bins.

Charlie placed the bar on a stack of tiles beside the bins. While Mr Mokmool and Charlie were moving the rubbish bins to the kerb, Mr Mokmool said *"Why do you want to kill me?"* Charlie denied that he wanted to kill him. After moving the bins Mr Mokmool and Charlie were sitting on a step having a cigarette and Mr Mokmool said *"Just hit me".* Charlie tried to reassure his brother that he loved him and didn't want to hurt him. A short time later, Charlie went out to meet friends.

Mr Mokmool also left the house. At 3.34pm Mr Mokmool telephoned emergency services saying that he was in fear of his life. He said that he was going into the city, as he suspected that his family wanted him dead. He told the operator that he was on public transport and when he was asked by the operator where she could send the police, Mr Mokmool replied that he would get an address and make contact. He then ended the call.

The operator called him straight back and asked him if he was currently in danger. Mr Mokmool replied *"I don't know. I ran away from them. They had a metal iron bar and plastic bags ready to chop me up and kill me".* He told her this happened at his home address (which he gave) and that he had left there "*about 20 minutes ago".* He again hung up. The operator tried to call Mr Mokmool back, but he did not answer the phone. Mr Mokmool travelled to Liverpool Railway Station by bus and then caught the train to Central.

At 6.22pm Mr Mokmool sent his mother, who was overseas, an SMS saying "IM POSSIBLE". At about 6.25pm two police officers, Senior Constables Arthurson and Hancock, proceeded to Mr Mokmool's address in Heckenberg to follow up the earlier telephone exchanges between Mr Mokmool and the emergency operator. At about 6.30pm Senior Constable Arthurson telephoned Mr Mokmool and asked him if everything was okay. Mr Mokmool said *"I just had a problem with my family and I left. It's nothing".* He told Senior Constable Arthurson that he was not at home and then started to giggle. Senior Constable Arthurson asked him if he would like him to visit his family and Mr Mokmool replied *"No that will make things worse, I'm not going back there anyway"*. He then started to laugh and hung up. Due to Mr Mokmool's demeanour and laughter, Senior Constable Arthurson did not consider Mr Mokmool's concern to be genuine and so did not call him back or enter the family home. Phone records for Mr Mokmool suggest that this call took place at 6:31pm and lasted 59 seconds.

Mr Mokmool is captured on CCTV disembarking the train at Central Station at 6:29pm, proceeding through the ticket barriers at 6:30pm and entering the Eddy Avenue concourse at 6:31pm. He appears to speaking on his phone (likely to Senior Constable Arthurson) while lingering on the eastern side of the concourse, north of the Eddy Avenue Florist ("the florist shop"). The Eddy Avenue concourse is a brick-paved outdoor pedestrian area on the ground level at the northern entrance to Central Railway Station. To the north, the concourse abuts Eddy Avenue, a busy road thoroughfare between Elizabeth Street and Pitt Street. The florist shop is situated on the south eastern side, abutting the train station. There is an open paved area in front of the florist shop. The remainder of the concourse is divided by a waist height wall running perpendicular Eddy Avenue.

CCTV captures Mr Mokmool first approaching the florist shop at about 6:35pm. Mr Mokmool is out of view of the CCTV cameras for a short period before being seen outside the florist shop again at 6.37pm. A few minutes later, Mr Mokmool entered the florist shop.

Mr Emmanuel Theoharis, who was 73 years old at the time, owns the florist shop and has worked there seven days a week for over 40 years. Mr Mokmool was observed to enter the florist shop and then walk out. He re-entered the shop and approached Mr Theoharis from behind. He held Mr Theoharis in a headlock with his left hand and held a piece of broken glass hard against the right side of Mr Theoharis' neck with his right hand. Mr Mokmool yelled out, *"Call the police".* Bystanders came to Mr Theoharis' aid and he made good his escape from Mr Mokmool's grip. Mr Mokmool remained in the florist shop smashing vases and pots, and throwing flowers. He continued to call out for the police to be called. He armed himself with scissors and began cutting himself.

Four police officers from the Police Transport Command arrived. Two plainclothes officers who worked within the Transport Action Group ("TAG") took up positions at the southern entrance of the shop and drew their firearms. Two uniformed police officers covered the northern entrance. The officers commanded Mr Mokmool to drop the scissors. He refused to do so, screaming out "*shoot me, shoot me in the head*". One of the uniformed officers attempted to use a non-lethal means to subdue Mr Mokmool, spraying OC defensive spray through the northern entrance to the florist shop toward Mr Mokmool. Mr Mokmool then ran out the southern entrance of the florist shop towards one of the plainclothes officers, at which point he was shot.

The Issues of the Inquest

The issues of the inquest were as follows:

(i) Was Mr Mokmool suffering from a mental illness or mental health condition immediately prior to his death? If so,

a. What was the mental illness or mental health condition from which he was suffering?

b. For how long had he been suffering from the mental illness or mental health condition?

c. Had the mental illness or mental health condition been the subject of a diagnosis from a qualified mental health practitioner?

d. Was Mr Mokmool receiving adequate treatment for the mental illness or mental health condition in the period leading up to his death?

(ii) Were there alternatives to lethal force available to the officers who discharged their firearms on 26 July 2017?

(iii) With the benefit of hindsight and reflection, could any steps have been taken by the police officers on 26 July 2017 that may have led to a different and better outcome for Mr Mokmool?

(iv) Whether and to what extent to date the NSW Police Force responded to and engaged with the recommendations made in the 2018 inquests into the deaths of *Stephen Hodge* and *Courtney Topic*.

(v) Whether there are any recommendations in relation to questions of public health and safety arising from the evidence and findings at the inquest.

The Brief of Evidence

Consistent with NSW Police Force policies, Mr Mokmool's death was a declared a Level 1 Critical Incident. Accordingly, the investigation was headed by a senior officer of the Homicide Squad, State Crime Command. That officer was Detective Chief Inspector David Laidlaw. He was assisted by Detective Sergeant Mitchell Bosworth.

As part of the coronial investigation, the directly involved officers participated in directed interviews, which were electronically recorded. Statements were obtained from numerous civilian eyewitnesses, some of whom had recorded parts of the incident on their mobile telephones.
Some of that footage, as well as CCTV footage from Sydney Trains was obtained by investigators. Transcripts of telephone calls to emergency services and police radio messages have also been obtained. These give an accurate picture of the unfolding of events. Statements were also obtained from Mr Mokmool's family members, setting out the history of Mr Mokmool's mental health.

Evidence and expert reports were obtained regarding the police officers' training and use of weapons, Mr Mokmool's psychiatric history and likely diagnosis, and his use of methadone and other drugs. Crime scene evidence and reports were also prepared, including a computer generated animated re-enactment showing positions and distances. The re-enactment was created from some of the mobile phone footage and CCTV.

Issue was not taken at the inquest that Mr Mokmool was armed with a pair of scissors in each hand when he ran at the police and was shot. The two pairs of scissors were not seized as exhibits, though they were present at the crime scene. By the time crime scene officers attended the scene, the scissors were on the ground near the first aid equipment. They were mistakenly believed to be contaminated medical waste and were disposed of as such. Exhibit 5 is a crime scene photograph of the two pairs of scissors said to have been in the hands of Mr Mokmool at the time he was shot.

Witnesses called at the Inquest

Detective Chief Inspector Laidlaw and the directly involved police officers - Senior Constable Frederick Tse, Senior Constable Jakob Harrison, Constable Trent Taylor and Senior Constable Leith Maranda - gave evidence in the inquest. Sergeant Justin Waters, a NSW Police Force weapons and tactics expert, and Chief Inspector Matthew Hanlon, the Manager of the NSW Police Force's Mental Health Intervention Team ("MHIT"), also gave evidence. Chief Inspector Hanlon's evidence focused on the role of the MHIT and the training it provides to officers to assess and manage offenders and others presenting with mental health issues.

Dr Peter Daniels, who reviewed Mr Mokmool at Liverpool Hospital in December 2016, gave evidence regarding Mr Mokmool's presentation to the Emergency Department on that date with anxiety and paranoia. Dr Kerri Eagle, an expert forensic psychiatrist, gave evidence that, in her opinion, at the time of the fatal incident Mr Mokmool was likely psychotic and had suffered psychosis over a long period of time. Evidence was also given by Mr John Farrar, a forensic pharmacologist, regarding the effect of the methadone taken by Mr Mokmool.

Mr Mokmool's mother and brother each gave a family statement, which though is not formally evidence in these proceedings was gratefully received. Their remarks showed how loved Mr Mokmool was, and demonstrated that he was known as a gentle and loving son and brother.

Summary of Eyewitness Statements

The events inside the florist shop were not captured on CCTV. Detailed statements were obtained from eyewitnesses and the form part of the brief of evidence (Exhibit 1). A summary of their statements is set out below. None of the civilian witnesses were called to give evidence at the inquest.

Mr Theoharis was alone in the shop standing at the southern entrance at about 6.40pm on Thursday 26 July 2017, a busy time for him as commuters buy flowers on their way home or out for the night. The two entrances of the florist shop are each about three metres wide. They open directly onto the concourse and are covered by roller doors when closed. Both doors were open and flowers were on display. The northern entrance is set back about a metre from the southern entrance. The southern entrance, which abuts the entrance to the station, is set back about a metre from edge of the station's arch. The florist shop has a floor space about three metres deep, with fridges at the back and flower displays along the side and back walls.\

Mr Theoharis said he felt someone reach around his neck and grab him from behind. He looked back and saw Mr Mokmool holding a smashed, clear glass bottle to his neck. As Mr Mokmool pushed the bottle into Mr Theoharis' neck, he felt it cut him. Mr Mokmool yelled *"Call the police".* Mr Theoharis used his right hand to push the bottle up and moved out of the "harness" grip Mr Mokmool had him in. Mr Theoharis suffered a two cm long superficial laceration on his neck and a cut to his thumb.

Ms Eliza Barnes was standing about seven metres from the northern entrance of the Central Station. She noticed Mr Mokmool because she thought he was "hovering around the area where she was standing". She saw him approach the northern entrance to the florist shop and she took a photograph of the lower half of his body. The photograph was recorded as taken at 6.48pm (but that time appears to be incorrect). Ms Barnes says Mr Mokmool went into the shop, walked around, came back out and said "*hi*" to her. A couple of minutes later, she saw him re-enter the shop and it looked like Mr Mokmool was hugging Mr Theoharis. She saw a man and a woman (Mr Clarke and Ms Smith) who were walking towards the station, stop and look. Ms Barnes then saw Mr Theoharis slip out of Mr Mokmool's arms and move out of the shop. She heard Mr Theoharis yell to Mr Mokmool, "*Get out*" and Mr Mokmool also yell something.

Ms Barnes moved towards the arches near the escalators. She saw Mr Mokmool reach behind him and grab what she thought looked like a knife. She wasn't sure whether it came from the store or his back pocket. As Mr Mokmool was yelling and screaming, another male (Mr Gardner) approached the store. Mr Mokmool started to yell more and she heard someone say that Mr Mokmool was stabbing himself. As Ms Barnes moved further away, she saw Mr Mokmool smashing vases and heard Mr Theoharis yelling for security.

Ms Jing Yu was walking up the concourse to enter the train station. As she neared the entrance she heard a male voice yell out, *"Call the police".* She turned and saw Mr Mokmool holding Mr Theoharis in what she described as a headlock and saw that he was holding something to Mr Theoharis' neck with his left hand. Mr Mokmool was loudly and repeatedly yelling out *"Call the police, call the police".* She saw Mr Theoharis slip out of Mr Mokmool's grip and walk away from the shop with a man in a trench coat (Mr Clarke). Mr Mokmool stayed in the florist shop and kept yelling out for the police to be called. Ms Yu continued to her train.

Mr Harrison Clarke was walking past the florist shop with his girlfriend, Lauren Smith, when they heard Mr Mokmool call out loudly, *"Call the police".*

They saw Mr Mokmool holding glass to Mr Theoharis' neck. Mr Clarke described the glass as being a broken part of a beer bottle, about 4 or 5 inches long. Mr Clarke called emergency services and remained at the scene and on the phone for the duration of the incident.

Mr Clarke tried to grab Mr Mokmool's hand holding the glass. As he did this, Mr Mokmool drew his hand back and released Mr Theoharis. Mr Clarke then saw Mr Mokmool standing with his sleeves rolled up and his arms down by his sides. He had both hands clenched and there was blood on the front of his hoodie jumper around the stomach area. Mr Harrison could not then see where the broken glass was. Mr Mokmool retreated inside the shop and Mr Clarke noticed blood around the middle of the floor. Mr Mokmool took a wallet out from the front of his pants and threw it out of the shop onto the ground saying, *"I'm sorry for this".* Mr Mokmool then started "trashing the florist", pulling vases and pushing flowers onto the floor.

Mr Clarke saw three police officers arrive. At this time, Mr Clarke noticed that Mr Mokmool had a pair of scissors in each hand. He described the scissors as having plastic handles and four inch blades. Mr Clarke heard the police call out for Mr Mokmool to stop and get down. He heard Mr Mokmool call out "*shoot me, shoot me right in the head*". He saw Mr Mokmool take two steps forward and then "charge" at the police. At the time Mr Mokmool ran towards the police, Mr Clarke saw that he had a pair of scissors in his right hand, but couldn't remember if he still had a pair in his left hand. Mr Clarke heard three gunshots and saw Mr Mokmool fall to the ground.

Ms Smith said that when Mr Mokmool had his arm around Mr Theoharis he was yelling out, *"Call the cops. I'm dying"*. He repeated *"Call the cops"* quite a few times. She saw the broken glass in his hand and saw the broken bottle on the counter inside the shop. After Mr Mokmool released Mr Theoharis and went back into the shop, Ms Smith observed him pacing back and forth around the rear of the shop.

At one point Mr Mokmool walked forwards asking *"Is he okay?"* He then walked back to the rear of the shop. Ms Smith saw Mr Mokmool take out an iPhone from the front of his pants and he seemed to be using it for a couple of seconds. At this time she saw that he had cuts to his left wrist and left forearm which looked old and dried out.

Ms Smith saw Mr Mokmool pick up two pairs of scissors from the counter of the florist shop. She said the scissors had blue handles, silver blades and were quite long. They looked like standard florist's scissors. Mr Mokmool began banging the scissors against the counter and becoming violent, kicking down pots and throwing flowers onto the floor. She said he was doing this for about three minutes and then the police arrived. Ms Smith heard the police yelling "*Get down on the ground*".

She saw Mr Mokmool move towards the police, and the police step back. This happened twice. Ms Smith saw Mr Mokmool "lunge" towards the police for a third time and then heard three gunshots.

Mr Yi Yang Yin and Ms Seung Jin Lee were standing about six metres from the florist shop when they saw Mr Mokmool with his arm around Mr Theoharis. Mr Yin walked over to them and yelled to Mr Mokmool *"What the fuck do you want?"* Mr Mokmool removed his arm from around Mr Theoharis' neck and said *"I just want to die".* Mr Yin described Mr Mokmool as saying this in a peaceful way and thought he sounded a bit depressed. Mr Yin noticed Mr Mokmool had a pair of scissors in his hand, and so Mr Yin moved back and used his phone to call "triple 0".

Mr Yin saw Mr Mokmool cut the side of his cheek with scissors, which caused a red scar. He saw Mr Mokmool kicking the flowers and heard glass breaking in the store. Mr Yin said that four police arrived, two uniformed and two in plainclothes, and took up positions with their guns drawn. Mr Yin remained on the phone to emergency services and heard police yell words to the effect, "*Put your weapon down*". Mr Yin saw Mr Mokmool run towards the police and heard three to four gunshots.

Ms Lee saw Mr Yin run to a position near the florist shop and *say "What the fuck are you doing?"* She saw Mr Theoharis outside the shop. She noticed that he had a cut to his neck and three girls were helping him. She saw Mr Mokmool with a pair of scissors in his left arm, he was smiling and he had some blood on his left cheek. Ms Lee saw Mr Mokmool grab another pair of scissors, which she described as looking "like they came from the florist because they were short and really sharp". She saw Mr Mokmool walking around, smiling and rubbing the scissors on his arms.

Ms Lee said that Mr Mokmool started to destroy everything in the shop, kicking things and knocking things over. She noticed he was smiling, but not saying anything. She saw Mr Theoharis try and re-enter his shop, but someone pulled him away. Mr Mokmool was still smiling and holding the scissors. Ms Lee saw Mr Mokmool pull a wallet out of his back pocket and throw it at Mr Theoharis. The wallet landed on the ground and a member of the public gave it to Mr Theoharis.

Ms Lee saw three police officers arrive and scream *"Put it down".* She told police, "The male had scissors in both hands still and began to walk towards the exit of the florist shop towards police. The male got out of the florist shop. I heard one of the officer say *"stop"* about one second later I heard I think four or five shots".

Mr Dale Hart, a train driver, was upstairs looking down at the concourse. He saw Mr Mokmool knocking over flowers and vases, and saw that Mr Mokmool had a pair of scissors in each hand. He told police, "They were decent sized scissors because I could see them clearly from where I was. I just saw the silver blade parts of them. He held them in his hands like you would a dagger. His fists were clenched and he held them in an overarm fashion above his shoulders". Mr Hart called emergency services and saw the police arrive. He saw a uniformed police officer use OC spray and he saw one uniformed officer and two plainclothes officers pointing their firearms at Mr Mokmool saying, *"Get on the ground"* and *"Drop it".*

Mr Hart heard Mr Mokmool scream, *"Fucken shoot me"*. At that time, Mr Mokmool had both hands in fists raised above his shoulders in an overarm action. He had a pair of scissors in his right hand. Mr Hart couldn't see scissors in his left hand. He saw Mr Mokmool run at the police, at which time he was shot.

A transcript of the "triple 0" call made by Mr Hart records that he told the operator the following: *"He was in the shop armed with scissors … Two pairs of scissors. He kicked up and chased the actual florist out of the shop … he started kicking up the shop. I've seen the officers then run down. He sort of taunted, I guess you would say, the officers...And yelled at them "Go on shoot me shoot me" and then he came running out at one and they shot him".*

Ms Esmerelda Paric was walking up the concourse to the station and saw Mr Theoharis outside his shop with his hand to his neck. Mr Theoharis said *"he cut me".* Ms Paric looked in the shop and saw Mr Mokmool. She told police "his hands were bloody … he was holding a pair of scissors by the blades. I can't be certain which hand, but I think he was holding them in his right hand.
He looked very confused and agitated as well". She saw the police arrive and she heard them say, *"Put it down*" about three times, after which Mr Mokmool was shot.

Ms Tanisha Duckford was standing opposite the northern entrance of the florist shop and heard a smash. She looked up from her phone and saw Mr Mokmool smashing pots inside the shop. She heard Mr Mokmool yell *"If anyone comes into the shop, I'm going to kill them"* and *"I'm going to kill everyone outside".* She saw Mr Mokmool at the southern entrance to the florist shop holding what she described as a small kitchen knife. She told police, "The knife looked really brand new and sharp".

She saw the police arrive and the two plainclothes officers draw their guns. She heard one of the plainclothes officers say, *"Drop it"* or something similar. From the corner of her eye she saw Mr Mokmool run at the police officer but she couldn't say what he was carrying at the time. Ms Duckford used her phone to take photographs of the incident.

Ms Ngoc Huang Lai gave a statement to police on 31 October 2017. She saw the police pointing a firearm at Mr Mokmool, who was inside the shop and had his arms out at shoulder height to each side of his body. She told police, "When I looked at the situation it seemed like the guy in the shop was harmless, because he doesn't carry any weapon and there are plenty of police man (sic) there, so I didn't think anything was going to happen. I stood there for about two minutes and then I turned around and started to walk back inside the Eddy Avenue entrance to the station. I had only taken a step or two and then heard four gunshots".

Ms Mengyu Wang was with her boyfriend, Mr Qingzhou Wang, walking on the concourse towards the train station. They both made statements at the end of August 2017. They saw Mr Mokmool smashing vases inside the florist shop. Ms Wang told police that she saw Mr Mokmool "grab something sharp in his left hand. I'm not sure what it was but the light above him reflected on it". They saw the police arrive. Ms Wang heard the plainclothes police ask Mr Mokmool to drop what was in his hand and walk out, but he refused. She saw one of the two uniformed police officers use his OC spray on Mr Mokmool. She told police that Mr Mokmool, "suddenly rushed out of the store and ran towards the plain clothed police officer standing directly in front of the store". She described seeing the plain clothes police officers shoot at Mr Mokmool four times. Ms Wang filmed some of the incident. Her recording was 10 seconds long and was tendered into evidence (Ex3, Tab 29 (MOAY3375)).

Mr Wang saw three police with guns pointed at Mr Mokmool. He saw another officer spray liquid at him. Mr Wang told police that, "about 10-20 seconds later the man ran out of the shop, he was dashing out of the entrance towards the outside ... about halfway through running out, he put I think his left arm up to cover his face". Mr Wang does not say he saw Mr Mokmool holding anything, but said that he heard the police say, *"Drop it off"* at least three or four times. He heard Mr Mokmool say words to the effect of, *"Back off, I don't want to hurt you".* Ms Cheryl Treharne also made a statement at the end of August 2017. She saw Mr Mokmool in the florist shop and noticed he appeared angry about something. She told police, "He went over to a bench in the middle of the store and was playing around with something.

It looked like he was using his mobile phone on the bench but I didn't actually see a phone. I saw he had something shiny and metallic in one of his hands which I thought was a knife." She described his movements as being very erratic and observed he was highly agitated. She said, "He looked as though he was going to walk out of the store but he just came to the front and kicked over some vases and flowers. When he walked back into the store I thought that I could now see a metallic object (which I thought were knives) in each hand".

Ms Treharne saw a plainclothes police officer arrive and hold something out in front of him (which she thought was a Taser), pointed towards the shop. She also saw two uniformed police arrive. She heard Mr Mokmool say, *"No I'm going to kill you"*. He then ran out of the store towards the police officer. She wasn't sure if he had anything in his hands at this stage. She then heard two loud bangs but was not looking at the scene when she heard this.

Ms Phoebe Gleeson was travelling down the escalators to the concourse level when she heard something smash and saw a man in the florist shop knocking over all the plants. Ms Gleeson thought he was mentally unwell or on drugs. She said, "I saw he had something in his hands. I thought it was a knife. It looked like a small size like a kitchen sharp knife. I saw the man hold the weapon out in front of him in one hand with the blade pointed outwards."

Ms Gleeson saw two police officers running up to where the florist was (a plainclothes officer and a uniformed officer) and heard them say something like, *"Put down the weapon".* Ms Gleeson thought that the police were trying to negotiate with Mr Mokmool for about a minute. She said, "The man was replying to the police, I think he was responding to the police but he wasn't yelling." She said that the uniformed policeman had his gun out and the plainclothes policeman was about two metres from the Mr Mokmool. Ms Gleeson turned away when Mr Mokmool didn't put down the knife and she heard four gunshots.

Mr Peter Gardner was walking up the concourse towards the station. He heard and saw Mr Mokmool smashing pots, but he says that apart from that Mr Mokmool seemed quite calm. He said, "He wasn't raving on and yelling anything out". Mr Gardner said something to Mr Mokmool to the effect that he needed to calm down, but Mr Mokmool just looked at him and grabbed another two or three pots and smashed them on the ground. Mr Gardner didn't see any weapons in Mr Mokmool's hands at that time. He moved into the station and saw the police arrive.

He heard them yelling, *"Put it down put it down. Put the weapon down and come out with your hands up"*. He then heard loud bangs.

Mr Vikram Singh, who is a duty manager for Sydney Trains at Central Railway Station, saw the plainclothes police with their guns drawn and a uniformed officer with his gun drawn. He heard the police repeatedly shouting, *"Put it down"* and *"Drop it"* and words to that effect. He said he heard the word 'Taser' and then immediately saw Mr Mokmool run out of the shop towards the police officers, who were about four to five metres from the front of the shop. He heard four loud bangs and saw Mr Mokmool on the ground. He said "On the ground next to the man I could see two pairs of scissor (sic), one pair had a purple colour handle and the other pair had pink coloured handles."

Mr Singh saw two Sydney Trains first aid officers arrive. He ran back to his office to get the defibrillator machine and handed it to the first aid officers. At that time Mr Theoharis gave him Mr Mokmool's wallet, which Mr Singh took and placed it on the floor next to the first aid kits near where the police officers were performing first aid. He told the police that the florist had given the wallet to him and that it may belong to Mr Mokmool. He then left to assist others elsewhere.

Mr Peter Cairns was working with Mr Singh and went to the scene with him. He too saw three police officers with their guns drawn. He heard them saying, *"Put it down. Put it down".* He saw Mr Mokmool run out of the shop straight ahead towards the three police officers with their guns drawn and heard four loud bangs. He saw the first aid officers arrive and he then went to obtain privacy screens.

Mr Said Abouloukme, another duty manager for Sydney Trains, had finished his shift and was on his way out when he was approached by Mr Theoharis complaining about Mr Mokmool hitting him with glass and "going mad" in his shop. Mr Abouloukme used his phone to call for assistance. He saw the police and two had their firearms raised and pointing at Mr Mokmool. He told police that Mr Mokmool "walked out of the shop towards the police, he was holding a pair of green handled scissors clenched in his hand". He said he was standing about nine to ten metres away from the police and Mr Mokmool was three to four metres in front of them, maybe less. Mr Abouloukme heard the police officers yelling at Mr Mokmool, but couldn't hear what was being said. Seconds later he heard 4-5 shots being fired and looked over and saw Mr Mokmool on the ground. Mr Abouloukme then returned to his office.

Mr Anthony Ungaro, a customer service assistant for Sydney Trains, was standing with Mr Abouloukme and on the telephone when Mr Theoharis approached them. Mr Theoharis asked Mr Abouloukme to call security. He saw Mr Mokmool fiddling with a pair of scissors in his right hand. He was moving his hands around and appeared to be "a bit aggro". Mr Ungaro said "I saw the handles of the scissors were coloured, I think they were light blue and the blades of the scissors were normal length … I don't know how long the blades were. I saw that he had something else in his left hand but I don't know what it was". He said that Mr Mokmool "was very aggressive; he was smashing things and throwing flowers around. He was pacing around the shop, so I could not always see him, but I could hear things banging around".

When the police arrived, Mr Ungaro heard an officer say *"Drop the weapon".* Mr Ungaro said that things happened quickly after this. He heard Mr Mokmool say, *"You're not going to take me. I'm not dropping the weapon"* at which point Mr Mokmool "lunged out of the shop entrance towards the police officers. The man ran with a good pace, he was leaning forward and looked like he was going to take the police on. I saw that the police offers were holding their black guns with both their hands in front of them. I heard about three loud bangs". Mr Ungaro saw Mr Mokmool fall to the ground and went to get some barricades.

Ms Natali Dunoska, who had been in the Sydney Trains office with Mr Cairns and Mr Singh, took up a position on the mezzanine floor balcony looking down over the florist shop. She said she could smell capsicum spray in the air, as though it had just been sprayed. She saw Mr Mokmool standing at the counter closest to the southern entrance of the florist shop. He was saying something but she could not hear what he was saying. He was holding a pair of scissors in his left hand, which she said looked like florist scissors. He was holding them in his fist by the handles, the blades of the scissors were together, and he was holding the blades away from his body. She was unable to say how long the blades were. She said Mr Mokmool was aggressive and was kicking the flowers over and pacing from side to side.

Ms Dunoska described three uniformed police officers and an undercover police officer arriving at the scene. The officers were three to four metres away from the entrance to the shop. She said that all three uniformed officers had their firearms in their hands, pointed towards Mr Mokmool. Ms Dunoska heard one of the police officers say something like *"Put down the weapon"*. She saw the taller police officer on the left move closer to the entrance to the florist shop let off some capsicum spray.

She said he did this from the second entry on the left, the opposite side where Mr Mokmool was standing. Ms Dunoska described the events as happening "really fast". She heard, *"Put down your weapon"* about four to five times and thought that all the police officers had a turn saying it. She said, "At no time did the male seem to actually try to put the weapon down. It just seemed like he was going to do what he was going to do, by this I mean from the way he was holding the scissors that he was going to stab someone or himself." Ms Dunoska saw Mr Mokmool move towards the police, holding the weapon in his left hand up about shoulder height. She saw that the blades were pointing towards the police officers. Ms Dunoska said that Mr Mokmool had just started to run towards the police officers when she heard four shots be fired.

Ms Dunoska said that after Mr Mokmool dropped to the ground the police immediately moved towards him and applied first aid. Ms Dunoska estimated that from the time she started watching until the time Mr Mokmool fell to the ground about 60 seconds had elapsed.

Scissors utilised by Mr Mokmool

As can be seen from the above accounts, some witnesses speak of two pairs of scissors, and others speak of one pair. The mobile footage recorded by Ms Wang does not clearly show what Mr Mokmool was holding when he ran towards the police. However, the two items in Mr Mokmool's hands evident in Sydney Trains CCTV camera 2 (at 6:44:42pm), when viewed with the crime scene photographs in Exhibit 5, clearly establish that Mr Mokmool did have a pair of his scissors in each hand.

Mr Theoharis claims that he saw Mr Mokmool take and hold two pairs of scissors in his hands and then put two pairs of scissors in his pants. In his statement, Mr Theoharis said "I saw the male had armed himself with scissors, he was holding a green pair and another colour pair in his hands. He also had another two pairs shoved down into the front of his trousers. I recognise these scissors as they are from my shop. They were inside the cup holder on the bench. The only thing the male was yelling out was, *'Call the police'* he remained in the store yelling this out. I was worried he was going to run out of my shop and start hurting people walking past. A short time later police arrived".

Five days after the incident, on 1 August 2017, Detective Senior Constable Sharon Neil attended Mr Theoharis' shop and conducted what is called a "video walk-through" where she asked Mr Theoharis a number of questions about the events of 26 July 2017. The entirety of the conversation was recorded on video (Ex1, Tab 18).

Mr Theoharis described how Mr Mokmool pulled everything down and was kicking vases at the southern end of the shop, and then went to the northern end of the shop and pulled all the empty vases off the shelves onto the floor, causing them to break. He said Mr Mokmool then came back to the southern side of the counter, which is in the middle of the shop. Mr Theoharis said Mr Mokmool was kicking the vases and then he grabbed the scissors. Mr Theoharis indicated at a container like a cup which contained numerous scissors sitting on the counter. He said *"I saw him take the scissors from here* (he lifts out two pairs of scissors from the container) *and then he was holding like this* (he holds one pair in each hand by the handles, with the blades pointing forward - hands in front of his stomach). *And then the police told him, I heard that, to drop them."*

Detective Senior Constable Neil asked him, "*How many pairs of scissors do you think?*" Mr Theoharis replied, *"Two. Two he had in his hands, but from there,* (pointing and referring to outside the shop from where Mr Theoharis was standing for his viewpoint on 26 July 2017) *I saw him putting another two pairs here* (indicating his waist of pants). Detective Neil asked him "*You saw him put two in his pants?*" and he replied *"Yeah".* She asked him "*So, potentially four pairs of scissors?*" to which he nodded and replied *"Yep".* He was asked, "*Then what did you see*" and he replied *"I heard the police telling him to drop them...but he didn't drop them, he went towards them with the scissors and that is why they shoot him. I believe".*

A week later, on 7 August 2017, Mr Theoharis was shown four photographs (Exhibit 5), one of which depicted the discarded scissors with blue and green handles. He identified them as belonging to him. He said *"I believe that these are the two pairs of scissors that the Asian male was holding in his hands before he was shot by police"*. Another photograph shows a pair of broken brown scissors which were also his and on the counter inside the shop.

Mr Theoharis must be mistaken about Mr Mokmool having put two pairs of scissors down his pants, as no scissors were found on Mr Mokmool.

What happened to the Scissors – Photographs in Exhibit 5

Graham Donohue and Alex Verbinyecz, Occupational First Aiders with Sydney Trains, attended Mr Mokmool at the scene. They brought two first aid bags and applied gauze to Mr Mokmool's wounds.

David Hommerson, one of the NSW Ambulance officers who attended the scene, said in his statement that upon seeing Mr Mokmool, "I immediately cut open his shirt to see his chest…I also cut open the left side of his pants…" He placed ECG stickers and leads, but Mr Mokmool had passed away. Mr Donohue told police, "I saw two pairs of scissors lying on the ground, they both had greeny coloured handles, and they were lying side by side about 2 or 3 feet away from the male's upper body. I saw blood on one of the handles of the pair of scissors, I may have nudged one pair of them out of the way at some stage towards the end, and they would have moved less than a foot".

Senior Constable Claire Power of NSW Police Force Forensic Services Group attended the scene at 8.40pm and, amongst other tasks, took photographs. She records that 2.5 metres from the head of Mr Mokmool she saw *"two pairs of scissors, one with a blue handle and the other with a green handle. Both pairs of scissors appeared to have blood stains on the handles".* She also saw a *"wallet containing $30 cash and cards in the name of Danukul Mokmool" and "three bags containing medical supplies and other medical paraphernalia"*.

Robert Petrou, a duty manager at Sydney Trains, said that the police handed the crime scene back at about 2.50am on 27 July 2017. He said "I saw three bags on the ground. I recognised that the red bags belonged to the station as used by the first aid officers.

I also (sic) a blue bag that had Police written on the side. I also sighted two pairs of scissors with green handles and a clear plastic air pump about 10 cm in width with dried blood on the floor as well as dried blood in the same area. The scissors were about 2 metres outside of the florist on the floor near the pump. I noticed that the scissors had blood on them. When the crime scene was released I collected the two red first aid bags and the defibrillator and returned them to the duty manager's office. I arranged for the blue first aid bag to be given to a Police inspector. The Police inspector stated that the scissors and pump were the train station's property.

Due to the dried blood on the scissors and fear of cross-contamination I advised Nathan Hesson, the incident rail commander, to throw them out and I will supply new items for the first aid bags. I saw Nathan pick up the scissors and other rubbish and he placed it into a plastic bag".

Mr Hesson said that he and his staff collected two pairs of grey two toned plastic handled scissors that he assumed were part of the first aid kits used by the first aid staff employed by Sydney trains. The scissors were discarded as they were blood stained. He confirmed that they were in the location depicted in the crime scene photographs.

Triple 0 calls, Computer Aided Dispatches and VKG Police Radio Messages

The brief of evidence contains transcripts and data relating to four emergency or "triple 0" calls made during the incident. The callers were Naveen Kariyawasam, Harrison Clarke, Yi Yang Yin and Dale Hart respectively.

The transcript records that Mr Kariyawasam called at 6:41pm and said, *"Hey there is a guy with a knife, ah Central Station. He's got the owner of the shop, Emmanuel the flower man. He's got him by the throat with a knife".* The operator asked if he was injured and Mr Kariyawasam replied, *"No. No I think he may have released him. I just walked away because I didn't want the guy to see me using my phone".* The operator told him that the message would be passed on to the police and asked where at Central Station this was occurring, however Mr Kariyawasam had ended the call by that stage.

Mr Clarke called at 6:42pm and said *"Hi there's been a knife attack or a bladed attack at Eddy Avenue florist just outside Central Station near the buses".* After confirming the location the operator asked, *"And so the florist is being held up with a knife is that right?"*

Mr Clarke replied, *"Yeah there was just a scuffle with some broken glass um two men have been cut with a broken bottle"*. The operator again asked, *"So there was someone there with a knife?"* and Mr Clarke replied, *"Ah yeah, sorry not a knife just broken bottle.* The operator said, *"Ok. So were they holding up the florist or is it just a scuffle?"* Mr Clarke replied, *"Um it was a robbery or attempted robbery".* The operator asked, *"It was a robbery?"* and Mr Clarke replied, *"Um Yeah, attempted".* The operator asked, *"How many people?"* Mr Clarke said, *"Ah 2".*

The operator asked, *"And they had broken glass?"* Mr Clarke replied, *"Yep".* Later Mr Clarke tells the operator that the police had arrived. The gunshots can be heard 18 seconds later.

Mr Yin also called at 6:42pm. Mr Yin initially reports an old man being kidnapped in the florist shop. One minute and 10 seconds into that call Mr Yin says *"he [referring to Mr Mokmool] is cutting himself with scissors right now … he said he wants to die"*.

Mr Yin's operator created an ICEMS message, which is a notification to NSW Ambulance, with the same information at 6:42:46pm and wrote "Concern 4 Welfare". At 6:43:32pm Mr Clarke's operator also created an ICEMS requesting an ambulance for "2 injured people from a robbery" and at 6:43:55pm he adds "2 Victims have lacerations".

Mr Hart called at 6:44pm and said "*the police officers are on their way, there's a guy here with scissors*". When the operator asks where it is Mr Hart replied "*Got police officers there now*". 35 seconds into the call it is apparent that there are gunshots.

As a result of the four calls to "triple 0", differing information was received and a running broadcast of information was provided to the police by the respective operators through the Computer Aided Dispatch ("CAD") system, which is distributed to police on their computers, and the police VKG radio operator who simultaneously relays and receives verbal communication with responding police officers.

Below is a table of the relevant entries taken from the CAD and VKG logs. It is to be noted that the CAD police computer information differs from VKG information. The caller is identified by their initials. Broadcasts from VKG radio log are italicised. Broadcasts made by PTC41 are made by Constable Taylor, recorded as "TT" and by "Senior Constable Maranda, recorded as "LM":

18:41:47	(NK)	POI with knife holding to shop-keepers throat
18:41:55	*VKG*	*PC Crews other city cars, central; welfare, ah central railway station report of a male POI with a knife holding to a shop keeper's throat. More information coming through. City car PTC crew*
18:42:15	(HC)	Florist held up by 2 men with broken glass
18:42:15	*PC4*0	*PC40, copy whereabouts is it*

	VKG	*Yeah, I'm trying to get an exact location. There's not enough info. Actually, another job in. Ah, it's the florist*
18:42:25	*(TT)*	***PC41 copy…as well. Be about 2 minutes***
	VKG	*41 copy ta. Car to back up.*
18:42:32	(HC)	Two Male POIs are still at AA and informant can see them
18:42:32	(YY)	Male in florist AA cutting himself on the throat with some scissors
18:42:35	*PC40*	*PC40 copy on foot. 3 minutes. Sounds like Eddy Avenue ramp.*
	VKG	*Ah Eddy Ave, yeah florist Eddy Ave*
18:42:45	*VKG*	*Being um held up by two males with broken glass. POIs are still at the location.*
18:42:47	(NK)	Informant stated victim is Emanuel from flower shop
18:42:55	(HC)	POI described as 1 Asian and 1 Caucasian
18:42:58	(HC)	POI now smashing up the store
18:43:05	*PC40*	*I'm a fair distance away on foot, if there's a car closer*
	VKG	*Copy that. Another job in. It's actually a male in the florist cutting himself …*
18:43:15	*VKG*	*… on the throat with scissors. There's another job, he's smashing up the store. Um so yeah, not sure if it's actually a florist who's being held up …*
18:43:25	*VKG*	*… or if it's the POI who's uh cutting himself. Still available cars to make their way back up, ah, 41 and 40*
	(LM)	***Yeah, PTC41 here now***
18:43:19	(YY)	Older male who is owner of the shop is now outside the shop
18:43:35	(YY)	POI still has scissors in his hands
18:43:35	***(LM)***	***But we haven't got as Taser***
	VKG	*40, have you got Taser?*
	(LM)	***We're up here now, 41's up here now, we haven't got a Taser, we have not got a Taser***
18:43:45	***(LM)***	***We need someone with a Taser now***
	VKG	*Stand by for PTC crew with Taser*
	PC40	*I've got one*
	VKG	*Thanks, 40*
18:43:46	(YY)	No one else in the shop
18:43:55	*VKG*	*40's on the way, 41*

	(LM)	*PTC 41, shots fired.*
18:44:05	*VKG*	*Standing by PTC supervisor, I've now got shots fired. PTC 41, situation?*
18:44:12	(DH)	M CT armed with scissors – shots fired
18:44:26	(YY)	Police have just shot the POI

The first VKG and CAD message transmitted after Mr Theoharis had freed himself from Mr Mokmool's grip was at about 6:42pm.

Sydney Trains CCTV shows the actions of the police

There is a police station in the Central Railway Station. Inside the station's Police Transport Command unit were two plain clothes officers, Senior Constable Tse and Senior Constable Harrison. Two beeps were transmitted over the loud speakers inside the office. Two beeps indicate that a most urgent police response is required. When he heard the beeps, Senior Constable Tse looked at his computer screen and read that a central railway station shopkeeper was being held with a knife to his throat. Senior Constable Harrison heard the same information being conveyed over the VKG radio and they both got up from their desks.

As Senior Constables Tse and Harrison ran through their office into the corridor, they met uniformed officers, Constable Taylor and Senior Constable Maranda, one of whom said that the incident was at the florist shop. There is only one florist shop at Central Railway Station and they all knew where it was located. They ran down the fire stairs, Senior Constables Maranda and Harrison exiting the building at the first floor landing, and Constable Taylor and Senior Constable Tse continuing to the ground floor exit.

Sydney Trains CCTV footage shows Senior Constable Tse and Constable Taylor exiting fire doors and running at speed to the florist shop. Senior Constable Tse ran along the eastern side of the pedestrian wall and Constable Taylor ran along the western side of it. Senior Constables Harrison and Maranda ran down the escalator to the concourse. Senior Constable Tse and Constable Taylor arrived at the florist shop at 6:43:35pm, about a minute after Constable Taylor had acknowledged response to the VKG broadcast. Constable Taylor went to the northern entrance of the florist shop and Senior Constable Tse stopped at the southern entrance.

About 10 seconds later, Senior Constables Harrison and Maranda arrived. Senior Constable Harrison took up position to the right of Senior Constable Tse, next to the wall bordering the entrance to the station, and Senior Constable Maranda took up a position to the left of Constable Taylor, taking the northern most position. The effect of where they stood was to form a perimeter between the shopfront and civilians. The one metre edge of the eastern arch provided a natural barrier to an otherwise very open area where people were coming and going from the station.

Constable Taylor and Senior Constable Maranda's view of Mr Mokmool was limited to the waist up as he was standing on the other side of a square counter which sits against the western wall of the florist shop between the two entrances. As Senior Constable Harrison took his position, Senior Constable Tse drew his firearm and pointed it at Mr Mokmool. Senior Constable Harrison did likewise. Senior Constable Maranda, who was a few metres back from the northern entrance outstretched his arm and tried to spray Mr Mokmool with OC spray but the stream or spray did not reach him. Mr Mokmool crouched to a sprinting position and took running steps towards Senior Constable Tse (this is captured on the mobile phone footage filmed by Ms Wang). Senior Constable Tse then stepped back and discharged his firearm three times. Senior Constable Harrison also discharged his firearm once. Mr Mokmool fell to the ground outside the shop at 6:43:58pm, 23 seconds after police first arrived at the scene. First aid was applied by both Sydney Trains staff and NSW Ambulance officers but Mr Mokmool was fatally wounded. He was formally pronounced deceased at 6:55pm.

Post Mortem Evidence

The post mortem report identifies that Mr Mokmool died from a gunshot wound to his head. The entry was on the rear left side and exit site was his right cheek. He had another gunshot wound which entered his rear right hand side shoulder and stopped on the left side of his chest. He had a gunshot wound to his leg and another to his arm. There is no evidence as to which one of those four was fired by Senior Constable Harrison. A toxicology report identifies that Mr Mokmool did not have any illicit drugs in his system and that he had an amount of methadone consistent with his prescribed daily dose. Mr Farrar gave evidence that the methadone detected in Mr Mokmool's blood sample played no role in Mr Mokmool's actions or death.

Evidence of the Four Directly Involved Officers

Consistent with New South Wales Police Force Critical Incident Guidelines the four directly involved officers were separated, tested for drugs and alcohol, and interviewed. Senior Constable Tse and Senior Constable Harrison were interviewed in the early hours of the following morning (27 July 2017) and Senior Constable Maranda and Constable Taylor were interviewed later that afternoon.

The evidence of each of the officers is contained in their directed interviews and their testimony in the inquest. Their evidence is supported by the CCTV footage and generally by the evidence contained in the eyewitness statements. Their involvement with Mr Mokmool, once they had arrived at the scene until when he was shot was no more than 23 seconds. Their examinations in the inquest dealt with issues such as:

- the use of VKG radio;
- communication and any planning;
- announcement of office;
- consideration of Mr Mokmool's mental health and the training provided by the NSW, including any awareness of each other's training;
- opportunity to contain the environment and forming a perimeter between Mr Mokmool and the public;
- the distance at which they stood from Mr Mokmool;
- the use of non-lethal force namely OC spray and its effects;
- the unavailability of a Taser and likely effect;
- the decision to their draw firearms; and
- the decision to discharge their firearms.

In his directed interview, Senior Constable Tse said that as he reached the florist shop he heard Senior Constable Maranda (it was, in fact, Constable Taylor) yelling something to someone in the shop. He looked in and saw Mr Mokmool standing towards the back of the shop where the flowers are, with his back to the fridge. He saw that Mr Mokmool had a pair of scissors in his right hand and something bladed, which looked like a knife, in his left hand (Ex1, Tab 11, A158). In the inquest he described the blade as about 10 cm poking up from his hand (D2 T8.10).

Senior Constable Tse saw the blades and said *"Drop the knife, drop the knife"* and as he said this he drew his firearm and pointed it towards Mr Mokmool but in a downward or cover position (Ex1, Tab 11 A313-314; D2 T9.4) He could hear other police yelling as well.

Senior Constable Tse said that Mr Mokmool replied *"I'm not giving up, I'm not giving up, shoot me, shoot me dead, shoot me in the head",* and then he took a couple of steps towards Senior Constable Tse (D2 T10.5). In his evidence, Senior Constable Tse said that Mr Mokmool said this calmly (as if he was talking now in the courtroom but louder) though he was moving around restlessly (D2 T13.45).

Senior Constable Tse thought he was standing seven to eight metres away from the front of the florist shop at that point (D2 T9.40). Senior Constable Tse took a couple of steps back and kept yelling *"Drop the knife".* Mr Mokmool stopped and moved back again to where he was had been standing (at the back of the shop). Senior Constable Tse saw that Senior Constable Maranda squirted OC spray towards Mr Mokmool's face. Senior Constable Tse said Mr Mokmool didn't respond. Senior Constable Tse wasn't sure whether the spray had hit Mr Mokmool or whether it had hit him but without effect (D2 T10.5).

Senior Constable Tse said in his directed interview, *"*within a couple of seconds, a second or less than a second of that he just looked at me and ran and said *"I'm gunna kill you, I'm gunna kill",* he yelled out *"I'm going to kill you",* straight towards me.

Um I started actually moving back, but I took about three steps back and realised he was advancing on me a lot faster than I was retreating and I knew eventually he was gunna get me because the way, like, he was just, the gap was just closing in real quick, so he would have been about three metres when I took my first shot. I think I pulled the trigger three times … he would have only moved less than a metre between the first and third shot and he dropped, um but I think once, but there was also a shot I heard from another police officer, I think it was Jakob" (A158).

In his evidence, Senior Constable Tse said that just before Mr Mokmool ran at him his demeanour had changed, his expression had changed. He said, "The way he ran at me it was either me or the public and there's nowhere to go" (D2 T13.25). Senior Constable Tse said that there were still large crowds of people in the area, and that if he kept backing up, he would have hit a wall or a member of the public (D2 T11.44). In his directed interview Senior Constable Tse was asked questions about whether he used the police radio he had taken. Senior Constable Tse said that he did not call VKG to log that he was attending the job. He said *"Trent called that we were attending the job"* (A166). In fact Constable Taylor had responded to VKG that he and Senior Constable Maranda were attending.

VKG did not know that either of the plainclothes officers were attending or were involved because neither of them had used the radios they each had to advise VKG they were responding to the urgent call-out.

Senior Constable Tse said that he took his radio and turned the volume on high so he could hear any updates and locations (A171), but later said he said that he wasn't listening for it anymore because once he knew where it was his purpose was just to get there (A221). He said that his appointments that day included his loaded pistol, on his right hip, a spare loaded magazine and a personal mini-torch and handcuffs in his front left pocket and OC spray in his left jeans pocket (A173-181). He told the inquest that in his backpack he also carried an extendable baton but no Taser (D2 T4.5). He did not take the baton with him, as he left his backpack in the office (D2 T6.9).

Senior Constable Tse was asked questions at the inquest about why he hadn't listened to the VKG radio whilst he was running from the office to the shop. He said "my priority was to get there and assess it when I get there because there it's going to be a lot clearer" (D2 T18.10). It was suggested to Senior Constable Tse that had he listened to the radio, he may have learned that the situation had changed and that Mr Mokmool was self-harming. Following on from these questions, Senior Constable Tse said, "A lot of jobs the details are wrong, exaggerated and that is why I said before it is best to assess the situation when you get there" (D2 T23:19). In his interview, Senior Constable Tse said that when he got there, "I thought, all right, this is exactly as they said (on the radio) it was going to happen" (A233). In his evidence, he agreed that the situation had changed because there wasn't a member of the public being threatened with a knife but explained that it was "just my thought process" (D2 T23.40).

Senior Constable Tse said that he had completed the one day Mental Health Workshop provided by NSW Police Force MHIT and he knew how to de-escalate a situation, but that he simply did not have time to do so because Mr Mokmool ran at him. He was not aware that Senior Constable Harrison had completed the four day residential mental health training course or what training the other officers present had completed. He wasn't aware that an officer who had completed the four day training course, such as Senior Constable Harrison, should take priority lead in responding a situation involving a person with a mental illness. He said there was no distinction between uniformed and plainclothes police roles in a responding situation (D2 T44-46).

Senior Constable Tse said that, though he was in plainclothes, as he was running he had put it his badge which was on a lanyard over his neck and ensured that it was visible over his clothes (D2 T8.40). The CCTV footage shows that it was visible. Senior Constable Tse was aware that there was a crowd of people at the location and that he and the other police had placed themselves such that they had formed a semi-circle in front of the shop, positioning themselves between Mr Mokmool and the public.

Mr de Mars asked Senior Constable Tse questions about his assessment of the situation and the distance at which he stopped in front of the shop. He was shown the CCTV footage (for the first time) and agreed that he was about five metres from Mr Mokmool (rather than the seven to eight metres he had said in his interview and earlier evidence). He agreed it was "probably not" a safe distance to be from someone armed with blades. Mr de Mars put to him that he had placed himself in a vulnerable position and that had he been at a safe distance he would not have needed to draw his firearm. Senior Constable Tse said he would still have had drawn his firearm even if he was further away (D2 T32-33).

Mr de Mars put to Senior Constable Tse that the words Mr Mokmool said to him as he moved towards him were "*shoot me*" (rather than "*I'm going to kill you*"). Senior Constable Tse denied that (D2 T35.49). Mr de Mars put to Senior Constable Tse that he should have backed off and moved away from the situation to assess the best way to handle the situation when he saw Mr Mokmool with blades in his hands speaking calmly saying "*shoot me*", to which the officer replied "On hindsight probably, like I said I probably got a little too close" (D2 T39.21).

Senior Constable Tse explained that he had moved so close so he could if another person was in the florist shop (D2 T48.10) and that he took two steps back to give himself more distance from Mr Mokmool (D2 T48.50). This was at the point at which Mr Mokmool had taken a step towards him and then moved back to the position where he had been standing when Senior Constable Tse first saw him. Later, Senior Constable Tse said that although Mr Mokmool wasn't making any threats he saw him as a threat because "He said '*I'm not giving up*' and that implies to me that he's not giving up without some sort of resistance. With two blades in his hand, resistance could mean a lot of damage to people" (D2 T43.30).

Senior Constable Tse agreed with Mr de Mars that there had been no discussion between the officers attending the florist shop in relation to planning what to do when they got there (D2 T22.29). He agreed with Mr Casselden SC that was because there was no time to stop and plan because they believed that there was a man in the shop with a blade to his throat (D2 T49.9). He said there was no time to speak to civilians or listen to VKG. He agreed that the position he stood in was so he could not only see whether there was a threat to the shopkeeper, but also to put himself between the offender and the civilians (D2 T49.21). In answer to Mr Madden, Senior Constable Tse said that even if he had a longer time (a minute) to assess the situation, if a person with blades ran at him, he would have still discharged his firearm (D2 T51.30).

In relation to the use of less lethal weapons, it was ascertained that Tasers are only issued to uniformed officers. Officers are trained not to use hand-to-hand combat, even with a baton, when confronted with an offender armed with bladed weapons because of the risk of serious harm. Senior Constable Tse referred to his understanding of his training of what a safe distance from an offender with a blade is and he said it was at least seven metres, as this allowed for sufficient time to draw and use a firearm without being harmed (D2 T20-21). He also said that police are trained to aim for the torso of an offender which is what he did (D2 T14.15). The reason for that training was explained by Sergeant Waters.

Senior Constable Harrison was the last of the four officers to arrive. He arrived about seven to eight seconds after Senior Constable Tse. He had carried with him his sling bag which contained his police radio. He did not use the radio (D2 T68.29). Like Senior Constable Tse, his police badge was on a lanyard around his neck visible over his jacket (D2 T57.15). He took the position to the right of Senior Constable Tse, against the wall of the entrance to the station. He saw Mr Mokmool standing in the shop near the back wall (D2 T56.20) with his muscles tensed and his arms outstretched in a position he describes as a "crucifix pose" (D2 T57.2) with three to four inch blades sticking out of each of his fists (D2 T58.25).

Senior Constable Harrison said that Mr Mokmool took a few paces towards Senior Constable Tse and himself, and that is when he drew his firearm, pointed it at Mr Mokmool and said "*Police, drop the knives*". He hadn't heard Mr Mokmool say anything up to that point. He could hear Senior Constable Tse yelling something but he couldn't make it out. He heard Senior Constable Maranda ask for a Taser to come to the scene. (D2 T57). He assumed that Senior Constable Maranda was using his radio (D2 T58.1).

After Senior Constable Harrison yelled, "*Drop the knives*", Mr Mokmool went back to the back wall and held his arms outstretched. He said, "*Shoot me, just fucking kill me*" and crouched down "like a sprinters pose … his hands were down towards his side but the blades in his hands were facing forwards ... he was still looking out but his head was a bit lowered…so his chin was a bit down but his eyes were still facing forward". Mr Mokmool was looking towards Senior Constable Tse. At the point at which he ran, Mr Mokmool would have been about six metres away from Senior Constable Harrison (D2 T59). Senior Constable Harrison said that when Mr Mokmool ran, he stepped back and to the side to create more space between himself and Mr Mokmool, who was still holding the blades facing forward. Senior Constable Harrison heard a gunshot from his left and then fired a shot. He then saw Senior Constable Maranda so did not shoot anymore (D2 T60).

Senior Constable Harrison said that he had completed the four day mental health training course and that they had tried to communicate with Mr Mokmool to de-escalate the situation by telling him to drop the weapons. Senior Constable Harrison said his next consideration was weapons control and that the officers should be seven metres away to allow sufficient reaction time (D2 T62 -63). He said that if he hadn't used his firearm, either Senior Constable Tse or a nearby member of the public would have been grievously injured, if not killed (D2 T63.10). He said there was insufficient time to assess Mr Mokmool's state of mind (D2 T63.18).

Mr de Mars asked Senior Constable Harrison about his roles and responsibilities as an officer who has completed the four day mental health training course. He agreed that as a result of completing the course he gets more involved as a first responder to incidents involving mental health concerns. He explained that, "If I'm not the one directly speaking to the person I might encourage more officers to stand further back so you're not crowding the person. Sometimes offer advice on what you can say and what you shouldn't say, if there's time, and usually a lot of it comes down to when you go to the hospital and do a section 22" (involuntary admission) (D2 T65).

Mr de Mars asked about the type of communication the course teaches is appropriate to use when the police deal with a person who has a mental illness. Senior Constable Harrison replied "Don't use police jargon, don't set timeframes, don't let them set timeframes, don't introduce third parties, don't lose credibility and don't deny their reality" (D2 T66.40).

He agreed with the idea of showing a degree of empathy to their situation "if you can build a rapport with them" (D2 T66.46). He agreed that sometimes a conversation is better than issuing orders but that sometimes orders are better reacted to (D2 T67.1).

Senior Constable Harrison said that when Mr Mokmool walked back to the wall of the florist shop he thought that might be an opportunity for communication with him, but it was then that Mr Mokmool ran at the police (D2 T77.13). If it was an opportunity, it was short-lived because Senior Constable Maranda used it to try to incapacitate Mr Mokmool with OC spray. While the spray did not reach him, it may have triggered him to run at police. However, I note that this was at least an attempt to use a less than lethal weapons option in extremely limited circumstances.

Senior Constable Harrison was asked questions about his familiarity with "situational awareness training" which has an acronym of STOPAR and he indicated he was familiar with the concepts (D2 T67). He was shown CCTV footage and he agreed with Mr de Mars that the position he took next to Senior Constable Tse was to provide cover and that he would have "absolutely" preferred to have been further back, but there was also the issue of the proximity of people standing around. He said he turned his mind to forming a perimeter and that is what they did, they formed a semi-circle with as much reaction space as possible (D2 T72-73).

Constable Taylor was on shift with Senior Constable Maranda. They were both in or near the meal room at the Police Transport Command when he heard the two beeps over the office speakers as well as the VKG broadcast on his radio which was attached to his shoulder (D3 T40-41). Constable Taylor ran towards the supervisor's office and saw Senior Constable Tse. They both ran down the four flights of stairs to the exit. Constable Taylor said he took a position about a metre from the shop and looked inside through the northern entrance of the florist shop. He saw Mr Mokmool stand up on the other side of the counter with what appeared to be scissors in his hand, but he could not recollect if it was his left or right hand (D3 T42-44). Constable Taylor told him to drop it. He unlatched his holster but did not draw his firearm. He saw Mr Mokmool run at Senior Constable Tse. In his evidence he was unable to recollect whether he heard Mr Mokmool or any of the other officers say anything (D3 T45-46).

Constable Taylor described Mr Mokmool as being agitated and said that Mr Mokmool had "More of a defensive pose when he stood up, not listening to instructions ... and then a few seconds from what I know of, it didn't change, it just escalated if he's running towards an officer with a gun" (D3 T49.9). Constable Taylor could see both Senior Constables Harrison and Tse from where he was standing. He couldn't recall if his vision was through the window, the northern door, or both (D3 T49-50). Constable Taylor was not carrying a Taser because he said "I just chose when to use a Taser on the day". (D3 T48.30). He was asked questions about this in his directed interview and said that it was a personal choice as to whether he carried a Taser (Ex1, Tab 15, A72-73). Mr De Mars asked Constable Taylor some questions further to that evidence. He was completely unable to proffer an explanation as to what exercised his decision to take a Taser or not for the day. It was completely random (D3 T54.35). Constable Taylor was asked about whether, before leaving the office, he gave consideration as to what kind of appointments he might take. His answer was "My initial thought was to just get there" (D3 T55.35).

In his directed interview, Constable Taylor said he was trying to listen to the radio but he "just wanted to get there fast" (A175). In his evidence, he could not recall hearing anything on the radio to the effect that the person was trying to cut himself. He did recall things about Mr Mokmool "smashing things and possibly a broken bottle". He said that he could only hear bits and pieces as they were running down the stairs (D3 T56:39). He couldn't recall whether he and Senior Constable Tse said anything to each other while they were running to the shop (D3 T57.42).

Senior Constable Maranda was in the meal room when he heard the two alerts on the speaker which he understood to mean something requires urgent assistance or could possibly be life threatening. He met Constable Taylor in the hallway and went through the TAG office where Senior Constables Tse and Harrison were (D3 T5-6). Senior Constable Maranda and Constable Taylor confirmed with them that the incident was at the florist and they ran down the fire stairs. Senior Constable Maranda turned his radio on as he was leaving the office with the volume on loud so he could hear the broadcasts. He and Senior Constable Harrison exited the fire stairs at level one and took the escalator. Senior Constable Tse and Constable Taylor continued down the stairs (D3 T6-7). When Senior Constable Maranda arrived, he saw Senior Constable Tse standing with his firearm drawn. Mr Mokmool was inside the florist facing out towards police.

Senior Constable Maranda recalled Mr Mokmool standing 2-3 metres back from the front right entry looking at Senior Constable Tse saying, "*Shoot me*" (D3 T8). At the time of his directed interview, Senior Constable Maranda was unable to recall any words being said, only later when he read news reports containing witness accounts did he recall those words (D3 T35.21). Senior Constable Maranda said he was unable to see whether Mr Mokmool was carrying anything (D3 T9.9). He saw that Senior Constable Harrison had his firearm drawn and so he used his radio to call for a Taser (D3 T10.9). Senior Constable Maranda then went around to the other entrance. He drew his can of OC spray, extended his arm out and sprayed it towards Mr Mokmool (Senior Constable Maranda is approximately 6'3" to 6'4" tall) (D3 T9.28). He said he went to that position because the other police had the other areas covered (D3 T37.7).

Senior Constable Maranda said the spray missed and went to Mr Mokmool's right. He said Mr Mokmool, "appeared to see that I was deploying it or appeared to realise and he looked to me, just had a very agitated look on his face and then he immediately looked back towards Senior Constable Tse and ran at him" (D3 T10.13).

Senior Constable Maranda was asked about what regard he had to his training. He spoke about his assessment of the risks and said there were numerous members of the public standing around. The VKG had said that Mr Mokmool was armed with a knife, and when he got there two police officers had their firearms out, so Senior Constable Maranda assumed they could see Mr Mokmool had a knife or was holding a knife (D3 T11.26). He used the OC spray in an attempt to resolve the situation by non-lethal means (D3 T11.40). Senior Constable Maranda said that the time was too short for him to make a mental health assessment. His reflection is that he wouldn't position himself in that way because he could have been in the cross-fire of Senior Constable Harrison's weapon (D3 T12.30).

In his directed interview, Senior Constable Maranda said that when he and Senior Constable Harrison exited the fire stairs at level one he was able to look over the balcony into the florist shop. Though he couldn't see inside it, he could see that there were pot plants being knocked over (Ex1, Tab 13, A106). He also said in his interview that he heard the radio operator say that the male was possibly cutting himself (A118; D3 T15.15-32). In his evidence Senior Constable Maranda confirmed that he was listening to information on the radio on his way to the florist shop and that he heard information that the incident may also involve a robbery (D3 T6.1).

In his interview, Senior Constable Maranda was asked what he was thinking when he heard on the VKG that the male was cutting himself, to which he replied it caused him to think that "maybe the male was cutting himself committing self-harm for whatever reason … I wasn't really thinking much. All I was thinking was just get there quickly and be prepared because this male is going to be armed with a knife" (A142-145). Mr de Mars asked him if at that point it went through his mind the need to have a Taser to which he replied, "No because at that point it's too hard to get a Taser ... it takes too long" (D3 T20.40).

Senior Constable Maranda said that for he used to carry a Taser regularly but in the last several months he had not, saying it was a personal choice. He said that a possible reason for changing his practice was because carrying a Taser required making room for it on his belt and redistributed the weight. He acknowledged, however, that a Taser is not heavy (A208-211; D3 T29).

Senior Constable Maranda was asked questions about the "contain and negotiate" approach he has been trained in. Senior Constable Maranda said in his interview that he thought that Senior Constable Tse was 18 metres from Mr Mokmool and when it was suggested that he was only five metres away Senior Constable Maranda said he felt like they were further away (D3 T33-34**).** I note that Senior Constable Maranda participated in a video walkthrough a week after the incident and he placed himself was a lot closer to Mr Mokmool on the night than he suggested in his interview. It would appear that Senior Constable Maranda is not very good at assessing or describing distance. Alternatively, it could be that the impact of the incident, be it stress or adrenaline or both which affected his sense of it.

Use of Force, Arms and Appointments

NSW Police Force officers are authorised under s. 230 of *Law Enforcement (Powers and Responsibilities) Act 2002* to use force:

It is lawful for a police officer exercising a function under this Act or any other Act or law in relation to an individual or a thing…to use such force as is reasonably necessary to exercise that function.

Sergeant Justin Waters has been a Senior Operational Safety Instructor in the NSW Police Force for 22 years and a Weapons and Defensive Tactics Instructor for 23 years. He works in the Weapons and Tactics Policy Review Unit ("WTPR"), which is within the Operational Safety and Skills Command.

I need not set out his qualifications as they are contained in his report (Ex1, Tab 115). Sergeant Waters was asked by Detective Sergeant Bosworth to provide a report addressing the following:

- The primary role of the WTPR provision of training;
- The current training, philosophy and practice in relation to the use of police firearms and appointments, specifically the:
  - Tactical Options Model
  - Police verbal challenge
  - Justification to draw and discharge firearm
  - Training in relation to tactical options for bladed weapons (including distance a person can travel in time to draw and fire)
  - Justification in the use of OC Spray
  - Policy in relation to the carriage of Conducted Electrical Weapons (Taser)
  - Standard Operating Procedures ("SOPs") in relation to carriage and activation of Body-worn video ("BWV"); and
- Whether the actions of the involved officers were consistent with training protocols.

To prepare his report in relation to the last issue, Sergeant Waters was provided with numerous eyewitness statements, mobile phone footage and Sydney Trains CCTV footage. The report sets out the policy and training the WTPR provides and confirms that each of the involved officers had satisfactorily completed all weapons and defensive tactics mandatory training requirements for the designated training period.

The NSW Police Force use a Tactical Operations Model whereby police are trained to take control of the offender or situation by the use of force "based on the officer's assessment of the level of resistance being met, weighed against the appropriate level of force or response required" (at [16]). The model sets a list of concepts of force ranging from officer presence, communication, weaponless control, tactical disengagement, contain and negotiate, OC spray, baton, CEW, firearm, and active armed offender tactics. The training includes planning, ongoing risk assessments, actions, taking charge in a dynamic situation. The mnemonic STOPAR is taught – (stop, think, observe, plan, act, review), applying policy and procedures, officer and public safety, legislation, investigation, customer service and ethical decisions (taught using the mnemonic POLICE).

Special circumstances might exist which might increase the danger to an officer such as proximity to weapon, special knowledge, injury or exhaustion, disability, imminent danger, drugs/alcohol and mental state. Limitations might affect the situation such as the officer of offender's age, gender, size, fitness, skill level or numbers.

The above is just an outline summary of what was explained more fully in Sergeant Waters' report. Suffice to say that the WTPR training provided to NSW Police officers is designed to achieve effective command and control with the least harm to possible to officer, offender and community.

Sergeant Waters wrote (at [52]-[59]):

"While the possibility exists where weapon-less control techniques, CEW, baton or Oleoresin Capsicum defensive spray may be a useable force option in specific circumstances, at the time of this event having received each of the recorded accounts from each witness in conjunction with forensic imagery photographs and CCTV/personal video, I believe these options would have been futile in the circumstance. In fact, this was the case when Senior Constable Maranda deployed OC defensive spray, as outlined in paragraph 9. Arguably, this could also be said regarding the use of CEW.

It should be clearly remembered, that at close range, an officer will only get one chance to ensure the discharged probes of the CEW hit their intended target, and should these probes miss, clearly the officer will be at extreme risk of serious injury or death, particularly given that on this occasion Mr Mokmool was armed with a pair of scissors and an unknown object. I draw the conclusion based upon the fact that generally, when within such close proximity to an extremely agitated, focus driven individual armed with a bladed weapon who suddenly and without warning, charges towards police unexpectedly, that unless an appointment such as a firearm or CEW, which delivers greater incapacitation values is at the ready, and/or discharged immediately, reaction times using alternate tactical options will significantly diminish. As a consequence, in all likelihood a police officer, victim or innocent bystander may be seriously injured or killed.

Senior Constable Tse or Harrison, who were both in plain clothes did not have access to a Taser as a tactical option. Although a Taser was requested by Senior Constable Maranda shortly after he arrived at the Florist shop.

The interaction with Mr Mokmool only lasted 21 seconds which did not provide sufficient time for a Taser to arrive. Senior Constable Tse and Harrison had access to OC defensive spray which was contained on their person but this would have been ineffective in stopping Mr Mokmool from charging at Senior Constable Tse.

The attack upon Senior Constable Tse by Mr Mokmool was in every sense directed, unprovoked and completely unexpected. In fact, at the time, none of the involved officers had been able to continue with their investigation as the time frame between Senior Constable Tse's arrival and the first shot was approximately 21 seconds. Senior Constable Tse found himself in an extremely vulnerable position by placing himself in an area with little to no protection and directly in the line of sight of Mr Mokmool.

Senior Constable Tse states that he was only 7-8 metres away from Mr Mokmool but given he was about 2-3 m from the entrance to the Florist shop it is more likely that Mr Mokmool was about 5-6 metres away. The only protection available to him was the light police to his left or the sandstone wall to his right where Senior Constable Harrison was positioned.

In his record of interview, Senior Constable Tse alludes to his vulnerable position when Mr Mokmool begins to run at him, stating the following:

"I started actually moving back, but I took about three steps back and realised he was advancing on me a lot faster than I was retreating, and I knew eventually he was gunna get me because the way like, he was just, the gap was just closing in real quick".

Subsequently, it is my view that both Senior Constable Tse and Harrison were confronted with a focused driven, charging aggressor who at the time was apparently armed with a pair of scissors and another unknown object. Mr Mokmool's actions caused him to be within extreme close proximity to these officers, who were in the very least, at risk of serious injury. In the circumstances, it is my view that police had no other alternative but to combat the immediacy of the threat that they faced by resorting to the use of their firearms.

After identifying what both officers considered to be an immediate risk to the life of, or in the very least the potential serious injury to Senior Constable Tse, their reactionary response by discharging their firearms at Mr Mokmool was predicated by the actions of Mr Mokmool, who at the time was armed with a pair of scissors and an unknown object.

Clearly both officers feared for the personal safety of Senior Constable Tse. The discharging of the Constables' firearms at Mr Mokmool whom at the time was not only armed with a pair of scissors and an unknown object, but appeared to be actively attempting to cause Senior Constable Tse serious injury at extremely close quarters, appears to be in accordance with NSWPF policy, procedures and training practice guidelines".

Sergeant Waters' report then continued to the following components, all of which he concluded were performed in accordance with NSWPF policy, procedures and training practice guidelines.

- Police Verbal Challenge;
- Tactical Options for Bladed Weapons (including distance a person can travel in time to draw and fire);
- Justification in the use of Oleoresin Capsicum (OC) Defensive Spray;
- Policy in relation to the Carriage of Conducted Electrical Weapons (Taser); and
- SOPs in relation to carriage and activation of BWV.

<u>Police Verbal Challenge</u>

Sergeant Waters comments (at [69]):

"It is clear that throughout the course of this incident, the mere presence of police and their communication with Mr Mokmool, who was clearly acting in an irrational manner, were not enough to convince or persuade him to comply and drop the scissors as instructed".

There is ample evidence that all police were properly identifiable as police officers, including the plainclothes officers, and that they clearly communicated with Mr Mokmool that he was to drop his weapon/s. Mr Mokmool would have known that they were police officers. He had been telling people to call the police from the time he assaulted Mr Theoharis and when he saw Senior Constable Tse he said "I'm not giving up". Senior Constables Tse and Harrison had continued their commands for him to drop the weapon/s. Mr Mokmool was aware that the police had drawn their firearms because he said "Just fucking shoot me".

The description of Mr Mokmool as "clearly acting in an irrational manner", whilst an accurate description, particularly in the later light of Dr Eagle's evidence, is a description that is perhaps at variance with that used in Sergeant Waters' opening conclusion where he describes Mr Mokmool as "focused driven" (at [57]). In any event, Dr Eagle's evidence provides some illumination into Mr Mokmool's likely state of mind during the incident.

Body Worn Video Camera

None of the four police officers had worn or activated a BWV camera. The plainclothes officers, due to the nature of their duties, carry them covertly but the policy is that their use is to be overt. Accordingly, Senior Constable Tse explained in his interview that he carries his in a bag and will take it out and use it if he is interviewing someone (Ex1, Tab 11, A81-87). The SOPs indicate that a BWV camera should be used in situations where the use of force is anticipated. Sergeant Waters was of the opinion that it was understandable that Senior Constable Tse left his BWV camera behind when he heard the urgent CAD because the officer's primary concern was to get to the location as quickly as possible. He did not consider that if Senior Constable Tse had time to take his VKG radio out of his bag he also had time to take the BWV.

(In his report Sergeant Waters made no mention that there was a failure by both Senior Constables Tse and Harrison to respond to VKG though in his evidence he agreed that was the case). In any event Sergeant Waters continues to say in his report (at [94]):

"Had Senior Constable Tse been wearing a BWV camera, I am of the belief that he would have failed to activate it due to the gravity of the situation before him."

With respect, I do not think that such an opinion is available on the evidence, nor is it within the ambit of the purpose of an expert report. I note that this was the first occasion that Sergeant Waters has been called upon to write an expert report in relation to a police shooting. It is important that where an actor has not articulated their reasoning or explanation, an expert does not then subject it to speculation. Sometimes in his report, and on occasion in his evidence, Sergeant Waters went beyond the evidence and his expert ambit which, as an expert, he must not do, so as not to appear to be wanting or trying to justify the police acts or omissions. Regardless, Sergeant Waters says that (at [95]):

"The non-use of a BMW camera by Constable Tse is an individual decision and it appears to be in accordance with NSWPF policy, procedure and training practice".

I take that to mean because the policy identifies circumstances when a camera "should" rather than "must" be used (as set out in paragraph [92] of Sergeant Waters' report). Sergeant Waters does not refer to this incident as being within that policy such as it being a "first response crime and incident investigation", or a "situation where the use of force is anticipated", nor does he comment upon the failure to carry or use the BWV camera of the other three officers. The failure to carry or use a BWV was not a significant issue in the proceedings given the short time frame of the incident and perhaps because bystander mobile footage was available to be viewed.

<u>Conducted Electrical Weapons – "Taser"</u>

According to the SOPs for the Use of Conducted Electrical Weapons (Taser), Tasers are only issued to uniformed officers undertaking response policing and are to be worn as part of their arms and appointments (Ex1, Tab 211, p.16). This includes police from the Police Transport Command (p.18). This policy applied to PTC41 (Constable Taylor and Senior Constable Maranda). I note in his interview, Senior Constable Maranda said that he considered carrying a Taser a personal choice (Ex1, Tab 13, A209).

As set out above, both Senior Constable Maranda and Constable Taylor were unable to explain in their evidence why they chose not to carry a Taser other than they thought they were not required to.

In his expert report, Sergeant Waters made no reference to their failure to have a Taser. Sergeant Waters' report only referred to Senior Constables Tse and Harrison as not being authorised to carry a Taser as they were plainclothes officers. The SOPs direct police to wear the appointments issued to them and that one Taser will be issued between two officers. There is, however, provision for the issuance of a Taser to a single officer. It seems the officers thought that if they did not have a Taser issued then there was no requirement to wear one.

Sergeant Waters, in answer to questions from Mr de Mars said his failure to refer to PTC41 not carrying a Taser was an oversight (D5 T27.15). In his evidence, Sergeant Waters said that he considered the officers' understanding that carrying a Taser was an individual's choice as being contrary to the SOPs. He said that he was the one that wrote the Taser SOPs and he considered it very clear that it was a mandated rather than a discretionary appointment to be worn by frontline and uniformed police officers (D5 T12.45, T15.30). Mr de Mars asked Sergeant Waters about his opinion that the use of a Taser would have been futile. Sergeant Waters agreed that a Taser (at the ready) would be a tactical option but that his report focused on the plainclothes officers without a Taser in that position (of being charged at by Mr Mokmool).

He said that "the idea of having tactical options and having multiple officers with different options, that's what we're trying to have, as many options as we can to resolve a situation, stop a threat, etcetera, so yes I accept that if a Taser had have been there, that it may have been an option, but I will preface that with if the Taser had have been deployed it is my opinion that a firearm would have been deployed at exactly the same time by either (or) another officer standing close by." (D5 T28.24). He explained this further saying, "I don't think it was appropriate straight away to discharge – the Taser is not an offensive weapon, it's a defensive weapon …The circumstances of discharging the Taser are ones that warrant where someone like Mr Mokmool has now started to run at the officers and caused a threat to them. We're not in the position of just turning up to a job and firing a Taser off, no" (D5 T35.20).

Sergeant Waters then agreed that at the point when Mr Mokmool moved forward two steps and moved back, "if a Taser had been available there, that may have been an option … for that officer and they need to adjudge that themselves" (D5 T35.47). Mr de Mars then asked if in training he would play the mobile phone footage to officers and tell them "Look it, may be, maybe not, it would have been appropriate for you to discharge the Taser at that point?" Sergeant Water's reply was then somewhat combative:

"I don't tell people in training when they can and can't use their appointments. It's an individual assessment of the situation and that what we allow the constable of police to do, is assess the situation and the threat to them, not to me, not to you, not to anyone else, to them" (D5 T36.29). Given that is the case, I think it is probably best not to comment about the futility or otherwise of the use of an appointment that wasn't present on the scene, nor make assumptions that if it was, it would have been deployed at the same time as the firearm.

In his earlier evidence when he was being asked questions by counsel assisting, Sergeant Waters had explained that his opinion that a Taser would have been futile was based on factors other than that its effect would have been lost because Mr Mokmool would have been shot by a firearm simultaneously. His explanation to counsel assisting was that an officer deploying a Taser had to remember to flick the switch which activated its electrical charge before firing the Taser which he said officers forget to do in stressful situations. Further, he explained that for an optimal effect, the officer needs to be within a 2.1-4.5 metre operational range (of the offender) to allow for a two probe spread of 33 to 66 cm. The probes need to connect within this distance to impact an offender's nervous system and achieve effective incapacitation. The effectiveness of a Taser is dependent upon the probes striking the offender in the torso, which can be difficult if the offender is moving around and arms are moving (D5 T76-77).

I accept that had a Taser been present on the scene and deployed, given the difficulties including lack of time, and lack of access to Mr Mokmool by a uniformed officer to achieve effective incapacitation it may well be that a different outcome may not, or even could not have been achieved. However, the fact remains, a Taser was not an available tactical option when it could or should have been due to a non-adherence to policy and this was not articulated in Sergeant Waters' report.

<u>OC Spray</u>

Under the Arms and Appointments guidelines in the NSW Police Force Handbook, OC defensive spray is used for the protection of human life, protection against animals or is a less lethal option for controlling people, where violent resistance or confrontation occurs (or is likely to occur) (Ex1, Tab 208, p.6). In his report, Sergeant Waters addressed the use of OC defensive Spray, in terms of "justification".

I note that Senior Constable Maranda had not seen that Mr Mokmool was armed but correctly assumed so – he had heard the VKG broadcasts, he had seen that the plainclothes officers had drawn their firearms pointing at Mr Mokmool and he heard Mr Mokmool say "*shoot me*". Officer Maranda said in his interview at Q108 that Mr Mokmool's face looked agitated and he deployed the OC spray in an attempt to subdue Mr Mokmool (Ex1, Tab 13, A108). That is not controversial and I accept that is so.

Sergeant Waters concluded that the use of it at the time prior to Mr Mokmool running at the police was appropriate. This was consistent with his ultimate concession to Mr de Mars, that a Taser, also a defensive tactical option, could have, if available, could have appropriately being used prior to Mr Mokmool running at police.

In his interview Senior Constable Maranda said, "As soon as I started spraying he, pretty much, darted out the front of the shop so he didn't really give me a chance to straighten my aim once I realised where the stream was going" (A220). The mobile phone footage MOAY3375 (Ex3, Tab 29) shows Senior Constable Maranda standing at the edge of the northernmost edge of the northern entrance holding his hand up with an elbow bent so that the can is a little in front of his face and stretched out slightly. The OC spray can be seen arcing up and out of sight where the brick wall between the two shop doors is situated. The spray is continuous at the time Mr Mokmool runs from the shop.

Senior Constable Maranda instantly stops spraying and very quickly moves away at sound of gunshots. This is consistent with Senior Constable Harrison's evidence that he did not fire a second shot because he saw a flash of light blue and was concerned that a police officer could be hit by his crossfire, and Senior Constable Maranda's evidence was that he would not put himself in such a position due to the risk of being caught in the cross-fire. In his evidence Senior Constable Maranda thought he was about 10 metres from Mr Mokmool (D3 T9.40), but given that the northern door measurement is about 3 metres and the upwards arc of OC spray is about 3.5 metres, Senior Constable Maranda was at probably within about 5 metres of Mr Mokmool.

Senior Constable Tse said in his interview that Mr Mokmool's demeanour changed at the point the spray was deployed. He had gone from calm to agitated. Senior Constable Maranda was of the opinion that Mr Mokmool looked agitated and he sprayed him to subdue him.

There is no doubt that many people viewed Mr Mokmool as agitated and what Senior Constable Tse was conveying was that Mr Mokmool's demeanour changed in such way to cause him apprehension.

The OC spray did not reach Mr Mokmool. A later analysis of his clothing showed that none of his clothing had any traces of OC spray (Exh1, Tab 107, at [29]). However, Mr Mokmool saw the spray coming from the direction of the northern door and ran out the southern door. It may be that spray effectively flushed him out of the shop ending any potential opportunity for the plainclothes officers to contain and negotiate with Mr Mokmool.

Both Senior Constables Tse and Harrison, and many eyewitnesses, say that Mr Mokmool ran at the police and I accept that both officers apprehended, and had a more than reasonable basis to apprehend, that Mr Mokmool presented not only a risk of serious harm or death to Senior Constable Tse but also to the public if he was not stopped. Sergeant Waters describes in his report that Mr Mokmool *"suddenly and without warning, charges towards police unexpectedly"* and he describes it as *"unprovoked and completely unexpected"* (Ex1, Tab 115, at [10], [55]). He has made this conclusion without considering or addressing whether the deployment of the OC spray triggered or "provoked" Mr Mokmool. There was no communication amongst the police officers so neither of the plainclothes officers knew that OC spray was going to be deployed, however they both saw the OC spray in the air and commented that Mr Mokmool's demeanour changed from calm to aggressive.

I am not critical of Senior Constable Maranda for attempting to subdue Mr Mokmool as an attempt to use a non-lethal tactical option. He had extremely limited options given that he had to avoid being in the line of fire of the firearms as keep out of the striking distance of Mr Mokmool who was armed with blades. However, I think it is useful to understand how this event played out. As Sergeant Waters said in his report "when considering the use of force, an officer's ultimate goal is control" (at [26]). The police had little to no time to assess, contain and negotiate with Mr Mokmool and his choice to run out at the police after just 20 seconds denied the police that opportunity. Understanding how that came to be might help form a strategy by which the ability to contain and negotiate might be achieved.

Tactical Options for Bladed Weapons - Drawing and Discharge of Firearms

The Arms and Appointments guidelines in the NSW Police Force Handbook includes the following instructions to officers (Ex1, Tab 208, p.3):

- **DO not** draw your firearm, point, or aim it unless you consider you are likely to be justified in using it. The discharge of your firearm is to be regarded as a last resort

- Only discharge your firearm when there is no other reasonable course of action available

- You are only justified in discharging your firearm when there is an immediate risk to your life, or the life of someone else, or there is an immediate risk of serious injury to you or someone else and there is no other way of presenting that risk.

There is a preamble to this which says (at p.3):

"This guideline applies to all situations regarding the discharge of your firearm. The decision to use your firearm rests with you. You are accountable for your actions. If you kill or injure a person when such action is not reasonable you could face serious criminal charges and civil action. You are only justified in discharging your firearm when there is an immediate risk to your life or the life of someone else or there is an immediate risk of serious injury to you or someone else and there is no other way of preventing the risk".

There is no mention in the policy and guidelines tendered in the inquest relating to what a police officer should do if the offender is armed with an edged or bladed weapon. Sergeant Waters says in his report that NSW Police Force does not have a set distance where an offender with a bladed weapon needs to be before the decision to use a firearm is made. Officers should create a reactionary gap. Such a gap is one where, if needed the officer can make an effective reaction, such as draw and shoot or as in this case, given that the firearms were already drawn, shoot (Ex1, Tab 115, at [73]).

The involved officers all said that their understanding was that they should be no closer than seven metres to an offender with a edged weapon. Sergeant Waters explained that though that is not a taught distance because other factors such as environment, noise, lighting and cover are involved in the equation, there is a distance known as the "Tueller Drill", a 1983 study where it was determined that an average healthy adult male can cover a distance of 6.4m in about 1.5 seconds (at [74]).

The policy in relation to use of a baton is as follows: "You may use your baton if in danger of being overpowered or to protect yourself or others from injury. The force used must be reasonable" (Ex1, Tab 208, p.9). Sergeant Waters said that the NSW Police do not ask (or train) officers to use batons against persons with bladed weapons because the officer would need to "approach that person and be within a striking distance to have any effect on that person and with somebody carrying two edged weapons we're not asking officers to put themselves in those positions so it's not a consideration" (D5 T50.35).

Mr de Mars questioned Sergeant Waters about some aspects of Senior Constable Tse's decisions particularly his proximity to Mr Mokmool, his failure to listen to the VKG as he was running to the shop, and his failure to plan with other police while they were running to the location. Sergeant Waters said the officers couldn't plan because they were not running together (D5 T47). This is not really correct as they did run as a group to at least level one where Senior Constable Tse and Constable Taylor continued to the ground floor and Senior Constables Maranda and Harrison exited to the balcony area and took the escalator. It appears that the concept of planning was disregarded as was listening to the VKG in preference to getting to the shop as soon as possible. Had they all left at level one and appraised themselves of the situation from the balcony, they might have communicated a plan with each other. However, I do not think that any of the officers can be criticised for splitting up to arrive at the location as soon as possible.

In relation to his proximity to the shop, Senior Constable Tse did not allow himself any time to fully consider his own safety. He was expecting a violent confrontation with a person holding a blade at someone's throat. He had limited tactical options given that his appointments were limited to OC spray, handcuffs and a firearm. When he said that he arrived at the shop and it was as they said it would be, I take that to mean that there was a man there with blades in his hand/s. There was no man being held and he could easily see that there was no other person in the florist shop though he had not identified where Mr Theoharis was.

The geographic location was difficult to contain. The florist shop was narrow and but for a small mid-section was entirely open to the public thoroughfare of a main railway station. There were two entrances which police had to cover to prevent Mr Mokmool running out with blades in his hands and posing a high risk to public. It was at a high risk time being still rush hour.

The public had seemed reasonably unperturbed, from a safe distance watching Mr Mokmool trashing Mr Theoharis' shop and hurting himself with scissors in an apparently reasonably calm way. It is likely that the police attendance at the shop did escalate the situation in that the entire dynamic changed.

Mr de Mars has not suggested that Mr Mokmool was not a potential high risk threat to the police or to the public. However, he submits that had Senior Constable Tse known that Mr Mokmool was engaging in acts of self-harm by stabbing himself, Senior Constable Tse's approach may have been different. Senior Constable Tse said that it would not have made a difference. Mr Mokmool had engaged in acts of harm both to Mr Theoharis and to himself, and he had damaged Mr Theoharis' property. He had been heard to yell out threats to the public as well as comments about wanting to die. Some eyewitnesses thought he was frightening, others thought he was disturbed. Had Senior Constable Tse been aware of all the things that had occurred from the time Mr Mokmool entered the florist shop to the time police arrived, he would have assessed Mr Mokmool as unpredictable and, from the fact that Mr Mokmool was armed and refusing to drop the scissors, that he was non-compliant. It is thus difficult to see how Senior Constable Tse's approach could have been different. Likewise, whilst it is possible, even probable, that Senior Constable Tse's show of a firearm at close proximity to Mr Mokmool escalated the situation, Senior Constable Tse had to place himself between Mr Mokmool and the public.

Constable Taylor had gone to the other entrance of the florist shop and Senior Constable Tse would have been rightfully criticised if he had gone anywhere else. The environment was so open that the only cover available was the edge of the sandstone arch to the rail station and that was limited because it only provided a very narrow strip adjacent to the shop. The wide entrances to the shop, the minimal cover the edge of the arch provided, and Senior Constable Tse's perception that the wall which he had run alongside was closer than it was, dictated his position.

In his report, Sergeant Waters said that part of the tactical options training includes an element of "expect the unexpected" (Ex1, Tab 115, at [26]. This can include a huge number of variables: the officers' individual responses to adrenaline, unwittingly placing yourself in a vulnerable position, realising that there were limited or no options of retreat or cover, an irrational and unpredictable offender, another officer's actions or their mere presence escalating an offender (at [46]-[50]).

In the circumstances it was reasonable for Senior Constable Tse to draw his firearm and command Mr Mokmool to drop his weapon/s. Senior Constable Tse had OC spray in his pocket. He knew that Constable Taylor was covering the northern entrance and that Senior Constables Maranda and Harrison were joining them. However, at that particular point in time, it was important to gain control, contain Mr Mokmool and issue him with the command he did. Mr Mokmool had conveyed to Senior Constable Tse that he was not giving up at around the same time as Senior Constable Tse was drawing his firearm. He had reasonable grounds to believe that he was likely to be justified in using his firearm should Mr Mokmool not comply with his command and escalate to use the weapons.

When Mr Mokmool advanced towards Senior Constables Tse and Harrison the first time, Senior Constable Tse did not discharge his firearm but stepped back to maintain a reactionary gap and repeated his command for Mr Mokmool to drop the weapon. This showed that he was applying his training of maintaining control, maintaining a reactionary gap and attempting to communicate. Mr Mokmool responded appropriately by retreating but he did not de-arm himself.

It was then that unbeknown to Senior Constable Tse, Senior Constable Maranda discharged the OC spray. Had Mr Mokmool at that point dropped his weapon and run out of the shop it would have been evident to Senior Constables Tse and Harrison he was fleeing and not a threat. However, Mr Mokmool's reaction was to maintain his grip on his weapon, to focus on Senior Constable Tse and to run as fast as he could at him. Both Senior Constables Tse and Harrison thought that he was going to stab Senior Constable Tse and they both fired to stop him. They both had reasonable cause to believe that Mr Mokmool was going to stab Senior Constable Tse. The discharge of their firearms was to stop him from doing so and accordingly was justified, to use the language of the NSW Police Force.

Mr Mokmool's Mental Health

Mr Mokmool's custodial and medical records were obtained (Ex1, Tabs 196–207 and 213). The records have been considered by Dr Eagle, forensic psychiatrist and she has accurately set out Mr Mokmool's medical treatment for his mental health in her report dated 3 May 2019, together with a collateral history from his family members (Ex1, Tab 212).

Mr Mokmool was 15 years old when his school counsellor referred him to Liverpool and Fairfield Mental Health Service on 27 May 2003. He was reported to have engaged in outbursts, experienced confusion, and thought he was hearing things. He was assessed as low average intelligence. Following a full assessment he was diagnosed with a conduct disorder and a provisional diagnosis of an adjustment disorder resulting in conduct problems. He was referred for counselling. On 4 June 2003, he reported to the psychologist that he and a friend had been assaulted by a gang of youths about three months earlier. He reported having lost consciousness and experiencing some transient memory loss. He described having been diagnosed alprazolam by his GP and at time of feeling angry and distressed would consume "handfuls of them". The psychologist noted previous incidents of self-harm including burning his forearms, cutting his arms and shooting air pistol pellets into his arms. In December 2004, he deliberately consumed an overdose of medication and was brought to hospital by police. He was diagnosed with depression and his suicide attempt was described as impulsive.

Corrective Services NSW records refer to Mr Mokmool experiencing psychiatric symptoms. In August 2011, he was noted to be experiencing auditory hallucinations (hearing the voices of the Devil and God), expressing paranoid and grandiose delusions and was at risk of self-neglect. The attending doctor, Dr Dayalan, opined a possible diagnosis of schizophrenia. Mr Mokmool was commenced on 10mg olanzapine daily, and after a week he was discharged back to the main gaol. The psychotic episode was considered drug induced and resolved.

On 8 November 2011, Mr Mokmool's mother contacted Community Corrections as she was concerned about him. That morning he had told her that he was seeing spirits at home, that he couldn't sleep and that the spirits were trying to harm him. On 10 November 2011, Mr Mokmool attended his GP, Dr Chau, and reported hearing voices in the background over the last few months, seeing shadows and people not talking to him. Dr Chau referred him to Dr Law, psychiatrist, on 11 November 2011. Dr Law diagnosed a psychotic illness and commenced Mr Mokmool on risperidone. Mr Mokmool continued with Dr Law for a period of about four months. On 5 December 2011, Mr Mokmool saw another GP, Dr Tan. Dr Tan's notes indicate that Mr Mokmool reported feeling better on risperidone and experienced less paranoia, though was still hearing voices in the background.

On 27 December 2014, Mr Mokmool presented to Liverpool Hospital. He was noted to have paranoid thoughts about his family and other people wanting to kill him.

He reported smoking crystal methamphetamine ("ice") two days prior. He was diagnosed with drug induced psychosis, provided with five days' supply of olanzapine and discharged home for outpatient mental health review. The Community Mental Health Team ("CoMHET") conducted a home visit two days later and spoke with Mr Mokmool's mother who said he was becoming more paranoid. They spoke with Mr Mokmool over the telephone and arranged further appointments, which he did not attend. As a result, Mr Mokmool was discharged from the service.

On 13 January 2015, Dr Nguyen, GP, received a letter from Tia Ven, clinical psychologist. Mr Mokmool was described as being flat and providing minimal responses during the assessment. He described "delusional thoughts of a persecutory nature and reported that a day prior to these thoughts had taken methamphetamines and he believes that this worsened his thoughts although they were apparent before taking methamphetamine". Mr Mokmool reported staying at home every day and checked his house for intruders, that he had used heroin for a few years and methamphetamine for seven years.

In February 2016, Mr Mokmool commenced on the methadone programme at Scott Street Clinic in Liverpool. He was reviewed on a two to four week basis by Dr Prakash who noted that he did not present as irrational, clinically depressed or psychotic. His monthly drug screens were clear since October 2016 (however, the medical records indicate that on 11 February 2016 a urine screening tested positive for amphetamine type substances). On 10 September 2016, Mr Mokmool was admitted to Liverpool Hospital having been brought in by ambulance voluntarily. He had run through properties into a creek in order to get away from a friend he believed was trying to kill him. He was highly agitated and suspicious. He was hallucinating and reported seeing people outside the windows with knives who were trying to kill him. Mr Mokmool reported that he had not used drugs, but then his friend had forced him to have four puffs. He then ran away thinking his friend was trying to kill him. The following day, 11 September 2016, he reported that his mother was trying to take out a hit on his life. On 12 September 2016, he denied a continuation of those persecutory beliefs and was discharged from hospital with CoMHET follow up. Despite several attempts CoMHET was unable to contact Mr Mokmool.

On 20 September 2016, Mr Mokmool was again brought to Liverpool Hospital by ambulance, having been found wandering on the road and jumping in and out of traffic. He had tried to jump out of the ambulance.

He reported using methamphetamine the previous night. He denied psychotic symptoms and reported having an anxiety attack. He was counselled about his methamphetamine use and discharged with a supply of olanzapine and CoMHET follow up.

A urine screening taken at the Scott Street Clinic on 26 September 2016 tested positive for amphetamine and benzodiazepines.

On 15 December 2016, Mr Mokmool was referred by his GP to Liverpool Hospital with anxiety and escalating paranoia. He saw Dr Daniels and reported to have not used methamphetamine since the 20 September 2016 admission. He reported increasing anxiety with paranoid thoughts and that he locked himself in his house at times due to his anxiety. Dr Daniels noted that Mr Mokmool would not let CoMHET into his house due to his paranoia. Mr Mokmool denied constitutional symptoms. He reported drinking one to two cups of coffee a day at work, but had left his job due to paranoia that people were going to jump out and hit him. Dr Daniels noted "acute on chronic exacerbation of anxiety with paranoid thoughts would likely benefit from restarting antipsychotic acutely (queried) quetiapine with close mental health follow up. Needs psychologist referral for guided relaxation and controlled breathing for anxiety and panics and could benefit from a brief course of Zyprexa prn, counselled again Benzo use".

Dr Daniels gave evidence speaking to his notes and impressed that the day he saw Mr Mokmool he did not display any symptoms of psychosis, disordered thought and was easily engaged (D4 T38.5). I accept that Dr Daniels did not observe any such symptoms. Mr Mokmool followed Dr Daniel's suggestion and attended a psychologist, Dr Camacho. Dr Camacho reported that Mr Mokmool did not display signs of mental issues such as schizophrenia or paranoia, but did identify to Centrelink that due to Mr Mokmool having significant psychological disorders made him unfit for work.

Mr Mokmool's family reported that, since about 2011, he had been highly paranoid and felt unsafe at home. He would lock windows and doors and not go out. In February 2017, when he was working for a relative in Cronulla, Mr Mokmool ran out to a coffee shop because of beliefs that his co-workers were preparing to kill him. His mother also reported that on occasion Mr Mokmool would attend a police station because of his fears and the police would call her to pick him up to reassure him it was safe to go home.

In addition to setting out Mr Mokmool's treatment history, Dr Eagle referred to Mr Mokmool's substance abuse history, criminal history, relationship, education and employment after which she outlined the events of 26 July 2017.

Dr Eagle opined that Mr Mokmool had a chronic psychotic illness, schizophrenia, at the time of his death. She noted that he experienced a gradual decline but had likely suffered from this illness since September 2011. She noted that at the end of 2017, at the time Mr Mokmool attended Dr Daniels at Liverpool Hospital, he was demonstrating an increased level of engagement and insight into his substance use and mental health for a chronic psychotic illness. Dr Eagle opined that adequate treatment, including anti-psychotic medication may have resulted in monitoring, stabilisation or even remission of his symptoms and an improvement in his level of function. Dr Eagle suggests that the attendance upon Dr Daniels may have been a lost opportunity to begin this process.

In my view, it is not possible to confidently say that Mr Mokmool would have successfully engaged in treatment as he had demonstrated non-compliance previously. Dr Daniels gave evidence that when he spoke with Mr Mokmool, Mr Mokmool was not psychotic and not apparently delusional and, though he did not recall his specific interactions with Mr Mokmool, from his notes Mr Mokmool was reporting signs of heightened anxiety. Mr Mokmool did engage with a psychologist as recommended and I note that when the police attended Mr Mokmool's family home after his death they located unused anti-psychotic medication. This suggests that Mr Mokmool, whilst having insight into his substance abuse, was attempting to address his psychiatric problem without such medication.

I have no difficulty accepting Dr Eagle's opinion that on 26 July 2017, Mr Mokmool was experiencing a psychotic episode and this impacted on his behaviour when he interacted with the police. She described that his thinking and emotional state were significantly impacted by his delusions (that his family wanted to harm him). His behaviour was incongruent, such as giggling on the phone to the police, smiling inside the shop whilst holding scissors to his arms, cutting himself. Disturbances in his thought processes, beliefs and emotions would have played a direct role in his behaviour leading to his death. Dr Eagle described how persons in such a mental state have major difficulty in processing information, commands or interpreting their environment (D4 T55.30). Mr Mokmool's conduct on the 26 July 2017 is entirely in keeping with a person suffering from a psychotic episode.

Though the police had all received training from the MHIT, and Senior Constable Harrison had undergone the four day residential training programme, their exposure to Mr Mokmool was for the briefest of time. Only Senior Constable Maranda had listened to the VKG on his way to the shop and heard that Mr Mokmool had observed to be engaged in deliberate self-harm. Senior Constable Harrison heard Mr Mokmool say *"shoot me in the head*" and Senior Constable Tse said he heard Mr Mokmool say, in apparent response to the OC spray, "*I'm going to kill you*". There was insufficient time for any of the police officers to proceed upon any assessment in any event, regardless of whether they did or could assess Mr Mokmool as having a mental health episode, no matter what kind, no matter whether it was drug induced or otherwise. The incident was frightening to the public, to the police and, no doubt, to Mr Mokmool himself.

The rapidity of the escalation is likewise overwhelming. Due to Mr Mokmool's psychotic state, I am unable to conclude what he believed was happening and what his intentions were when confronted by police. Regardless of his suffering a mental illness, the police had every reason to assess him as posing a very serious risk to their safety or lives, as well as to the public should he have run amok outside the shop where there were many people gathered and passing.

NSW Police Force Mental Health Intervention Team

The recommendations arising from two previous inquests into deaths involving a civilian being shot by police were referred to in counsel assisting's opening. Both those deaths occurred after Mr Mokmool's death. The recommendation in the Inquest into the death of Stephen Hodge was in relation to integrating mental health training into tactical operations training with an emphasis on specific de-escalation techniques practiced by role play exercises. Likewise, a similar recommendation was one of several made in the Inquest into the death of Courtney Topic. Another particularly relevant recommendation in that inquest was that "*consideration be given to the Mental Health Intervention Team ("MHIT") and Weapons and Tactics Policy Review ("WTPR") establishing and documenting a joint review of training packages for defensive tactics training where mental health is likely to be a relevant factor*".

Chief Inspector Matthew Hanlon provided two statements in the inquest. The first statement addressed the training provided by the MHIT and the training completed by the directly involved officers (Ex1, Tab 185A).

The second statement addressed the steps taken by the NSW Police Force to consider and implement the recommendations made in the Inquest into the death of Stephen Hodge and the Inquest into the death of Courtney Topic (Exhibit 15).

Chief Inspector Matthew Hanlon expanded on the content of the training programs run by the MHIT in his evidence. The one day Mental Health Workshop is an abridged version of the four day residential course. It was commenced on 4 February 2014 and was delivered face to face throughout NSW by December 2015, as well as being delivered at the NSW Police Force Academy at Goulburn. As of 4 December 2018, some 16,141 had completed the one day Mental Health Workshop. Senior Constable Tse and Constable Taylor completed the programme in early 2015, Senior Constable Maranda completed it in June 2014, and Senior Constable Harrison completed the four day programme in March 2015.

Chief Inspector Hanlon gave evidence that the four day residential course can accommodate 30 officers a month, as is run 10 months of the year. As only 300 officers can complete the residential course each year, it will take decades for each officer in the NSW Police Force to complete the programme. However, officers involved in weapons and tactics training have priority placement and so far 80% of those officers have completed that programme. It is anticipated that the remaining 20% will be accommodated in the very near future.

Chief Inspector Hanlon agreed that the one day Mental Health Workshop dedicates a significant period of time to s. 22 of the *Mental Health Act*. In his first statement, he cites that in 2018 some 14,724 persons were taken to hospital by police under s. 22 of the *Mental Health Act*. Those figures are taken from the police Computer Operations System ("COPs"). Chief Inspector Hanlon gave evidence that in 2018 the police engaged with persons suffering mental illness on no less than 24,000 occasions where police record their intervention or engagement with family or carers to assist someone voluntarily into care and treatment. That does not take into account where the police have assisted NSW Ambulance.

Chief Inspector Hanlon later referred to those numbers as showing that the police are continuously and positively engaged in assisting and managing persons with mental illness and reflects the efficacy of the training MHIT provides. I accept that that number indicates that an adverse outcome such as this case is, thankfully, rare. Mr de Mars successfully sought to tender statistics in relation to deaths from police shootings (Exhibit 8).

There is no suggestion that there is a trend that would indicate that the police have disregard for this issue. Indeed the number of police shootings is decreasing, or at least static overall, rather than rising.

Chief Inspector Hanlon gave evidence that STOPAR de-escalation training is a mandatory subject in all police training and that it was developed in mid-2018. The MHIT is currently engaged in producing a variety of online training modules to update officers' skills in relation to mental health. Chief Inspector Hanlon was asked questions about VKG radio operators attending an MHIT training day and indicated that at this stage there has been no formal approach in that regard. Likewise, there has been no movement on having a scheme whereby officers who have attended the four day residential course are despatched as first responders as the challenges in relation to doing so are unable to be accommodated.

Mr de Mars asked Chief Inspector Hanlon about the resources of the MHIT. Chief Inspector Hanlon was very positive about the work his unit does - he not only heads the unit but he himself is involved in the actual training. He explained the rationale behind that: "I'm required to simply on the basis that there's only two staff". He delivers the one day course for each of the quarterly training intakes at the Police Academy. Prior to end of 2018, a full time Clinical Nurse Consultant was part of the team, but has now been replaced with a temporary senior policy officer to do research and evaluation. Given the number of tasks of the MHIT, the prevalence of police officers engaging with persons suffering mental illness, and the need for targeted and ongoing training, the personnel resources of the unit are minimal to say the least. The modules of online training do not involve officers engaged in actual face-to-face role plays which the recommendations in the Inquest into the death of Stephen Hodge envisaged. Perhaps if there were additional trainers, the provision of training to VKG operators could be earlier rather than later given the demands on the programmes and training schedules available. As the VKG outgoing communications were not an issue in this inquest. It is a matter which does not attract my consideration of recommendations.

Submissions by Counsel

I will not set out each of the submissions as I have dealt with some in the body of these reasons for my findings. Counsel Assisting submitted that an appropriate recommendation arising from this inquest is in relation to the requirement that front line officers carry a Taser.

The evidence from the uniformed officers showed that they did not usually carry a Taser and that incident on 26 July 2017 was no exception to this practice, which they had each adopted without any reason, let alone any good reason. Sergeant Waters was adamant that policy requires the carriage of the defensive weapon.

The SOPs state, "Only one (1) Taser is to be issued to a minimum two (2) officer uniformed team deployed to undertake operational response" (Ex1, Tab 211, p. 16). The SOPs also state, "Tasers will only be issued to uniformed officers undertaking response policing and will be worn as part of their Arms and Appointments" (p. 18).

A Taser is issued at the request of an authorised officer so if an officer does not ask for a Taser they are technically not in breach of the policy. It needs to be clarified and I will make a recommendation that the SOPs are amended as soon as possible and the amendment be communicated effectively. Mr Casselden SC on behalf of the Commissioner of Police NSW is content with such a recommendation.

Mr de Mars asks on behalf of the family that my findings document the events prior to the arrival of the police, which I trust I have adequately done. Mr de Mars particularly points out that the events "on the ground" had changed somewhat by the time the VKG and CAD announcements are made. For example, the evidence shows that Mr Theoharis was no longer being held by Mr Mokmool by the time the urgent beep was sounded in the police station. That is so, and had Senior Constable Tse heard the VKG he may have been aware that Mr Mokmool, rather than still having a piece of glass at Mr Theoharis' neck, was in fact harming himself. It was a dynamic situation that some eyewitnesses expressed as alarming and others not so. The arrival of the police changed the dynamic dramatically. Mr de Mars submits that if the police had not been so physically close, had taken more time to assess the situation, communicated with each other the situation would not have escalated so rapidly.

I accept that the police can gain opportunities to de-escalate a situation if they have or take the time and distance and exercise the STOPAR principles. That did not occur in this matter for a number of reasons including the perceived urgency of the situation, the environment being open to the public and the number of people in the vicinity. The response to the urgency of the situation resulted in each officer who attended thinking that the most important thing to do was to get to the location and assess it, and they didn't think anything beyond that.

Once they arrived and drew their firearms, which in the circumstances, was justified, there was little to no opportunity to de-escalate.

Mr de Mars submitted that Senior Constable Tse was too close to Mr Mokmool. I agree, I think he unwittingly placed himself in front of the shopfront because of the width of the entrance, the geography of the location and the lighting. Senior Constable Tse thought he was about seven metres, whereas the reconstructed imagery shows that he was within half that distance. Whilst Senior Constable Tse was too close for his own safety, as I have stated above at [172], he was right to stand where he did as there was a real risk that Mr Mokmool could run out of the shop and hurt a police officer or a member of the public.

Mr Madden submitted that the police had no choice but to discharge their firearms when they did so. That might be the case but there is a choice whether to draw the firearm in the first place. I make no criticism that they did so and I note that the Arms and Appointments guidelines seem to lack any "edged weapon" or "blade" specific guidelines.

Mr de Mars submitted that I would make recommendations in relation to the Arms and Appointments guidelines including minimum distances at which the police can be in relation to offenders armed with blades. This inquest did not engage in examining the alternatives to the training currently given to officers, which is that they are not to engage in baton combat within striking distance of someone with a knife. To place a determinate distance would be inappropriate given that sometimes police have to physically remove an armed offender from vehicles and other locations so to place a mandated distance would not be appropriate. All four officers were aware of the reactionary gap of seven metres and at least Senior Constables Tse and Maranda thought they were twice the distance away from Mr Mokmool than they were. The Arms and Appointments guidelines do make clear that non-lethal options such as OC Spray and Taser should be considered. However, the plainclothes officers are not issued with Tasers and the uniformed officers didn't have one. Unless there is a plan so that the use of OC Spray can be deployed with some other tactic, this case shows how the spray can trigger an escalation rather than subdue the situation. However, Mr Casselden SC rightly submitted that the police were "between a rock and a hard place" – they could well have been subject to criticism if they did not attempt non-lethal means to subdue Mr Mokmool.

Mr de Mars has submitted that I adopt the language of Dr Eagle where she suggests that Mr Mokmool's attendance on Dr Daniels at the Liverpool Hospital was a "missed opportunity" for him to have commenced a treatment regime to address his schizophrenia. Mr de Mars submitted that, if Mr Mokmool had done so, the events of 26 July 2017 would not have unfolded. In written submissions on behalf of the South Western Sydney Local Health District, Ms Gerace submitted that there are too many variables to allow a conclusion that a differing diagnosis or course of treatment on 15 December 2016 would have prevented the events of 26 July 2017.

I decline to find that the attendance on Dr Daniels was a "missed opportunity", as Mr Mokmool engaged with a number of health professionals since that attendance who did not identify Mr Mokmool showing any symptoms and the period of time since that attendance. Additionally, Mr Mokmool's established resistance to engaging with CoMHET and non-compliance with medication suggests that there is no nexus between Mr Mokmool's attendance upon Dr Daniels and the circumstances of his death.

Mr de Mars sought a recommendation for the Commissioner of Police to consider a policy whereby that when both plainclothes and uniformed officers attend a scene, the uniformed officer takes command. That submission is founded on the fact that plainclothes officers do not carry Tasers. I do not agree with that submission as it is fraught with potential that the safety of first responding police and the public could be jeopardised because of limitations placed on them due to a ranking system.

Findings and Recommendations

The findings I make are as follows:

Danukul Mokmool died on 26 July 2017, at Central Railway Station, Eddy Avenue, Sydney, of a gunshot wound to the head, as a result of a police operation. He was experiencing a psychotic episode and was shot by police officers in circumstances where he ran at police with scissors in his hands.

To the Commissioner of Police NSW:

That consideration be given to amending the applicable Standard Operating Procedures so that uniformed officers performing frontline duties are required to carry a Taser absent good reason not to.

21. 256295 of 2017

Inquest into the death of Arthur ROBERTS. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 27th March 2019.

Mr Roberts Personal History

Mr Roberts was born on 30th September 1959 to Arthur and Dorothy Roberts. He had 3 sisters Rosemary, Carly and Deborah and a half-brother Fred. Mr Roberts grew up mainly in the Redfern and inner-city area, attending Enmore Boys High School where he gained a Year 9 education. After school, Mr Roberts performed a number of factory jobs before eventually gaining employment with Sydney buses.

Mr Roberts married in 1985, though the marriage lasted only a year and produced no children. Mr Roberts joined Alcoholics Anonymous in 1987. He remained in Alcoholics Anonymous his whole life, becoming a mentor to other participants. He joined Sydney Buses as a driver in the late 1980's and remained with them until about the year 2000, leaving in uncertain circumstances after a physical altercation with a colleague. From that time Mr Roberts was only able to hold down casual jobs. From 2000-2010, Mr Roberts was in a relationship with Wanda, who he loved dearly and travelled extensively with. Unfortunately, this relationship broke down in 2010 and Mr Roberts fell into depression.

Mr Roberts Medical History

Little is known about Mr Roberts' medical history. His sister Rosemary describes Mr Roberts as "very private, with a lot of issues". Rosemary believes that the loss of his job at Sydney Buses and the breakdown of his relationship with Wanda were triggers for Mr Roberts' to suffer depression.

Rosemary suspected Mr Roberts may have suffered undiagnosed manic depression and/or schizophrenia; however, this has not been able to be confirmed. Mr Roberts was very secretive and did not divulge his health details readily, even to family.

Mr Roberts Custodial History

Mr Roberts first came into contact with the criminal justice system in 1973. From 1973 to 1982 he was charged and convicted of some relatively minor offences, most being traffic related.

He was next charged in NSW in October, 2015 for assaulting a male in Coogee causing the victim to suffer a fractured cheek bone, fractured nose, and bruising to both eyes of the victim. Initially released on bail, Mr Roberts entered Correctives Services Custody for this offence on 21 October 2016 after being refused bail by the Sydney District Court. He was convicted of the offence and on 31 May 2017, he was sentenced to 5 years imprisonment, with a non-parole period of two years and six months. Mr Roberts spent his initial time in gaol at Parklea Correctional Centre. On 7th December 2016, Mr Roberts was assaulted by another inmate. He was treated at the Prince of Wales Hospital and was transferred to the Metropolitan Special Programs Centre (MSPC) at Malabar in July 2017.

Mr Roberts appeared to be a quiet prisoner, with no breaches of discipline or security recorded against him. Mr Roberts' sister, Debra Swinbourne visited Mr Roberts on 30 July 2017. This was his last reported visit in custody. There is no evidence to suggest Mr Roberts complained of any health issues.

Every time a prisoner is received into Corrective Services custody, a case management file and warrant is created. These files contain documents including inmate requests, alerts, programs or further education plans and behavioural type offences committed within Corrective Services custody. Mr Roberts's case management file contains nothing of great note regarding any ongoing or recurrent health issues. As mentioned, he was assaulted by another inmate in 2016. This was acted upon appropriately, with Mr Robert's receiving medical treatment at Prince of Wales Hospital and having five teeth removed.

Justice Health provides medical care to inmates within the Correctional System. They maintained 1 volume of medical records relating to Mr Roberts. The records indicate that Mr Roberts rarely required medical assistance or attended the medical clinic.

The records show Mr Roberts was assessed by nursing staff in October 2016 upon reception to Parklea Correctional Centre. He refused to answer several questions relating to his mental health and denied any self-harm or suicidal thoughts. Mr Roberts denied taking any medication and denied smoking. He complained of mild back pain, explaining that he heard his back crack when bending down a few days earlier. He refused an offer of pain relief. Mr Roberts divulged to Justice Health staff that he had been seen by a doctor at Nepean Hospital some time prior to entering custody. There, he had been told that it appeared he had suffered a heart attack some three years prior.

Mr Roberts however refused all requests of Justice Health to sign Requests for Information consent forms. These forms would have allowed Justice Health staff to obtain his medical history and records from medical providers in the community. Mr Roberts was added to the General Practitioner waitlist for review.

On 15 November 2016 Mr Roberts was seen by a Justice Health doctor. Mr Roberts refused to provide any medical history, refused a clinical examination and denied any medical issues. He stated, "I am well and I don't want to see you".

In November 2016 Mr Roberts was transferred to the Metropolitan Special Programs Centre (MSPC). Upon admission, he advised Justice Health staff that whilst he had been previously treated for a mental health issue, it had been wrongly diagnosed. Mr Roberts would not discuss this further. No mention or complaint was made of any heart issues. He was referred to a psychologist for assessment. On 21 March 2017 Mr Roberts was seen by a Justice Health psychiatrist for a court report. The psychiatrist noted that Mr Roberts was extremely suspicious and guarded, with little insight into incarceration.

In June 2017, Mr Roberts was moved from the MSPC to Parklea before being returned to the MSPC in mid July 2017. Upon re-admission, Mr Roberts was again screened by Justice Health staff. Mr Roberts indicated he was not taking any regular medications and he made no complaint about his health. When questioned by Justice Health staff about the unconfirmed heart attack previously mentioned, Mr Roberts denied any such heart issues.

Events leading up to the death.

On Monday 21 August 2017 Mr Roberts was secured in cell 15 of Wing 16 at the Long Bay Correctional Centre. He was seen alive and well by Corrections staff at 6.15 pm and again by his cellmate at 7.30pm when they both retired for the evening. His cellmate awoke to use the toilet during the night, around 1.00am of Tuesday 22 August 2017. Mr Roberts was heard breathing and making gurgling sounds in his sleep. About 6.30am on Tuesday 22 August 2017, Mr Roberts' cellmate awoke and attended to stripping his bed for the laundry that day. He thought Mr Roberts was sleeping, and when he tried to rouse him, Mr Roberts was unresponsive.

He called Corrective Services staff and they attended immediately. In turn they notified Justice Health staff and two registered nurses arriving shortly after.

One of the first Correctives Officers on scene was Corrective Officer Kelly, a former paramedic of 11 years' experience. In his statement, Corrective Officer Kelly said,

> *'Inmate ROBERTS was not breathing and unresponsive to verbal commands to wake up. I felt for a carotid and radial pulse with no success.'*

NSW Ambulance staff also arrived shortly after. A defibrillator was applied to Mr Roberts; however, a shock was deemed of no use. Mr Roberts was formally declared life extinct at 7:02 am by ambulance staff.

Police Investigation

Police were notified of the death. Uniformed police and Detectives attended. Specialist investigators from the NSW Police Corrective Service Investigative Unit conducted the investigation. No evidence was found suggesting foul play. Staff from Corrective Services and Justice Health was spoken to. A forensic crime scene examination was conducted of cell 15. There were no signs of a struggle. The cell appeared neat and tidy. No suspicious circumstances were found. No systemic failings were identified.

All protocols were followed by Corrective Services with regard to deaths in custody. The Crime Scene was managed by Corrective Services staff in an efficient and competent manner. A post mortem examination was conducted by Dr Elsie Burger. She opined the cause of death to be from the effects of ischaemic heart disease.

Mr Roberts' Refusal of Medical Treatment

As part of staged health care, Justice Health requests all inmates to complete a 'Consent to Obtain Health Information' form in order for Justice Health and Forensic Mental Health Network to be able to contact their regular health provider. All information is scanned and made available on the Justice Health electronic Health System. Justice Health has developed a centralised model of coordinating access to patient's health information through this process.

Mr Roberts refused to sign this consent form. Though Justice Health and Forensic Mental Health Network continue to work to identify and treat patients who require health interventions within the correctional environment, however they also respect the rights of patients to refuse treatment in line with existing community standards.

During the assessment process it is not always possible to identify existing health concerns without the cooperation of the patient. Any health concerns that are identified are referred for appropriate treatment with patient's encouraged to engage in such treatment.

Conclusion

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

An extensive review has been conducted of the evidence contained within the file. Records from Justice Health and Corrective Services have been reviewed. Mr Roberts has died of natural causes. There are no relevant matters in relation to Mr Roberts' care and treatment whilst in custody which enliven the consideration of any recommendations of policy or procedure of either the Corrective Services or Justice Health.

Findings

Identity
The person who died was Arthur Roberts.

Date of death
Mr Roberts died on 22 August 2017.

Place of death
Mr Roberts died at Long Bay Correctional Centre, Malabar NSW.

Cause of death
The cause of death is ischaemic heart disease.

Manner of death
Mr Roberts died of natural causes.

22. 266269 of 2017

Inquest into the death of Christopher Robert HILL. Findings handed down by Deputy State Coroner Forbes at Armidale on the 13th March 2019.

Christopher Hill died on 31 August 2017 as a result of injuries he suffered in a motor vehicle collision along the New England Highway at Bendemeer, NSW. He was driving in a utility vehicle that belonged to his employer in Victoria.

At around 8.30am an operator at the Caltex Service Station on the New England Highway, Armidale reported to police that the vehicle Christopher was driving had driven away without paying for fuel.

A broadcast was made by the NSW police. Senior Constable Gersback was travelling north on the New England Highway and heard the broadcast.

About 8 minutes later, Senior Constable Gersback passed Christopher's vehicle travelling in the opposite direction. He conducted a U-turn and about two minutes later observed Christopher's vehicle travelling at the speed limit, of about, 100kmh. Senior Constable Gersback activated his lights and sirens but Christopher continued driving at the speed limit as if he didn't notice Senior Constable Gersback behind him. Senior Constable Gersback made a radio call requesting any highway patrol vehicles head to his direction and stated, "I'll be in pursuit of this vehicle."

Within 20 seconds of this broadcast Christopher's vehicle travelled across the centre line and was involved in an off-set head-on fatal collision with a semi-trailer travelling in the opposite direction.

Inquest

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

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 Act also requires a Senior Coroner to conduct an inquest where the death appears to have occurred "as a result *of police operations".* (s.23, s.27).

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

This inquest is not a criminal investigation, nor is it civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. This Inquest has been a close examination of the circumstances surrounding Christopher's death and of the police actions on the day of Christopher's death and pursuant to s.37 of the Act a summary of the details of this case will be reported to Parliament.

Christopher Hill

Mr Hill was only 29 years old at the time of his death. He lived with both parents until their separation when he was about 2 years old. Both his parents and other family members have attended each day of this inquest which of itself demonstrates the depth of their loss.

After his parents separated Christopher lived with his mother and had regular fortnightly contact with his father until his father moved overseas when Christopher was 7 years old. He was then estranged from his father for about 14 years until he was reunited briefly with his father around his 21st birthday.

At the age of 15 years he started to clash with his mother and his stepfather. Mrs Hill and her partner attempted to refer her son for counselling but he refused to go.

Christopher lived at home with his mother until he was 18 years old. He left in 2006 and there was reduced contact between them. Intermittent contact with his mother was maintained but their relationship was strained. Contact ceased in early 2012 and unfortunately Mrs Hill did not see her son for several years before his death.

Christopher did not have other any known significant relationships. An investigator interviewed Christopher's housemate Ryan Smith. Mr Smith told him that Christopher, with whom he had lived since 2012, was a good housemate and usually paid his rent on time.

After the housemates moved to a new property in February 2017, however, things changed and Mr Smith stated that Christopher did not become involved in any social activities and mainly "lived to work". Mr Smith told the investigator that he was unaware of Christopher having any intimate relationships.

Other people who knew Christopher described him as a hard worker and friendly. They say he was not a heavy drinker or a drug taker, although he did dabble in cannabis and had tried methyl amphetamine.

In 2017, Christopher became evasive about paying bills and rent and when Christopher left on the morning of 18 July 2017, he left behind a total debt in rent and other bills of about $8,800. Mr Smith was aware that Christopher had previously left other lodgings without paying rent and he said he knew Christopher would not be coming back this time. He concluded Christopher might have been doing a runner.

Subsequent investigations found that in the months before his death Christopher had losses amounting to $27,000.00 with Crown Bet although these had been paid back. He also was in debt to his credit card in the sum of $450.00. His total debt including owed rent and other bills was about $9300.00.

Facts in outline

Christopher was employed at Dirty Diggers Earth Moving Company, Ferntree Gully, Victoria (Dirty Diggers) at the time of his death. He commenced employment at Dirty Diggers in March 2015.

In the week of 3 July 2017, Christopher called in sick for several days. He worked between 10 and 15 July 2017, although he did not submit job sheets recording his time on the last 3 days he worked – which was unusual.

On Monday 17 July 2017, about 6 weeks before his death, Christopher failed to report to work. He had been using the company vehicle, the blue Nissan Navara utility with distinctive Victorian plates "DIRTYD" and when he failed to show up to work, Dianne McCullough, part owner of Dirty Diggers, contacted the Victoria Police to report Christopher as missing.

Ms McCullough subsequently discovered that Christopher had been attempting to use the company credit card, so she reported both the vehicle and the credit card as stolen. Mrs McCullough and her husband began to receive phone calls from motels and service stations complaining that Christopher had not paid for accommodation and fuel.

Friends and workmates of Christopher tried contacting him in the days and weeks following his disappearance but despite call records indicating that he listened to numerous voicemail messages and readings texts, Christopher did not respond to any of them and made no calls after 24 July 2017.

The senior investigator, Detective Inspector Joy, has determined that after he failed to turn up to work on 17 July 2017, Christopher travelled in various directions through Victoria, NSW and Queensland. He stopped at numerous motels and service stations but failed to pay at many.

On 15 August 2017, Christopher visited his uncle, Michael Rennison in Moss Vale whom he had not seen for 8 years. Mr Rennison said Christopher discussed feeling unappreciated at work and they conversed about Christopher finding alternative work in Melbourne. During this short stay, Mr Rennison wrote a list of helpful matters for Christopher to consider. This list was found in the vehicle after the collision. Christopher stayed the night at his uncle's house and after he left on 16 August 2017, Mr Rennison did not see or hear from his nephew again.

Christopher stayed at the Kaputar Motel, Narrabri from 25 to 29 August 2017. He had booked two rooms (a single and a double) until 31 August 2017. He informed the manager, Mr Elliott, that his boss would be arriving on 28 August 2017. Mr Elliott saw that Christopher's room had been emptied out on the morning 29 August 2017 and Christopher had apparently left without paying.

It is not known where Christopher stayed on the night of 30 August 2017.

Christopher's utility was seen on CCTV travelling north at Uralla at about 7.58am on 31 August 2017. This is about 250km from Narrabri. At around 8.09am, Christopher put 70 litres of fuel into the vehicle at Armidale Airport Caltex Service station on New England Highway in Armidale. It is unclear why Christopher travelled an extra 20km further north to fill up with fuel when he could have refuelled in Uralla. Christopher left the Caltex without paying and the employee called the police to report the theft. He travelled south and was again seen on the Uralla CCTV at 8.22am.

A police CAD incident log was created soon after by Constable Matt Lee-Windsor and a broadcast was put on the police radio. Senior Constable Gersback of the Dog Unit, who was driving a police vehicle carrying two dogs, acknowledged the call at 8.33am.

At 8.41am, Senior Constable Gersback was travelling north on the New England Highway. He spotted Christopher's vehicle and did a U-turn in order to stop the vehicle. Senior Constable Gersback estimates that his own vehicle was travelling at speeds of up to 109kmh shortly before the collision.

A civilian truck driver witness, Richard Schaffer, observed the police vehicle when it overtook him northbound on the New England Highway, then again when it passed him in the opposite direction a short time later. At both times, he thought the police vehicle was travelling at normal speed and at neither time did it have its lights or sirens activated.

At 8.43am, Senior Constable Gersback stated that he was travelling about 100kmh, about to try and stop the vehicle of interest near the intersection with Muswell Hill Road. Less than a minute later, he declared that he was in pursuit of the vehicle and asked for the assistance of any highway patrol cars. He had already activated his sirens when he called the pursuit. His voice on the police VKG radio recorded broadcast is quite calm and measured when making this call.

Senior Constable Gersback reported seeing nothing to indicate a change to the way in which Christopher was driving after he activated his lights and sirens. He concluded that Christopher might not have heard or seen the police vehicle as he continued to travel at the speed limit in a normal fashion.

Another civilian truck driver witness, Nicholas Dunn, was traveling north and saw both cars pass him in the opposite direction. The police vehicle had its lights and sirens turned on. He observed the cars through his windscreen and his rear vision mirror (after they passed him) and at no time did he observe either car being driven erratically.

As he followed closely behind Christopher's vehicle, Senior Constable Gersbeck then saw it cross onto the opposite carriageway and hit head-on with a semi-trailer. There was no indication of braking. He had been pursuing the vehicle for only approximately 20 seconds.

Senior Constable Gersback braked and swerved to the right and his vehicle miraculously passed in between the semi-trailer and Christopher's vehicle, colliding with each on the way.

Christopher's vehicle ended up on the eastern side of the roadway facing in a westerly direction approximately 20 metres north of the police van. The force of the impact had been so severe that the whole cabin was buckled and twisted. Sadly, Christopher was entangled within the damage and he was confirmed dead at the scene. A post mortem report concluded that he died as a result of multiple injuries.

The semi-trailer, driven by Mr Dixon, had veered onto the southbound carriageway and stopped one hundred metres north of the police van facing in a northerly direction. It burst into flames and although attempts were made to put out this fire, it took hold of the cab and, eventually, the entire trailer. Both were destroyed. Thankfully Mr Dixon suffered no physical injuries.

Senior Constable Gersback was at the scene for about half an hour before assistance arrived. While his car was still in motion after the impact he picked up his radio and yelled "urgent, it's had a head on with the truck" he then jumped out of his car, taking his radio with him. He ran to Christopher's car and ran from side to side looking for a way of getting him out but the damage to the vehicle made it impossible. He then ensured Mr Dixon was moved to safety and attempted to stop the fire in the semi- trailer. He attempted to assist Christopher again. He made arrangements for the traffic to be stopped.

I agree with Counsel Assisting's conclusion that Senior Constable Gersback showed enormous composure, courage and compassion in the horrific incident he himself had been involved in.

What was the cause of Christopher's collision with the semi-trailer?

There is nothing to suggest that Senior Constable Gersback changed the way in which he drove after he caught up to Christopher's vehicle. I accept Senior Constable Gersback's evidence that there appeared to be no change in Christopher's driving and there was no apparent reaction or other movement in the cab to indicate Christopher was aware of his presence or the lights and sirens.

I also accept that Senior Constable Gersback was travelling at 109kmh at the time of catching up and at one point he dropped back a little from Christopher's utility but was gaining on it slightly at the moment of the collision. Senior Constable Gersback thought he was about three seconds behind Christopher. Mr Dunn thought just a few car lengths when he made the observation. In any event I am satisfied there is certainly nothing to suggest he drove in a manner that may have directly contributed to the collision.

The driver of the semi-trailer had been driving vehicles for over forty years, and driving trucks became his main occupation in 2004. He had driven that stretch of road over 2000 times. He was well-rested, had a usual start to the day and was carrying a fairly light load of parcel freight.

He was travelling slightly uphill at the time of the incident at about 90kmh around a sweeping right-hand bend.

He described Christopher's vehicle as appearing out of nowhere before he had a chance to even react. I accept that there was nothing in the manner of Mr Dixon's driving that contributed to the collision.

On all accounts Christopher was driving in his lane at the beginning of the long sweeping bend in the road then at one point without any warning he continued straight ahead onto the wrong side of the road into the semi-trailer.

The question becomes why Christopher drifted onto the wrong side of the road?

It is evident from the post mortem report his driving was not affected by drugs or alcohol at the time of the collision.

The vehicle Christopher was driving was examined and showed no signs of mechanical failure that might have contributed to the collision. The brakes worked, the steering and suspension was fine and the accelerator functioned normally. The tyres were in good condition and there was no evidence of tyre failure before the collision.

There is some evidence to suggest that Christopher intentionally drove his vehicle into the path of the semi-trailer with the desire to end his life. Specifically, the evidence to support this theory is as follows:

a. Christopher had stopped recording his time sheets in the several days before he left work and he stopped going to work without warning. This was out of character for him. His friends described him as hard working.

b. Christopher's use of the company car and company credit card to make illegal transactions in relation to the purchase of fuel and accommodation could indicate that he had no intention of coming back.

c. When Christopher visited his uncle in the Southern Highlands of NSW, he seemed disgruntled and unappreciated at work. The fact that he paid this visit, completely out of the blue, was also unusual.

d. By not answering his phone or returning calls for a month or so before he died, one might infer that Christopher wanted to disappear.

e. It was discovered after his death that Christopher had some debts, both from gambling and also from failure to pay rent and other bills. The total amount was less than $10,000.

f. Christopher had been driving the company car without permission, stealing from the company credit card, not paying for fuel or accommodation, including on the morning of his death.

g. When confronted with the presence of a police car with lights and sirens, assuming he was aware of this, it could be inferred that he did not want to face the consequences and decided to end his life.

However, there is also evidence to suggest other possible reasons for Christopher's death. For example, the following:

a. Christopher's friend told police that he had left lodgings before without paying. It is possible he was doing the same.

b. Christopher had never displayed any intentions to kill himself or displayed any actions consistent with suicidal ideation.

c. Christopher had no diagnosed mental health problems or drug dependency issues that may have played a part.

d. Kevin Elliott, manager of the motel in Narrabri, who was the last person we know of to have dealings with Christopher, did not notice any odd or otherwise remarkable behaviour. He described him as a "polite, normal tradesman" who spoke about work.

e. We do not know much about the days (in particular, the 24 hours) immediately before the collision so we cannot know how much sleep Christopher had the night before the collision or how far he had driven on the morning of the crash. He could have been very tired.

f. We do not know if Christopher was aware of the police car behind him. Senior Constable Gersback commented that there was no change in Christopher's driving or movement in the cab and he thought perhaps the driver was unaware of the presence of the police vehicle.

g. We don't know if Christopher had the radio on and we are aware that the sound of the police sirens may have dissipated in the rural area in which this pursuit took place. Certainly, Mr Dixon did not hear any sirens before the collision.

h. There is no evidence of Christopher accelerating immediately before impact or of him abruptly turning the wheel of his car which one might expect if a person were intent on killing himself.

i. Christopher still had his seatbelt attached after the collision.

Sergeant Samuel, the crash investigator, said that the accident was not a true head-on. That the vehicles were off-set. The driver's side of the front of Christopher's vehicle hit the driver's side of the front of the semi-trailer.

It is open to find on the evidence Christopher may have fallen asleep, had a moment of inattention for some unknown reason, or become aware of the police behind him and panicked causing him to drift into the north bound lane as he drove around the bend rather than that he consciously drove into the truck's path.

A finding of suicide is often a difficult task for a coroner. Historically, there was a presumption against a finding of suicide because of the legal and religious consequences of such a finding and the stigma attached to it. In light of changing laws and social values, it is no longer presumed that a person did not intentionally kill themselves and if it is appropriate for such a finding to be made, it may assist in addressing what has become a large social problem in recent decades.

Even though the consequences of a suicide finding have been ameliorated and would have no legal effect in this case such a finding should not be presumed without proper regard of all the evidence and the alternatives.

All decisions made in inquests are made to the civil standard. In the decision of *Briginshaw v Briginshaw* (1938) 60 CLR 336 Dixon J stated;

> *"The truth is that, when the law requires the proof of any act, the tribunal must feel an actual persuasion of its occurrence before it can be found. It cannot be found as a result of a mere mechanical comparison of probabilities independently of any belief of its reality…"*

In this case there is no clear evidence to prove that Christopher caused his own death by a deliberate or intentional act and that at the time of the act he consciously intended to cause his death. The evidence leaves open the possibility that his death was accidental. In those circumstances I am unable to make a finding in relation to whether his death was intentional or accidental.

Was the relevant NSW Safe Driving Policy adhered to?

Policies have been designed to provide checks and balances to ensure police pursuits do not occur in situations that might put members of the public and police in undue danger.

The main safeguard is the relevant parts of the NSW Police Force Safe Driving Policy (SDP). Version 8.2 of this policy was in place on 31 August 2017. (It has been superseded by version 8.3.)

S. 8-6-1 SDP sets out the guidelines for police to perform traffic stops.

Senior Constable Gersback heard on the police radio that Christopher's vehicle had just failed to pay for petrol and that the vehicle had number plates that were cancelled in 2005. It was a clear sunny day and there was minimal traffic, no pedestrians and in a rural area. It was 8:30 in the morning, Senior Constable Gersback had the appropriate silver driving classification and the vehicle he was following was travelling at the posted speed limit of 100kmph. I am satisfied it was appropriate for Senior Constable Gersback to conduct a U-turn and endeavour to stop Christopher's vehicle. His actions complied with the SDP.

Senior Constable Gersback then informed radio operators of his location and activated his lights and sirens attempting to stop Christopher's vehicle. Christopher continued driving.

S. 8-6-3 SDP states that when a driver appears to be ignoring requests to stop and a decision to pursue has been made then the SDP pursuit guidelines must be adhered to.

Part 7 SDP sets out the pursuit guidelines. Senior Constable Gersback's vehicle was a Category 3 vehicle and accordingly was the least suitable one for a pursuit. I note that he appropriately requested the radio to try and raise a highway vehicle and then he began the pursuit. It was only seconds later that the accident occurred.

I am satisfied the SDP was adhered to.

On one reading of the SDP there is an anomaly. Part 5 of the SDP (SDP 5-1-7 p18) deals with vehicle categorisation. It states that Category 3 vehicles are the "*least suitable for pursuits. May be used for Urgent Duty in matters that are Life Threatening or in an Emergency where such response is appropriate*."

It has been submitted by counsel assisting that it would be a perverse outcome that there are less restrictions on officers engaging in a pursuit than those responding to urgent duty.

It was also submitted that other ambiguities and uncertainties in the SDP are:

a. The Traffic Stop provisions are contained within the Coded System of Driving (Part 8) yet they make reference to Urgent Duty in terms of the category of vehicle and distance required to catch up (8-6-2);

b. The fact that the Coded System of Driving seems to define Code Red in similar terms to the actions of SC Gersback in this situation makes it difficult to determine if he was in fact driving Code Red;

c. Reference in SDP 6-1 to "driving police vehicles under urgent duty or pursuit conditions" seems to suggest all pursuits are urgent duty, but that may not be the case.

d. There is a lack of assistance in how Urgent Duty (Part 6) and Pursuit (Part 7) of the policy interrelate and overlap. For example, clearly an officer can be on Urgent Duty but not in pursuit, but can an officer be in pursuit but not engaged in Urgent Duty?

   If the latter is correct, why is the threshold for such an inherently dangerous activity such as a pursuit, set so much lower than urgent duty?

I suggest that the NSW Commissioner of Police consider the submissions made by counsel assisting with a view to clarifying any confusion that may arise where these parts of the policy interact.

Findings: s 81 Coroners Act 2009

I find that Christopher Hill died on Thursday 31 August 2017, on the New England Highway, at Bendemeer in the State of NSW. The cause of his death was multiple injuries sustained in a motor vehicle collision that occurred when his vehicle drifted onto the wrong side of the road during a police pursuit. The evidence is such that I am unable to make a finding in relation to whether his death was intentionally self-inflicted or accidental.

23. 272539 of 2017

Inquest into the death of Shaun CRIGHTON-COMB. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 15th April 2019.

In the early hours of the morning on 4 September 2017 Shaun Crighton-Cromb was driving along a street in East Albury. Travelling behind him was a marked police vehicle containing two police officers. The two police officers were following Shaun in an attempt to ascertain whether the vehicle that he was driving matched the details of a vehicle which had been reported stolen earlier that night.

Approximately 60 seconds after the police officers first sighted the vehicle Shaun was driving it was seen to swerve, lose control, leave the road, and collide with a tree on a steep embankment. The collision resulted in flames which rapidly engulfing the vehicle. Shaun could not be extricated before succumbing to the effects of the collision and fire. Shaun was later pronounced deceased at the scene. Tragically, he was only 19 years old.

Why was an inquest held?

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

Due to the circumstances surrounding Shaun's death, he was regarded as having died in the course of a police operation. This meant that, according to the relevant section of the Act which applied at the time, an inquest into Shaun's death was mandatory. Inquests are mandatory for these types of deaths to ensure that there is an independent and transparent investigation of the circumstances of the death, and the relevant conduct of any of involved police officers.

Shaun's life

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

Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Shaun's important life. It is hoped that the brief words below do so in a meaningful and respectful way.

Shaun was born on 15 August 1998 and was one of seven siblings to his parents, Toni Crighton and Dean Cromb. With the rest of his family, Shaun grew up in the Albury-Wodonga area and attended primary and high schools in the area. At an early age Shaun was diagnosed with a serious heart condition which required annual check-ups. Shaun continued with school until Year 8 and later commenced an external education program to assist him in developing his employability skills. Although Shaun did not have a full-time job he would perform casual work with his grandmother.

Shaun had a love for the outdoors and possessed a keen sense of adventure. He enjoyed camping and motorcycle riding and was known to try anything at least once on a motorcycle. Shaun also had a great love for all animals, but in particular reptiles. He was known to spend many hours reading and researching about them and taking part in one of his favourite past times, hunting for lizards in the bush.

With his adventurous spirit Shaun was known by his family to suffer the occasional mishap and accidental injury, although none were truly serious. It was because of these accidents that Shaun came to believe that his life would not be a long one. Despite this sense of foreboding from Shaun, his family could never have expected to lose him at the young age of 19.

Shaun's passing is all the more tragic because at the time of his death he was at a point where he planned to make some major life changes. He was preparing to move out of the family home and find a place of his own, as well as seek more permanent employment. It is most heartbreaking to know that Shaun was on the cusp of much potential that will, sadly, never be realised.

Despite his young age, Shaun was not unfamiliar with the pain that loss brings. He had lost an uncle, a cousin, and his beloved grandfather, who he was particularly close with. Shaun's sense of family, and the importance of it, only serves to underline what his loss means to those who loved him most. He leaves behind his loving parents and siblings, along with his extended family, all of whom are proud to call Shaun their son, brother, grandson, uncle, nephew and friend.

The events of 3 and 4 September 2017

On the evening of 3 September 2017 there was a 21st birthday party for Shaun's brother, Tristian, at the Boomerang Hotel in Lavington. At about 5:30pm Shaun left his family home at 381 Dale Crescent and drove to the party with his younger brother, Jake, Joel McKillop (Shaun's cousin) and Tylan Graham. The group of four young men travelled in a white Holden VT Commodore (**the Commodore**), which belonged to Tylan's mother, and which was driven by Tylan.

Shaun and the group arrived at the hotel at around 6:00pm. During the course of the evening Shaun was seen to drink several cans of mixed spirits. The party finished at around 10:00pm. Shaun was not seen to be affected by alcohol at this time.

Shaun left the hotel with his father, one of his cousins, and his cousin's girlfriend. After dropping his cousin and his cousin's girlfriend home, Shaun and his father returned to 381 Dale Crescent. A number of other family members also returned there. They spent some time sitting around a fire chatting.

At about 12:30am on 4 September 2017 Tylan, Joel and Jake decided to go for a drive in the Commodore. Whilst driving around, the group realised that the Commodore needed petrol. Joel rang Shaun to ask if he had any money for petrol. Shaun said that he did and so the group drove back to 381 Dale Crescent to pick up Shaun. Upon their arrival, Shaun got into the Commodore and sat in the rear driver's side seat. Tylan was driving, with Joel in the front passenger seat and Jake in the rear passenger's side seat.

At this time Acting Sergeant Johan Medina and Senior Constable Luke Porritt were conducting patrols in the Lavington area in a marked police vehicle, a Toyota Camry sedan with call sign Albury 14 (**Albury 14**). As Albury 14 pulled into Dale Crescent, Acting Sergeant Medina saw the Commodore reverse from a driveway and noticed that it was not bearing any licence plates. Moments later, after the Commodore reversed, it sped off along Dale Crescent. Albury 14 commenced following but Acting Sergeant Medina saw that the Commodore was swerving onto the incorrect side of the road and that it did not have its headlights on. Having regard to these observations Acting Sergeant Medina decided not to initiate a pursuit.

Acting Sergeant Medina saw the Commodore turn onto Tracey Street. At 12:34am, Acting Sergeant Medina made the following broadcast over police radio (also known as **VKG**): "*Yeah radio we have just had a car take off from us, a white Commodore, Dale Crescent, no plates last seen heading off on Tracey, Lavington*". This resulted in a subsequent message being broadcast on VKG for any police vehicles in the Albury area to be on the lookout for the Commodore.

Leading Senior Constable Trent Williams and Senior Constable Andrew Sutherland were, at that time, in another police vehicle with call sign **Albury 16**. They had just conducted a random breath test on Bralgon Street, and were travelling east along Union Street, when they heard the broadcast in relation to the Commodore. In the distance Senior Constable Sutherland saw the Commodore turn out from Turner Street onto Union Street, and then make an immediate left turn onto Boronia Street. Albury 16 followed the Commodore down Boronia Street to the intersection with Wingara Street. Senior Constable Sutherland saw that the Commodore did not have its headlights on and later lost sight of it after it turned off Wingara Street at some point.

The Commodore proceeded to the United Petroleum petrol station on Melrose Drive in Wodonga. After filling up, the Commodore travelled a short distance to the corner of Magnolia Crescent and Wattle Court.

Parked on Wattle Court was a white 1997 Ford Courier dual cab utility, Victorian registration QSM-405 (**the Courier**). The Courier was registered to Mark Korneluk and mainly driven by Mr Korneluk's wife. It had last been used, and parked by Mrs Korneluk, at about 3:00pm on 3 September 2017. The Commodore did a u-turn and parked next to the Courier. Shaun exited the Commodore and, by means unknown, entered the Courier without permission. A short time later, the Commodore left Wattle Court, followed by the Courier being driven by Shaun. Shaun did not hold, and had never been issued with, a valid driver's licence.

At about 1:09am Leading Senior Constable Kylie Clarkson and Senior Constable Daniel Braines, of the Victorian Police, were patrolling the vicinity of Magnolia Crescent, Wodonga in a police vehicle with call sign **Wodonga 311**. About 25 minutes earlier they had been informed by other Victorian police officers in the Wodonga area that Albury police had sighted the Commodore, and had been requested to keep a look out for it. The police officers in Wodonga 311 saw the Commodore and the Courier travelling east on Magnolia Crescent before turning into several other streets, and eventually come to be travelling north on Morrison Street. Leading Senior Constable Clarkson activated the emergency warning lights on Wodonga 311 in an attempt to intercept the Courier. Moments later, the Courier crossed to the opposite side of the road, causing Leading Senior Constable Clarkson to deactivate the warning lights and pull Wodonga 311 over to the side of the road. The police officers in Wodonga 311 saw the Courier turn onto Baelon Street and neither officer saw the Courier or the Commodore (which they presumed had been travelling in tandem with the Courier) again. Senior Constable Braines made a radio broadcast for Victorian and NSW police vehicles to remain on lookout for the Commodore and Courier.

A short time later Joel rang Shaun on his mobile phone and they made arrangements to meet at a location in Wodonga. However, Shaun subsequently told Joel, "*The police are coming*", and then made subsequent arrangements to meet at a location in Albury. At the time, Shaun told Joel that he was on High Street in Wodonga and making his way to the Hume Highway towards Sydney. Shaun later took the South Albury exit off the Hume Highway and turned onto East Street.

At about 1:20am the police officers in Wodonga 311 attended the registered address for the Courier and spoke to Mr Korneluk, who confirmed that the Courier had been stolen. Senior Constable Braines made a further radio broadcast for Victorian and NSW police vehicles with this information.

At this time Acting Sergeant Medina and Senior Constable Porritt were travelling on Dean Street towards Wodonga, and heard Senior Constable Braines' broadcasts. They had earlier been patrolling the Lavington and North Albury areas. Acting Sergeant Medina decided to monitor the Hume Highway in case the Commodore and Courier travelled in that direction. Albury 14 travelled along Hume Street towards the South Albury exit from the Hume Highway. At this time Acting Sergeant Medina saw the Commodore exit the Hume Highway, about 30 to 40 metres away, turn right onto East Street, and noticed that it was "*driving fairly quick straightaway*". Moments later Acting Sergeant Medina saw the Commodore turn left from a roundabout onto Schuback Street. As this occurred, Acting Sergeant Medina looked ahead and saw the Courier on East Street, travelling up an incline.

Acting Sergeant Medina and Senior Constable Porritt had a brief discussion about whether the Courier was the same vehicle that had been broadcast over police radio as being stolen. Acting Sergeant Medina decided to continue in the same direction as the Courier along East Street.

At 1:24:21am (according to the VKG timestamp) Acting Sergeant Medina made this radio broadcast: "*Just sighted, we just sighted the Commodore heading [sic] Schuback Street towards um south on Schuback. We think we have the other car going on East Street going across towards the hospital. We are just trying to ascertain if it's the right car*".

As Albury 14 followed after the Courier, Shaun remained on his earlier phone call with Joel. Shaun said to Joel, "*The police are right up my arse*". Joel told Shaun to slow down and, as the Commodore by this time had turned onto Schuback Street and lost sight of the Courier, asked him where he was. Shaun said that he was still on East Street and, at some point, said, "*What do I do? I'm really scared. They're right up my arse*". As Joel had placed the phone call on speakerphone the other occupants of the Commodore were also able to hear the conversation. Jake recalled hearing Shaun say, "*Coppers are up my arse, help*", whilst Tylan recalled Shaun saying, "*I'm going up East Albury Hill. The cops are right behind me*".

The Courier and Albury 14 continued travelling along East Street, with both vehicles travelling in excess of the designated 60 kilometres per hour speed limit. At a point along a downhill stretch of road the police officers in Albury 14 observed the Courier to swerve from side to side and lose control. Upon seeing the Courier start to lose control, Acting Sergeant Medina applied the brakes on Albury 14 and decreased its speed. Whilst still on the phone call with Shaun, Joel heard Shaun say, "*Oh shit*", followed by a loud bang, and then the phone went silent. The Courier left the road, mounted the kerb, and travelled down a steep embankment before impacting with a tree on the right hand side of the road. The Courier caught alight with flames engulfing its cabin within a short space of time. In a subsequent recorded interview, Acting Sergeant Medina described what he observed in this way: "*…[The Courier] started swerving between both lanes. I could see the tail end of the car started sort of skidding. It's had to tell but yeah it started swerving a bit and then he just completely lost control and yeah went on the side of the road and hit the tree*".

After Albury 14 came to a stop, Acting Sergeant Medina made this broadcast at 1:25:11am: "*Albury 14. Yeah this car has just collided. We are on um we are on East about two hundred metres from the hospital*". Thirty seconds later, at 1:25:41am Senior Constable Porritt broadcast the following, "*Yeah we need ambos and firies. It's just come alight radio not sure if the occupant's in the car still, it's just caught on fire*".

Senior Constable Porritt attempted to approach the Courier to see if any person remained in the cabin, or had been ejected from the cabin in the area surrounding the vehicle. However, as the flames were too intense he was unable to approach the Courier. Other NSW and Victorian police vehicles arrived at the collision site a short time later. Road blocks were established to prevent civilians from approaching the scene and to ensure the clear passage of emergency services.

As this was occurring, and within about two minutes of the collision the Commodore was seen to travel along East Street, past the collision site at high speed.

NSW Fire and Rescue officers based at Albury Central Fire Station responded to the request for assistance and arrived at the scene at about 1:35am. At this time the Courier was well alight with flames engulfing the engine and cabin. One of the attending officers observed that flames were impinging a gas cylinder under the Courier's utility tray area but that there was no visual or audible indication that the cylinder was leaking or had been damaged. Firefighting efforts commenced with a focus on preventing flames from impacting the LPG gas cylinder. One the flames were extinguished the firefighters observed that Shaun was still in the cabin, deceased.

What was the cause of Shaun's death?

Shaun was later taken to the Department of Forensic Medicine in Newcastle where a postmortem examination was performed on 12 September 2017 by Dr Brian Beer, forensic pathologist. Dr Beer noted that Shaun's body had been extensively incinerated, that he had sustained significant injuries to his chest and abdomen, and that there was evidence of smoke inhalation and a raised carbon monoxide level. In an autopsy report dated 27 October 2017, Dr Beer opined that Shaun's death was caused by multiple injuries, smoke inhalation and carbon monoxide toxicity.

What issues did the inquest examine?

Prior to the inquest a list of issues was circulated amongst the interested parties. These issues are set out below:

(a) Did the conduct of Acting Sergeant Medina amount to a "pursuit" for the purposes of the New South Wales Police Force's Safe Driving Policy?;

(b) If it did amount to a 'pursuit', was the Policy followed by Acting Sergeant Medina, and if not, why not?

(c) If the conduct did not amount to a "pursuit" for the purposes of the Policy, was it nevertheless appropriate in the circumstances, or should other action have been taken which would have minimised the risk of a collision?

(d) Could NSW Police officers who attended the scene have rendered assistance to Shaun following the collision, so that he could be retrieved before the vehicle was alight?

(e) Are there any recommendations that are "*necessary or desirable to make in relation to any matter connected with the death*", for example, should there be any amendment to the policies, procedures or training of NSW Police to minimise the risk of collision in these circumstances?

Each of these issues is considered in more detail below. Before doing so, it is convenient to describe the physical location at, and leading up to, the collision site as well as some matters relevant to consideration of the issues.

Relevant features of the location

East Street is a sealed asphalt road with marked road lines and a single lane of traffic in either direction. It commences at a roundabout which intersects with Atkins Street to the west of the Hume Highway and travels in a general northeast direction towards Albury Wodonga Health, Albury Campus (**the Hospital**), ultimately terminating at an intersection with North Street.

A number of commercial premises line both sides of the initial approximate 200 metre stretch of East Street between Atkins Street and a roundabout located at an intersection with Schuback Street (**the Schuback roundabout**). From the Schuback roundabout there is a long right-hand bend before a sharper left-hand bend towards the intersection with Hampton Court. From Hampton Court there is a straight stretch of road (**the straight**) until the road begins to approach a crest (**the first crest**) about 100 metres past the intersection of Heath Street (**the Heath Street intersection**). A number of residential premises line both sides of East Street from the Schuback roundabout to the Heath Street intersection. The section of road between this intersection and the collision site is generally through bushland which gradually thins out as the road approaches the collision site and the descent towards the Hospital.

The roadway from the first crest follows a moderate side-to-side undulation, with a gentle dip in the road at the intersection with Walsh Street (**the Walsh Street intersection**), before a moderate rise over a distance of approximately 100 metres to a second crest (**the second crest**). From the second crest there is a long but gentle right-left-right curve before the road straightens out, leading to the collision site and more level ground at the base of the descent. The roadway through the curve and straight section is at a gradient of almost 13 degrees.

There is intermittent street lighting from the Schuback roundabout to the Heath Street intersection, but only a single street light at the Walsh Street intersection between the first crest and second crest. There is no street lighting from the second crest to the collision site.

The subsequent police investigation identified that three premises along East Street were equipped with CCTV cameras which captured footage of the Courier and Albury 14 on 4 September 2017: two separate commercial premises at 206 and 315 East Street, and a residential premises at 331 East Street.

The police investigation was also able to establish the following approximate distances between points of interest along East Street:

(a) The Schuback roundabout is located two kilometres from the collision site;

(b) 331 East Street is located 1.3 kilometres metres from the collision site;

(c) The first crest is located 700 metres from the collision site; and

(d) The second crest is located 400 metres from the collision site.

There had been some light rain earlier in the evening and the road conditions were described by Acting Sergeant Medina as being "*a bit damp*". Senior Constable Porritt described the road conditions in this way: "*I did notice around the bend it was a bit more damp, where the car actually did crash was quite damp once you got around that, that bend. Um, just in this one little patch really, from what I thought I saw anyway*".

What condition was the Courier in?

Information obtained from Mr Korneluk established that prior to September 2017 the Courier had been regularly serviced and was in good mechanical condition. Mr Korneluk described the vehicle as having a light body, particularly when there was no load in the rear tray, and therefore being light to drive. The Courier's power steering only tended to add to its lightness whilst driving. Mr Korneluk went on to explain that in his experience the Courier had to be driven with care when there was moisture on the road as it had a propensity to lose traction due to its lightness and the fact that it was fitted with four light truck tyres.

Mr Korneluk expressed the view that the Courier was responsive to acceleration, particularly if being driven aggressively. However, because it was a four cylinder engine it was not as responsive as a six cylinder engine. Mr Korneluk described the Courier as driving "*beautifully*" and indicated that it would only suffer a slight loss of speed when being driven up an incline, but was able to maintain its speed, or only experience a marginal decrease, when being driven on level ground or the approach to an incline.

Was Albury 14 engaged in a pursuit of the Courier on 4 September 2017?

The NSW Police Force Safe Driving Policy (**the Policy**) governs the conduct, role and responsibilities of police officers involved in the pursuit of a civilian vehicle. Part 7 of Version 8.2 of the Policy (which was in force at the time of Shaun's death) defines a pursuit in this way:

> PURSUIT: A pursuit, regardless of speed, commences at the time you decide to pursue a vehicle that has ignored a direction to stop.
>
> It is an attempt by a police officer to stop and apprehend the occupant(s) of a moving vehicle, regardless of speed or distance, 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.

Having regard to the definition provided by the Policy, the initial question to be answered is whether Acting Sergeant Medina or Senior Constable Porritt issued Shaun with a direction to stop the Courier at any time on 4 September 2017. If the answer to this question is in the affirmative, then the next question to answer is whether Shaun ignored such a direction.

There is no evidence to suggest that Acting Sergeant Medina or Senior Constable Porritt issued Shaun with a verbal direction to stop the vehicle that he was driving. Therefore, the only means by which Acting Sergeant Medina or Senior Constable Porritt could have issued such a direction to Shaun is if either police officer activated the emergency warning devices on Albury 14; that is, if the warning lights and/or siren on the police vehicle were turned on.

An examination of the available evidence establishes that the emergency warning devices on Albury 14 were not activated at any stage on 4 September 2017. This is because:

(a) Both Acting Sergeant Medina and Senior Constable Porritt maintained in their recorded interviews conducted after the incident, and in oral evidence given during the inquest, that they did not activate the emergency warning devices on Albury 14 prior to the impact;

(b) Indeed, Acting Sergeant Medina said that he was just about to activate the emergency warning lights on Albury 14 moments before the Courier lost control;

(c) Joel stated that as the Commodore turned onto Schuback Street, he saw Albury 14 continue along East Street without its warning lights or siren activated. Further, Joel recalled that he did not hear any sirens from a police vehicle in the background during his phone call with Shaun. Jake similarly recalled that he did not hear the sound of sirens in the background;

(d) There is no evidence that Acting Sergeant Medina or Senior Constable Porritt informed police VKG that a pursuit had been initiated, or provided VKG with certain information, which would have been required in accordance with the provisions of the Policy;

(e) Following the incident, investigating police conducted a canvass of residences along East Street. This canvass was unable to identify any resident who positively heard any sirens or saw any emergency warning lights prior to the collision. To the contrary, a number of residents positively told police that they did not hear any sirens prior to the collision;

(f) The CCTV footage taken from the three premises along East Street does not contain audio recordings. Therefore, it does not assist in determining whether the sirens on Albury 14 were activated prior to the collision. However, examination of the video footage captured by the CCTV cameras depicting Albury 14 indicates that it was travelling past each of the cameras without its emergency warning lights activated.

It was submitted on behalf of the Crighton-Cromb family that the events of 4 September 2017 may have amounted to a pursuit in another way. This submission referred to the provisions of Clause 8-6-3 of the Policy which relates to the performance of Traffic Stops (this topic is discussed in greater detail below). Clause 8-6-3 provides:

> "*Should the driver of the other vehicle attempt to avoid apprehension or appears to be ignoring requests to stop and a decision has been made to pursue the vehicle, then a pursuit has commenced and the Safe Driving Policy pursuit guidelines must be adhered to*".

It was submitted that because Acting Sergeant Medina and Senior Constable Porritt both suspected that the Courier had been stolen and because they knew that it was associated with the Commodore, that it should have been evident to both police officers that the driver of the Courier was attempting to avoid apprehension. If this was the case, then it was submitted that Clause 8-6-3 applied so as to render the following of the Courier by Albury 14 a pursuit.

The difficulty with this submission is that even if the evidence established that Acting Sergeant Medina and Senior Constable Porritt knew that the driver of the Courier was attempting to avoid apprehension, a pursuit would only have commenced if either police officer made a decision to pursuit it. As explained already, the evidence establishes that neither police officer made such a decision.

For avoidance of doubt, it should also be noted that the evidence does not establish that either Acting Sergeant Medina or Senior Constable Porritt knew that the driver of the Courier was attempting to avoid apprehension. Acting Sergeant Medina rejected a suggestion that he possessed such knowledge as the Courier was being followed. Senior Constable Porritt similarly rejected such a suggestion. He summarised the situation best by explaining that whilst such an assessment might be available with the benefit of hindsight (and with knowledge of information, such as the phone call that Shaun was on, that could not have been known at the time), it was difficult to make any accurate judgement as to the speed that the Courier was travelling and changing distances between it and Albury 14 so as to give rise to such an assessment as the dynamic events were unfolding.

Conclusion: There is no evidence that the emergency warning devices on Albury 14 had been activated by Acting Sergeant Medina or Senior Constable Porritt at any time before the collision. This means that neither Acting Sergeant Medina nor Senior Constable Porritt issued Shaun with a direction to stop the vehicle that he was driving at the time.

As no direction had been given (and, consequentially, Shaun had not ignored it), this means that the definition of a pursuit in the policy was not met. Further, there is no evidence to establish that the provisions of Clause 8-6-3 of the Policy were enlivened at any time. Accordingly, no pursuit took place on 4 September 2017.

Were the actions of police on 4 September 2017 appropriate in all the circumstances?

Although it has been established that Part 7 of the Policy, relating to pursuits, did not apply to the events of 4 September 2017, there is a need to give consideration to another relevant part of the Policy. Part 8 of the Policy deals with the Coded System of Driving (**CSD**). The CSD sets out a number of parameters and obligations for police officers when the CSD applies.

The evidence established that by following after the Courier along East Street, Acting Sergeant Medina and Senior Constable Porritt were performing urgent duty response. This meant that, according to Part 8 of the Policy, Albury 14 was being driven under Code Red within the CSD. This in turn meant that, pursuant to Clause 8-3-1 of the Policy, Acting Sergeant Medina and Senior Constable Porritt had an obligation to advise VKG of their response code and provide an estimated time of arrival. However, evidence given by Senior Sergeant Kris Cooper of the Traffic and Policy Section of the Traffic & Highway Patrol Command, who conducted an internal police review to determine if the Policy had been complied with, established that the terms of Clause 8-6-1 of the Policy obviated the need for such advice to be provided to VKG.

Clause 8-6-1 provides:

> "*It is permissible for police to perform traffic stop…or reduce the distance to an offending vehicle without informing VKG of a response code or activating warning device. However, police must take reasonable care and it must be reasonable that warning devices are not used…*".

In evidence Senior Sergeant Cooper explained that the rationale behind Clause 8-6-1 of the Policy is grounded on the recognition that requiring all police vehicles performing a traffic stop to notify VKG in accordance with Clause 8-3-1 would be procedurally unmanageable.

The evidence established that in following after the Courier along East Street, Albury 14 was being driven in a manner in order to reduce the distance between it and the Courier. As Acting Sergeant Medina explained, this was done in an attempt to identify the licence plate of the Courier in order to in turn verify whether it matched the licence plate of the vehicle that had been broadcast by Victorian police as having been stolen. Therefore, in accordance with the terms of Clause 8-6-1, Albury 14 was not required to comply with the terms of Clause 8-3-1. However, a requirement remained for Acting Sergeant Medina and Senior Constable Porritt to take reasonable care, and for it to be reasonable to not use the warning devices on Albury 14, in seeking to reduce the distance to the Courier.

Was reasonable care taken by the police officers following after Shaun?

Two questions relevant to this issue were raised for consideration during the course of the inquest:

(a) How fast was Albury 14 travelling along East Street; and

(b) In seeking to close distance, how close did Albury 14 actually get to the Courier.

Albury 14 was fitted with a mobile Computer Aided Dispatch (**CAD**) system. This system has an on board global positioning system (**GPS**) which is capable of sending vehicle waypoints, speed, direction and other data to the other parts of the Police CAD clients. This information is capable of being tracked either in real time, or retrieved from historical data (**the GPS data**). An extraction of the GPS data for Albury 14 was later conducted and revealed certain information about Albury 14, most relevantly the speed that it was travelling.

The GPS data was subsequently plotted against a road map showing East Street and revealed that Albury 14 was travelling at the following speeds at the following points:

(a) 85 kilometres per hour at 1:24:17am as it passed 331 East Street;

(b) 106 kilometres per hour at 1:24:26am as it travelled along the straight;

(c) 114 kilometres per hour 1:24:32am as it approached first crest;

(d) between 89 kilometres per hour (at 1:24:39am) and 106 kilometres per hour (at 1:24:53am) between approximately the first crest and second crest; and

(e) 101 kilometres per hour shortly before the collision site.

The GPS data is broadly consistent with the evidence given by Acting Sergeant Medina. Although Acting Sergeant Medina explained in evidence that he only glanced at the speedometer in Albury 14, he estimated that Albury 14 was travelling at around 100 kilometres per hour at different times, and accepted that it reached a maximum speed of 114 kilometres per hour at one point.

In evidence Acting Sergeant Medina estimated that Albury 14 was about 400 metres behind the Courier when the Commodore turned left at the Schuback roundabout off East Street. The GPS data establishes that Albury 14 travelled at speeds of between 77 and 103 kilometres from the Schuback roundabout to 331 East Street. At this point the CCTV footage captures Albury 14 passing the frame of the camera seven seconds after the Courier. Therefore, despite travelling more than 40 kilometres over the speed limit at one point, Albury 14 had only come within seven seconds of the Courier by the time it reached 331 East Street.

Conclusion: The evidence established that the road condition along East Street was good, that there were no other vehicles travelling either direction, that there were no pedestrians along East Street, and that there was intermittent street lighting up to the point of the Heath Street intersection. In these circumstances it can be accepted that Acting Sergeant Medina and Senior Constable Porritt took reasonable care in following after the Courier, even though Albury 14 was being driven at high speed. This is because there is no evidence that the speed at which Albury 14 was being driven represented a direct risk to any pedestrian or other motorist at the time.

However, the more relevant question is whether the speed at which Albury 14 was being driven represented a risk to Shaun. Given the speed that Albury 14 was travelling up to the point of 331 East Street, and that it was still seven seconds behind the Courier, it may be inferred that the Courier was also travelling in excess of the speed limit. As will be discussed further below, both Acting Sergeant Medina and Senior Constable Porritt agreed in evidence that Albury 14 closed distance on the Courier along the straight, and that there was a gap of about 100 metres between the two vehicles at the first crest. Given that Albury 14 was travelling at speeds between 106 and 114 kilometres per hour along the second half of the straight, it may equally be inferred that the Courier was travelling at similar speed, if slightly lower, in order to maintain the distance between it and Albury 14 by the time of the first crest.

The evidence established that a number of factors likely contributed to Shaun's loss of control of the Courier, and it eventually leaving the road prior to impact:

(a) The fact that it was being driven in excess of the speed limit;

(b) The damp road conditions;

(c) The relatively steep incline at the point where control of the Courier was lost;

(d) Shaun's relative inexperience as a driver, having never held a driver's licence;

(e) Shaun's unfamiliarity with the Courier and its handling characteristics, particularly in circumstances where it needed to be driven with care in damp conditions and the absence of any load in the tray contributed to its lightness;

(f) The possibility that Shaun's attention may have been partially diverted by the phone call that he was engaged in with the occupants of the Commodore;

(g) Shaun's state of mind in the sense that he told Joel over the phone that he was aware that Albury 14 was behind him and that he was "*really scared*", from which it may be inferred that Shaun believed that he was being pursued, likely in order to be apprehended. Given the fear that Shaun expressed and his likely belief as to the reason he was being followed, it may be inferred that his state of mind would likely have hindered his ability to control the Courier in a calm and rational manner.

The evidence suggests that there was a direct correlation between the speed which Albury 14 was travelling and the speed which the Courier was travelling. That is, the Courier was being driven at speed in order to maintain or increase distance from Albury 14 because of Shaun's likely state of mind as described above. However, it is not possible to know whether Shaun would have slowed down the speed of the Courier if he was aware that Albury 14 had decelerated. This seems an unlikely scenario given that Shaun did not slow down as urged upon him by Joel during their phone call. In other words, it is unclear whether the speed at which the Courier was travelling was attributable solely to the speed at which Albury 14 was travelling, or whether the speed of the Courier would be maintained even if Albury 14 had not increased its speed after sighting the Courier, or decreased its speed at some point along East Street.

Conclusion: Therefore, it could not be said that the speed at which Albury 14 was being driven represented an unreasonable risk to Shaun and that therefore Acting Sergeant Medina and Senior Constable Porritt did not take reasonable care in following after Shaun. Firstly, it is evident that there were a number of factors which contributed to loss of control of the Courier moments before impact, with excessive speed being only one of the identified factors. Secondly, even if it was accepted that Shaun was only driving at speed because Albury 14 was also being driven at speed, there is no evidence that, up until the point of loss of control, there was any indication that loss of control was likely.

In evidence Acting Sergeant Medina said that he had no concern that the speed at which both vehicles were travelling would cause Shaun to lose control. Acting Sergeant Medina explained that this is because he could see that Albury 14 was closing the distance to the Courier which meant that the Courier was driving at a lower speed than Albury 14. Further, Acting Sergeant Medina said that he did not think that Shaun was in significant danger by the mere fact that Albury 14 was following after the Courier. Senior Constable Porritt said in evidence that if had observed the Courier suffer any loss of control he would have considered it inappropriate to continue follow it. Further, Senior Constable Porritt also explained that if considered that there was any aspect of Acting Sergeant Medina's driving which raised a concern in his mind, he would have felt comfortable raising that concern with Acting Sergeant Medina.

One further point should be noted. There is evidence that Acting Sergeant Medina had, on two prior occasions on 4 September 2017, made an assessment of the risk associated with following after a vehicle which was being driven in an erratic manner. Following that assessment Acting Sergeant Medina made a decision, on each occasion, that it would be unsafe to follow the vehicle. The first occasion occurred when Acting Sergeant Medina first sighted the Commodore in Dale Crescent after it sped off without its headlights on. The second occasion occurred when the Commodore turned off East Street at the Schuback roundabout. Senior Constable Porritt described the second occasion in this way in his recorded interview: "*[The Commodore] turned down Schuback Street , ah and that [sic] sped off in that direction um, and I remember [Acting Sergeant Medina] saying that, um we're not going to bother pursuing him because he's going to drive like a dickhead anyway so there's no point…*".

Conclusion: Having regard to the above evidence it could not be said that the speed at which Albury 14 was travelling demonstrated that Acting Sergeant Medina and Senior Constable Porritt were not exercising reasonable care in following after Shaun. The evidence establishes that Acting Sergeant Medina made an assessment of whether following the Courier in the manner that he did represented an unreasonable risk. It can be inferred, consistent with the two other assessments previously made by Acting Sergeant Medina, that if such any such risk existed, Albury 14 would not have continued following the Courier.

As already noted above, the evidence established that, at least from 331 East Street on wards, Albury 14 was closing the distance to the Courier. This raised the question of whether Albury 14 closed the distance to the point where its proximity to the Courier adversely affected Shaun's ability to safely control it.

In evidence Acting Sergeant Medina said that Albury 14 managed to close the distance to the Courier by the time it reached the first crest. However, Acting Sergeant Medina went on to explain that he then mostly lost sight of the Courier as it travelled through the undulating section of road between the first crest and the second crest. He went on to explain that he regained sight of the Courier after passing over the second crest, and that Albury 14 was within 60 to 80 metres of the Courier at the point that it began to lose control. This evidence was consistent with the version which Acting Sergeant Medina gave in his recorded interview where he said that Albury 14 was about 60 metres from the Courier when it lost control, with the second closest distance between the two vehicles (of about 80 to 100 metres) occurring near the Walsh Street intersection.

In his recorded interview, because of his unfamiliarity with the locale, Senior Constable Porritt expressed some difficulty in calculating how close Albury 14 managed to get to the Courier. However, he eventually estimated the closest distance between the two vehicles to be 200 metres, and maintained that at no stage could he see whether the Courier was bearing any registration plates. However in evidence Senior Constable Porritt accepted that it was possible that the closest distance between the two vehicles (according to estimates given by Acting Sergeant Medina) was between 60 to 100 metres, and that Albury 14 was about 100 metres behind the Courier when it suffered a loss of control. Senior Constable Porritt explained that was able to provide a better estimate of distances in evidence as he had driven the route along East Street since participating in his recorded interview.

The solicitor for the Crighton-Cromb family put to Acting Sergeant Medina in evidence that once Albury 14 drove past 331 East Street it was within 200 metres of the Courier. Acting Sergeant Media rejected this submission and explained that at this point the Courier was approximately 200 to 300 metres away, approaching the first crest, and disappeared from view a short time later. It has been submitted on behalf of the Crighton-Cromb family that when Albury 14 passed 331 East Street it is likely that the Courier was no more than 165 metres ahead of it. This submission was grounded on a calculation using information taken from the CCTV camera at 331 East Street and the GPS data. That information established that Albury 14 was seven seconds behind the Courier at 331 East Street and travelling at 85 kilometres per hour; a mathematical calculation establishes that a vehicle travelling at 85 kilometres per hour will travel 165 metres in seven seconds.

However, the submission made is flawed for a number of reasons. Firstly, in order to establish the distance between Albury 14 and the Courier, one would need to know the speed that the Courier was travelling and, consequentially, what distance it travelled in the seven seconds after it passed the 331 East Street CCTV camera. There is no objective evidence as to the speed that the Courier was travelling at any stage along East Street. Secondly, the calculation of 165 metres is dependent on Albury 14 maintaining a constant speed of 85 kilometres per hour over seven seconds. The evidence instead establishes that the speed of Albury 14 increased to 106 kilometres per hour by 1:24:26am, some nine seconds after it passed 331 East Street. It can be inferred from this that in these nine seconds the speed of Albury 14 gradually increased from 85 to 106 kilometres per hour, indicating that its speed did not remain constant. Thirdly, any calculation of distance between the two vehicles using the speed at which Albury 14 was travelling would be dependent on both vehicles maintaining their speed. As noted already, there is no objective evidence as to the speed that the Courier was travelling.

The evidence also demonstrates that the estimates as to distance given by Acting Sergeant Medina in evidence were also incorrect. The evidence establishes that 331 East Street is located approximately 1.3 kilometres metres from the collision site and that the first crest is located approximately 700 metres from the collision site. Applying a simple calculation, this means that the distance between 331 East Street and the first crest is approximately 600 metres. If this is so then Acting Sergeant Medina's estimate of the Courier being near the first crest and 200 to 300 metres away when Albury 14 passed 331 East Street must be incorrect. If it is accepted that the Courier was near the first crest when Albury 14 passed 331 East Street, then it must have been closer to 400 to 500 metres away.

Conclusion: Ultimately, the above comments serve only to demonstrate the difficulty in performing a precise calculation as to the distance between the two vehicles using limited objective information. The best assessment that can be made of the objective evidence is that taking into account what is known about the engine capacity of the Courier and its ability to accelerate, and the acknowledgements given by Acting Sergeant Medina and Senior Constable Porritt, it is most likely that Albury 14 was able to close the distance to the Courier by the first crest. Exactly how far apart the vehicles were at that stage is impossible to determine.

However, there is no evidence to suggest that the distance between the two vehicles was sufficient close to allow Acting Sergeant Medina or Senior Constable Porritt to clearly see the Courier's licence plates. Further, there is also no evidence to clearly establish that Albury 14 remained inappropriately close to the Courier as both vehicles travelled between the first crest and second crest. The undulating and winding nature of the road along this section suggests that it would have been difficult to remain in such close proximity. There is therefore no evidence to establish that Acting Sergeant Medina and Senior Constable Porritt did not exercise reasonable care in following after the Courier.

Was it reasonable for the warning devices on Albury 14 to have not been activated?

In evidence Acting Sergeant Medina said that he did not activate the warning lights on Albury 14 because the police vehicle never got close enough to the Courier. He explained that, given the distance between the Courier and Albury 14, he did not know if the lights could be seen by the driver of the Courier; to activate the warning lights in such circumstances would have served no practical purpose. In evidence Senior Constable Porritt similarly said that he did not believe that the driver of the Courier could see Albury 14 because of the distance between the two vehicles and the fact that it was night time.

Acting Sergeant Medina said in evidence that he believed that where a police vehicle follows another vehicle to perform a traffic stop, or reduce distance, there is no minimum distance at which the warning lights of a police vehicle must be activated. It was submitted on behalf of the Crighton-Cromb family that this created a hypothetical situation where a police vehicle might follow another vehicle indefinitely without activating its warning lights. This submission was put to Senior Sergeant Cooper in evidence who agreed that the Policy does not stipulate that a traffic stop must be affected as soon as practicable, and that no aspect of the Policy prevents a police vehicle following another vehicle at speed without activating its warning lights or performing a traffic stop.

Having regard to Senior Sergeant Cooper's evidence it was submitted that it was unreasonable for the warning lights on Albury not to have been activated prior to the collision. However, as Senior Sergeant Cooper explained, the decision to activate warning lights and effect a traffic stop is governed by a number of tactical considerations. As general examples, Senior Sergeant Cooper referred to the need for a police officer to ensure that a traffic stop is effected in a safe environment and in circumstances where a police officer is satisfied that he or she is capable of dealing with any occupants of the vehicle being stopped. In relation to the specific events of 4 September 2017 Senior Sergeant Cooper opined that it may not have been appropriate to conduct a traffic stop near the first crest (as was suggested to him in evidence) because the area was not lit by street lighting, because there was no shoulder on the side of the road to safely effect a stop, and because the reaction of the driver of the Courier to the stop was an unknown factor.

In evidence neither Acting Sergeant Medina nor Senior Constable Porritt made reference to the considerations referred to by Senior Sergeant Cooper. However, Acting Sergeant Medina said that, in not activating the warning lights of Albury 14, he did give consideration to the fact that it was the middle of the night, and that there were no other vehicles or pedestrians nearby who needed to be warned of the fact that two vehicles were travelling over the speed limit along East Street. Senior Constable Porritt gave similar evidence that he considered that it was reasonable for the warning lights on Albury 14 not to have been activated because of the time of night and the absence of other traffic and pedestrians.

In his recorded interview, Acting Sergeant Medina was asked whether he considered activating the warning devices of Albury 14 at any point during the ascent up East Street so as to effect a traffic stop. He responded in this way: "*I didn't really get a chance to think about it to be honest. I was just trying to catch up the [sic] car and see if it was the same*". Acting Sergeant Medina explained that he was aware from the broadcast made by Senior Constable Braines that the registration plate of the stolen car was QSM-405. However, Acting Sergeant Medina explained that Albury 14 never got close enough to the Courier for him to read the Courier's registration plate although he said that he saw that the first letter appeared to be "Q". Acting Sergeant Medina went on to explain that he only gave consideration to activating the warning lights once past the second crest and shortly before the Courier lost control. At this point Acting Sergeant Medina explained, "*we could see [the Courier] and we thought it might've been the same car so at that point we were about to hit the lights…*".

Conclusion: Consideration of the application of Clause 8-6-1 of the Policy as it applies to the events of 4 September 2017 raises two questions: should the anticipated traffic stop have been discontinued, and should the warning lights on Albury 14 have been activated prior to the collision? The evidence establishes that the answer to both questions should be no.

In consideration of the first question, it has already been established on the evidence that no aspect of the manner in which the Courier was being driven caused Acting Sergeant Medina or Senior Constable Porritt to consider that it was unreasonable or unsafe to continue to follow the Courier. It is accepted that Shaun was clearly frightened about the events that were transpiring; so much is clear from his conversation with Joel and from an objective assessment of the events from the point of view of a young 19 year old man. However, this would not have been known to either Acting Sergeant Medina or Senior Constable Porritt, who had no information at all about the occupant, or occupants, of the Courier. Further it should be remembered that Acting Sergeant Medina had twice previously demonstrated a willingness to discontinue following the Commodore in circumstances where he considered it unsafe to do so. There is no basis to infer that Acting Sergeant Medina would not have followed a similar approach if he had formed a similar view in relation to the circumstances involved in following the Courier. The fact that he did not follow such an approach supports the conclusion that it was not unreasonable for the anticipated traffic stop to be discontinued.

In consideration of the second question, there is no evidence to contradict the evidence given by Acting Sergeant Medina and Senior Constable Porritt that Albury 14 was sufficiently close to the Courier to allow for either the licence plate of the Courier to be verified, or for the Courier to see the warning lights on Albury 14. This is supported by the fact that it appears that by the time Albury 14 had closed distance to the Courier at the first crest, both vehicles were about to travel through the section of East Street between the first crest and second crest which was undulating and winding, and mostly unlit by street lighting. In such circumstances it could not be said that it was unreasonable for the warning lights on Albury 14 to not have been activated.

Two final matters should be noted. Firstly, even if the warning lights on Albury had been activated prior to the collision, it is not possible to know what reaction (if any) this might have prompted from Shaun. It may have caused him to slow or pull over the Courier; equally it might have caused him to seek to increase his distance from the police vehicle. Any response which Shaun may have had simply cannot be known. Secondly, it cannot be positively stated said that the non-activation of the warning lights contributed to loss of control of the Courier and the subsequent collision.

Could assistance have been rendered to Shaun immediately after the collision?

Acting Sergeant Medina notified VKG of the collision at 1:25:11am. He explained in evidence that at this time the Courier was not alight. Thirty seconds later Senior Constable Porritt made a second broadcast, whilst still inside Albury 14, notifying VKG that the Courier was alight and that emergency services were required on scene. Acting Sergeant Medina said that he made his broadcast prior to exiting Albury 14. Although he was also carrying a portable radio, Acting Sergeant Medina said that he did not believe that it was possible that he made his broadcast after exiting Albury 14.

After exiting Acting Sergeant Medina said that his intention was to proceed towards the Courier to see whether any person, or persons, remained inside the vehicle, explaining that he had no knowledge as to its occupants. He said that within a few seconds of walking towards the Courier, and when he was within about five metres of it, he saw the flames at the front of the vehicle engulf the entire cabin. Acting Sergeant Medina explained that he had no time to do anything else.

Senior Constable Porritt said that he was also "*fairly certain*" that Acting Sergeant Medina made his broadcast before exiting Albury 14. Senior Constable Porritt was asked in evidence what was occurring in the 30 seconds before he made his broadcast. He said that he recalled that he was listening to VKG for information, and to provide information if it was asked for. After making his broadcast Senior Constable Porritt explained that he exited Albury 14 and started to approach the Courier, with Acting Sergeant Medina ahead of him. Senior Constable Porritt said that by this stage the right hand side of the Courier was already in flames and that his intention was to see whether there was any person or persons in the cabin, or whether any person or persons had been ejected from the Courier. However, Senior Constable Porritt explained that within seconds of approaching the Courier it became engulfed and there was no opportunity to check the cabin.

Conclusion: It can be accepted that Acting Sergeant Medina notified VKG of the collision moments after it had occurred, and after he had brought Albury 14 to a stop. The evidence establishes that Senior Constable Porritt exited Albury 14 about 30 seconds later and that within seconds of this the Courier became engulfed in flames, thereby preventing any assistance being rendered to Shaun. The question therefore is whether either Acting Sergeant Medina or Senior Constable Porritt could have done anything in the critical period of about thirty to forty seconds (the precise time being unknown) before the Courier became engulfed in flames. It appears that the risk of the Courier catching alight, and then suddenly becoming engulfed in flames, may not have been fully realised by either Acting Sergeant Medina or Senior Constable Porritt.

That said, there is no evidence to suggest that such a realisation was obvious or apparent on the events that either police officer had just witnessed. The evidence establishes that both police officers were acting in accordance with protocol in notifying VKG of the collision and providing information pertaining to it. The evidence also establishes that the police officers called for further assistance upon sighting flames, and that they acted out of concern for the welfare of any occupant of the Courier by seeking to check whether any person remained in the Courier or was in the vicinity of it, after being ejected. Even if Acting Sergeant Medina or Senior Constable Porritt had been able to reach the Courier and access the cabin prior to it becoming engulfed in flames, it is most likely that the outcome would not have been altered. Upon the later arrival of emergency services, considerable time was required to extract Shaun from the crush effects of the collision. This indicates that, tragically, Acting Sergeant Medina and Senior Constable Porritt would not have any opportunity to extract Shaun from the Courier or provide any assistance.

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

Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Dr Peggy Dwyer, Counsel Assisting, and her instructing solicitor, Ms Kate Lockery of the Crown Solicitor's Office. Their assistance during both the preparation for inquest, and during the inquest itself, has been enormous. I also thank and commend Detective Sergeant Trent Swinton for conducting a thorough, detailed and independent investigation into Shaun's death and for compiling a comprehensive initial brief of evidence. I thank all them for the sensitivity and empathy that they have shown in what has been a particularly distressing matter.

Identity

The person who died was Shaun Crighton-Cromb.

Date of death

Shaun died on 4 September 2017.

Place of death

Shaun died at East Albury NSW 2640.

Cause of death

The cause of Shaun's death was multiple injuries, smoke inhalation and carbon monoxide toxicity.

Manner of death

Shaun died after a vehicle that he was driving, and which was being followed by a police vehicle in the course of a police operation, lost control, left the road, and collided with a tree. The resultant collision caused a fire in the vehicle during which Shaun suffered fatal injuries.

24. 275550 of 2017

Inquest into the death of Ahmed RIZK. Findings handed down by State Coroner O'Sullivan at Lidcombe on the 4th April 2019.

Ahmed Rizk was 49 years old at the time of his death on the 10 September 2017. He was an inmate of Long Bay Hospital, but was being treated at the Prince of Wales Hospital, Randwick. He was pronounced dead at 5:50 a.m. on the aforementioned date. As Mr Rizk 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 role of the Coroner

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

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

The Inquest

A short inquest was held on 4 April 2019. The officer in charge of the investigation, Detective Senior Constable Michael Cambridge, gave evidence and the brief of evidence was tendered.

The Evidence

Background:

Ahmed Rizk entered custody on the 21 June 2017. He was sentenced to nine months imprisonment commencing 21 June 2017 and expiring 20 March 2018. The non-parole period was 6 months commencing on the 21 June 2017 and expiring on 20 December 2017. On the 24 June 2017, Justice Health assessed Mr Rizk and did not note any medical, mental health or drug and alcohol issues. On the 25 July 2017, Mr Rizk was transferred to the Glenn Inness Correctional Centre as a C2 – Minimum Security inmate.

On the 10 August 2017, Mr Rizk complained to nursing staff at Glen Inness Correctional Centre of abdominal pain and difficulty emptying his bowel. His abdomen was tender to the touch. Laxatives and an analgesic were given. The abdominal pain persisted over several days, during which Mr Rizk returned to the clinic complaining of being scared to eat and increasing pain. On the 19 August 2017, Mr Rizk was taken to Glen Inness District Hospital where blood tests were done.

On the 21 August 2017, Mr Rizk was again taken to Glen Inness District Hospital where he remained for three days. On the 23 August 2017, a gastroscopy was conducted, which revealed a malignant tumour in the gastro-oesophageal tract.

On the 24 August 2017, Mr Rizk was transferred to Armidale Hospital for specialist treatment. On the 26 August 2017, Mr Rizk suffered a large haematemesis (vomiting of blood). Consequently, on the 27 August 2017, he was transferred to the Armidale Hospital's Intensive Care Unit. On the 30 August 2017, Mr Rizk was transferred from Armidale Hospital to Prince of Wales Hospital. On the morning of the 1 September 2017, Mr Rizk was found to be aphasic, with right sided facial palsy and inhibited limb movement. It was determined that between arriving at Prince of Wales Hospital on the 30 August 2017 and the 1 September 2017, Mr Rizk had suffered a left sided Middle Cerebral Artery infarction (stroke). Due to the stroke, Mr Rizk was transferred to the Prince of Wales Hospital Stroke Ward.

Medical notes made on the 2 September 2017 record that Mr Rizk had suspected early in the year that he had cancer and had been suffering haematemesis since then.

On the 7 September 2017, treating teams determined that Mr Rizk was not well enough for surgery or chemotherapy and that symptom management and palliative care were Mr Rizk's best options. On the 8 September 2017, Dr Sands of the Department of Palliative Medicine expressed the opinion in writing that Mr Rizk's life expectancy was potentially days or weeks.

About 5:50 a.m. on the 10 September 2017, Mr Rizk was pronounced life extinct by Dr Naseer Mohammed Abdul. On Mr Rizk's resuscitation plan, which forms part of the tendered medical records, the "No CPR" option is selected. The form is signed by Dr Karsovitsky and dated the 9 September 2017.

Autopsy:

Pathologist Dr Irvine examined Mr Rizk's body and found the direct cause of death to be Complications of Metastatic Gastric Adenocarcinoma. She found no significant injuries or evidence of maltreatment.

Issues raised by Mr Rizk's Family:

Family members stated that the presence of Corrective Services staff within Mr Rizk's room caused them distress and impinged on the privacy they had with him in his last days.

Treating doctor, Hanka Laue-Gizzi, expressed to investigating police her disappointment that Correctives Officers were not able to wait outside the room as there was no chance of Mr Rizk escaping.

Mr Terry Murrell, General Manager Statewide Operators for Corrective Services New South Wales, provided a statement addressing this issue. He states that a Medical Escort Unit has been approved to commence a 12 month pilot and is currently in the set-up phase. The Unit will be based within the Sydney Metropolitan Region and will be responsible for the management of all state-wide scheduled medical appointments co-ordinated through the Justice Health Co-ordination Centre.

Mr Murrell states that a new paragraph "5.2 – Risk Assessments, End of life care" has now been included within the section of the Custodial Operation Policy and Procedures that governs medical escorts. The "End of life care" paragraph states that if an inmate is receiving end-of-life care, security arrangements can be reviewed to assess supervision requirements and visiting arrangements by family and friends. This is to be determined on a case-by-case basis, and in consideration of the security of the hospital.

Conclusion

There is no evidence that any action or inaction by Corrective Services or Justice Health contributed to Mr Rizk's death. Given Mr Rizk's age and health issues and his rapid deterioration whilst in hospital, it does not appear that anything could have reasonably been done to prevent Mr Rizk's death. While it is regrettable that Mr Rizk's family felt that the actions and presence of Corrective Services officers encroached on their final moments with him, Corrective Services have now amended their policy in a way that addresses those concerns.

Findings.

The identity of the deceased:

The deceased person was Ahmed Rizk.

Date of death:

He died on 10 September 2017.

Place of death:

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

Cause of death:

He died as a result of complications of metastatic gastric adenocarcinoma

Manner of death:

He died of natural causes whilst serving a custodial sentence.

25. 286401 of 2017

Inquest into the death of CD. Findings handed down by Deputy State Coroner Forbes at Lidcombe on the 4th October 2019.

This is an inquest into the death of CD who died on 20 September 2017 as a result of severe burns. On 19 September 2017, he barricaded himself into his house in the remote township of Gloucester NSW and set it alight.

The primary duty of a Coroner, as described 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, or in other words, the circumstances surrounding the death.

This inquest is not a criminal investigation or proceedings intended to determine fault or lay blame. It is an examination of the circumstances of the manner of CD's death, to understand how the situation developed and what was being done to address the situation at the same time.

CD

CD moved to Gloucester in about 2015 and had a dream of running a bed and breakfast. He had spent $8000 on towels and sheets and $10000 on antique furniture.

He was separated from his wife with whom he had three sons.

He had a history of alcohol abuse and mental health issues. His son explained to this court that he was proud of his father, who towards the end of his life had stayed dry for a two year period and was making great efforts to clean up his life.

Hospital records from the early 1990s show that CD had several admissions for treatment of suicidality arising from what was variously described as schizophrenia and schizoaffective disorder, on a background of abuse of alcohol and benzodiazepines. In 2014 he was briefly hospitalised at the Mater Hospital for mental health reasons after refusing to take medication. More recently however there is little evidence of any ongoing mental health condition, which is consistent with his son's observations.

CD's local general practitioner ("GP") in Gloucester stated that CD did not disclose his history of mental illness, and denied having depression, when he was first seen. The GP described CD as showing no signs of mental illness in their initial appointments.

Background

CD was in a relationship in 2017. According to his then partner, he resumed drinking in May 2017. She reported that they broke up shortly after. Nevertheless, CD asked to see her on her birthday, in late June 2017. On that day, she took him to Taree hospital as he appeared suicidal and paranoid to her. CD became angry and departed when medical staff called for mental health assistance, as he believed he would be scheduled. CD returned to Gloucester and attended an Alcoholics Anonymous meeting the next morning.

CD's partner stated that CD continued to demand large sums of money, and appeared paranoid and irrational. In the weeks prior to his death, he said that he had a private detective following her.

CD also had regular phone contact with a woman he met at Alcoholics Anonymous (his "AA Sponsor"). In about August 2017, CD called his AA sponsor and asked her in a long argumentative conversation to guarantee in six to nine months that she would enter into a romantic relationship with him. She explained that they were just friends, at which point he "cancelled" their friendship the next night by text, saying that she didn't fit into his plans.

On 30 August 2017 a council surveyor inspected a garage at CD's property and found it to be unsatisfactory (CD had purchased the property without a final inspection certificate for the garage). CD appeared reasonable but spoke very rapidly. He said he was a builder of 43 years' experience. The council surveyor left after asking CD to follow up the engineering plans for the garage.

In early September CD called his son and was verbally aggressive. His son knew immediately that his father had started drinking again. He appeared paranoid. His son arranged for a local in Gloucester, to check on his father. She reported back a few days that CD had attended an AA meeting but had sat at the back, disengaged.

On 8 September CD attended his GP. CD appeared unwell and stressed. He said that one of his sons had tried to commit suicide (which appears to have occurred several months before) and that his partner had left him and stolen all his money. His diabetes was poor as he was drinking soft drinks; he denied consuming alcohol within the preceding five weeks. The GP gave him a small quantity of Valium, to assist with his stress and anxiety, and asked to see him in a few weeks. The GP did not think that CD was suicidal or depressed.

On 12 or 13 September, CD called a local electrical company to whom he owed money about an outstanding bill. He sounded agitated and was talking rapidly. He said his ex-partner had taken money from him and that he had met a woman on a train to whom he'd loaned $80,000 which she had not returned and that she had given him a signed statutory declaration that she owed him the money and he was taking her to court. That Friday night he called a fellow Alcoholics Anonymous participant, saying he was drinking again and that he was having some financial difficulties. He sounded "manic", talking rapidly, but also appeared calm.

On 15 September, CD saw his GP again. His impression was that CD was very angry at his partner and expressed vague thoughts about harming her for having allegedly robbed him and treating him badly. He said he had been in touch with his lawyers. He had no specific plans. He denied depression and suicidal thoughts. The GP thought he was possibly hypomanic (but CD denied a history of bipolar disorder) but did not consider that he was exhibiting thoughts of significant harm to self or others, such that he should be scheduled. The GP tried to arrange urgent follow up with the local psychologist and prescribed Seroquel to assist sleeping and settle his mood, as well as Zoloft.

In subsequent statements, the GP has explained how in hindsight he failed to appreciate how disturbed CD was and considered, at the time, his speech to be coherent and cohesive albeit pressured. The GP accepted CD's outrage at his ex-partner at face value as a real rather than imagined concern. In hindsight, he thinks that CD's mental state may have been subsequently exacerbated by drinking alcohol.

On about 16 September a neighbour saw CD taking 3 gas bottles into his house.

On 17 September CD called his ex-partner and accused her of stealing $25,000 from him. He threatened to shoot her or a member of her family if she did not provide the funds. He said he had no money left and was getting money from Centrelink and the Salvation Army. He said he had been drinking for a fortnight.

On 18 September, CD made a call to the Catholic diocese in Newcastle (and another the next morning) and also to the Department of Human Services Sickness and Disability line. Long calls to other unknown numbers occurred the same day. The contents of those calls are unknown.

19 September 2017

At approximately 2.30pm on Tuesday, 19 September, CD angrily confronted his neighbour about alleged damage from stormwater flowing from their property.

On the same afternoon at about 2.35pm, the Council surveyor returned a call from CD about the garage. The surveyor recorded that CD was very angry and frustrated, describing himself as bankrupt and possibly having to sell the property in the near future. He was talking very quickly.

Later that afternoon CD, now calmed down, phoned his neighbour to discuss the stormwater. CD said he had been drinking heavily lately. The neighbour suggested that CD call Alcoholics Anonymous.

He rang his AA sponsor and she relayed concerns to his son via a number of text messages. First she messaged that she was talking to CD, that he was in financial trouble and she was trying to find out if he was drinking. The next message asked him to call the police as CD was threatening to kill himself.

The AA Sponsor later told police that in the first call CD said he had just borrowed $250 from a neighbour, he was down to his last $1.85 and he had enough alcohol for the next three days. She described him as having a racing mind, switching from topic to topic.

In the second call, CD said he was drinking. He said the pension had sent him a letter questioning where all his money was coming from, the council were after him about an approval and stormwater was coming in from next door. He said, "*Are you ready for it, here comes the bang now, are you listening*" and that he was going to shoot himself. She kept him talking for twenty minutes while texting his son to ring the police. She then ended the call to do the same. As she was doing so, CD said he did not want to talk to her again.

The AA Sponsor then called "000" at approximately 9.20pm, and then called CD back. CD said he was very tired, wanted to lie down and have a cup of tea, and had not eaten for three days. CD said that he had been to Court in Newcastle on the 18 September. He said he had ran into an AA friend, borrowed $100, and that his house insurance expired at midnight and he did not have the money to pay for it.

The AA Sponsor subsequently received a further call from CD. This was clearly after police arrived and spoken to him because he said "*you caused all this, you stabbed me in the back, you betrayed me and called the police*". He said something like "*I've got enough gas to blow the police and neighbours up and half of Gloucester*" and that she was going to read about him in the paper. She told him the police were only there to help him and to let them in. He said he couldn't talk as they'd see the light (presumably from his phone). He sounded very angry and then hung up. The AA Sponsor called 000 back and reported what she had been told. She then texted his son telling him to contact the police.

Police received the first 000 call at 9.20pm. Sergeant Kirk, the shift supervisor at Taree, asked Senior Constables Mitchell and Abbott, in Taree, to support Senior Constable Chester who was the only officer available at Gloucester. Those officers arrived after approximately forty minutes at 10PM. Senior Constable Chester, who was off-duty and received the call to attend at approximately 9.20PM, arrived at approximately 9:50PM, after first going to the police station to retrieve his appointments.

At 10.07pm Senior Constable Chester broadcast by VKG, "*This bloke barricaded himself in the house won't let me in. Stated if I kick the door or try to enter, he stated he has gas cylinders ready to ignite and blow us all up*". A minute later Senior Constable Chester noted via radio that there was only old intelligence in relation to firearms: "*He's got nothing I'm aware of – old intelligence there about firearms. Just an angry old man at the moment. Everything is locked right up. Verandah is barricaded and I got to the front door before he made threats. There is a close house right next door on the corner we will be evac the next door neighbours. Form up Ravenshaw St - will sort it out when they get here - will need them pretty close if it does turn - lives alone - I believe he is alone - Can't hear or see anyone else so just assuming it's him*".

Senior Constable Chester later told critical incident investigators that he jumped the fence, as the gate was locked, and that the blinds were drawn. He asked CD to come to the front door, as they had reports of concerns for his welfare. CD told him to "*fuck off and go away*" and that he wasn't coming to the door, he wasn't in a good space and come back tomorrow, and he just wanted to go to bed.

The Fire Brigade received a call at 10.07pm and were on scene at 10.21pm. They were asked by police to meet them in the nearby Ravenshaw St. The message they received was that the AA Sponsor had received a call from CD at about 9.10pm, saying there was a conspiracy against him and that he would pull a gun on himself.

At 10.13pm a broadcast for ambulances to attend with no lights and sirens and go to Ravenshaw St was broadcast, with the comment "*it appears we have a siege on our hands*".

The door was barricaded from the inside and out.

At 10.16pm, Sergeant Kirk broadcast that he was on his way and estimated that he would arrive in 30 minutes. At 10.17pm, the radio operator asked Sergeant Kirk "*who is onto the negs* [negotiators]*? I have contacted the on-call DO* [duty officer] *just waiting for them to call me back*". The on-call duty officer that night was Chief Inspector Fidock. At 10.22pm police VKG reported that they were on the phone to the informant (the AA Sponsor) who was on the phone to CD and he was saying that if he hears police rattle the keys and try and get in he has enough gas to blow everyone up and that the informant has stabbed him in the back. Senior Constable Chester broadcast that he had formed up Ravenshaw St and that he'd unlocked the gate to get access to the front door.

The Northern Region Co-ordinator, Senior Sergeant Lawson, first became aware of the incident at 10.22pm, when he received a call from police radio saying that negotiators had been requested. In his role as co-ordinator, it was Senior Sergeant Lawson's job to manage the deployment of negotiators and tactical police. If an incident was defined as high risk, it requires the use of tactical operations police to support any negotiators.

It appears that it was Senior Sergeant Lawson's job to make recommendations at to what was required to the Assistant Commissioner, Assistant Commissioner Mitchell, who had the ultimate authority to authorise deployment of negotiators and tactical operations officers. Both were located remotely.

Senior Sergeant Lawson's information at that stage was that CD was threatening to shoot himself and that he had a warning for firearms from 2003 and a 'mental health event' from Belmont in 2014. Senior Constable Chester was on scene and Sergeant Kirk was about 25 minutes away. At 10.25pm he phoned Senior Constable Chester, and was told that CD had said "*I'll just get my pants on*," then "*I just want to go to bed, come near the place I'll blow the place up. I have 40 litres of petrol and a cigarette lighter*". Senior Constable Chester said he could hear CD saying to someone, possibly the AA Sponsor, "*blow the place up*" and "*gas stove*".

Senior Constable Chester said he had spoken to neighbours who said that CD was back drinking alcohol and he said that CD won't be going peacefully. Senior Sergeant Lawson became aware that Chief Inspector Fidock was trying to ring Senior Constable Chester, so he got off the phone.

It appears from Chief Inspector Fidock's statement that he was first alerted about the incident shortly before 10.25pm, when he then asked for the police Computer Aided Dispatch ("CAD") information to be read back to him. He called Senior Constable Chester at 10.30pm, and was told that the front door was barricaded with various objects including a lounge, mobility scooter and trolleys, and that CD had said he had gas cylinders and forty litres of fuel and a cigarette lighter. CD had refused to open up the blinds on the house. As that information was obtained by phone, it was not shared on police radio at that point.

Chief Inspector Fidock asked Senior Constable Chester to have Senior Constable Mitchell contact the informant and accurately define the reason for the call and the information. Chief Inspector Fidock then gathered some clothes and got ready to drive to Forster police Station. Senior Sergeant Lawson recalls that he called Chief Inspector Fidock at 10.37pm, while he was still at home. Senior Sergeant Lawson recalls that they discussed that the information was conflicting-that he told the AA Sponsor that he would shoot himself but hadn't made that threat to police, that he wanted to go to bed but was threatening to blow the place up if police entered. They apparently discussed the option of leaving the place and refer to mental health in the morning or deploy negotiators and tactical police and deal with possible scheduling of CD. Chief Inspector Fidock said that he would get Senior Constable Chester to contact Senior Constable Mitchell to clarify.

At 10.40pm Senior Constable Chester radioed that he had evacuated some residents but not other houses some slight distance away and they were trying to organise emergency accommodation; he said they weren't sure if CD even had gas but he claimed to have 40 litres of petrol and gas cylinders. At 10.47pm Chief Inspector Fidock spoke again to Senior Constable Chester by phone who advised that CD had said, "*Fuck off or I will blow the place up*".

At 10.57pm the other Senior Constables at the scene confirmed to police radio that there was no gas connected to the premises. At 11.01pm the radio advised that the informant (the AA Sponsor) had spoken to CD son who advised that his father had schizophrenia but it was unknown if he was medicated and that he was a recovering alcoholic who also suffered from diabetes. At 11.04pm Senior Constable Mitchell informed Chief Inspector Fidock by phone that he had spoken to the AA Sponsor and that CD had apparently been on a three day drinking bender and believed there was a conspiracy against him. It appears that shortly after this Chief Inspector Fidock began to drive towards Gloucester from Forster.

At 11.07pm Senior Constable Chester advised radio that they had spoken to neighbours and CD had been seen taking in gas bottles a few days ago. He said they tried phoning him but the phone went to voice mail. At 11.16pm the other senior constables advised radio that Sergeant Kirk, who was now on scene, was "*talking through door at moment*" (in discussion with CD). In his interview, Sergeant Kirk said that he and Senior Constable Chester went to the front door and CD was talking over the top of them and saying that he didn't want them to come in and if they did he'd kill them by blowing them up. Sergeant Kirk said he had no intention of coming in as he had four children.

They tried to get him to come to the door. CD was talking about the council contacting him about something and said if you think I'm going to sleep I have one hand on the gas tap. It appeared to Sergeant Kirk that CD had been drinking. CD concluded by saying "*turn the torch off, get off the verandah because I'm opening the gas tanks up, I'm going to kill the lot of you*." Police then left the house verandah and retreated to the opposite corner.

Senior Constable Chester recalled recalled CD saying that he wouldn't negotiate.

At 11.26pm Sergeant Kirk came on police radio, saying that CD was ranting and raving and threatened to open up the gas valves in the house and was very angry. Chief Inspector Fidock recalls that Sergeant Kirk relayed this information to him by phone at 11.29pm.

At 11.35pm Chief Inspector Fidock rang Senior Sergeant Lawson and said that the incident would require negotiators. This is the point at which it appears a decision was first made at a senior level to request that negotiators attend. It is also the point at which Senior Sergeant Lawson says he first learnt that CD may have schizophrenia. Senior Sergeant Lawson gave evidence that he was not able to listen to the radio broadcast from his location.

At 11.38pm Chief Inspector Fidock called Superintendent Thurtell and briefed him, seeking approval to deploy specialist units. Verbal approval was given for Chief Inspector Fidock to make that request to Northern Region, who then relayed that to Senior Sergeant Lawson at 11.41pm.

Sergeant Kirk says that he then got in contact with Chief Inspector Fidock to make sure that he'd contacted the tactical police and negotiators. Chief Inspector Fidock recalls this call coming at 11.43pm. It appears that police on the scene at that stage expected that decision to have been made. Sergeant Kirk's memory is that when this conversation was happening that he then noticed the house was on fire.

At 11.58pm, Senior Sergeant Lawson called Chief Inspector Fidock back and said that approval for negotiators had not yet been given as further assessment of the scene was required. Assistant Commissioner Mitchell felt that it was critical that a senior officer such as Chief Inspector Fidock be at the scene given the lack of clarity in the available information, as he could not decide on the conflicting and limited information available to him (including CD having said he wanted to go to bed versus making threats to blow up the house with gas) whether it was high risk or self-harm. He was also under the impression that Chief Inspector Fidock was only minutes away from the scene when the request for his approval came through. He did not however consider it appropriate for police to simply leave the scene and return in the morning. Assistant Commissioner Mitchell also noted that negotiators generally work in teams of four. It appears that resources would have had to come from various areas including Newcastle, involving a 90 minute travelling time. Tactical operatives with breathing apparatus would have had to come from Sydney back in 2017.

At 11.56pm, the Fire Bridge radio reported that the house had "*just gone up*". Further resources were requested. It apparently took about an hour to extinguish the fire.

The home was described as a weatherboard. Chief Inspector Fidock, still driving to the scene, learnt at about that time from Senior Sergeant Lawson that further assessment was required. He did not arrive on scene until 12.13am.

Senior Constable Chester and Sergeant Kirk ran to the house when the flames started. Senior Constable Chester heard what he thought was CD moving in the house. The two officers heard gas hissing and told everyone to evacuate.

The RFS arrived on scene at 12.35. Access is reported on the fire brigade radio as having been gained at 01.01am and that at that time CD was showing signs of life (a paramedic attended at that point and found CD unconscious). He was stretchered out about 1.13am and taken to Gloucester Hospital, then airlifted to Royal North Shore Hospital where he passed away from his burns at 9.10am on 20 September 2017. The pathologist at autopsy described the cause of death as "*burn wounds and the consequences thereof*".

On inspection of the home, fire brigade officers found inside the premises three nine kilogram gas bottles, two five-litre lawn mower petrol cans and a lawn mower with the fuel cap off.

Conclusion

The Court heard oral evidence from Senior Sergeant Lawson that he performs the Northern Region's Operations Coordinator role both during shift hours and in an on-call capacity after hours, and when performing the role at home and out of business hours, he does not have use of, or access to the VKG radio or CAD system. He gave evidence that while he is updated regularly over the phone during an incident, that co-ordinating an incident such as this would be enhanced by access to one or both of those methods of communication. Senior Sergeant Lawson expressed interest in having access to the CAD systems after hours, if it was feasible and permitted. This court has not heard any evidence about the feasibility of making those systems available to coordinators working after hours and accordingly, it would be inappropriate to make any recommendations in that regard. I do however encourage the Commissioner of Police to consider this suggestion for any future high risk situations in remote country townships. At the hearing, the solicitor for the Commissioner indicated that he would raise the issue with the Commissioner of the Northern Region Command.

Before the Court were the Australia New Zealand Guidelines for Deployment of Police to High Risk Situations 2016 ("the Guidelines"). The Guidelines describe principal response strategies for High Risk situations such as this one. There was no suggestion that the police officers involved in this incident departed from the Guidelines. Assistant Commissioner Mitchell provided written evidence which explained his decision to require Chief Inspector Fidock to attend the scene, after he had received a briefing from Senior Sergeant Lawson, before he would authorise the deployment of negotiators to the scene.

Assistant Commissioner Mitchell's evidence explained that the initial information relayed to him was that CD made no threats to shoot himself and simply wanted to go to bed. His decision regarding Chief Inspector Fidock was made because the lack of clarify of information prevented him from being able to decide whether the matter could simply be handled as a concern for welfare. He also considered the time for tactical police and negotiators to reach the remote location. Risk and threat assessment, which could be provided by Chief Inspector Fidock, could assist to determine other mitigation strategies to resolve or calm the situation whilst awaiting tactical Police.

Senior Sergeant Lawson also gave oral evidence that since September 2017, tactical support police in Newcastle have been trained and given the appropriate breathing equipment to enter a house such as the one barricaded by CD. This has been arranged so that police in areas such as Gloucester are no longer dependent on the Sydney-based tactical response team to attend.

Nothing further could have been done by the officers involved in this tragedy. Each of them carried out their duty in a professional and appropriate manner.

Findings: s 81 Coroners Act 2009

I find that CD died on 20 September 2017 at the Royal North Shore Hospital, St Leonards, NSW as a result of burn wounds he received when he set his house alight. His death was intentionally self-inflicted.

26. 343689 of 2017

Inquest into the death of AA. Findings handed down by Deputy State Coroner Ryan at Lidcombe on the 14th November 2019.

Non Publication orders

In addition to the non publication orders made by Deputy State Coroner Ryan in these proceedings on 4 October 2019, Deputy State Coroner Ryan further orders that:

1. Pursuant to section 75(5) of the Coroners Act 2009 there be no publication of any report of these proceedings after the delivery of formal findings. A copy of these findings may be disclosed to those assisting the Deputy State Coroner, the Officer in Charge of the coronial investigation, the legal representatives of the interested parties to the inquest, and to AA's family members.

2. There be no publication of material which tends to identify AA and/or his relatives as that term is defined in section 75(3) of the Coroners Act 2009.

Findings required by s81(1)

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

Identity
The person who died is AA.

Date of death:
AA died on 13 November 2017.

Place of death
AA died at Wakehurst Parkway, North Narrabeen NSW 2101

Cause of death:
The cause of AA's death is multiple injuries.

Manner of death:
AA died in the course of a police operation, when he intentionally drove his car into a tree while suffering the effects of a mental health disorder.

27. 344706 of 2017

Inquest into the death of Cameron TOWNLEY. Findings handed down by Deputy State Coroner Forbes at Lidcombe on the 8th February 2019.

Introduction

On Monday, 13 November Mr Townley was at home lying in bed. His mother noticed that he had a rifle beside him with rounds of ammunition. His mother contacted police for assistance and specialist resources were deployed. When police gained entry to the house they located him on his back in bed with the rifle on his chest and one gunshot wound to his head.

The Inquest

The coroner's primary role is to investigate sudden and unexpected deaths with a view to identify the person who has died; the date and place of his or her death; the cause of death and the manner or circumstances in which that death took place. Pursuant to section 23 of the *Coroner's Act 2009* an inquest is mandatory when a death occurs as a result of a police operation. This is an enquiry into how it happened that Mr Townley died while an operation was being carried out by the police with the intention of saving his life.

Background

Mr Townley was born on 13 December 1989 in Macksville. He was 27 years old at the time of his death. He was the son of Cathy Forsyth and John Townley and he had an older brother Jason.

He lived in the Nambucca Valley and attended Bowraville Public School and the Macksville High School. Following school he worked as a farm hand on properties within the Nambucca Valley. Mr Townley was a recreational shooter and had a number of registered firearms. In 2014, his father, John Townley died and apparently he had taken his father's death quite hard.

In November 2015 Mr Townley was treated as an outpatient at Macksville Hospital with an abscess on his left arm. His general practitioner, Dr. Edwina Guard, formed the opinion that the wound may have resulted from IV drug use. Dr. Guard made arrangements for Mr Townley to see her for dressing of the wound and she spoke to him about concerns she had that he was using ice. Although Mr Townley denied he had used ice regularly, he did admit to Dr. Guard that he had tried it. He also denied that the wound was an IV site. Dr. Guard attempted to continue to see him and made a follow up appointment for Mr Townley however he failed to attend.

In 2016 rumours began circulating that Mr Townley was a user of methamphetamine. In April 2017 Mr Townley moved in with his mother Cathy Forsyth at 263 Bellingen Road, Bowraville.

In the months leading up to his death his mother noticed a decline in his mood and personal drive. In October 2017 she consulted his doctor in relation to her concerns and his use of methyl amphetamine. In October 2017 his mother confronted him about her suspicions that he was using methyl amphetamine. He denied using methyl amphetamine and became defensive.

The Fatal Incident

At about 4:20 PM on 13 November 2017 Mr Townley was lying in his bed. His mother noticed a rifle under his sheet and ammunition rounds near the bed. She tried to grab the firearm but he would not allow it. She took hold of the rounds of ammunition and he told her that he had plenty more and that the rifle was loaded. She told him that she was going to seek help and he replied "don't go and get the police or anyone. If you bring anyone here I'll shoot you as well"

She left and made contact with his girlfriend.

At 4:46 PM Mr Townley sent a text to his girlfriend that read "I will look down on you from heaven"

Mrs Forsyth rang Senior Constable Jamie Kennedy with her concerns. Senior Constable Kennedy contacted Chief Inspector Guy Flaherty before meeting with Ms Forsyth to obtain further information.

Around 6:10pm Senior Constable Kennedy and Chief Inspector Flaherty arrived at the property and stopped about 300-400 meters away to make observations. They attempted to contact Mr Townley by ringing the landline telephone but it rang out. They tried ringing Mr Townley's mobile phone but it went directly to voicemail.

Following this Chief Inspector Flaherty notified Detective Chief Inspector Thomas and Sergeant Terry and sought the escalation of the State Protection Support Unit (SPSU).

Around 7:15pm – 7:20pm SPSU operatives and negotiators made their way to Bowraville Police Station. A/C Mitchell approved the use of SWAT (Special Weapons and Tactics).

The briefings at Bowraville Police Station were held and a plan was devised whereby perimeter teams would be sent in to lock down the house; then an Armoured Response Vehicle (ARV) holding negotiators and the Alpha SPSU team would drive up and commence negotiations using the PA system. This plan was approved by A/C Mitchell.

About 10:40pm the perimeter teams were dropped off at the command post to move forward on foot and establish a boundary and perimeter. Shortly after 11pm the perimeter was closed and the ARV was deployed from the command post to a position in front of the premises on the northern side. They were about 20-30 metres from the house. The premises were in complete darkness and the blinds / curtains were closed. Lights from the ARV illuminated the side of the house. There were no other lights apparent.

A senior police negotiator commenced negotiations from the ARV using the public address system. He identified himself to Mr Townley and said words to the effect of: "We are here to talk to you.

If you are inside please yell out." Attempts were made to contact Mr Townley's mobile phone. The negotiator also tried calling the landline. The perimeter teams confirmed the phone was ringing inside the house. The lights remained off and the curtains drawn.

Given the lack of response, at 11:36pm Chief Inspector Flaherty and A/Sergeant Casey discussed approaching the window and popping it and trying to engage Mr Townley further. This action plan was approved by A/C Mitchell.

SPSU officers smashed a window of the house and after observing for a time, they saw no signs of anybody in the house. The SPSU operatives moved to a sliding door to clear the area. They soon saw Mr Townley lying on the bed with severe head injuries. First aid was attempted and ambulance officers standing by attended upon him.

Mr Townley was transported to Coffs Harbour Base Hospital and he was pronounced deceased at 1:45am on 14 November 2017.

Conclusion

Having considered all of the material in this matter I am satisfied that the New South Wales police undertook appropriate steps to reduce the risk of harm to Mr Townley.

Findings

The identity of the deceased

The deceased person was Mr Cameron Townley

Date of death

He died on 14 November 2017

Place of death

He died at Coffs Harbour Hospital, Coffs Harbour, New South Wales

Cause of death

The death was caused by a gunshot wound to head

Manner of death

The death was intentionally self-inflicted

28. 39867 of 2018

Inquest into the death of Anthony WRAY. Findings handed down by Deputy State Coroner Forbes at Lidcombe on the 27th May 2019

Mr Anthony Wray died at Long Bay Gaol on 6 February 2018. At the time of his death he was in custody serving a 12 year sentence.

Section 23 of the *Coroners Act 2009* makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that the care of that person was appropriate and adequate.

Between 2013 and 2016, Mr Wray was regularly reviewed by nursing and medical officers whilst he was in custody. In October 2017, he complained of constant coughing, with headaches and facial pain. He was reviewed at the gaol health centre and noted to be coughing blood. Subsequent testing revealed the presence of significant metastatic lung cancer.

Due to the nature of his illnesses, a management plan was implemented where outside public health facilities and specialists were utilised to manage his conditions.

On 1 November 2017, Mr Wray was transferred from Goulburn Hospital to the Prince of Wales Hospital (POWH) Sydney, for further investigations and treatment. Evidence from his treating physician, Doctor Wong, indicates the cancer was at an advanced state and had spread to Mr Wray's liver, spleen and brain. The cancer was considered inoperable and irreversible. Chemotherapy was considered inappropriate due to Mr Wray's poor functional status and he was commenced on palliative radiotherapy for symptom control.

Mr Wray was in and out of Prince of Wales Hospital during November and December 2017. On 30 November 2017, Mr Wray received his first cycle of radiotherapy to his chest however declined to receive further treatment.

On 1 December 2017, Mr Wray signed formal documents indicating he wished for no further active treatment of his cancer; he was only to receive treatment to alleviate his symptoms. A 'not for resuscitation' form was signed.

On 30 January 2018, a specialist palliative care team visited Mr Wray. Mr Wray agreed to receive care to maintain his comfort and that he would no longer attend hospital for acute care. On 6 February 2018 at 02:00 hours, Mr Wray was reported to be resting comfortably and in no distress within his gaol hospital cell. About an hour later, Justice Health nurses on their rounds noted Mr Wray had stopped breathing. Mr Wray was assessed, and he was formally pronounced dead at 3.00am.

Police were notified of the death and attended shortly after. Uniformed police and detectives attended. Specialist investigators from the NSW Police Corrective Service Investigative Unit conducted the investigation. No suspicious circumstances were found. No systemic failings were identified. Pathologist Dr Szentmariay conducted a post mortem examination of Mr Wray. The direct cause of death was found to be metastatic lung cancer. The gaol and health records reveal Mr Wray's care and treatment were appropriate. No family member or associate of Mr Wray's have raised any care and treatment issues. Mr Wray was regularly seen by Justice Health doctors and nurses whilst in custody. He was taken to outside facilities where the treatment needed proved beyond the capability of the gaol he was housed in at the time. Given Mr Wray's health issues and his deterioration whilst in gaol, it does not appear that anything could have been reasonably done to prevent his death.

Findings required by s 81 (1)

The identity of the deceased

The deceased person was Anthony Wray

Date of death

Died on 6 February 2018

Place of death

Died at Long Bay Hospital Gaol

Cause of death

The death was caused by metastatic lung cancer

Manner of death

Natural causes

29. 40544 of 2018

Inquest into the death of Terence Reddy. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 7th May 2019

This is an inquest under sections 23 and 27 of the Coroners Act 2009 into the death of Terence Reddy who died of natural causes whilst in the custody of NSW Department of Corrections.

As Mr Reddy was in custody at the time of his death NSW Police conducted an investigation. His death is not considered to be suspicious. Mr Reddy's death followed a 42 hospital admission the course of which is well documented and described in the Post Mortem Report of Dr R Irvine.

Mr Reddy was serving a number of sentences for fraud offences. Effectively, he was serving a 7 year head sentence dating from 4 January 2014. He was due to be eligible for parole on 3 October 2018. Though the sentence was expressed to commence in January, Mr Reddy did not enter corrective services custody 21 until November 2014 when the first sentence was handed down. It appears to have been backdated to take into account some pre-trial custody he had served some time prior to 2014.

Prior to his imprisonment Mr Reddy had suffered coronary disease. In 1998, at the age of 36, Mr Reddy suffered an acute anterior myocardial infarct caused by an acute occlusion of his left main coronary artery. This was successfully stented at Royal North Shore Hospital. He made a good recovery from this event however he started showing signs of heart failure from 2014. He had ongoing cardiac arrhythmias both supraventricular and ventricular.

On 14 November 2014, Mr Reddy was admitted to St Vincent's Hospital with atrial fibrillation. On 21 November 2014, he was sentenced and when he was received into the Metropolitan Remand and reception Centre Mr Reddy reported that he had several cardiovascular conditions and was prescribed several medications. He did not report any mental health, drug or alcohol concerns. On 22 November 2014 a chronic disease screen was completed with Mr Reddy.

That screen documents a significant cardiac history of acute myocardial infraction in 1998, atrial fibrillation, severe ischaemic cardiomyopathy, hypercholesterolemia, mitral incompetence, dilated atria, myocardial infarction, non-rheumatic valvular heart disease and left ventricular hypertrophy.

Mr Reddy received regular assessments, appropriate treatment and medication whilst under the care of the Justice Health & Forensic Mental Health Network. His treatment also including attending medical facilities outside the prison system. On 10 July 2015 Mr Reddy attended Prince of Wales Hospital for a transesophageal Cardiogram and successful cardioversion. In 2016 he was reviewed by the cardiology team at Prince of Wales Hospital.

In July 2017 an automatic implantable cardioverter-defibrillator (AICD) was inserted and during that procedure he sustained a dysrhythmic arrest. On 14 December 2017 Mr Reddy was transferred to Prince of Wales Hospital and then on 16 December 2017 he was transferred to St Vincent's Hospital in Darlinghurst for management of his decompensated heart function and consideration for a heart transplant. He was in advanced heart failure complicated by severe hepatic congestion and cardiac cachexia.

An Echocardiography showed severe dilation of the left ventricle, severely impaired systolic function, an estimated left ventricle ejection fraction of 15%, dilatation of the left atrium, moderate regurgitation of the mitral valve, moderately impaired systolic function and dilatation of the right ventricle, moderate to severe incompetence of the tricuspid valve, moderate pulmonary hypertension, and extensive scarring and thinning of the anterior, anterior septal and anterior apical myocardium. On 10 January 2018 he manifested features of delirium which was to prove ongoing and fluctuating. He had multifactorial diffuse encephalopathy, with potential factors including hepatic insufficiency, recurrent urinary tract infection, fluctuating electrolytes and a possible cerebral hypoxic event.

On 18 January 2018 he exhibited seizure-like activity and ventricular tachycardia followed by loss of consciousness, spontaneous circulation was restored following defibrillation and he was transferred to Intensive Care Unit. He was later transferred back to the Coronary Care unit. On 25 January 2018 Mr Reddy underwent a procedure involving the insertion of an intra-aortic balloon pump to stabilise his cardiac function. Before this procedure was carried out management of Mr Reddy's coagulation status was undertaken.

Despite the procedure being completed without complication on 27 January 2018 Mr Reddy appeared confused and had tremors followed by a period of unconsciousness of about 45 seconds. He may have had subsequent seizure activity. One of his coagulation laboratory tests (APTT) was significantly elevated which Dr Irvine describes as "indicative of supratherapeutic heparin administration".

A CT scan of the brain showed that Mr Reddy had suffered a haemorrhage within the left occipital parietal pole and multifocal subarachnoid haemorrhage. He recovered to full normal consciousness (Glasgow Coma Score 15 out of 15) but developed a severe headache and photophobia. He then developed prolonged seizure activity that was refractory to medical control; an extension of his intracerebral bleed was suspected. His Glasgow was 3 and he showed no neurological recovery. On 29 January 2018 the decision was made to change treatment goal to that of comfort measure. The intra-aortic balloon pump was removed and Mr Reddy was transferred to Sacred Heart Hospice, Darlinghurst on the 1 February 2018. He died at 4:05 a.m. on 6 February 2018.

The Mr Reddy's family did not raise any issues about the care and treatment provided to Mr Reddy. Ms Notley read onto the record a statement from Sue Kristanna, Mr Reddy's sister who expresses her sorrow on behalf of their family. I offer my sincere condolences to Mr Reddy's family. Mr Reddy's direct cause of death has been confirmed by Dr Irvine, Forensic Pathologist who undertook a medical records review and conducted an external examination of his body.

Findings

Terence Reddy died of complications of atherosclerotic cardiovascular disease and its treatment on 6 February 2018 in Sacred Heart Hospice, Darlinghurst. The manner of his death was natural.

30. 41984 of 2018

Inquest into the death of Patrick Norman FISHER. Findings handed down by Deputy State Coroner Forbes at Lidcombe on the 23rd August 2019

Introduction

This is an inquest into the death of Mr Patrick Fisher who died on 7 February 2018, after falling from a 13th floor apartment balcony. Mr Fisher slipped while he was trying to climb to the balcony below to avoid being arrested by NSW Police Officers who were knocking at the door.

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

i. the identity of the deceased;

ii. the date and place of the person's death;

iii. the physical or medical cause of death; and

iv. the manner of death, in other words, the circumstances surrounding the death.

The Act also requires a Senior Coroner to conduct an inquest where the death appears to have occurred "*as a result of police operations".* (s.23, s.27).

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

This inquest is not a criminal investigation, nor is it civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. This Inquest has been a close examination of the police actions on the morning of Mr Fisher's death and pursuant to s.37 of the Act a summary of the details of this case will be reported to Parliament.

Mr Fisher

Mr Fisher was the youngest of nine siblings. His father died when he was just twelve years old. He is dearly missed by his family and in particular his mother who had a deep connection with him. She described him as being well liked, with good manners and a sense of respect. She said that as a young boy he was a successful and keen footballer and a natural leader who became the school captain of his primary school. She said that he was the sort of person who loved and believed in other people and that when you were with him you gained an insight into yourself.

Mr Fisher was a father to three children, who were aged 14, 11 and 8 at the time of his death.

I received a statement from Carly Bianca White, who is the mother of two of Mr Fisher's children. She writes about how the grief is still very raw and that they all miss him very much. The boys are receiving counselling at school to help them manage their grief.

Sergeant Ross Veltman of Redfern Police had opportunities to meet and talk with Mr Fisher prior to his death. He described him as a nice person to talk to, who was athletic and lively and talked openly about himself, chatting about his children and other things that were important to him.

Background

From an early age, Mr Fisher struggled with alcohol and drugs. He revealed to Police and medical teams, that he had developed an alcohol problem between the ages of 12 until he was 14. He started smoking cigarettes at the age of 12 and cannabis at the age of 13. He then used cocaine at the age of 13, and heroin at the age of 14. Mr Fisher's record on the NSW Police Force database (COPS) includes 280 events and 118 Intelligence Reports. The COPS entries are for a range of offences including larceny, robbery, assault, malicious damage, resist/hinder/assault police. The intelligence reports include issues of being armed, street crime and larceny. There were 21 warnings on Mr Fisher's 'Police profile', including, "may assault police", "known prohibited drug user", "may carry weapon", "may become violent when intoxicated", "POI has threatened to kill any Redfern Police officer whilst on or off duty- warning should be taken seriously", "approach with caution", "consideration should be given to handcuffing whilst speaking to POI for Police officer safety", "self-admitted ice user", and perhaps most relevantly "May escape or attempt to escape; May resist arrest".

Mr Fisher's juvenile criminal history is recorded from 24 February 2000 (first charge date) until 25 August 2003. There are 15 convictions recorded during his juvenile period and he served one period of incarceration in 2003 with a control order of 7 months for the offences of Malicious Wounding and Robbery in Company. His adult criminal history extends from 4 February 2005 until 5 November 2017. There are 45 convictions recorded during his adulthood and he served a number of custodial sentences, with the last release date being 29 March 2016. He was given a further suspended sentence of 7 months on 17 May 2017.

Police records show that Mr Fisher had avoided or attempted to avoid police on 44 occasions. These included 20 occasions of running from police when there was no offence detected, nine times when he ran when there was an arrest warrant, 11 times when he ran from police and was apprehended and four motor vehicle pursuits.

On two occasions, Mr Fisher fled Police and jumped over a balcony to escape;

i. On 8 March 2007 Police attended 39 Eveleigh Street Redfern to arrest a person. During this arrest police observed Mr Fisher to be hiding under a bed in an upstairs bedroom. When discovered by police he crawled out, but after a short struggle with Police fled over the first floor balcony. Police had hold of his shirt, and Mr Fisher was dangling from the balcony whilst being held. Due to his struggling, police lost grip of Mr Fisher who dropped to the footpath and escaped. He was later arrested inside a neighbouring premise and charged (H28787834).

ii. On 13 June 2010, Mr Fisher and a co-accused climbed an awning of a shop at 34 Redfern Street, Redfern, and gained access to an adjoining premise at 36 Redfern Street, where they stole property through a window of a room. The occupants called police who attended and saw Mr Fisher on a balcony on the third floor of this building. He then leapt over the balcony and hung onto the railing, then let go of the balcony railing and fell to the ground. Mr Fisher produced a knife, ran, but was chased by police and subsequently arrested and charged (E41472473). On 3 November 2017, Mr Fisher was charged with Assault Occasioning Actual Bodily Harm. He was charged with punching a member of the public and breaking their jaw.

iii. He failed to appear at the Downing Centre Local Court on 8 December 2017 for that charge. He was also due to appear at court on that day in relation to offences of Destroy/Damage Property and Larceny for which he had been placed on s.12 bonds.

In his absence he was convicted of the Assault Occasioning Actual Bodily Harm offence and the court issued a warrant for his arrest pursuant to section 25 (2) *Crimes (Sentencing Procedure) Act*. As a consequence of the conviction, the bonds were 'called-up' and a warrant was also issued in relation to the s 12 Bonds pursuant to section 98 l A (a) of *Crimes (Sentencing Procedure) Act.*

It was these warrants that police planned to execute when they arrived at the apartment on 7 February 2018. The section 12 Bonds related to suspended sentences that he was facing serving in custody once arrested.

Undisputed Factual outline

Following the issuing of the two warrants, the Redfern Police Local Area Command updated their intelligence bulletin to include the information that Mr Fisher had outstanding arrest warrants. The 'Intelligence bulletin' is a weekly summary of individuals at large or wanted for questioning, any particular crime trends or hot spots and some general information relating to the relevant local area command. It is a protected internal document circulated to all police.

The bulletin is emailed to police officers in the command and is also uploaded as a rolling slide show on monitor screens within the command, such as the muster room or meal room, so that police may be kept up to date with local crime trends and local individuals wanted by police.

In January 2018 Mr Fisher was identified as a suspect in steal from motor vehicle offences in the Sydney City Police Area Command and on 24 January 2018 his profile was added to the Redfern Police Area Command's morning briefings as being wanted for those offences. He also appeared in the Sydney City Police Area Command's intelligence bulletin for these offences.

Police attended Mr Fisher's mother's residence in Redfern in an attempt to arrest him. Senior Constable Broadfoot searched the unit, but Mr Fisher was not there.

Police also attended the security office of the Sir Joseph Banks Building and showed the Security Concierge for the building, Mr Mir Rana, a photograph of Mr Fisher. Mr Rana recognised Mr Fisher as being a person who had visited Naomi Dixon in unit 1312 on occasions over the last year. The police told Mr Rana to contact either the security control room or Redfern Police Station if he saw Mr Fisher.

Police also attended the security office at 3 Phillip Street Redfern. They spoke with security officer Samir Rafraf and asked him to call the police station if he saw Mr Fisher. Mr Rafraf confirmed that he knew who Mr Fisher was.

In his interview after this incident, Sergeant Veltman, the officer who was in charge of the attempt to execute the warrants on Mr Fisher, explained that:

" ... we have a very good relationship with them [building security] and it's quite common that, um, that we, that we get some photographs are left or something and we will act on the information … and, um, I've arrested hundreds of people [in] those blocks over my eleven years and it's always found to be accurate".

7 February 2018

At about 10.40am on Wednesday 7th February 2018, Mr Fisher went to the outside of the Sir Joseph Banks Building at 249 George Street, Waterloo. A male by the name of Anthony Weldon, who has known Mr Fisher since he was a child, stopped and spoke to him outside the building. Mr Weldon later told Police that he thought Mr Fisher was 'on something' because his speech was rapid and movements were jerky. During the conversation Mr Fisher told him that he had no place to stay or go.

Mr Weldon walked away as another male, Brett Jennings, arrived on his push bike. Both Mr Jennings and Mr Fisher banged on the front door to the building and asked Mr Rana, the concierge/security officer, to let them into the foyer, which he did. Mr Rana recognised both men from photographs provided by police in the weeks prior. Brett Jennings refused to sign the visitor book and Mr Fisher signed a false name, before they both went to the lift.

Shortly afterwards, Mr Fisher and Mr Jennings entered unit 1312. Peter Williams was already in the unit with Naomi Dixon. Mr Williams saw Mr Fisher and Mr Jennings enter the unit, Mr Williams was dozing off on the lounge after their arrival.

After Mr Fisher got in the lift Mr Rana contacted the security control room at 3 Phillip Street Redfern and continued to watch the CCTV of Mr Fisher's movements. Mr Rana spoke with Security Officer Mr Rafraf and advised him that Mr Fisher had exited lift number one on level 13. Security Officer Mr Rafraf reviewed the CCTV footage and confirmed it was Mr Fisher and Mr Jennings in the lift. He called Mr Rana back and advised him to continue to watch the lift and fire exit cameras to see if Mr Fisher left the building.

Security Officer Mr Rafraf called Redfern Police Station and recalls asking a male police officer if police still wanted Mr Fisher, as he was on level 13 of the Sir Joseph Banks Building. The police officer advised they would send someone shortly.

Constable Edward Archbold-Digby received the phone call from Mr Rafraf. He consulted with Leading Senior Constable Carter, who advised him to check COPS to confirm that FISHER was still wanted on a warrant and if so, put the job on as a check bona fides. About 10:54am Constable Archbold-Digby created a job on the NSW Police Force Computer Aided Dispatch (CAD) system.

Within two minutes of the creation of the CAD job, Sergeant Veltman acknowledged the job and requested assistance. In his interview he described himself as responding

"let's go, arrest him as soon as possible, cause, I'm aware that several police have been in four pursuits with him the last couple of weeks and I, myself, I keep patrolling where he lives, um, I've been looking for him with other police, um, for the past, probably six weeks, to two months ... and he's managed to get away every time. And I thought, well, that's good, he's quite contained in there, so we should be able to get him no problem".

Sergeant Veltman called for assistance and he and Sergeant Hill made their way to the Sir Joseph Banks Building.

Just prior to 11am, CCTV depicts Sergeant Veltman, Sergeant Hill and Constables Kearney and Gardiner arriving at the building and parking their cars. They walked to the security office area of the building where Sergeant Veltman spoke with security officer Mr Rana. Mr Rana told Sergeant Veltman that two men had gone up to level 13 together. Mr Rana showed Sergeant Veltman a photograph of one of the men he had seen entering the building. Sergeant Veltman thought he recognised this man as someone else who he thought was also subject of a warrant.

The four police got into a lift and made their way up to level 13.

Outside on George Street, Detective Egan and Detective Smith were arriving in their police car after hearing a report of the job on the police radio. Over the radio Detective Sergeant Egan told Sergeant Veltman he had arrived and stated that he thought Cherie Jackson, wanted for armed robbery, might also be in the apartment.

Sergeant Veltman requested Constable Lockwood take a position downstairs with a view of the Western side of the building in case someone tried to climb down the balcony.

He requested another officer make their way up to level 13 to assist, because, he said:
" ... *I know that Mr Fisher does usually bung it on ...”*

Constable Switzer, who had just arrived, made his way up to level 13 while Constable Lockwood took up a position outside on the Western side of the building with a view of the thirteenth floor balcony

On level 13, Sergeant Veltman, Sergeant Hill and Constable Kearney and Gardiner waited for Constable Switzer to arrive.

Constable Switzer arrived and knocked on the door. The voices within went quite. A female voice said "who is it?” Constable Switzer replied, "It’s the police, open the door". There was silence. Sergeant Veltman kicked the door a number of times. Different police officers had a different estimate of the time that passed, somewhere between 10 and 30 seconds after police had first knocked, and after Constable Switzer kicked the door more than once, Naomi said that she was coming and she opened the door. At that time a number of police entered. Sergeant Veltman was first through the door.

As he entered the apartment Sergeant Veltman heard Ms Dixon say that Mr Fisher had gone over the balcony. Sergeant Veltman quickly made his way to the open balcony door. He looked down and saw Mr Fisher on the ground below. Constable Lockwood immediately attended upon Mr Fisher. She described that she was looking up towards the balcony of the unit from the car park below.

She watched as Mr Fisher walked out onto the balcony and swung one leg, and then another over the railing, and it looked like he lost his footing. She heard him say “oh fuck” before he fell.

Justin Flanagan, a resident of the same building, who was returning to the building with his dog, also saw Mr Fisher fall. In his interview, he told police

" ... he moved his body over the side of the balcony so that he was holding onto the brick ledge on the outside of the balcony. I could see his body dangling over the balcony ... he crouched down ... I watched him at this point bounce or lean back. He lost his grip from where his hands were positioned on the ledge ... the man fell ... ".

Police and paramedics attended on Mr Fisher. Detective Sergeant's Egan and Smith who were patrolling the area immediately responded after Mr Fisher came to rest on the ground and commenced performing CPR.

A call was received by the NSW Ambulance Service at 11:10am and paramedics arrived at the scene at 11:16am. Tragically there was nothing that could be done to save his life. He was pronounced deceased at 11:20am.

At autopsy the forensic pathologist determined that his cause of death was multiple injuries and that Methylamphetamine was a significant condition that contributed to but did not cause his death. Dr Farrar, consultant forensic pharmacologist, is of the opinion that the concentration of methylamphetamine in his blood indicates he was in the process of smoking methylamphetamine just prior to his death. He stated that the concentration is associated with profound behavioural change and that there would have been deficits in cognitive and psychomotor performance, reduced judgement and decision making ability and a propensity for increased risk taking activities.

Brett Jennings, who was up in the apartment with Mr Fisher, participated in an electronic interview with Police. He said:

“Four coppers come to the door. I didn't know at first. They're knocking on the door. Two times. So four times they knocked. Like one, two, four. You know what I mean. Anyhow fucking, they knocked then he started booting on the door, Mister Swelter or whatever his name is and said police and all this and that and then Pat's run out and I don't know, slipped to his death. That's as far as I know.”

Issues

It is not in dispute that the Police had the power to enter the unit to execute the warrants.

It was necessary for them to find Mr Fisher as soon as they could as he was wanted for the court warrants and also for questioning in relation to further offences it was alleged he was committing while at large. It is not in dispute that in climbing over the balcony and attempting to swing onto the balcony below Mr Fisher slipped and fell. It is not in dispute that the police were either still knocking on the unit door or just entering the door when Mr Fisher fell.

The issue that remains for this inquest to consider was whether anything should have been done differently by the police in light of the fact that the police were aware that Mr Fisher had a history of trying to escape police, including climbing over balconies, and were also aware he used 'ice' and may act irrationally.

It is conceded by all parties that containing the building and waiting for Mr Fisher to leave were not realistic. There was no way the police could know how long Mr Fisher would stay, furthermore, the building had five exits to the street and CCTV cameras did not cover the hallways and stairwells within the building.

It is not in dispute that there was, however, an onus on the police to properly assess the risk of the situation before they embarked upon the arrest.

The representative for Mr Fisher's mother submitted that an outcome of a careful assessment of the risk may have been that further police could have been placed on the balcony in the unit below so that Mr Fisher would have been deterred from attempting to climb over the 13th floor balcony.

This may have been a successful idea however it is also fraught with difficulties. In his drug affected state Mr Fisher was not acting rationally. He may have continued to attempt to climb over the balcony or try to climb up to the one above. If police were below there may well have been a greater risk of danger to all. The fact that Mr Fisher was not successful in his attempt to climb to the lower balcony is not because it was not possible. Unfortunately as a result of the effects of the drug or by accident he slipped and fell. I'm not persuaded that having police on the balcony below would have been a safer and preferred approach to undertake the arrest. It is beyond reasonable to expect police to gain access to someone else's apartment and become involved in such a potentially dangerous situation.

Sergeant Veltman did undertake a risk assessment before he commenced the arrest. He knew Mr Fisher and he was well aware of the warnings on the police systems. He knew Mr Fisher would try to avoid being arrested. He arranged for extra police to assist him and for Probationary Constable Gardiner to guard the door while the other police went in with him to affect the arrest. He told investigating police that the plan was to rush in and catch them by surprise, Mr Fisher first. He was aware of the possibility that Mr Fisher may attempt to climb over the balcony. He didn't think it was likely as it was a 13th floor balcony and Mr Fisher had only climbed over balconies closer to the ground before.

Furthermore, the last time he had climbed from a balcony to evade arrest was eight years earlier. He formed the opinion that if Mr Fisher did try that he would be able to do it successfully. He was an athletic and agile young man and the design of the balconies made it possible. He made arrangements for an officer to remain on the ground to watch the balcony in case that possibility did arise. Sergeant Veltman said that he did not know that Mr Fisher had just been smoking methylamphetamine that morning and didn't foresee the possibility that Patrick would slip and fall.

I am satisfied that the assessment of the risks and the preparations that were put in place by police before the warrant was executed were appropriate.

Within an hour of Mr Fisher's death a Level 2 Critical Incident was declared. The critical incident guidelines were put in place and an independent investigation was undertaken by Detective Sergeant Babb. I commend him on the excellent brief he prepared for this matter.

This was a tragic ending for a man who had great potential. I extend my sympathies to all of his family.

Findings: s 81 Coroners Act 2009

I find that Patrick Fisher died on 7 February 2018 at the Sir Joseph Banks Building, 249 George Street, Waterloo, NSW as a result of multiple injuries he received when he fell from a 13th floor balcony. Methylamphetamine intoxication was a significant condition that contributed to but did not cause his death.

31. 79469 of 2018

Inquest into the death of Marlene McHardy. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 28th February 2019.

This is an inquest into the death of Marlene McHardy, who died on the 11th of March 2018 in Long Bay Hospital. Ms McHardy was aged 50. She was a prisoner on remand awaiting sentence in the Local Court for committing the offence of breaching an apprehended violence order.

The breach was being at home whilst having consumed alcohol. She had pleaded guilty and the offence placed her in breach of three s12 suspended sentence bonds. One for 9 months for driving whilst disqualified and the other for 2 were each of 3 months for contravention of an apprehended violence order one of which had initially been dealt w9ith by a sentence of 12 months bond under s9.

BACKGROUND

Limited background history was available from the information provided to the court, but we know that Ms Hardy became a ward of the state at a young age. She attended High School in Muswellbrook until the age of 15, completing year 9. She had a history of alcohol abuse, reportedly beginning at the age of 15, and ran away from a girls home, living on the streets in Kings Cross for some time.

She has a son, Dyson, who is 31 years of age, and a de-facto partner, Daryll Johnson, with whom she was residing prior to going into custody. She reported having limited contact with her mother and brother.

INCARCERATION

Ms McHardy had a criminal history dating back to the late 1980's. She had drink driving charges in the early 90s and was imprisoned for the first time in 1997 for high range drink driving whilst disqualified. She was imprisoned for the second time in 2013 for similar charges when she breached a suspended sentence for similar charges and re- offended. She was last released from prison on 4 January 2014. It is clear looking at her history that she had a significant alcohol abuse problem for a very long time. At the time of her recent incarceration Ms McHardy had End Stage Liver disease and Liver cancer, relating to her excessive alcohol consumption. She had been receiving palliative care from Community Health.

On the 27th of January 2018, Ms McHardy was arrested and charged by police with breaching the Apprehended Domestic Violence Order by being intoxicated whilst at home with her partner Daryl Mr Johnson. She was taken to Taree Police Station and kept in custody overnight.

Ms McHardy appeared before the Local Court Bail Court on the 28 of January, being represented by the Legal Aid roster duty solicitor. She made an application for release, but she was refused bail and the matter adjourned to the Taree Local Court on 30 of January 2018. On the 29 of January, Ms McHardy was received into custody at Mid North Coast Correctional Centre. During her screening assessment, she identified a history of seizures, cirrhosis of the liver and liver cancer.

On the 30 of January, she was represented by a private solicitor retained by Legal Aid, NSW on the duty roster. A further release application was made, but she was again refused bail by the local court magistrate. A plea of guilty was entered, and the matter was adjourned for sentence to the 14 of March 2018. An application for Supreme Court Bail was lodged and listed for 12 February 2018.

On the 31 of January, Ms McHardy attended a consultation with a doctor whilst in custody. It was noted that she was receiving palliative care in the community, had a high bleeding risk and a life expectancy of less than six months. On the 2 of February, she was transferred to Kempsey District Hospital Emergency Department and admitted for treatment of her liver condition. She was discharged on the 5 of February and on 6 February she was transferred to the Medical Subacute Unit at Long Bay Hospital to continue receiving palliative care.

On 12 February 2018 Ms McHardy's Supreme Court bail application was adjourned to 19 February 2018. Medical records to show Ms McHardy's health status were required. Legal Aid apparently did not have a file or instructions apparently due to Ms McHardy being represented by a private practitioner on legal aid duty basis at the Local Court and then having multiple transfers prisons and hospitals.

On 12 February 2018 Ms McHardy was admitted to the Prince of Wales Hospital with hepatic encephalopathy. She received IV antibiotics and whilst in hospital had a therapeutic paracentesis draining around 7 L of ascites. She was discharged back to Long Bay Hospital on 21 February. The hospital's discharge document indicates that the medical staff at Long Bay Hospital planned to submit an application for Ms McHardy's release on compassionate grounds.

Prisoners' Early Release Provisions

Section 160 of the Crimes (Administration of Sentence) Act 1999 empowers the Parole Authority to make an order directing the release of an offender on parole who would otherwise not be eligible for release on parole if the offender is dying or if the Parole Authority is satisfied that it is necessary to release the offender on parole because of exceptional extenuating circumstances. This applies to prisoners regardless, if their sentence is below or above 3 years imprisonment but it does not apply to prisoners serving a life sentence. The process by which an application is brought to the Parole Authority may be by way of the prisoner, their legal representative or a family member.

In the last 18 months an arrangement has been developed between Justice Health and the Department of Corrective Services whereby a prisoner who may be eligible for early release is identified and forwarded to Sentence Administration. I have heard evidence from Mr Neil McNamara who is the Snr Project Manager in Sentence Administration. He liaises with Justice Health, the prisoner, family and or legal representative so that an application might be made.

Upon receipt of such an application the Parole Authority may invite the Commissioner of Corrective Services to make submissions. Section 141A of the Act empowers the Commissioner to make submissions to the Parole Authority concerning the release on parole of an offender. Those submissions will include amongst other matters material in relation to the prisoner's deteriorating health and prognosis.

If Ms McHardy had been a sentenced prisoner such an application for early release would have likely taken this course. However, as she was a remand prisoner this process was not one which was able to be pursued.

Prior to Ms McHardy's transfer from Kempsey to Long Bay Hospital on 5 February 2018 Stephen Ward, Acting Manager of Service & Quality, Clinical Operations, Justice Heath wrote to Neil McNamara, Snr Project Officer Sentence Administration, Corrective Services, raising the issue about whether Ms McHardy *"is someone that might be considered for early release and providing a formal diagnosis and prognosis from a Medical Officer would assist in the decision making process".*

As a result Mr McNamara first contacted the Local Court at Taree on 7 February 2018. Ms McHardy did not have a legal representative, and Mr McNamara went to significant lengths to liaise with the Registrar of the Local Court in Taree to have a bail application listed and Ms McHardy to be legally represented. He informed the Registrar about Ms McHardy's medical condition and life expectancy so that she might make a new application for release.

On 9 February he emailed the Court again to follow up his initial request and again on 13 February 2018 and again on 14 February. On 14 February 2018 Mr McNamara was advised that a message had been left for Legal Aid to contact the Registry. On 20 February 2018 those emails were forwarded by the Local Court Registry to Legal Aid. Included in those documents were 3 pages sent by Mr McNamara including one titled Corrective Services NSW Long Bay Hospital with a photograph of Ms McHardy and the words LIMTED LIFE EXPECTANCY, a document written by Cheryl wood, Manager of Security which indicates that Ms McHardy was being managed for End of Life Palliative Care for end stage liver disease. The third page is a letter from Ms McHardy's treating Dr Kostas G Brooks setting out a prognosis that Ms McHardy had a 50% chance of dying in the next 3 months.

On 2 March 2018 Ms McHardy signed an application for bail which was listed on 6 March. Ms McHardy's bail was heard on 6 March 2018 but was again refused. Mr McNamara has given evidence about the process by which a prisoner whose health is deteriorating (such as in this case), is identified as being someone who may seek release essentially so that they do not die in custody. I wish to commend the Department of Corrective Services for initiating the process by which it is sought that a prisoner on remand has the same opportunity as a sentenced prisoner in seeking release to die in the community.

The reason for the 4 week delay between Mr McNamara's first approach and the ultimate application is unclear. But I note that it seems that it was not until Ms McHardy had completed a bail application form on 2 March 2018 that her bail application was listed to be heard on 6 March. This suggests that the Local Court did not list the application as a result of Mr McNamara's approach on 7 February but rather waited until the form was filed.

Regulation 16 Bail Regulations 2014 prescribes that (1) a release application may be made by a person accused of an offence either (a) orally if they are in court or (b) if the person is not appearing before the court, in writing in the approved form. Under 16(2) A written release application may be signed by the accused person or, on the accused person's behalf, by his other lawyer, spouse, de facto partner, parent or guardian.

However, that requirement is not essential as under 16(3) a court may make a decision on a release application even if the accused person has not complied with the provisions of subclause (1) or (2). Though a person may be so unwell as not to be able to sign a release application form such a document would, if sent by the Department of Corrective Service with accompany health records to be considered in the release application at least cause the matter to be listed promptly. It would also effectively be an authorisation by the prisoner for the Department of Corrective Services/ Justice Health to release otherwise private health information. Obviously, securing Legal Representation would be useful particularly if the prisoner is so unwell they are in a hospital facility and unable to appear in court even by audio visual link.

On Mr McNamara's evidence there are about 10 occasions each year where the Department of Corrective Services assist a prisoner in having a release application brought before the Courts which might otherwise not proceed. Given the limited numbers and variety of factors including whether a prisoner is legally represented or not, whether that representation is private or legal aid, the location of the prisoner which might include numerous transfers to and from different prisons and hospitals and indeed whether they have capacity and/or family support available. I have determined that each matter should be dealt with on a case by case basis. That is, policy as to how these matters are best managed need not be subject to recommendations. However, I understand that Legal Aid NSW's Prisoners Legal Service, may be able to assist where a prisoner is without representation support or capacity.

Death

After Ms McHardy's transfer from Prince of Wales Hospital on 21 February she to receive comfort measures at the Medical Subacute Unit of Long Bay Hospital while her condition continued to deteriorate, with periods of non-responsiveness increasing in length.

On the 11th of March 2018, at approximately 10:30pm, a nurse observed that Ms McHardy was no longer breathing and no pulse was detected. She was declared life extinct at 10:35pm.

A limited autopsy was conducted on the 14th of March 2018 by Dr Rebecca Irvine. The direct cause of death was recorded in the autopsy report as decompensated liver failure, caused by alcoholic and viral liver disease with hepatocellular carcinoma.

FINDINGS

Identity

The person who died is Marlene McHardy

Date of death

She died on 11 March 2018

Place of Death

She died in Long Bay Hospital

Cause of death

She died of decompensated liver failure caused by, alcoholic and viral liver disease with hepatocellular carcinoma.

Manner of death

Natural Causes

32. 109798 of 2018

Inquest into the death of Ivan Metcalfe. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 4th September 2019.

This is an inquest into the death of Ivan Metcalfe who died, aged 82, on 8 April 2018 whilst in the custody of the New South Wales Department of Corrective Services.

At inquest the coroner is required if possible to make written findings as to whether the person died and if so, to determine if possible

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

Mr Metcalfe was born on 14 January 1936 in Auckland, New Zealand. He later immigrated to Australia. Mr Metcalfe was married to Elaine Metcalfe. The Officer in Charge of this matter, Detective Sergeant Palmer has spoken with Mrs Metcalfe. She did not wish to raise any issues about Mr Metcalfe's custodial or health care but was upset at not being informed that he was dying and was upset by the manner in which she was told that he had died.

Background

In December 2014 and January 2015 Mr Metcalfe was charged with several historical sexual offences. At special hearing, on 31 January 2018, following a qualified finding of guilt he was sentenced to a limiting term of 2 years and 6 months under section 23 of the Mental Health (Forensic Provisions) Act 1990. He entered NSW Corrective Services custody on that day.

Mr Metcalfe was received at the Metropolitan Remand and Reception Centre. A comprehensive reception Screening Assessment was conducted. It was Mr Metcalfe's first time in custody. He reported multiple health concerns including, Angina, Chronic Obstructive Pulmonary disease, Diabetes Type 1, Gastroesophageal Reflux Disease, Hypertension, Non- Rheumatic Valvular Heart Disease and Sleep Apnoea. He was receiving a continuous flow of oxygen (as required) for his Chronic Obstructive Disease and from 7 February 2018 he was provided with a CPAP machine which he used whilst sleeping.

On 1 February 2018 he was transferred to Long Bay Hospital Sub Acute Unit then the Long Bay Hospital Aged Care Rehabilitation Unit. He was reviewed by a medical officer and his community general practitioner consulted. No changes were made to his current medication. On 5 February 2018 Mr Metcalfe underwent a psychiatric review. There was no evidence of psychotic symptoms and no psychiatric history reported. The psychiatrist's impression was that Mr Metcalfe had a major neurocognitive disorder most likely secondary to vascular disease. Mr Metcalfe remained under the care and treatment of a medical officer throughout his time in custody.

On 28 February 2018, Mr Metcalfe was again reviewed by the psychiatrist who formed the opinion that he remained unfit to plea. The psychiatrist was to prepare a report for the Mental Health Review Tribunal scheduled for April 2018. Mr Metcalfe remained under the care of a medical officer. On 21 March 2018 Mr Metcalfe was transferred to the Prince of Wales Hospital for further assessment and management in relation to complaints over the previous 2 days that he was experiencing shortness of breath, dizzy spells and chest pain. He was admitted to the respiratory ward and commenced on intravenous antibiotics to treat community acquired pneumonia. On 30 March 2018 Mr Metcalfe was being discharged from Prince of Wales Hospital back to Long Bay Hospital Aged Care Rehabilitation Unit.

The hospital discharge summary reported that Mr Metcalfe was diagnosed as having drug induced pulmonary fibrosis; non-ST segment elevation myocardial infarct, angina chest pain at rest, shortness of breath; chronic type 1 respiratory failure and myoclonus. On 1 April 2018 Mr Metcalfe was reviewed by a medical officer and following that review he returned to Prince of Wales Hospital for management of exacerbation of Congestive Cardiac Failure, unresolved chest infection and bilateral leg oedema. On 4 April 2018 Mr Metcalfe suffered a minor heart attack and on 5 April 2018 he informed medical staff that he did not wish to have any further medical interventions. A low dose of opiates was administered to relieve the sensation of severe breathlessness. He died at 12.08pm on 8 April 2018.

Though Mr Metcalfe died of natural causes, because he was in custody at the time of his death the NSW Police are required to conduct an investigation into his death and provide a brief to the coroner. A limited autopsy was conducted on 10 April 2018. The direct cause of death is listed as complications associated with advanced chronic lung disease. Other significant conditions contributing to his death but not relating to the disease or causing it include Diabetes Mellitus (Type 2), ischaemic cardiovascular disease and atrial fibrillation.

There is a limited issue in relation to the circumstances of Mr Metcalfe's death. Though his family do not have any issues in relation to his care and treatment by the Department of Corrective Services, Justice Health & Forensic Mental Health Network (JHFMHN) or the Prince of Wales Hospital, complaint is made by Mrs Metcalfe that the Department of Corrective Services failed to notify her, as Mr Metcalfe's emergency contact, that has treatment had become "end of life" care. The Department of Corrective Service New South Wales have policies which govern the notification of a next of kin when inmates are transferred from a prison to a non-prison hospital for medical care.

The Custodial Operations Policy and Procedure, 6.2.1.3 'Hospitalisation of inmates,' states that the inmates *'emergency contact person (who may be the next of kin) is to be contacted when an inmate is admitted to a hospital as an inpatient with no advanced warning or their medical condition becomes life threatening and death is imminent.'*

Section 13.2.2 'Medical Emergencies' prescribes that *'an inmate's Emergency Contact person must be informed if an inmate is taken to hospital with life threatening injuries and it is obvious he or she will be admitted. For non-life-threatening injuries, the inmate's emergency contact person must be notified on the day the admission is confirmed. An inmate's consent to contact the emergency contact person should be obtained unless the inmate is incapable of giving consent. The emergency contact person must be further notified if an inmate inpatient medical condition deteriorates or the hospital stay is extended.'* Mrs Metcalfe is listed as Mr Metcalfe's emergency contact person on the New Inmate Lodgement Form. She was advised by a CSNSW welfare officer that Mr Metcalfe had been transferred to the Prince of Wales Hospital on 1 April 2018. She visited him the following day. However, she received no further advice except for 8 April 2018 when she was notified of his death. She had not been aware that his health had deteriorated or that an end of life care plan had been put in place.

Graham Kemp, a Senior Investigation Officer of the Corrective Services Investigations Branch provided a Serious Incident Report dated 27 April 2018, a statement dated 5 July 2019 and a statement dated 13 August 2019.

In his July 2019 statement Mr Kemp advises that Mr Metcalfe *"has no NOK or emergency contact on his file due to the nature of his crime*". He further explains this in the August statement, that it may have been due to Mr Metcalfe advising a Corrective Services intake officer that his family "didn't want to know him". In evidence he has said that it would appear that though the emergency contact details were provided by Mr Metcalfe to the intake officer and written by hand on his file, they were not entered into the database. Whatever the explanation, when Mr Metcalfe was transferred to POW Hospital on 1 April 2018 his file did not contain the name of his next of kin or any family contact details so his hospital file did not have those details either.

In his evidence Mr Kemp said that a welfare officer of DCNSW did contact Mrs Metcalfe to advise her that Mr Metcalfe had been transferred to the hospital. I accept the DCSNSW complied with its policy in relation to notifying a prisoner's emergency contact that he was transferred from a prison to a hospital. However, though there is liaison between DCSNSW and the Hospital/Local Health District in relation to the arrangements for a prisoner's custody or security there is no communication in relation to the management of the prisoner's health and wellbeing which would include notifying family members when a prisoner enters "end of life" care and remains in the hospital. Ultimately, it is the responsibility of the DCSNSW as the custodian of a prisoner to ensure that proper notification is provided to the prisoner's family.

Mrs Metcalfe visited Mr Metcalfe the day after she was advised that he had returned to hospital. She was able to do this because she had previously become an approved visitor having visited him in the prison. Apparently there is no procedure whereby the hospital would then obtain her details to then contact her directly or through the prison system to advise her of Mr Metcalfe's deteriorating health. She had not been aware that Mr Metcalfe's death was imminent and when she was advised by DCSNSW that he had died she was shocked and disappointed that she had not been told that he was dying.

Mr Kemp set out in his statement that after becoming aware of this situation the matter was referred to the CSNSW Organisational Review Committee. Mr Kemp's statement of 13 August 2019 sets out that the committee discussed the need to review the Memorandum of Understanding between CSNSW and NSW Health and section 13.2.2.2 of the Custodial Operations Policy and Procedures ("COPP") to reflect that it is the responsibility of NSW Health to notify next of kin of the implementation of an end of life care plan and/or deteriorating health of an inmate. Mr Kemp writes "If NSW Health notified JH&FMHN of an inmate's deteriorating health and/or implementation of an end of life care plan, and JH&FMHN informed CSNSW of this information it would be of great assistance to CSNSW personnel and would enable them to comply with section 13.2.2.2 of the COPP". I note that there are some NSW Prisons operated by non CSNSW organisations which are contracted to comply with CSNSW policies. At least one of the prisons has a health provider other than JH&MHFN (MTC's Parklea Corrections health provider is St Vincent's Health). Accordingly, the recommendation will be directed solely at CSNSW so that any Memorandum of Understanding with various health providers is consistent across the State.

Formal Finding:

That Ivan Metcalfe died on 8 April 2018 at Prince of Wales Hospital, Randwick NSW 2031. He died of Complications associated with advanced chronic lung disease. He had other significant conditions contributing to his death but not relating to the disease or condition causing it, namely: Diabetes Mellitus (Type 2), Ischaemic Cardiovascular Disease, Atrial Fibrillation. When he died Ivan Metcalfe was in the lawful custody of Department of Corrective Services NSW.

To The Minister of Corrections:

- That the Department of Corrective Services NSW amend 13.2.2.2 Custodial Operations Policy and Procedures (COPP) to ensure that when a prisoner in the care of an external heath care provider enters palliative care or end of life care, the prisoner's "Emergency Contact Person" (next of kin) is notified so that final visits with the prisoner can be undertaken.

- To that end, I recommend that the CSNSW enter into discussions with NSW Health to amend their Memorandum of Understanding so that NSW Health staff will be responsible for advising on the custodial patient's clinical status and CSNSW staff will contact the custodial patient's ECP if their medical condition becomes life threatening, subject to receiving advice from NSW Health staff.

33. 119731 of 2018

Inquest into the death of Douglas Anderson. Finding handed down by Deputy State Coroner Ryan at Lidcombe on the 9th December 2019.

Introduction

On 14 April 2018 Douglas Anderson aged 84 years died at Westmead Hospital, where his medical conditions were being managed palliatively. On 5 April 2018 he had entered custody on charges of child sexual assault. As Mr Anderson was in custody, the responsibility for ensuring that he received adequate care and treatment lay with the State. Pursuant to sections 23 and 27 of the Act, an inquest is required when a person dies in custody to assess whether the State has discharged its responsibilities. Pursuant to section 81 of the Act a Coroner must make findings as to the date and place of a person's death, and the cause and manner of death. In addition the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Background

Douglas Anderson was born on 21 November 1933 in Scotland. He emigrated to Australia and had two children who are now adults. Mr Anderson lived alone in the Gorokan area north of Sydney. He had an extensive history of medical conditions and was under the care of Wyong Hospital as well as a geriatric home visit service. In the weeks prior to his arrest he had been losing weight steadily.

Douglas Anderson's health and treatment in custody

Mr Anderson's death occurred after he had been only nine days in custody. On 5 April 2018 he was arrested and charged with child sexual assault offences. He was refused bail at Wyong Local Court and was taken to Silverwater Metropolitan Remand Centre. As a result of an initial health assessment he was taken later that day to Westmead Hospital with suspected congestive heart failure. Here he remained under corrective services supervision until his death nine days later. The Justice Health assessment had identified that Mr Anderson had a history of heart disease, hypertension, osteoarthritis, alcohol abuse, mild dementia and basal cell carcinoma. A CT scan was performed which showed a large right pleural effusion with possible pleural lesions. A chest drain tube was inserted and he was moved to a high dependency ward. Over the following days Mr Anderson showed symptoms of dementia and his chest was monitored. Further chest x-rays identified a mass in the gastro oesophageal junction.

The gastrointestinal team considered conducting a biopsy of the mass, but after consultation with medical oncology and radiation oncology teams they determined that further investigations and treatment would not be appropriate given Mr Anderson's dementia, frailty and multiple comorbidities. He was provided with palliative care, and died at 8.42am on 14 April 2018.

The post mortem examination

A post mortem examination was performed by forensic pathologist Dr Jennifer Pokorny. The examination revealed a large right sided hydropneumothorax, a collapsed right lung, and a mass in the right adrenal gland. Dr Pokorny concluded that Mr Anderson had a metastatic malignancy, most likely originating as a gastro-oesophageal tumour. His condition was complicated by the development of the staphylococcus infection.

What was the manner of Mr Anderson's death?

The coronial investigation establishes that Mr Anderson's death was one of natural causes. It was not brought about through any deficiency in the care and treatment he received while at the Metropolitan Remand Centre or at Westmead Hospital. From the outset of his time in custody his health problems were properly managed, and appropriate decisions were made and implemented about his medical treatment. The care and treatment which he received from Corrective Services NSW and Justice Health and Forensic Mental Health Network was adequate and appropriate.

There is no evidence that another person caused Mr Anderson harm, or that his death was caused by an accident or other form of misadventure. The manner of his death was by natural causes.

Findings required by s81(1)

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

Identity

The person who died is Douglas Anderson.

Date of death:

Douglas Anderson died on 14 April 2018

Place of death:

Douglas Anderson died at Westmead Hospital, Westmead NSW 2145.

Cause of death:

Douglas Anderson died as a result of staphylococcus aureus sepsis complicating metastatic malignancy.

Manner of death:

Douglas Anderson died as a result of natural causes while in custody.

34. 142510 of 2018

Inquest into the death of Jordan Wayne Cruikshank. Findings handed down by Deputy State Coroner Ryan at Lidcombe on the 10th October 2019

Jordan Cruickshank was 24 years old when he died in Shoalhaven District Hospital in the early hours of 6 May 2018. He had been taken there by ambulance after he was found unconscious in the backyard of a house in Bomaderry, the town where he lived in NSW's south coastal region.

On the night of Jordan's death a police operation was underway to arrest him for outstanding driving charges. He was the subject of an arrest warrant and two police officers had been pursuing him on foot before they lost sight of him. It was very shortly after this that he was found unresponsive and taken to hospital.

This is a mandatory inquest pursuant to sections 23(1)(c) and 27(1)(b) of the *Coroners Act* 2009 *(NSW)* [the Act]. An inquest is mandated when a person dies '*as the result of police operations*'. The purpose is to ensure there is an independent and transparent investigation of the circumstances of the death, and the conduct of any involved police officers.

Jordan Cruickshank's life

Jordan is an Indigenous man who was born on 29 January 1994. He and his five siblings grew up in the town of Bomaderry in southern NSW. He was particularly close to his brothers Edward and Cody, and three years ago he became a father with the birth of his little daughter.Jordan struggled with problems of drug addiction and he also had diabetes. Friends and family reported that around the time of his death he was using crystal methamphetamine heavily.

Jordan's mother Debbie Walker attended the inquest, together with her partner Tim Foster and Nakita Pender who is the mother of Jordan's child. They were supported by Aboriginal Community Liaison Officer Arthur Wellington. At the close of the evidence Ms Crellin read to the court Ms Walker's loving tribute to her son. She spoke of his love of playing cricket and football and his many friendships. She spoke too of her deep sadness that she had not been able to see his body after he died and say her last goodbyes, a source of enduring grief for her.

Ms Crellin also read to the court the words of Ms Pender, who is the mother of Jordan's child and had been his friend from their earliest years. She spoke of a man who was loyal and kind, and who had dreams of living a life different to the one he was living at the time of his death. It was clear that despite his struggles Jordan was much loved by his family, and they grieve his loss deeply.

The attempt to arrest Jordan

On 25 April 2018 Court Attendance Notices were issued for driving offences allegedly committed by Jordan. Earlier that day police officers had seen Jordan driving a car in Nowra. Aware that he did not hold a current driver's license they followed him in two police cars with lights and sirens activated. Allegedly, Jordan did not respond to their indications that he pull over, instead driving away at speed. Police unsuccessfully attempted to serve Jordan with Court Attendance Notices containing the above charges, before obtaining an arrest warrant on 30 April to bring him before a court. He was also the subject of an arrest warrant for previous driving charges. On 5 May 2018 police officers became aware of information that Jordan had been at a house in Samuel Street in Bomaderry earlier that day. This was the home of Ms Casey Ardler. There was also information that he had been inside a red Hyundai vehicle that had been reported stolen. It was not alleged that Jordan had been involved in the theft of the car.

Shortly before midnight on 5 May Sergeant Mark Watson and Senior Constable Jessica Thomas, both attached to Nowra Police Station, drove to an intersection near the house in Samuel Street. They observed a male person looking out from behind a curtain in the house, and decided to knock at the door to see if Jordan was there. If he was they intended to arrest him. Behind the front fence of the house the two officers saw the stolen red car. Ms Ardler allowed the two officers to enter the house. Once inside they saw Jordan's two brothers Edward and Cody, whom they recognised. The officers then heard a loud noise and realised Jordan had jumped out of a bedroom window and was running from the house. They gave chase on foot. SC Thomas saw Jordan run into a reserve before she lost sight of him in the darkness.

In the meantime Sgt Watson had called for police assistance. One of those who drove to the area was Inspector David Cockram. In nearby Katela Street he encountered Ms Lorraine Trindall, who lived in the street. She was shaken and told him that she had just found Jordan in her backyard, '*sitting partially upright*'. He had not responded when she called out to him. Just prior to that, while inside her house she had heard a sound outside like '*a grunting noise'* and '*a kind of groan'*, followed by a louder noise as though someone had fallen over. Police went immediately to Ms Trindall's backyard where they found Jordan slumped over and unresponsive.

They called an ambulance and commenced CPR, which was maintained until the arrival of ambulance officers about ten minutes later. Inspector Cockram and SC Justin Kelly, both of whom were involved in the CPR, told the court that at no time could they detect a pulse and that as the minutes passed Jordan's body became colder. Treatment continued in the ambulance on route to Shoalhaven District Hospital, but Jordan could not be revived and he was pronounced deceased at 1.02am.

The medical cause of Jordan's death

The cause of Jordan's death was clear on the evidence.

The autopsy report of forensic pathologist Dr Elsie Burger found that Jordan had died of methamphetamine toxicity in the background of atrioventricular node artery dysplasia (described below).

Toxicological analysis of Jordan's blood had detected methamphetamine in a concentration where potentially toxic levels overlap with lethal levels. Small concentrations of cannabis and naloxone were also present. 'Atrioventricular node artery dysplasia' describes abnormality in the atrioventricular, or 'AV' node of the heart. The AV node controls the heart rate, by slowing electrical currents from the upper chambers of the heart before they reach the lower chambers. Prolonged use of stimulant drugs is associated with structural change such as AV node artery dysplasia. In her report Dr Burger commented that methamphetamine can cause potentially fatal electrical rhythm disturbances in the heart. In Jordan's case the abnormalities in his AV node may have made him more susceptible to this phenomenon. In addition his flight from police, most likely involving production of adrenaline, may have increased the effect.

The manner of Jordan's death

As Jordan's death occurred in the course of a police operation to arrest him, it was necessary to examine the conduct of the police officers involved and whether they performed their duties lawfully. At the inquest the court heard evidence about the night's events from the following officers:

- the Officer in Charge, Detective Inspector Bradley Ainsworth
- Detective Sergeant Jason Hogan
- Detective Sergeant Mark Watson
- Senior Constable Jessica Thomas
- Inspector David Cockram
- Senior Constable Justin Kelly.

Having reviewed their evidence and the other evidence contained in the coronial brief I am satisfied that the police officers involved in this operation did not act unlawfully or improperly. I accept the submission of Counsel for the Commissioner and for the involved officers, that the warrant for Jordan's arrest was lawfully obtained and that the officers were subject to a duty to execute it. I accept further that their entry into the house in Samuel Street and subsequent foot chase of Jordan did not involve any illegality or impropriety.

At the inquest Officers Watson, Thomas, Cockram and Kelly each gave evidence that they had not physically contacted Jordan that night, except in the case of Officers Cockram and Kelly who performed CPR upon him at Katela Street. Each gave further evidence that at no time had they used their arms or appointments on Jordan, nor seen any other police officer do so. It was important for Jordan's family to hear this, as in the aftermath of his death rumours had circulated that he had been harmed by police officers and that this may have caused or contributed to his death. The cause and manner of Jordan's death are thus able to be established.

I turn now to consider an issue raised by Jordan's mother Debbie Walker which was of particular concern to the inquest.

Communications with Jordan's family

Visual identification of a son or daughter who has died is likely to be the saddest experience a parent can ever have. But it is also a precious opportunity for the parent to see their loved one for the last time. Jordan's mother never saw him again after being told of his death, and this has added to her sorrow. The reasons why Ms Walker was not given the opportunity to see Jordan were examined at the inquest. Immediately after Jordan's death, NSW Police's Professional Standards Command took appropriate action and declared it to be a Critical Incident.

This requires that a death be investigated by a team from another police district to that where the death occurred. Detective Chief Inspector Bradley Ainsworth of Wollongong Police District was appointed as the Critical Incident Investigation team leader, with the assistance of Detective Sergeant Jason Hogan. At about 4.30am on the morning Jordan died DCI Ainsworth arrived at Nowra Police Station where he met with Superintendent Stephen Hegarty, the District Commander of South Coast Police District. Together they went to the home of Debbie Walker to give her the tragic news. Present with Ms Walker was her de facto partner Tim Foster. It was by then about 6.15am.

In his evidence DCI Ainsworth described how Ms Walker became extremely upset upon hearing what happened, retreating into her bedroom and shutting the door. DCI Ainsworth then spoke to Mr Foster, explaining there would be an independent police investigation into Jordan's death and giving him his contact number. DCI Ainsworth did not tell either Ms Walker or Mr Foster that Ms Walker had the right to view Jordan's body, which was at Shoalhaven District Memorial Hospital. This information is required to be given to the family, pursuant to the Professional Standard Command's Critical Incident Guidelines (further described below). Nor did he tell Ms Walker that she was able to formally identify Jordan's body herself.

At the inquest DCI Ainsworth was asked why he had not told Ms Walker she would be able to see Jordan's body if she wished. He was aware this was a right afforded to families under the Critical Incident Guidelines. DCI Ainsworth explained that Ms Walker had been so upset he didn't want to further distress her. DCI Ainsworth agreed he could have given this information to Mr Foster when Ms Walker had gone into her bedroom. He also agreed, on the basis of his experience, that even when a relative is deeply distressed he or she may very much want and need to see the body of their loved one. He conceded that Ms Walker ought have been given the opportunity to see Jordan and that he could see this was important to her. Attempts were made to contact Jordan's father for the purpose of visually identifying his body. Police officers went to his address that morning but he was not there, nor was he when they visited on subsequent days. Jordan's body was formally identified by comparison with police fingerprint records.

The Critical Incident Guidelines

NSW Police Force guidelines are available to assist police with the difficult task of notifying a family that their relative has died in the course of a critical incident. In particular:

- The local area commander is to personally inform relatives of any deceased person, or to delegate the responsibility to a fully briefed senior officer
- The local area commander should ensure all reasonable requests of the family of the deceased, including viewing the body and the scene, are discussed with the investigation team leader
- If possible, arrangements are to be made for other family members to be in attendance as support, '*particularly if the deceased is from the Aboriginal or Torres Strait Island community or non-English-speaking background*'
- Unless the on duty Coroner directs, '*the family of the deceased or their representative have the right to view the body.'*

[Part 4.2.3 of the Critical Incident Guidelines.]

The Guidelines further provide that if the deceased person is from the Aboriginal or Torres Strait Island community '*it is important to consider local aboriginal protocols and ensure the requisite notifications are made'*. These include notifications to the Aboriginal Legal Service and the Aboriginal Community Liaison Officer [ACLO].

The above guidelines are appropriate in that they recognise the importance to a bereaved family of being able to spend time with their loved one and to be personally involved in his or her identification. They recognise further the value of calling upon the resources of the Aboriginal and Torres Strait Island community when one of their community has died in the course of a police operation, to ensure as far as possible that communications with the family are conducted sensitively and appropriately. In closing submissions Counsel for the NSW Commissioner properly conceded that more should have been done that morning to observe the letter and spirit of these guidelines. I agree with this submission. I accept that in their communications with Jordan's family the police officers wished to avoid causing Ms Walker further distress; nevertheless in doing so they did not place sufficient importance on her very human need to be with her deceased son for the last time and to make her goodbyes.

Submissions were made by Counsel Assisting that it would be beneficial for there to be reinforcement of the importance of the above guidelines. Ms Hopper proposed that the Commissioner of Police consider adding an item to the Senior Critical Incident Checklist, of advising the next of kin of their right to view the body of the deceased. The court heard that this Checklist is routinely used by local area commanders and their delegates to ensure they fulfil the many duties and obligations they must perform in the event of a critical incident. The Checklist does not currently contain any reference to this task. I accept this submission.

So too does the NSW Commissioner, whose Counsel Mr Edwards conveyed the Commissioner's support for the above proposal.

Mr Edwards advised that the current Critical Incident Guidelines are in the process of being reviewed, and that this process will include updating the Critical Incident Checklist to include the specific action of advising relatives of their right to view the body of the deceased.

Counsel Assisting proposed a further recommendation. This is that the Commissioner consider introducing a training course or training material regarding the obligations of relevant officers under Part 4.2.3. of the current Critical Incident Guidelines. The training would focus on the need for senior police to familiarise themselves with the relevant local contacts within the Aboriginal and Torres Strait Island community. Counsel for the Commissioner indicated that the Commissioner accepted that this proposal too would be appropriate. It is encouraging and welcome news that the two proposed recommendations are supported by the Commissioner of Police. They are also supported by the Aboriginal Legal Service.

Conclusion

Notwithstanding the high level of methamphetamine found in Jordan's post mortem blood sample, there is no evidence that he ingested the drug that day or evening with the intention of ending his own life. On behalf of the Coroner's Court and the assisting team I offer my deepest sympathy to Jordan's family for their loss, and thank Ms Walker for sharing her loving memories of her son.

I express my appreciation to Counsel Assisting Ms Justine Hopper, and the NSW Crown Solicitor's Office for their excellent assistance throughout the inquest. I also thank Counsel for the NSW Commissioner of Police and Ms Crellin of ALS for their assistance throughout the inquest.

Findings required by s81(1)

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

Identity

The person who died is Jordan Cruickshank.

Date of death:

Jordan Cruickshank died on 6 May 2018.

Place of death:

Jordan Cruickshank died at Shoalhaven District Hospital, Nowra NSW 2541

Cause of death:

The cause of Jordan Cruickshank's death is methamphetamine toxicity in the background of atrioventricular node artery dysplasia.

Manner of death:

Jordan Cruickshank died in the course of a police operation.

Recommendations pursuant to section 82 of the Act.

1. The Commissioner of Police consider adding an item to the Senior Critical Incident Checklist, of advising the next of kin of their right to view the body of the deceased.

2. The Commissioner of Police consider introducing a mandatory training course and/or disseminating training material on the obligations of senior police under the equivalent section to the current Part 4.2.3 of the Critical Incident Guidelines, which includes:

- that specific notifications need to be made if the deceased person is from the Aboriginal or Torres Strait Island community; and
- emphasis on the need for officers to familiarise themselves with the appropriate local contacts for those notifications, including Aboriginal Community Liaison Officers.

35. 150088 of 2018

Inquest into the death of Thomas MILLER. Findings handed down by Deputy State Coroner Forbes at Lidcombe on the 4th September 2019.

This is an inquest into the death of Thomas Millar, who was 53 years old when he died on the 13th of May 2018 at Prince of Wales Hospital in Randwick. At the time of his death he was serving a custodial sentence at Long Bay Hospital before being transferred to Prince of Wales Hospital due to deteriorating health.

Section 23 of the *Coroners Act 2009* makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that the care of that person was appropriate and adequate.

Thomas Millar

Mr Millar was separated, and he had no contact with his wife or children prior to his death. At the time of his arrest Mr Millar was residing with his mother. Prior to entering custody, in 2015, Mr Millar was diagnosed with metastatic adenocarcinoma of return, with pulmonary nodes and large hepatic metastases in both lobes. Mr Millar was given less than 12 months life expectancy and about 20% chance of living beyond two years. Whilst in custody, Mr Millar's cancer continued to progress and ceased responding to treatment. Mr Millar was in palliative care at the time of his death with no systematic treatment options available.

On the 15th December 2016, he was sentenced to a minimum of six years imprisonment and a maximum of nine years. His earliest release date would have been 9 December 2022 with a latest release date of the 9th of December 2025. Mr Millar was lawfully in custody and was detained by virtue of sentence warrant 2013/00379765 issued on 15 December 2016 by the District Court of NSW at Sydney Downing Centre. Mr Millar had launched appeal proceedings that were pending at the time of his death.

Medical Treatment whilst in Custody

Mr Millar continued his chemotherapy treatment whilst in custody. On the 23rd of August 2017 Mr Millar completed Cycle 14 of chemotherapy treatment. Despite ongoing treatment, there was progression of the disease with increasing liver and lung metastases. On the 24th of October 2017, Mr Millar commenced phase 1 of a clinical trial for patients with advanced solid tumours, but he was removed from the trial due to his disease progression. Mr Millar was transferred to Metropolitan Special Programs (Area1) on the 23rd of December 2016 to facilitate his ongoing medical treatment for cancer at Prince of Wales Hospital. During his treatment, Mr Millar was admitted to hospital numerous times for management of his symptoms. He developed liver failure caused by worsening liver metastasis and due to his liver failure, he was no longer considered for further chemotherapy.

In April 2018, Mr Millar was referred from Long Bay Correctional Centre to the Prince of Wales Hospital for ongoing treatment of his condition. On the 18th of April 2018, Mr Millar completed documentation for Resuscitation Plans to be put into place while an inpatient at Prince of Wales Hospital. He was not for resuscitation (NFR) meaning that in the event of cardiac arrest, Mr Millar did not wish for CPR to be administered. A letter from Professor David Goldstein dated 18 April 2018 outlined that Mr Millar had developed malignant ascites, which are cancer cells within the ascities fluid requiring percutaneous drainage. This was identified as being due to cancer progression of his liver failure caused by worsening metastasis. Mr Millar's life expectancy was expected to be in the region of two to four weeks from 18 April 2018. The management of his care was changed to palliative care. Mr Millar was discharged from Prince of Wales Hospital on 24 April 2018, back into the care of Long Bay Hospital with a management plan of pathology and analgesia in place. On the 7th of May 2018, Mr Millar again completed documentation for resuscitation plans in consultation with the admitting medical officer at Long Bay Hospital confirming that he was not for CPR. Mr Millar was reviewed on an ongoing basis by the Prince of Wales Hospital Palliative Care Team at Long Bay Hospital, in conjunction with the Network multidisciplinary care team under a palliative care pathway.

On 9th of May 2018, Mr Millar was transferred to Prince of Wales Hospital for an iron infusion and ascitic tap (fluid draining). This transfer was managed under escort by ambulance. Whilst at the hospital, Mr Millar was in the custody of Correctional Officers under escort. Whilst at Prince of Wales Hospital, as part of Mr Millar's "End of Life Management" Professor David Goldstein, Medical Oncologist, Prince of Wales Hospital requested Mr Millar's family have extra visitor rights.

In response to this request Senior Assistant Superintendent Ford authorised Mr Millar to have longer and more frequent visits in light of his declining health. On the 13th of May 2018, at about 7pm Mr Millar was seen to stop moving and breathing. Medical staff attended promptly. In accordance with Mr Millar's wishes, no attempt was made to resuscitate him. Mr Millar's mother was present. Mr Millar passed away at 7.40pm on 13 May 2018.

Investigation following Mr Millar's death

About 8pm on the 13th of May 2018 police attended Prince of Wales Hospital. A Crime Scene was established and maintained. Photographs were taken, and Mr Millar's body was transferred to the Department of Forensic Medicine, Glebe Morgue. A limited autopsy was conducted by pathologist Dr Alan Woo on 16 May 2018. Dr Woo concluded that the direct cause of death was complications of metastatic rectal cancer. A post-mortem CT detected multiple lesions in both lungs and the liver, in keeping with the history of metastatic colorectal cancer. Ascites (fluid in the abdomen) was also detected in keeping with the documented history of liver failure. Pericardial and pleural effusions were also noted. No significant acute injury was detected. The gaol and health records reveal Mr Millar's care and treatment were appropriate. No family member or associate of Mr Millar's have raised any care and treatment issues. Given Mr Millar's health issues and his deterioration whilst in gaol, it does not appear that anything could have been reasonably done to prevent his death.

Findings required by s 81 (1)

The identity of the deceased
The deceased person was Thomas Millar

Date of death
Died on 13 May 2018

Place of death
Died at Prince of Wales Hospital, Randwick

Cause of death
The death was caused by complications of metastatic rectal cancer

Manner of death
Natural causes

36. 287982 of 2018

Inquest into the death of Graham Robert Lawson. Findings handed down by Deputy State Coroner Truscott at Lidcombe on 15th July 2019

This is an inquest into the death of Mr Lawson 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 role of a coroner, as set out in s 81 of the Coroners Act, is to make findings as to the following:

(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

Pursuant to s 82 of the Act a coroner can make recommendations concerning any public health or safety issues arising out of the death. Graham Lawson was 68 years of age at the time of his death at 11:00 p.m. on the 19 September 2018. Mr Lawson was an inmate of Long Bay Correctional Centre and was receiving palliative care within Long Bay Prison Hospital for metastatic hepatocellular carcinoma. He suffered from pre-existing Hepatitis C and cirrhosis at the time of his cancer diagnosis. He also suffered from congestive cardiac failure, hypertension, dyslipidaemia and benign prostatic hyperplasia.

Mr Lawson was sentenced on 1 February 2017 for two serious offences that resulted in two sentences of full-time imprisonment: the first sentence was for a period of 18 months from the 21 February 2016 to the 20 August 2017; the second sentence was for a total of 7 years from the 21 August 2016 to the 20 August 2023, with a non-parole period of 3 years 6 months from the 21 August 2016 to the 20 February 2020. Records indicate that he was held in multiple correctional facilities between 2016 and 2018.

Justice Health & Forensic Health Network (JH&FHN) clinical notes indicate that on the 24 September 2017, Mr Lawson attended the gaol clinic and complained of feeling weak as well as unexplained weight loss, approximately 10 kilograms over the past 3 months. The notes indicate that Mr Lawson was otherwise experiencing no new pains or symptoms.

On the 26 November 2017 Mr Lawson was seen in the gaol clinic and was still losing weight and feeling weak. On the 6 February 2018 a medical note was made that a request form for a liver ultrasound had been written and Mr Lawson was awaiting an appointment.

Clinical notes on the 13 February 2018 record that Mr Lawson was very underweight. Blood tests were undertaken the following day but did not immediately disclose any issues. On the 16 February 2018, the clinical notes record that a test had returned an elevated AFP result, suggestive of the possibility of liver cancer. Due to Mr Lawson having a history of Hepatitis C and rapid weight loss, an urgent ultrasound arranged. On the 20 February 2018, Mr Lawson reported he had suffered central abdominal pain the previous night.

On the 21 February 2018, Mr Lawson underwent an abdominal ultrasound at Lithgow. Dr Healy, the attending physician, identified numerous liver lesions and a large mass that he described as concerning for hepatocellular carcinoma. Dr Healy suggested further investigation via multi-phase CT. An abdominal CT was conducted on the 7 March 2018. The results were suggestive of multifocal hepatocellular carcinoma, complicated by a left portal vein tumour thrombus.

Mr Lawson was henceforth treated as an outpatient in the clinic of Professor Goldstein, Senior Staff Specialist in the Department of Medical Oncology at Prince of Wales Hospital. Correspondence approved by Professor Goldstein and signed by Gary Tincknell, a Medical Oncology Trainee, records in notes made on 15 March 2018 that multifocal hepatocellular carcinoma is an incurable disease and that Mr Lawson had an estimated life expectancy of six months. The median survival in trials on Sorafenib, a drug later used to treat Mr Lawson, was in the region of 11 months.

Correspondence dated 29 March 2018 to Professor Goldstein from Dr Charlotte Knox, palliative care registrar under Dr Victor Sze, records that Dexamethasone was initiated to manage Mr Lawson's pain. She records that Mr Lawson said that if further treatment was not able to significantly prolong his life and was to cause him significant side effects, he would opt not to have treatment. Mr Lawson expressed his wish that he not be for CPR, intubation or ICU. Dr Spasojevic documented a Not-For-Resuscitation form to that effect. The no cardiopulmonary resuscitation order in question was discussed with Mr Lawson on the 21 March 2018 and on the 22 March 2018 it was put into place under the authorisation of Dr Spasojevic. A segmental Transarterial chemoembolization (TACE) procedure was done at Prince of Wales Hospital on the 24 April 2018.

The consulting clinician was Professor Goldstein. A post- procedure CT scan completed on the 27 April 2018 revealed "marked hypoattenuation within many of the previously demonstrated arterially enhancing lesions". A further CT completed on the 13 June 2018 revealed expected improvement in the treated areas but progression of enhancing lesions in the left liver lobe (which was untreated) along with increased tumour thrombus in the left portal vein. Professor Goldstein records on the 5 July 2018 that the repeat CT scan showing the response to the TACE treatment showed a rapid progression of the left lobe of the liver. As a result, Mr Lawson was no longer suitable for further TACE treatment. Dr Goldstein recommended switching to the drug Sorafenib as a treatment option. Side-effects were discussed with Mr Lawson. Dr Goldstein also recommended an increase to the Endone dose to better manage Mr Lawson's pain.

Correspondence dated the 12 July 2018 under the hand of Dr Victor Sze, Staff Specialist Pallliative Care, records that Mr Lawson was told his prognosis was poor and that his malignant disease had progressed. Dr Sze was going to trial Sorafenib, but Mr Lawson stated that if he developed any undesirable side effects he would like to stop the treatment and opt for best supportive care/comfort measures instead.

Mr Lawson's pain treatment was changed from MS Contin to regular Oxycontin. Breakthrough Endone was also prescribed for pain treatment. On 3 August 2018, Mr Lawson was transferred into palliative care within the Long Bay Hospital. Due to complaints about pain from the underlying malignancy, Dr Sze, Staff Specialist Pallliative Care, converted his regular Oxycontin to regular hydromorphone.

Correspondence for the 9 August 2018 under the hand of Dr Victor Sze records that Mr Lawson did not want further anti-cancer treatment and had ceased Sorafenib the previous week complaining of increased fatigue, nausea and diarrhoea.

Dr Sze records that Mr Lawson wished to remain in the Medical Sub-Acute Unit in Long Bay Gaol for his end of life care and did not wish to be transferred back to the acute hospital. He was complaining of increased fatigue over the previous weeks and while still independent for daily living would exhaust easily and feel dizzy when mobilising. His appetite was reduced with further weight loss.

On the 19 September 2018, Mr Lawson was being cared for in room 30, a private room. Notes recorded at 4:00 p.m. suggest he was lethargic and his condition was deteriorating. His medications included regular hydromorphone for pain relief and cyclizine for nausea and vomiting.

At 10:45 p.m. Nurse Maher records that Mr Lawson was checked and exhibited a minimal response when attempting to verbally engage. At 11:00 p.m. Nurse Maher again checked Mr Lawson and found him not breathing. Due to the no CPR order in place, no CPR was attempted and Mr Lawson passed away.

Findings

Identity
The deceased person was Graham Lawson.

Date of Death
19 September 2018.

Place of Death
Long Bay Hospital, New South Wales.

Cause of death
Metastatic hepatocellular carcinoma

Manner of death
Natural causes whilst serving a custodial sentence.

37. 58026 of 2019

Inquest into the death of Ivan ALLWOOD. Findings handed down by Deputy State Coroner Forbes at Lidcombe on the 15th October 2019.

Mr Allwood was born on 15 May 1957 in Tolaga Bay, New Zealand. He had two brothers and a sister. His parents separated when he was young, and he lived with his mother for a few years before going to live with his father full time. Mr Allwood finished school in year eleven and moved to Australia around 1990. After moving to Australia, he began to use alcohol and drugs excessively. He worked as a furniture removalist until 1996.

In July 2018 Mr Allwood was diagnosed with left tongue base squamous cell carcinoma with bulky left sub-mandibular lymph node metastasis. He commenced radiotherapy. In October 2018 he was fitted with a Percutaneous Endoscopic Gastrostomy (PEG) for supplementing his nutritional intake.

On 15 November 2018, Mr Allwood was arrested by Police and taken to Parramatta Police Station. While in custody he advised the custody manager that he had a PEG for medical reasons and that he had recently undergone chemotherapy and radiation treatment for throat cancer. He was bail refused by Police, provided medical clearance by doctors at Nepean Hospital Emergency Department and taken to Amber Laurel Correctional Centre. On 16 November 2018 he appeared before Parramatta Local Court and was remanded to the Metropolitan and Remand Centre (MRRC) until 11 January 2019. He remained at the MRRC where Justice Health provided and coordinated his care and treatment. On 19 December 2018 he was reviewed by Doctor Khoo and his allied health team. A staging scan was ordered by Dr Khoo.

On 11 January he was again remanded by the court until 12 March 2019. On 14 January 2019 he had a PET-CT whole body scan which showed the developed cancer had spread to the lung and heart, and tumour recurrence along the opening of the neck. At this time no further treatment options from an oncology perspective existed and his prognosis was poor. He was given an anticipated life expectancy of 3-6 months. On 24 January 2019 he was moved to Long Bay Hospital and reviewed by the Department of Palliative Care, Prince of Wales Hospital, in the presence of Justice Health Doctor Spasojevic where treatment options were discussed. Given the prognosis, Mr Allwood was provided palliative treatment with a focus on symptom management and comfort care.

On 20 February 2019 Mr Allwood was in cell 31 of the Subacute Unit of Long Bay Hospital. About 2.10am Justice Health nurses attended his cell to provide a gastrostomy tube feed. Mr Allwood was seated on the side of the bed with his eyes open. He appeared drowsy with his head nodding; he was asked to lie down on his bed and as he did became pale and unresponsive. He died at 2.21am. He was aged 61 years at the time of his death.

The gaol and health records reveal Mr Allwoods's care and treatment were appropriate. No family member or associate of Mr Allwood have raised any care and treatment issues.

A limited autopsy was conducted on 5 March 2019. The direct cause of death was determined to be metastatic squamous cell carcinoma.

Findings required by s 81 (1)

The identity of the deceased
The deceased person was Ivan Allwood

Date of death
Died on 20 February 2019

Place of death
Died at Long Bay Hospital, Malabar, NSW

Cause of death
The death was caused by metastatic squamous cell carcinoma

Manner of death
Natural causes

The following 2 findings were conducted in 2018 however not included in the 2018 Annual Report

1. 161961 of 2015

Inquest into the disappearance and suspected death of Jordan Morris. Finding handed down by Deputy State Coroner Grahame at Glebe on the 2nd March 2018.

Jordan Morris was last seen on 24 April 2015. Jordan was greatly loved and his family suffers the torment of not knowing where he is or what has happened to him since that time.

Jordan was reported missing to NSW Police by his father, on 26 May 2015. At that time some members of the NSW Police Force were already aware that Jordan had been involved in a police pursuit on 24 April 2015, however they believed Jordan had evaded detection and was likely to be hiding out somewhere in fear that he would be arrested. At that stage investigations in relation to possible criminal charges were still ongoing.

Subsequently further search operations were launched and extensive investigations commenced. However, no credible information has been received indicating any further sightings of Jordan alive. There has also been no recovery of Jordan's body, despite extensive physical searching in the area where he was last seen.

Jordan's suspected death was reported to the Coroner on 30 May 2015.

The role of the coroner and scope of the inquest

The role of the coroner in a case such as this is to make findings firstly as to whether the nominated person is actually dead and only if that can be established, to make further findings as to the date and place of death and to the manner and cause of death.

The decision about whether a person is dead is considered a "threshold question" in a missing person case. Given the seriousness of the finding, it is well established that the court should apply the Briginshaw standard. The proof of death must be clear, cogent and exact. At common law, there is a presumption in favour of the continuance of life however, it is not a rigid presumption and the circumstances of any given case must be carefully examined before a finding of death can be made. In addition to deciding these questions, at the conclusion of proceedings, the coroner may make recommendations in relation to matters arising directly from the evidence if they have the capacity to improve public health and safety in the future.

The evidence

The inquest proceeded over four days. It was adjourned at one stage for fresh evidence to be investigated. A nine volume brief was tendered, including statements, expert reports, audio and visual recordings, photographs and maps. The brief contains detail in relation to each of the reported sightings and the follow up investigations which took place. None of the sightings is credible. Investigative work and analysis. Oral evidence and supplementary statements were also received, including from police involved in the search process. It is impossible to refer to all the material in the scope of these short findings, however, all of the material has now been carefully considered.

Jordan's background

Jordan was born in England on 13 December 1992. He is the son of Jayne McGonigal and Michael Morris. He has one sister, Meghan and a brother Leyton. The family moved to Australia in 2006. At the time of his disappearance, Jordan had recently been living with his brother and parents in Toongabbie, NSW.

Jordan attended high school up until year 10. He experienced some difficulties at school and had been diagnosed with attention deficit disorder and obsessive/compulsive disorder. At around the age of 16 he became involved in drugs and was known to use cannabis and "ice" on occasions. Jordan is reported to have developed a problem with alcohol and gambling. He was known to disappear from his family home for days at a time, but would always keep in contact via phone calls, text messages or on Facebook.

Despite his difficulties, Jordan was greatly loved by his parents and siblings. They spoke of his loyalty and love of family. His parents and brother attended the inquest each day and his sister attended the inquest on its final hearing day. Their grief in not knowing what has happened was clearly profound.

The lead up to Jordan's disappearance

On 10 March 2015, Jordan attended the funeral of a friend, David Campbell. That afternoon he went to a barbeque. This was the last time his mother saw Jordan, although he kept in contact with her up until 17 or 18 April 2015. The following week, on 17 March 2015, Jordan had an argument with his father and left the family house. This was the last time his father saw him. Shortly afterwards, Jordan sent his father a new mobile number in a text message. This was their last contact.

Leyton Morris last saw his brother in March 2015. He described Jordan as very shaken up by the death of his friend. He stated that although Jordan would disappear from time to time, he would always eventually make contact with the family. Jordan was a keen user of social media, however there has been no activity by Jordan on his Facebook page since April 2015. His family assumed that Jordan would be back in touch soon and did not report him missing straight away. There had been other periods where he was out of contact for a while but he always returned to the family home.

The pursuit

On 24 April 2015, police officers in Mudgee identified a silver Nissan Pulsar, registration number BG75CD, as a stolen vehicle.

We now know that the vehicle had five occupants, Jordan Morris, Joshua Hines, Tahlia Needham, Justin Jones and Kelly Lucas, however they were not all identified at that time.

When officers attempted to stop the vehicle, the driver, subsequently identified as Joshua Hines, rammed the police car. At this point, Kelly Lucas got out of the car and was taken into custody. The stolen vehicle left the scene and a police operation commenced, spanning multiple commands, as the stolen car made its way, via Lithgow and the Bells line of road, in the direction of Sydney. There were a number of separate pursuits over the next few hours. The car was driven by Joshua Hines and Jordan was apparently sitting in the front passenger seat.

The police operations were captured on both audio recordings by police radio and on video recordings made by Polair. The court has had the opportunity to review these records. Around 2.55pm, police stationed themselves at the North Richmond Bridge on Kurrajong Road in Richmond in response to information received on the police radio about the pursuit. After stopping westbound traffic, Constable Sruhan threw tyre deflation devices onto the roadway in front of the silver sedan. The car drove over the devices causing significant damage to its rear wheels. It then continued to travel at speed eastbound and was pursued by a marked police car, with warning lights and sirens activated. The stolen car then travelled south towards Penrith, at which point police vehicles were advised to cease pursuit.

At 3.07 pm, the stolen car stopped on the median strip near the Water Treatment Facility, located on Castlereagh Road in Penrith. Joshua Hines and Jordan Morris ran from the car. Talia Needham and Justin Jones remained in the vehicle and were arrested by police officers Constable May and Constable Barnes. At 3.08pm police helicopter, Polair 7 captured footage of something in the Boundary Creek line moving towards Castlereagh Road, then moving out of view of the camera. Searching in the area commenced immediately, with police hoping to catch the two runaways quickly.

At some stage in the process of escaping police, Joshua Hines twisted his ankle and was unable to keep moving. He was subsequently found hiding in bushes located on the northern bank of Boundary Creek, behind the Water Treatment Plant, upstream and east of Castlereagh Road. Joshua Hines was found as a consequence of the operations of Polair 4, which was conducting an aerial search of the riverine corridor, utilising both visual tracking and infra-red tracking technology. Information that police in that helicopter gathered was sent to Police Dog Handler, Senior Constable Bennett, who was working with his dog Otis, on the ground. Jordan, on the other hand continued to evade capture by the police. At this stage he had still not been positively identified by NSW Police, although as the afternoon wore on, some officers appeared to suspect his identity and it was later confirmed.

When was Jordan last seen in the area of Boundary Creek?

On all the available evidence the last known sighting of Jordan was shortly after 3pm on 24 April 2014 in the riverine corridor near the fence line at the rear of a car yard, named Heartland Motors, adjacent to Castlereagh Road, Penrith. It appears that after leaving the stolen car, Jordan had entered Boundary Creek to the east of Castlereagh Road and travelled downstream in the creek passing through the culvert under Castlereagh Road.

After emerging from the culvert to the west of Castlereagh Road, it is likely that he exited onto the southern bank.

Jordan would have been wet and struggling through thick undergrowth. From there, Jordan seems to have made his way up the southern side of the riverine corridor to the area adjacent to the fence line at the rear of Heartland Motors. At this point he was seen by Terry Byrnes, Lynette Byrnes, Roderick Byrnes and Bradley Colligan near the fence line at the rear of Heartland Motors. It appears that Jordan was at this time moving in a westerly direction towards the Nepean River. Ms Byrnes noticed that he was "really struggling in the bushes…he was definitely tangled in the blackberries".

All of the witnesses described the sound of snapping branches, however they did not describe hearing any splashing sounds. They saw the young man, we now know was Jordan, struggle and slip as he moved in the bushes. Mr Colligan told Senior Constable Bennett that Jordan appeared "worn out".

This is the last reliable sighting of Jordan.

As a result of the report, various police moved into the area to continue searching. Police Officers Detective Wheeler and Constable Johnston were involved in searching the southern side of the creek bed. Senior Constable Andrew Bennett, the dog squad officer, scaled the fence of Heartland Motors with his Police dog, Otis and commenced tracking the area. Almost immediately the dog indicated the presence of a human scent. Shortly afterwards, at about 3.18pm, Police dog Otis located a grey hoodie in the foliage to the north west of the fence line at Heartland Motors. The hoodie was later identified, by Jordan's sister as belonging to him. The dog continued tracking the scent through thick vegetation for a short period until it appeared to Senior Constable Bennett that the scent was exhausted.

During a subsequent Police search of the area in June 2015, a black bum bag belonging to Jordan was located close to the same point where the hoodie had been found. It was about 3 to 3.5 metres above the creek line, (as it stood on 1 June 2015).

It was to the south of Boundary Creek, at a point approximately 50 metres west of Castlereagh Road. The backpack contained $1525 in cash, a mobile phone, 2 USB flash drives, a number of credit/debit cards in the name of Jordan Morris and two credit cards in other names.

The search after the sighting at Heartland Motors

After the sighting at Heartland Motors the search continued into the afternoon of 24 April.

Senior Constable Bennett continued to move in a westerly direction, also casting the dog down towards the water's edge. The vegetation was impenetrable in places. At one point, Senior Constable Bennett and his dog crossed to the northern bank of Boundary creek. While the current was not strong enough to knock him off his feet, Senior Constable Bennett described having to cross in a diagonal line. Once over the creek, Senior Constable Bennett continued searching the bushland and the adjacent industrial area.

A large number of police, including three dog squad units, continued to search a wide area on foot. Two helicopters from Polair continued to search from above. The search is well described in the material before the court and I do not intend to describe it in great detail. Suffice to say, the search was extensive and continued for over two hours. The search was abandoned at 5.03pm. At that time, Senior Constable Bennett was of the belief that Jordan was no longer within the search area and that he had somehow evaded police and made good his escape. This opinion was also shared by the officer in charge of the operation, Detective Superintendent McFadden.

The decision to call off the search

Detective Superintendent McFadden gave evidence that the search was finalised about 5pm. At that time he was satisfied that "*all the information and intelligence that was available to us on sightings, locations, areas of travel had been considered, exhausted and yielded no result and my assessment at the end of the day is that the offender that we were looking for had made good his escape*." He communicated that fact to Acting Inspector Zahra, who was the operational Duty Officer for Penrith and St Marys Local Area Command. Penrith Local Area Command became responsible for the ongoing investigations arising from the pursuit and the arrests that had already been made.

Acting Inspector Zahra was also responsible for the mandatory debrief that follows any police pursuit. According to Acting Inspector Zahra, the debrief was "*solely focussed on the manner in which the pursuit was conducted and whether there were any issues internally that required referral to Penrith Safe Driver Panel*" He identified "no adverse issues" in relation to the pursuit. In other words, Acting Inspector Zahra did not turn his mind to the dangers that could have arisen for Jordan once he left the car and entered the bushland.

Detective Superintendent McFadden explained to the court that there was no formal or documented separate debrief in relation to the search operation. While he conceded that people trying to escape police will frequently engage in "risky conduct". He suggested that this was the kind of risk that police were well used to evaluating. Under cross examination, he was emphatic that at the time the search was called off, there was "*no other information available to us that would give us a direction to start any further operation to search for the offender. As far as I was concerned…he had eluded the police cordon at the time and made good his escape*." I accept, without hesitation, that this was his genuine belief at that time.

The subsequent searches

Subsequent to the missing person report made on 26 May 2014, there were three major police search operations to see if any further evidence could be obtained or if any human remains could be located.

The first took place between 1 June 2015 and 6 June 2015. It was co-ordinated by an accredited search co-ordinator, Sergeant Atkinson. It was an extensive land and water search performed within the riverine corridor of Boundary Creek concentrating on an area extending 800 metres west from Castlereagh Road to the junction with the Nepean River.

The searching involved land searches and also the use of police divers, a police dog trained in detecting cadaver scent, and police aircraft conducting aerial visual and infrared searches.

On 16 September 2015, Detective Senior Constable Morgan, in conjunction with Sergeant Atkinson decided that a second even more intensive search should be undertaken in and about the environs of the Boundary Creek corridor. It commenced on 8 October 2015 and continued over four days. Police Officers, combined with SES and RFS volunteers cleared vegetation and searched within the Boundary Creek riverine corridor from a point adjacent to Castlereagh road all the way up to the junction of the Nepean River. A section of about 200 metres of land was cleared and a number of tracks were cut to provide better access to the southern banks of Boundary Creek. While some areas of heavy vegetation remained undisturbed, particularly near the junction with the Nepean River, it was considered that they would have been impenetrable and unlikely to have been accessed by Jordan.

- On 10 November 2015, there was further searching with cadaver dogs, with no result.

- On 13 November 2015, Police divers returned to conduct a water search of Peachtree Creek from the Nepean River junction to the railway crossing. Again no items of relevance were located and the police dogs did not indicate the presence of human remains.

- On 15 November 2015, further land searching took place, this time involving two teams of SES volunteers.

- On 17 November 2015, police divers returned and commenced a search of part of the Nepean River. Nothing of relevance was discovered.

- On 6 December 2015, a search in relation to another matter took place around Boundary Creek, Peachtree Creek and the Nepean River at Penrith involving 100 volunteers. They were briefed to take note of the possibility of human remains, none were found.

The brief contained considerable material outlining the searches which have taken place. I consider that there have now been significant attempts to locate evidence which might provide further information about what happened to Jordan. Unfortunately nothing further has been recovered.

Sergeant Atkinson's view at the conclusion of the subsequent searches

At the conclusion of these subsequent searches, Sergeant Atkinson thought that it was unlikely that Jordan Morris drowned in Boundary Creek on the afternoon of 24 April 2015, because if he had, Sergeant Atkinson was confident that some of his remains would have been found in the extensive searching that took place. Equally he was confident that the search was extensive enough to find Jordan's remains if he had drowned in an area proximate to Peachtree Creek, northwest of where Jordan had been last sighted at Heartland Motors.

However, Sergeant Atkinson conceded that it was possible that if Jordan had re-entered Boundary Creek, passed downstream to the junction of the Nepean River and beyond, he could have drowned past the search area in fast flowing water.

The evidence of Senior Constable Bennett and the possibilities that Jordan escaped or entered the Creek

Given the lack of evidence arising from all the subsequent physical searches, it is necessary to carefully review the results of the searches that occurred on 24 April 2015 in an attempt to understand what might have happened.

I am well satisfied that the person seen by witnesses at Heartland Holden shortly after 3pm was indeed Jordan Morris. It is certainly consistent with the physical evidence found nearby. The question that remains is where did he go from there? At the time the search concluded on 24 April 2015, it was the accepted police view that he had somehow got away, but with hindsight it is necessary to consider the real possibility that Jordan re-entered Boundary Creek.

It is necessary to understand that initially police thought that a heat source seen to the west of the Heartland Motors fence might indicate Jordan Morris. The heat source appeared to be moving in a westerly direction. It appeared possible that this indicated Jordan making his escape from the area on land. At the time, Senior Constable Bennett shared the belief of other officers that somehow Jordan had evaded him and his police dog and escaped the area.

However, on further reflection, Senior Constable Bennett expressed the view that this was unlikely. A number of reasons were given, including,

Extensive fencing capped with barbed wire limited access to Heartland Motors from the riverine corridor. It was Senior Constable Bennett's evidence that during his later searches he kept having to circle back to the point where he had initially jumped the fence from Heartland Motors into the corridor. This was because the fencing at other points was too difficult to scale as it was too high and capped with wire. For this reason it appears likely that Jordan would have experienced similar difficulties had he tried to scale the fence at another point. It is therefore unlikely that Jordan was able to cross back over the fence at the rear of Heartland Motors, at least during the search period. Jordan's scent was not subsequently detected in or near Heartland Motors. It is likely that if Jordan had backtracked through the area, his scent would have been discovered by the tracking dog, Otis.

There were large numbers of police and members of the public monitoring the area that afternoon. It is likely that had Jordan scaled the fence to pass through Heartland Motors that he would have been seen. For these reasons I accept that it is more likely that the heat source seen on land was an unidentified member of the public or a police officer, rather than Jordan making good his escape.

After the search on 24 April 2015, Senior Constable Bennett continued to wonder what had happened, particularly as the evidence that Jordan jumped the fence and escaped was weak. He told the court that it was a matter of "professional pride and ego" and that he wanted to know why he had been unable to find Jordan. It was for this reason, he explained, that some time after 24 April 2015, he conducted some research and carefully reviewed what he remembered of the reactions of his police dog. He came to believe that Jordan must have re-entered the water.

Senior Constable Bennett described in court that with hindsight and the benefit of additional research, he was able to re-interpret his dog's behaviour. He remembered Police dog Otis demonstrated clear behaviour that indicated he was following human scent up until the time his dog reached the riverbank, and "*suddenly there was no more scent*". The scent appeared to have disappeared and could not be located again. Somewhat surprisingly, at the time, this did not make Senior Constable Bennett think that the person they were following may have entered the water.

Senior Constable Bennett explained that, as he learnt more about what happens to human scent on water, his view changed. He explained that he now knew scent was "*like an oil slick…it sort of spreads out across the water, sits on top and then is – is blown by the wind and the prevailing currents and stuff and spreads out and disperses that way.*"When he put that information together with what he remembered about Police dog Otis's behaviour on the day, he developed a theory that Jordan is most likely to have re-entered the Creek.

The evidence of Dr Tate

The court was also assisted by the evidence of Dr Tate, an expert oceanographer with specialist training, skills and experience in the study of physical processes in marine, estuarine and fresh waters, including the study of currents and tides. Dr Tate also has extensive experience in the investigation of fatalities in the waters around Sydney Harbour and Botany Bay. Dr Tate expressed the view that, *if* Jordan had re-entered Boundary Creek on 24 April 2015 and got into trouble in the water, it is unlikely that his body would remain in Boundary Creek. There were very high flows in the Creek leading up to that day and the water was fast flowing.

It is likely that *if* Jordan re-entered Boundary Creek, he would have been swept quickly into the Nepean River. If he drowned (or became incapacitated) in Boundary Creek or after he entered the Nepean River, Jordan's body could have become entangled in vegetation either along the bank or deeper in the water, well past the main search area. If Jordan survived in the water for a while or his body was free to move with the flow, Jordan could have been washed kilometres downstream.

Did Jordan re-enter Boundary Creek?

There is no way of knowing with complete certainty whether or not Jordan entered Boundary Creek after he was seen at Heartland Motors. Undoubtedly, Jordan was anxious to get away from police, especially once he had been spotted by customers at the caryard.

While I accept, that at the time the search was abandoned on 24 April 2015, NSW Police believed that Jordan had escaped the area, it now appears much more likely that he re- entered the water in a desperate attempt to escape. Certainly, there is no eye-witness evidence that Jordan re-entered Boundary Creek after he had been seen near Heartland Motors. However, with the benefit of hindsight, taking into account Senior Constable Bennett's later evidence, it appears to be the most likely possibility. Unfortunately, it would have been potentially very dangerous. Boundary Creek flows directly into the Nepean River. It is subject to considerable erosion with high cliffs and very dense vegetation. In the days leading up to the pursuit there had been very heavy rainfall, which would have created high, turbulent flows in Boundary Creek.

While Jordan's brother suggested that Jordan was a strong swimmer, the conditions would have made swimming or keeping afloat extremely difficult, particularly given the fact that Jordan was clothed and by all accounts already tired from battling the dense vegetation.

Other inquiries into the possibility that Jordan survived

Since Jordan's disappearance police have also undertaken substantial inquiries to ascertain whether Jordan could still be alive somewhere. These include inquiries include:

- Obtaining information about his possible movement out of Australia. Jordan Morris is recorded as "onshore" by the Department of Immigration and Border Protection. There is no evidence he has left the country or applied for or used a passport.

- Obtaining information which might indicate later separate contact with police. There is no evidence that Jordan has come into contact with NSW, Commonwealth or any interstate law enforcement agencies during the years since his disappearance. There is also no evidence of activity recorded for Jordan Morris on the RMS system.

- Obtaining information about his Centrelink status. There is no evidence that Jordan has made contact with a Centrelink Office since 24 April 2015. He was previously dependent on this source of income and had submitted his last benefit claim on 22 April 2015. Jordan was subsequently suspended when he failed to lodge his next claim form.

- Obtaining information about his Medicare status. Jordan's last known Medicare transaction was on 16 March 2015. There is no evidence of any subsequent pharmaceutical benefit scheme claim.

- Obtaining information about his banking status. Jordan was known to bank with the National Australia Bank. His last identified banking transaction was a credit card transaction on his NAB Visa Card at Woolworths, Wentworthville on 23 April 2015. CCTV footage confirms Jordan was using his card on that day. Inquiries with other banks have failed to identify any transactions.

- Obtaining information from Police Missing Persons Units throughout Australia. There have been no unidentified bodies or remains that could match Jordan Morris.

- Checking his use of social media. There has been no activity on Facebook from Jordan since 24 April 2015. The last post on Jordan's wall that can be attributed to him was made on 10 April 2015.

In addition to these inquiries, police have interviewed each of Jordan's associates involved with the pursuit on 24 April 2015. None of these people have had any further contact with Jordan. Police have also conducted searches at places where Jordan is known to have stayed from time to time, with no positive result. Police have obtained statements and interviewed a large number of Jordan's friends and associates, but unfortunately this has not provided any further reliable information.

Police have obtained intelligence from a wide variety of sources, but this too has been unsuccessful in identifying any reliable information. Each lead and rumour has been carefully assessed and none have appeared to contain reliable information when checked.

Police have investigated numerous possibilities, including that Jordan escaped the search area and was later harmed in relation to a failed drug transaction. There is no evidence to support this theory. I also note that there has never been any evidence to suggest that Jordan may have taken his own life.

Jordan's disappearance has been widely reported in the media, but this has not produced any reliable information. However, there have been a number of reported sightings. I am confident that each has been fully investigated and found to be mistaken. The recent alleged sighting of Jordan was thoroughly investigated by Detective Senior Constable Morgan and it has also been discredited. I am confident that despite a major and coordinated investigation, there is no evidence which positively indicates that Jordan may still be alive.

Is Jordan Morris dead?

Tragically, in my view the strongest evidence that Jordan is dead is his total lack of contact with his family. Even when things were not going well for Jordan, he kept in sporadic contact with his family; particularly his mother, Jayne. During the inquest, the love the Morris family demonstrated for Jordan and each other confirmed my thoughts on this issue. If Jordan Morris was alive, he would have found a way during the past – almost three years - to contact his family, or to send a message to them. I do not believe that he would allow his family to suffer, if he could avoid it. In my view, Jordan's failure to contact his family is, in itself, extremely strong evidence that he is no longer alive.

Given that it appears Jordan lost his money, phone and bag on the day of the pursuit, he would have had nothing to start a new life. He does not appear to have contacted anyone he ever knew prior to that day and he has sent no message home to the family he clearly loved.

Starting a new life under a false name is extremely difficult. Jordan's own sister stated that Jordan would not have had the capacity, without money or support, to stay hidden from authorities for such a long period of time.

Having weighed up all the evidence before me I am able to make the formal finding that Jordan Morris is dead. I understand that for a family clinging to hope, these must sound harsh words, spoken without concrete evidence. Nevertheless, my task is to make findings "on the balance of probabilities" and I am satisfied that the evidence in this case reaches that standard.

Is it possible to say where, when or how Jordan died?

While I am able to make a finding, based on all the available evidence that Jordan is dead, other questions are more difficult to answer.

I am satisfied, to the requisite standard, that given the complete lack of later contact or evidence of any administrative or financial activity, Jordan's death occurred on or shortly after, 24 April 2015.

I am also satisfied that that Jordan died somewhere in the vicinity of Boundary Creek, Peachtree Creek and the Nepean River at Penrith NSW. Unfortunately, given what is known about the swollen river and recent rain at that time, it is possible that Jordan could have been washed a long way down the river. In my view, if he died in the bushland, away from the water, it is highly likely that Jordan's remains would have been found in the extensive searching which took place, however I cannot be certain of that.

Tragically it is also impossible to know if Jordan drowned as he swam or tried to float downstream.

It remains possible, though less likely, that he died from injuries he sustained in the undergrowth or nearby the bank of the river. While I think it likely that he got into trouble in the water, it is impossible to know if some other misfortune or accident befell him as he attempted to evade police in the undergrowth.

For these reasons I am unable to find a medical cause of death.

In my view it is possible to say something about the manner of his death. The evidence establishes that Jordan Morris died during or shortly after an attempt to evade police, who were searching for him in bushland, after a vehicular pursuit.

Did Jordan die in a police operation?

A critical incident was declared by Assistant Commissioner Jobson on 30 May 2015 and strike force Kalmia was established to investigate the disappearance of Jordan Morris and investigate the critical incident. The depth of the investigation, after the declaration, has given the court confidence that all available leads have now been pursued.

The fact that Jordan remained missing would have warranted an inquest in any event. However I am now satisfied that an inquest was also mandatory pursuant to section 23 of the *Coroners Act* (2009) NSW. I have been able to find, on all the available evidence that Jordan's death occurred in the general vicinity of the search area, during or soon after the search. I am thus satisfied that his death occurred "*as a result of, or in the course of police operations*".

Jordan had not been arrested, so he was not "*attempting to escape the custody of a police officer*" but, Jordan was clearly making decisions to avoid being captured or arrested.

I am satisfied that "but for" the police operation, Jordan would not have died as he did. However, I should clarify that this does not necessarily suggest criticism of the police operation. I note that the pursuit was terminated before Jordan left the car, for safety reasons. I also note that the stolen car was being driven in such a dangerous manner that there were a number of risks of serious injury or death in relation to those inside the stolen car and to members of the public, even before it reached the Penrith area.

Is there a need for recommendations?

I have carefully considered whether there is a need for recommendations arising out of the evidence before me. Counsel for the Morris family urged the court to identify a failure by the relevant police to recognise, in a timely manner, that Jordan was facing potential danger.

Counsel suggested that there was enough objective evidence, available on 24 April 2015, to warrant serious consideration of the possibility that Jordan had re-entered the water and could thus be at considerable risk of harm. It was well known that the terrain was difficult and that the vegetation was thick. The water levels were up and the recent rain meant that the current was particularly fast flowing. When he was last seen, Jordan appeared to be tired and struggling. Counsel submitted that it was obvious that Jordan might enter the water and once there, that he faced real danger.

Further it was suggested that the police failure to recognise the potential danger faced by Jordan on this occasion was likely to indicate a systemic or more general issue, rather than one merely arising from the particular facts of this case. It was submitted that the introduction of a policy or protocol to alert police to the possibility of risk in search situations was likely to promote public safety. The range of environments where alleged offenders might be chased is unlimited and could involve bushland or urban landscapes where very different risk factors exist.

Counsel urged the court to consider a recommendation, which in general terms would, by formal protocol, encourage police, to turn their minds to the risks persons being pursued might face and to take steps to mitigate those risks. On reflection, it was unclear to me exactly when this risk assessment should take place. Should it occur after the search has been called off in a debrief type situation or must it occur as an ongoing assessment as risks develop or change?

Counsel assisting and counsel for the NSW Commissioner for the Police urged against any recommendation in this regard, pointing out that there remains no direct evidence that Jordan re-entered the water, it exists at best as a theory, developed over time, with the benefit of hindsight. They submitted that in all the circumstances, it was a genuine and reasonable belief on the part of involved police to hold that Jordan had left the search area on 24 April 2015. Counsel for the Commissioner suggested that Police are well used to assessing risk, but even if they had been made to turn their mind to the dangers that might face Jordan that evening, given that they thought he had left the area, it is unlikely they would have come up with a plan to search the water at that time.

I have given the matter considerable thought. While I accept that on this occasion NSW Police appear to have missed the possibility that Jordan remained in the area, I am not convinced that the recommendation in its current form has sufficient clarity to assist police in dealing with the difficult task of risk assessment in operational policing of this sort. I accept that if it were known that Jordan had re-entered Boundary Creek on 24 April 2015, it would have been incumbent upon Police to mount a search of the local waterways in an attempt to find him. However, given that Police firmly believed that Jordan had escaped the area, a risk assessment of the dangers facing Jordan would have needed to focus on quite different concerns.

In my view, a timely review of what had occurred by an uninvolved, accredited search co-ordinator might have been more useful than asking involved police to review the risks on the day.

Nevertheless, the proposal raised by counsel for the Morris family is not without merit and I commend the proactive approach taken to look for ways to improve current practise. I understand that counsel for the Morris family suggest that, even if earlier water searching did not result in finding Jordan alive, it may have recovered his remains. This would at least have provided the Morris family with some certainty.

On balance, I have decided not to make a formal recommendation in the terms sought. I remain of the view that the proposal currently put forward is not sufficiently developed or targeted at a systemic problem. Nevertheless, I am concerned that any lessons that could arise from this tragedy are not lost and I intend to send a copy of these findings to the Commissioner of Police for his consideration of the issues that may be raised in relation to both the conduct and the aftermath of this search.

Findings pursuant to sections 81 *Coroners Act* 2009 (NSW)

Jordan Morris is dead. He died on or soon after 24 April 2015. He died in the vicinity of Boundary Creek, Peachtree Creek and the Nepean River at Penrith NSW. The exact medical cause of his death remains unknown. He died during or shortly after an attempt to evade police, who were searching for him in bushland, after a vehicular pursuit.

2. 302875 of 2016

Inquest into the death of CK. Finding handed down by Deputy State Coroner Grahame at Glebe on the 9th April 2018.

Introduction

On 10 October 2016 CK died after the small motorcycle he was riding collided with a utility vehicle in Kurrajong Avenue, Mount Druitt, NSW. CK's 12 year old pillion passenger, J was seriously injured. CK was only 14 years of age. At the time of the collision, the two boys were being followed by a fully marked police sedan, Mount Druitt 35. That vehicle was driven by Leading Senior Constable (LSC) Irayne Omoregbee, with Constable Christopher Azzopardi in the front passenger seat.

CK was born on 16 September 2002. CK and his four brothers lived with their mother, Ms MH at Mount Druitt. CK loved motorcycles of any sort. He would often swap small bikes, referred to as "monkey" bikes or "thumpsters" with other young people in the local area or over the internet. He had a talent for fixing motorcycles and a passion for riding them. His mother would often caution him about riding, especially without a helmet. He was an affectionate and happy boy, with a close relationship to his mother and siblings.

Ms H acknowledged that CK had been cautioned by police on two previous occasions for riding a motorbike unlicensed, uninsured and unregistered on the road. CK apparently believed that if he were to be caught again, he would have to go to court. He was anxious to avoid that possibility.

CK's death is a terrible tragedy. He is missed by his mother and siblings every day.

The role of the Coroner

The role of the Coroner is to make findings as to the identity of the nominated person and in relation to the place and date of death. The Coroner is also to address issues concerning the manner and cause of the person's death. A Coroner may also make recommendations in relation to matters that have the capacity to improve public health and safety in the future.

In this case there is no dispute in relation to the identity of CK, or to the date, place or medical cause of his death. For this reason the inquest focused on the manner and circumstances of CK's death and on questions about whether his death could have been prevented.

At the time CK died he was being followed by a NSW Police Force vehicle. His death clearly occurred "in the course" of police operations and arguably "as a result of" police operations. In these circumstances, pursuant to the relevant legislation, the conduct of an inquest, by a senior coroner, was mandatory.The purpose of these provisions is to ensure that a death of this nature is thoroughly and carefully reviewed. The public must have confidence that all deaths which occur during police operations are scrutinised carefully and independently and that any opportunities for improving police practice are quickly identified.

I am satisfied that, after CK's death, a proper investigation of the events surrounding the collision took place pursuant to the relevant NSW Police Force critical incident guidelines and that the necessary information was gathered by non-involved officers so that these matters can now be properly and fully reviewed in an impartial manner.

Three issues were raised for particular consideration during the inquest. The first concerned CK's manner of driving, the second concerned the application of the NSW Police Force's "Safe Driving Policy" and the third involved consideration of whether there is a systemic issue in relation to the use of trail bikes and mini-motorbikes in the Mount Druitt area, and if so what, if anything, can be done to reduce the danger involved.

The evidence

The Court heard oral evidence over two days and received extensive documentary material in three volumes. The material included witness statements, medical records, photographs, CCTV and various policy documents. At the conclusion of the evidence, detailed written submissions were prepared by the parties.

The Court was helped by a careful review of the evidence provided by those assisting the court. The parties acknowledged its accuracy and I intend to rely heavily on that document in my chronology of the events which occurred on the day of CK's death.

Background

The collision which caused CK's death was not an isolated incident. The Court was informed that there is ongoing and widespread dangerous use of trail bikes and mini- motorbikes in the Mount Druitt area and that the NSW Police Force continue to face difficulties in providing an adequate response. Sergeant Julie Underwood, the Traffic Sergeant stationed at Mount Druitt Police Station, told the Court that trail bikes were a "huge problem". She told the Court that it was common to see "juveniles riding, they are not protected, they are in unroadworthy….states, they're driven on roads. We have that many complaints in relation to trail bikes, we've had serious injuries, we've had deceased…They have no respect for police, they know that we can't pursue them…"

Sergeant Underwood explained that it was so commonplace, that it was difficult to give accurate numbers about how often police had to deal with dangerous trail bike situations. However she estimated that in the two months prior to the inquest there would have been over 100 telephone complaints and further complaints would have been received in person or by email.

The Court heard that there is nowhere within the Mount Druitt Local Area Command (LAC) where people can ride trail bikes legally, with the exception of private property with the permission of the owner. Thus, even if a young person is eventually able to gain a licence and has a roadworthy bike, there is nowhere in the local area to enjoy it.

Unfortunately, it is well beyond the scope of the evidence raised in this inquest, but one wonders what Local Government Authorities can do to assist in enriching the leisure life of young people in the local area as a strategy to reduce dangerous riding.

The events of 10 October 2016

At about 9.00 am on Monday, 10 October 2016, CK's mother, Ms H, left to go to work. She thought that it was likely that CK would ride his motorbike in Whalan reserve, an open space in Mount Druitt. A short time later, Ms Anne Maaka observed CK with a pillion passenger on the back of a bright red motorcycle, riding along a street in North St Marys.

At about 9.30 am, Mr Don Lawliss also observed CK riding a small red trail bike towards North Debrincate Avenue, North St Marys. CK was doubling another small boy. Mr Lawliss knew CK and had seen him ride small trail bikes on many prior occasions. He saw the two boys riding in traffic and riding faster than the other cars, with CK overtaking traffic. At one point he also saw a car pull over to let CK go by.

Another witness, Mr Matthew Bateman, observed a small red motorcycle with CK and J on board travelling east along Kurrajong Avenue, Mount Druitt, towards Belmore Avenue. CCTV footage indicates that this would have been about 10.59 am. Mr Bateman estimated that CK and J were driving at a speed of around 50 km/h. They were not wearing helmets.

At about 11.00 am, LSC Omoregbee and Constable Azzopardi were travelling in a fully marked police sedan, Mount Druitt 35, on Luxford Road, Mount Druitt. LSC Omoregbee was the driver of Mount Druitt 35 and Constable Azzopardi was the passenger/observer.

LSC Omoregbee originally joined the NSW Police Force in 2002. He left the NSW Police Force in 2007 and had rejoined in 2012. LSC Omoregbee was attached to Mount Druitt LAC from March 2012 until the date of the incident. LSC Omoregbee undertook a Silver Response Course, which he completed on 25 September 2012. LSC Omoregbee obtained silver classification on 26 September 2012.

That classification under the Safe Driving Policy determines the level to which a driver may respond to particular incidents. The Safe Driving Policy states that silver classified drivers may engage in a "pursuit". However, LSC Omoregbee's civilian licence had been suspended for a period of three weeks from 25 July 2016 until 14 August 2016. It appears from police records that LSC Omoregbee's driving certification and response classification were not properly reinstated following the period of suspension.

According to police records, Constable Azzopardi was confirmed as a Constable on 1 May 2016. He held a bronze driving certification. Bronze classified drivers are not, in any circumstances, to engage in a pursuit as a driver.

Both LSC Omoregbee and Constable Azzopardi observed CK riding a small red trail bike in a westerly direction on Luxford Road, Mount Druitt, with J riding as the passenger. Both police officers observed that the boys were not wearing helmets and were riding in traffic. In his directed interview with Detective Sergeant Evans on 11 October 2016, LSC Omoregbee stated that the boys looked at him and kept on going. LSC Omoregbee also stated that when he initially sighted the boys he activated the yelp/wail button. He was unable to recall whether he activated his light bar. LSC Omoregbee further stated that he wanted to stop the boys for a number of reasons.

He noted that they looked extremely young, they had no helmets on, they were riding in lanes of traffic which is illegal but also dangerous and "*he wanted to know why they were doing it*".

LSC Omoregbee then drove east along Luxford Road, to the roundabout intersection of Luxford Road and Belmore Avenue, and performed a u-turn. He then travelled west along Luxford Road. In his directed interview, LSC Omoregbee stated that following his sighting of CK traveling onto the incorrect side of Luxford Road he activated the light bars and pressed the wail/yelp button. It appears that the two boys saw the police car and continued to ride along Luxford Road.

LSC Omoregbee performed a u-turn at the corner of Luxford Road and Saidor Road. In his directed interview, LSC Omoregbee stated that he activated his light bar when he was completing the u-turn. He also stated that he activated the wail/yelp button. LSC Omoregbee stated that, at this point in time, he intended to get out of the car and talk to the boys. LSC Omoregbee stated that the boys stopped and looked at him and then kept on going – that is, the boys turned around and rode down Luxford Road in an easterly direction. In his directed interview, LSC Omoregbee also stated that "it looked like they were panicked".

In contrast to LSC Omoregbee, Constable Azzopardi recalled, in his directed interview with Detective Sergeant Bayliss on 11 October 2016, that the first time LSC Omoregbee activated the lights and sirens was between Saidor Road and Sunda Avenue. Constable Azzopardi noted that he understood that LSC Omoregbee activated the lights and sirens "hoping to pull them over… or just stop them or freak them out or so just get off the bike essentially".

At some point on Luxford Road, the police officers observed CK and J travel diagonally across the lanes of traffic to the opposite footpath. LSC Omoregbee and Constable Azzopardi both observed the boys nearly collide with a black Holden Captiva which was forced to suddenly brake. In his directed interview, LSC Omoregbee stated that the rider's control of the motorbike "was very shaky but it almost looked like they were going to come off at some point. I know they clipped a garbage can here, right on the corner of Luxford and Belmore, which is at the time, the exact same time when they nearly, oh sorry, where the gentleman in the black captiva nearly ran into them". When asked by Detective Sergeant Evans in his directed interview as to what his thought process was, or reason for trying to apprehend the boys, at that point in time, LSC Omoregbee stated "I thought they would seriously injure themselves or, or another road user, or potentially kill themselves or somebody else".

CK turned right from Luxford Road into Belmore Avenue. LSC Omoregbee stated in his directed interview that he did not activate the lights and/or sirens as he travelled southbound on Belmore Avenue. However, in his evidence at the inquest, LSC Omoregbee stated that he activated the wail/yelp button once whilst travelling down Belmore Avenue. LSC Omoregbee stated in his directed interview that he was at a distance of 50 metres or so behind the boys and that there was traffic in front of the police car, perhaps three or four cars. The boys continued on Belmore Avenue and at some point mounted the curb to travel southbound on the western grassy footpath. When asked by Detective Sergeant Evans as to his reasoning for travelling south on Belmore Avenue, LSC Omoregbee stated "to make sure no further incidents happened…see where they went…if the bike broke down or, or they fell off…perhaps I could have an opportunity to apprehend them and take the appropriate action".

In contrast to LSC Omoregbee, Constable Azzopardi recalled in his directed interview that LSC Omoregbee activated his lights and sirens on Belmore Avenue. Constable Azzopardi further stated in his directed interview that whilst he was not aware of LSC Omoregbee's reasons for activating the lights and sirens,

"I believe it was an attempt to basically make people aware that they've got two guys on a trail bike". However, it is noted that Constable Azzopardi denied, in his evidence at the inquest, that the lights and sirens were activated on Belmore Avenue – instead, he recalled that the yelp/wail button was activated for two yelps. Overall, it is difficult for the Court to be clear about exactly when lights and sirens were activated, given the variously conflicting accounts.

The police saw the two boys turn right into Kurrajong Avenue, and the police followed, travelling behind a truck driven by a witness, Mr Sidney White. In his directed interview, Constable Azzopardi recalled that the boys narrowly missed a pedestrian on Belmore Avenue in the vicinity of a parked white ute.

Mr Kurt Machut was working at 47 Kurrajong Avenue on the morning of 10 October 2016. Mr Machut is a mechanic. Mr Machut gave evidence at the inquest that he personally rides a motorbike and is quite familiar with motorbikes. Mr Machut stated at the inquest that he was at the front of his business premises when he heard a short burst of what he believed to be a fire brigade siren. He next heard a motorbike, which he described in his statement as being, "absolutely 'cained', it was revving so high, I mean they were really squeezing the juice out of it. The bike came from the northbound footpath of Belmore Avenue, it turned right into Kurrajong Avenue still on the footpath which meant that the bike was heading west along Kurrajong Avenue, Mount Druitt."

Mr Machut described the bike as a "red pocket rocket". He remembered that the driver was looking where he was going and the passenger was looking behind at the police car. He watched the police car give way to a B Double Truck at the roundabout. He was still watching the truck when he heard a huge bang.

Two witnesses, Mr David Bartley and Mr John Bartley, also provided statements regarding what they saw on Belmore Avenue. David Bartley owns a business on Kurrajong Avenue with an entrance onto Belmore Avenue. Around 11.00 am on 10 October 2016, David Bartley and his brother John Bartley were at work. David Bartley stated,

"it was a distinct sound, I knew it was a motorcycle. I look towards the entrance door [on to Belmore Avenue] and saw a small motorcycle flash past. I saw that it was red and had two kids on it. It was just a blur, it happened so quick. I did see that it passed between the workshop entrance door and the flag I put out on Belmore Avenue. They were doing a fair rate of knots, but I couldn't say what speed they were doing. It happened so quick I couldn't describe the motorcycle any further or the two kids that were on it."

Slightly later, David Bartley saw the police car turn right at the roundabout. He said that it had flashing blue and red lights and that its siren was activated. Within a couple of seconds of the police car turning on the roundabout, he heard the siren stop. His brother, John Bartley, provided similar observations.

It should be noted that LSC Omoregbee denied the use of lights and sirens whilst Mount Druitt 35 was travelling south on Belmore Avenue. In this he may be mistaken, given the independent evidence.

The police car turned right into Kurrajong Avenue behind the truck. LSC Omoregbee stated in his directed interview and in oral evidence that he did not apply the light bar or the wail/yelp button to overtake Mr White's truck.

Both police officers then saw the two boys accelerate along Kurrajong Avenue until they collided with the utility driven by Mr Giuseppe Perricone. LSC Omoregbee estimated the boys' speed just prior to the collision must have been in excess of the speed limit, which was 50 km/h. In his directed interview, LSC Omoregbee stated that prior to this incident he had not previously seen either of the boys and that he did not have any means to identify them.

Mr Perricone gave oral evidence at the inquest. He explained that he was coming out of his driveway at the time of the collision. There is some loss of vision on the left hand side, due to a retaining wall, but he was used to that situation and was moving slowly. Suddenly and without warning he felt a "crack" to the side of his vehicle. He had not seen or heard the motorbike or the police car. At first he thought that he may have hit something and cracked a light, but he could not see anything in his rear vision mirror. It was not until he exited his vehicle that he saw the mini-motorbike and the boys on the ground. Mr Perricone immediately got out his mobile phone and contacted Triple 000.

Almost immediately, he also saw the police. Both police officers provided first-aid and also requested assistance.

The boys were transported to Westmead Children's Hospital for further treatment. J suffered a broken leg and other injuries. CK died from his injuries at 12.46 pm on 10 October 2016.

A limited autopsy was conducted on CK by Dr Bernard l'Ons at the Department of Forensic Medicine at Glebe on 12 October 2016. The cause of death was recorded as multiple blunt force injuries. CK had multiple lacerations and abrasions. CT scanning showed a large amount of blood in his chest cavity, suggesting the possible tearing of a major vessel. There was also a peritoneal and retroperitoneal haemorrhage, especially surrounding the liver, spleen and pelvis.

The motorbike

Senior Constable Peter Kleinig, a police officer with experience as a motor mechanic, stated that the "micro-motorcycle" ridden by CK was unregistered and did not display any form of identification. On inspection, the motorcycle had the rear brake caliper assembly removed. In Senior Constable Kleinig's view this may have compromised the braking ability of the motorcycle and may have been a contributing factor in the collision occurring.

Leading Senior Constable Matt Wright, a member of the NSW Police Force Crash Investigation Unit inspected the mini-motorcycle. His view was that the mini-motorcycle, commonly referred to as a "Thumpstar" or "Monkey Bike" could not be registered for road use and is designed to be ridden off-road on private property. Leading Senior Constable Wright requested a speed analysis of the mini-motorcycle to be conducted by the Forensic Imaging Unit.

Leading Senior Constable Wright was advised that the mini-motorcycle was travelling at an average speed of not less than 54.6 km/h whilst riding on that section of the footpath immediately prior to the location of the collision on Kurrajong Avenue.

There is no doubt that riding the mini-motorbike, with compromised brakes, at that speed was inherently dangerous. It was dangerous to the boys, the police and anyone who may have crossed their path.

The Safe Driving Policy

In recent times the complex issues surrounding police pursuits have been widely debated in public and have been the subject of significant research and investigation throughout many parts of the world. A number of the issues as they relate to NSW have previously been examined by this Court. The issues clearly have a wide public interest. The question of whether and in what circumstances police should pursue a vehicle is a complex one and one that is currently approached differently in various jurisdictions. There are no obvious or easy answers and reasonable people may differ on the correct approach to take. Ultimately, it involves a careful balance between interests that at times conflict. Providing police with sound and accessible guidance on the operation of their discretion to pursue becomes a difficult but necessary task, particularly when decisions to pursue are so often made quickly and in stressful circumstances. Over the years many in the community have been rightly concerned at the number of deaths arising from police pursuits.

The Safe Driving Policy is a NSW Police Force internal policy document which guides police driving practice and strategies, including the conduct of police pursuits. The previous Commissioner Scipione APM, notes in the foreword of the policy that the NSW Police Force has a major responsibility to improve road safety and in doing that, "we must lead by example". Right from the start, the policy makes it clear that oversight of pursuits is essential and the Duty Operations Inspector (DOI) is especially charged with the role of determining whether a pursuit shall terminate or continue. Individual officers no longer have an unfettered discretion in this matter. A clear head, away from the stressful operational environment, must be involved if a pursuit is to continue.

Traffic and Highway Control Command is responsible for the Safe Driving Policy, which is updated from time to time. The version in place at the time of CK's death is version 8.2, which was published in July 2016 and is due for review in July 2018.

Part Seven of the policy deals specifically with pursuits, providing a definition and guidelines to support officers in making their decisions to initiate and/or continue pursuits. It is clear that a pursuit commences at the time a decision is made to pursue a vehicle that has ignored a direction to stop, regardless of speed. It continues if the police vehicle follows the offending vehicle in an attempt to remain in contact, whether or not warning lights or sirens are activated. Police are given guidelines to consider prior to making a decision to pursue, which involve weighing up the danger to themselves, other road users and the subject of the pursuit. Police are reminded that the driver and the vehicle must be appropriately classified. speed, weather, traffic and other issues are to be considered.

Importantly, in the factual circumstances of this case, the Safe Driving Policy contains a clear direction that when a vehicle engages in a pursuit, the DOI or VKG shift operator must be informed and certain information must be communicated immediately, including the reason for the pursuit and the conditions at hand. If communication cannot be made with VKG, police must not pursue. This policy is aimed at giving proper independent oversight to each and every police pursuit which occurs in NSW. If police in pursuit are told to terminate, they must do so. It is an essential and important plank of the current policy.

Was there compliance with the Safe Driving Policy?

Breach of the Safe Driving Policy

Unfortunately, each of the involved officers in this matter showed a flawed understanding of the relevant NSW Police Force policy governing the situation they found themselves in. Specifically, during their respective directed interviews, both police officers displayed a significant misunderstanding of the application of the Safe Driving Policy as it relates to pursuits.

LSC Omoregbee, in his directed interview, stated that "*my understanding of a pursuit is you're attempting to pull over a vehicle that's failed to stop and whether that is for a traffic offence or for a random breath test*". When asked if following a vehicle would constitute a pursuit, he answered,

"Q95

Um, I don't believe following a vehicle constitutes a pursuit unless you're driving at speed with your lights and sirens on. No.

Later he explained his reason for travelling south on Belmore Avenue, "Q236

"Well to make sure that no further incidents happened. I mean I could have just ignored it…but ah, I chose to follow it because I believe something may have happened….as I said, I wasn't prepared to engage in a pursuit based on the danger that they present to themselves and the other road users, so I just decided to follow them at normal speed and see where they went. If I got an, if the bike broke down or, they fell off….perhaps I could have an opportunity to apprehend them and take the appropriate action."

LSC Omoregbee demonstrated his lack of understanding of the policy throughout his directed interview. He appeared to draw a distinction between "following" a vehicle and being in pursuit, which he thought involved high speed. It was disturbing that he also suggested that part of his reasoning in not informing VKG was that they would not have allowed a pursuit in any event. At question 329, LSC Omoregbee stated,

"I just want to clarify that I wasn't chasing the trailbike with the pillion passenger. I wasn't in pursuit of it, I didn't call a pursuit, um, as I said we have lots of instances around here with trailbikes and they're just far too dangerous to pursue.

I merely followed that rider and his passenger because of their actions and I don't believe that pursuing them would have been a safe and reasonable thing to do, given what they had already done in the first instance when I saw them. It's unfortunate that's what happened and I don't believe that my actions were responsible for the young boy dying and the other one being seriously injured".

During his evidence at the inquest, LSC Omoregbee accepted that in hindsight his actions "technically" constituted a pursuit. However, in my view, a critical and troubling tension remains in his evidence. He explained that with hindsight he should have called a pursuit.

Nevertheless, he appeared somewhat puzzled when he explained that there would not be much point in notifying a pursuit because once he informed the DOI that the rider had crossed to the incorrect side of the road, it would have been terminated in any event. It was unclear to me whether LSC Omoregbee properly understood that the very purpose of the policy is to ensure safety and the fact that it would be terminated immediately might indicate that it was inherently too dangerous to undertake. The obvious corollary of this is that he should not have continued "following" the bike at close range, even if he was using his siren or whelp button only occasionally.

LSC Omoregbee's lack of understanding of the policy and his lack of appreciation of the importance of oversight in pursuits is disturbing, given that he had apparently been trained in the policy and had previously been accredited to the silver level.

Constable Azzopardi provided evidence at the inquest that he had been taught about the Safe Driving Policy during his initial training at the Police Academy. He also stated that, prior to the incident, he had undertaken several drives with a Field Training Officer – Driver

Development and he may have also undertaken an online course regarding the Safe Driving Policy.

In his directed interview, Constable Azzopardi stated that the two police officers were continuing to follow the boys in order to observe them. Constable Azzopardi's opinion was that by following the boys the police officers were ensuring the community's welfare and safety by alerting members of the public to the boys' presence. In his evidence at the inquest, Constable Azzopardi stated,

"the way they were riding a bike and the way that there was other people out on the road we had essentially a duty of care to make sure that basically their safety was fine as long as other people who were on the footpath and on the road and as well as I know we glanced over it but the manner of the bike itself, it was just dangerous to be on."

Constable Azzopardi's understanding of a "pursuit" under the Safe Driving Policy was "essentially when you jump on radio, call pursuit with lights and sirens when someone fails to stop". Further, his understanding was that after the two boys failed to stop once the police had used lights and sirens, they had instantly terminated any pursuit and just "followed" to observe the boys behavior. Accordingly in his view, the police officers were no longer in pursuit.

It appears that during the course of the incident, Constable Azzopardi turned his mind to whether they should report the developing incident to VKG – but not for the purpose of reporting that Mount Druitt 35 was in pursuit. In his evidence at the inquest, Constable Azzopardi clarified that when he asked LSC Omoregbee whether they should "call it", this question was “more a reference to should we advise radio that we are following these boys who are now riding on the footpath on a bike…if it’s a trail bike we do have a habit of saying we do – we spot a bunch of trail bikes riding in this direction, they’re doing this and that, we’re not in pursuit”.

During his evidence at the inquest, Constable Azzopardi accepted that in hindsight Mount Druitt 35 was in pursuit of CK and J under the Safe Driving Policy. As part of the critical incident investigation, LSC Omoregbee’s course of driving was reviewed by Detective Chief Inspector Almer. Detective Chief Inspector Almer was of the view that there was a “technical breach” of the Safe Driving Policy.

Also tendered as part of the brief was a report provided by the Traffic Policy Section, Traffic and Highway Patrol Command of the NSW Police Force. The report writer reaches the following conclusions:

- LSC Omoregbee was permitted, within the scope of the Safe Driving Policy, to attempt a traffic stop of the motorbike;
- LSC Omoregbee and Constable Azzopardi were in pursuit of the motorbike at the time of the collision, and both police officers failed to comply with the requirements of the Safe Driving Policy in respect to the pursuit; and
- non-compliance appears to arise from a failure by LSC [Omoregbee] to properly identify that a pursuit as defined under the policy had commenced.

This is a more satisfactory response than merely recording that a “technical breach” occurred. It is clear that LSC Omoregbee was permitted, within the scope of the policy, to call a pursuit. However, if he did, it needed to be properly overseen. What he was not permitted to do, in the circumstances of what had already transpired, was “just follow” the boys, particularly when part of his reasoning was that he was unlikely to get permission to pursue.

It was submitted by counsel for the involved officers that they were in an unenviable position and that their actions on the day were both reasonable and appropriate. Their concern for public safety meant that they needed to try and stop the motor bike, they could not “disengage” and just let the boys ride off. Counsel for the involved officers stressed that if they had called a pursuit, it would have been terminated. In those circumstances, the officers “really had no choice”.

I accept that the officers were in a difficult situation and that they were both genuinely concerned with public safety. I accept that the decision to pursue was made in an attempt to prevent harm. However, the officers acted in contravention of the current Safe Driving Policy. An essential part of that policy mandates oversight of all police pursuits. Calling a pursuit cannot be avoided because advice to terminate is likely to be forthcoming. I do not accept that it is useful to describe what happened as a “technical breach”. If the Safe Driving Policy is somehow unworkable, review of that policy rather than acceptance of ongoing breaches is called for.

Advice to terminate is often based on the recognition that the vehicle being pursued may take even more dangerous action when followed by police and thus further escalate the level of risk that already existed. In this case, it is clear that the motor bike was being driven dangerously before police saw it, but it appears that CK's recklessness increased once he realised that he was being followed by Mount Druitt 35.

LSC Omoregbee's licence and driver certification

The other identified contravention of the Safe Driving Policy related to driver certification. As stated earlier, LSC Omoregbee had previously been certified as a silver driver pursuant to the Safe Driving Policy. However there is clear evidence that, at the time of CK's death, LSC Omoregbee did not hold the correct certification to engage in a police pursuit.

LSC Omorgebee had his civilian licence suspended for three months for an offence of speeding (30km and over) in January 2016. He lodged an appeal to dispute the length of the automatic suspension in the Local Court and later completed a Traffic Offenders Program. LSC Omoregbee was then suspended for a period of around three weeks. That suspension dated from 25 July 2016.

It appears that on that day LSC Omoregbee informed his local Traffic Sergeant, Sergeant Underwood, that his civilian licence had been suspended for three weeks. He was told that his police certification would reflect his civilian suspension dates. Sergeant Underwood told the court that she informed LSC Omoregbee that his certification would be "automatically reinstated" at the end of his civilian suspension. This was clearly incorrect.

Part 4 of the Safe Driving Policy contains provisions in relation to the removal and reinstatement of certification. There is a clear process that must be followed which involves the satisfactory completion of a program of driver development.

At the time LSC Omoregbee followed CK, he had not undertaken the five assessment drives with a Field Training Officer – Driver Development as required by the Safe Driving Policy. Further, he had not undertaken the Silver Response Classification Test in the Computerised Assessment System. Sergeant Underwood, explained to the Court that these failings were partly her fault and based on her misunderstanding of the policy. When asked if he had completed these requirements she stated, "well I didn't ask him to do it, so I'm assuming no".

In summary, there were a number of breaches and misunderstandings of the relevant police policy. They included,

- LSC Omoregbee was not correctly certified to engage in a pursuit.
- LSC Omorgebee did not clearly understand that he was engaging in a pursuit, pursuant to the Safe Driving Policy.
- LSC Omoregbee did not notify VKG that he was in pursuit.
- Constable Azzopardi did not clearly understand the meaning of pursuit, pursuant to the Safe Driving Policy

- Sergeant Underwood, the relevant Traffic Sergeant, did not understand the process of reclassification under the Safe Driving Policy.

What other strategies are available to police?

The Court accepts that police are faced with a very difficult situation when they see young people riding small bikes, such as CK's. In CK's case, the independent evidence is such that it is very clear that he was riding dangerously and very fast even prior to the time police commenced their pursuit. He was a danger to other road users and to himself. In my view, it is likely that his manner of driving became even more risky once he saw that police were behind him. He certainly made some extremely dangerous manoeuvres in an attempt to escape apprehension. The issue of what police can do to increase public safety in these difficult circumstances was canvassed in evidence. Ideally, the number of dangerous pursuits must be reduced. Confiscation of bikes was raised as a possible strategy, but the available mechanisms were described as unwieldy, time consuming and not well targeted for dealing with the kind of situation under review.

Sergeant Underwood was of the view that, in practice, the process in place under the *Road Transport Act 2013 ("RT Act"*) is unworkable. There was general consensus that the powers currently in place for use by police under the *RT Act* to confiscate unregistered trail bikes are unnecessarily complex and in need of review.

Pursuant to s. 79(1) of the *RT Act*, a police officer may seize any unregistered "registrable vehicle" (other than a registrable vehicle exempted from registration under the *RT Act*) that is being used on a road. A vehicle is unregistered if it is not registered on the NSW registrable vehicles register.

Whilst, as a practical matter, the motorcycle ridden by CK was not eligible for registration within NSW, it was submitted that the motorcycle would still have been considered to fall within the definition of a "registrable vehicle" under the *RT Act* for the purposes of s. 79(1).

Section 4(1) of the *RT Act* defines a registrable vehicle as meaning, inter alia, any "motor vehicle". A "motor vehicle" is defined in s. 4(1) as meaning "a vehicle that is built to be propelled by a motor that forms part of the vehicle". A "vehicle" is defined, inter alia, in s. 4(1) as meaning "any description of [a] vehicle on wheels". Consequently, the Crown Solicitor submitted that the mini-motorcycle ridden by CK would arguably have fallen within the definition of a "registrable vehicle" for the purposes of s. 79(1).

Furthermore, with reference to s. 79(1), in the circumstances of this matter, the motorcycle ridden by CK would not have been exempt from registration under the *RT Act*. Part 2 of Schedule 1 to the *Road Transport (Vehicle Registration) Regulation 2017 ("RT Regulation")* lists the registrable vehicles that are exempt from registration under the *RT Act*. For example, cl. 6 of Part 2 to Schedule 1 provides that the registration provisions do not apply to any registrable vehicle being driven across any road when travelling to or from land that is being used mainly for primary production. As none of the categories of exemption specified by the *RT Regulation*, in the circumstances, applied to the motorcycle ridden by CK, the motorcycle would not have been exempt from registration.

However, it was submitted that the primary difficulty for police under s. 79 of the *RT Act* in successfully obtaining an order for forfeiture of a motorcycle in the circumstances of a young person such as CK arise from s. 79(3). This section provides that "no order of forfeiture may be made if the owner of the vehicle satisfies the Local Court that there has been no intent to evade registration of the vehicle". As CK was under 16 years of age, unless he had satisfied the Authority that it was appropriate that he be eligible to be the registered operator of a registrable vehicle, he would have been unable to apply for registration of his motorcycle. Furthermore, even if CK had been eligible to be the registered operator of the motorcycle, it is unlikely that the motorcycle would have been eligible for registration by virtue of non-compliance with applicable vehicle standards.

In view of the above, the Crown Solicitor submitted that, as a hypothetical example, if police had seized CK's motorcycle and sought a declaration in the Local Court that the motorcycle be forfeited to the Crown under s. 79 of the *RT Act*, this application would not have been successful. This is because it is unlikely that the Local Court would have been satisfied that there was an intent to evade registration in circumstances where CK was, because of his age, unlikely to have been eligible to register his mini-motorcycle and, furthermore, the motorcycle was not eligible for registration.

This is the kind of issue that police told the court they face in trying to get dangerous vehicles such as CK's off the road. In her evidence at the inquest, Sergeant Underwood outlined the issues which have previously arisen for police in seeking to confiscate trail bikes under s. 79(1) of the *RT Act,*

"Firstly, you have to ensure that, well they have to be of an age to be able to prove that they were trying to avoid registration. The vehicle, the trail bike also has to be a trail bike where that if you were to spend an amount on it, it could become registrable. So you're little Pee Wees and Thumpstars, they would never get registered. We then have to, we then have to take it to put it through court to get it forfeited. They then have an option of appealing which is what happened in my case, then it becomes a brief of evidence and you have to go to court. And then we, we won the matter in relation to because there was the issue of trying to prove whether it could have been a registrable vehicle. And then the court upheld that it would be forfeited and then within a week he had it back because he went through the RMS, paid I think $40.00 or $80.00 for the registration evasion and got the bike back.

…for a start general duties police as such don't have the time and that's exactly why I did it so I could see how, I kept on hearing it was a drawn out process. It's a very drawn out process for something that you don't get any result from.

…the problem is too when they're, the younger kids that are on it, well they're not to know about registration so we could never get up in court in relation to that because we could never prove that they were avoiding registration when they are not of an age that they can pay registration."

The Court's attention was also drawn to s. 239(1)(a) of the *RT Act* which, in summary, provides a police officer with the power to "seize and take charge" of a motor vehicle if the officer reasonably believes that a circumstance set out in s. 238 of the *RT Act* exists. Relevantly, s. 238 includes the use of the vehicle to commit a "sanctionable offence". A sanctionable offence is defined by s. 237(1) of the *RT Act*

as:

- a high range speed offence (driving more than 45km/h over the speed limit): *RT Act* s. 237(1);
- the "street racing" offence provided for by s. 115 of the *RT Act;*
- the "burnout" offence provided for by s. 116 of the *RT Act;*
- engaging in a police pursuit contrary to s. 51B of the *Crimes Act 1900 (NSW);* and
- any other offence prescribed by statutory rules.

On the face of it, this section does not cover the situation before the Court. Counsel for the NSW Commissioner of Police submitted that it would be useful to include in the rules a reference to "riding an unregistered motor bike". The implications of such a change would need further thought but in general the issue deserves appropriate consideration.

The need for recommendations

Section 82 of the *Coroners Act (2009) NSW* confers on a Coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned.

It is essential that the Coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the particular death.

Two issues emerged for possible recommendations. Firstly in relation to training and education with respect to the Safe Driving Policy and secondly in relation to the currently unwieldy process involved in confiscation of dangerous and unregistered motor bikes.

Counsel for the NSW Commissioner of Police accepted that there had been a breach of the Safe Driving Policy and that the officers demonstrated a flawed understanding of it. However, counsel did not support a recommendation aimed at increasing training for police in relation to the Safe Driving Policy. It was submitted that education already occurs at initial training at the Goulburn Police Academy, when officers are accredited for silver certification and through other training modules which also occur from time to time throughout the year. It was submitted that it formed part of the Mandatory Education Program that was delivered in 2016/17 across the State.

I do not share the Commissioner's confidence that the message is getting across. LSC Omoregbee, Constable Azzopardi, and Sergeant Underwood each failed to grasp aspects of the policy. In my view, further work needs to be done to make sure the policy is well understood and followed. Auditing of this work should also to take place to ensure that further training is successful.

The issue of whether confiscation rules and regulations should be broadened so that dangerous bikes can be taken out of the equation is also one that deserves further attention and consideration by the relevant stakeholders. There was general agreement that the current process, as it relates to riders such as CK, is confusing and unwieldy. Whether stronger confiscation rules will assist in promoting public safety is something which should be considered carefully. CK's bike was inherently dangerous to himself and others, the way he drove it only increased the risk. It may be that we need to work harder towards permanently removing these kinds of bikes from our roads.

I intend to urge the Minister of Roads, Maritime and Freight to review current confiscation powers in an attempt to see if they can be streamlined and improved. I note the Commissioner of Police has endorsed this approach.

Findings

The findings I make under s. 81(1) of the *Coroners Act (2009)* NSW are:

Identity
The person who died was CK.

Date of death
He died on 10 October 2016.

Place of death
He died at the Westmead Children's Hospital of injuries sustained at Kurrajong Avenue, Mount Druitt, NSW.

Cause of death
He died from multiple blunt force injuries after his mini-motorcycle collided with another vehicle.

Manner of death
CK died of injuries he received in a collision between his mini-motorcycle and another vehicle. At the time of his death, CK was being followed by members of the NSW Police Force. Their conduct was not compliant with the NSW Police Force's Safe Driving Policy.

Recommendations

For reasons previously stated, I make the following recommendations pursuant to s. 82 of the *Coroners Act (2009)* NSW:

To the Commissioner of Police

That the NSW Commissioner of Police implement further training and educational initiatives aimed at developing a better understanding of the requirements of the Safe Driving Policy regarding pursuits amongst the employees of the NSW Police Force to whom the Safe Driving Policy applies and, furthermore, undertakes a full audit regarding the effectiveness of these training and educational initiatives.

To the NSW Minister for Roads, Maritime and Freight

That the NSW Minister for Roads, Maritime and Freight consider consulting all relevant stakeholders with a view to establishing a working party to review of the current confiscation powers available to police under the *Road Transport Act 2013* (NSW) in relation to trail bikes and mini-motorcycles.

Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed as at 31 December 2019

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	343092/14	20/11/14	Hurstville	18	Police Op
2	124745/15	27/04/15	Camden	43	Police Op
3	141693/15	12/05/15	Silverwater	31	In Custody
4	208086/15	15/07/15	Maryvale	18	Police Op
5	289369/15	02/10/15	Parramatta	15	Police Op
6	323840/15	03/11/15	Malabar	74	In Custody
7	323811/15	03/11/15	Wellington	34	In Custody
8	329568/15	09/11/15	Camperdown	25	In Custody
9	373099/15	19/12/15	Penrith	54	In Custody
10	18089/16	18/01/16	Lismore	23	Police Op
11	19119/16	19/01/16	Quakers Hill	46	Police Op
12	24535/16	22/01/16	Malabar	19	In Custody
13	56536/16	20/02/16	Marayong	37	Police Op
14	56558/16	20/02/16	Marayong	35	Police Op
15	56518/16	20/02/16	Westmead	36	Police Op
16	73098/16	07/03/16	Ingleburn	33	Police Op
17	88742/16	21/03/16	Bradbury	36	Police Op
18	186812/16	19/06/16	Westmead	28	In Custody
19	290240/16	27/09/16	Sth Windsor	46	Police Op
20	39421/17	06/02/17	Westmead	67	In Custody
21	99958/17	02/04/17	Silverwater	32	In Custody
22	100899/17	03/04/17	Parklea	38	In Custody
23	121886/17	24/04/17	Malabar	72	In Custody
24	136779/17	05/05/17	Parklea	52	In Custody
25	142803/17	09/05/17	Blacktown	20	In Custody
26	157550/17	25/05/17	Goulburn	49	In Custody

27	185430/17	20/06/17	Camperdown	47	In Custody
28	188495/17	23/06/17	Goulburn	21	In Custody
29	202885/17	04/07/17	Westmead	35	In Custody
30	225703/17	23/07/17	Malabar	67	In Custody
31	256693/17	06/08/17	Grafton	44	Police Op
32	264782/17	30/08/17	Kelso	47	Police Op
33	275511/17	08/09/17	Parklea	81	In Custody
34	288854/17	22/09/17	Tamworth	22	In Custody
35	297414/17	29/09/17	Silverwater	34	In Custody
36	311913/17	15/10/17	Randwick	49	In Custody
37	371691/17	07/12/17	Parklea	37	In Custody
38	373943/17	10/12/17	Penrith	35	Police Op
39	15741/18	15/01/18	Malabar	57	In Custody
40	28682/18	26/01/18	Maroubra	33	Police Op
41	37983/18	03/02/18	Junee	23	In Custody
42	46266/18	09/02/18	Westmead	55	In Custody
43	54603/18	15/02/18	Westmead	44	In Custody
44	54392/18	18/02/18	Camperdown	30	Police Op
45	60363/18	20/02/18	Goulburn	67	In Custody
46	63185/18	24/02/18	Liverpool	26	Police Op
47	80723/18	12/03/18	Emu Plains	23	In Custody
48	114791/18	11/04/18	Collingullie	42	Police Op
49	123983/18	18/04/18	Kogarah	54	In Custody
50	136203/18	30/04/18	Randwick	44	In Custody
51	150097/18	13/05/18	Randwick	53	In Custody
52	166031/18	25/05/18	Surry Hills	48	In Custody
53	194750/18	23/06/18	Malabar	86	In Custody
54	199143/18	27/06/18	Randwick	52	In Custody
55	206773/18	04/07/18	Randwick	69	In Custody

56	209734/18	07/07/18	Silverwater	30	In Custody
57	269824/18	01/09/18	Bershire Park	36	In Custody
58	279370/18	11/09/18	Silverwater	48	In Custody
59	281398/18	12/09/18	Goulburn	43	In Custody
60	283647/18	15/09/18	Malabar	68	In Custody
61	291962/18	23/09/18	Brocklehurst	51	Police Op
62	297261/18	27/09/18	Tweed Heads	22	Police Op
63	314209/18	12/10/18	Randwick	85	In Custody
64	328285/18	25/10/18	Berkshire Park	30	In Custody
65	334938/18	31/10/18	Randwick	78	In Custody
66	338690/18	03/11/18	Ryde	26	Police Op
67	362245/18	23/11/18	Engadine	81	Police Op
68	369349/18	29/11/18	Richmond Vale	55	Police Op
69	372498/18	03/12/18	Silverwater	30	In Custody
70	391439/18	19/12/18	St Leonards	23	Police Op
71	392964/18	20/12/18	Malabar	34	In Custody
72	400495	30/12/20	Tumbarumba	27	In Custody
73	2380/19	02/01/19	Wagga Wagga	60	In Custody
74	4700/19	04/01/19	Arncliffe	24	Police Op
75	10495/19	10/01/19	Silverwater	43	In Custody
76	20200/19	18/01/19	Glen Innes	74	Police Op
77	28070/19	25/01/19	Villawood	33	Detention Centre
78	49616/19	13/02/19	Randwick	82	In Custody
79	53379/19	15/02/19	Randwick	66	In Custody
80	59022/19	21/02/19	Malabar	67	In Custody
81	69926/19	04/03/19	Randwick	45	In Custody
82	70710/19	04/03/19	Villawood	26	Detention Centre
83	83697/19	14/03/19	Glendale	22	Police Op
84	85457/19	15/03/19	Lismore	43	In Custody

85	106322/19	04/04/19	Eden	50	Police Op
86	110322/19	08/04/19	Silverwater	39	In Custody
87	114274/19	11/04/19	Broken Hill	45	Police Op
88	120612/19	13/04/19	Cessnock	57	In Custody
89	117552/19	14/04/19	Junee	66	In Custody
90	126969/19	21/04/19	Aldavilla	24	In Custody
91	146621/19	08/05/19	Silverwater	27	In Custody
92	154687/19	16/05/19	Randwick	28	In Custody
93	159733/19	17/05/19	Garran (ACT)	70	In Custody
94	179888/19	09/06/19	Silverwater	55	In Custody
95	181202/19	09/06/19	Cooma	45	In Custody
96	182081/19	10/06/19	Aldavilla	52	In Custody
97	184669/19	13/06/19	Silverwater	25	In Custody
98	200952/19	25/06/19	Lithgow	44	In Custody
99	218076/19	12/07/19	Westmead	26	In Custody
100	221339/19	16/07/19	Prairiewood	79	Forensic Patient
101	221357/19	16/07/19	Randwick	53	In Custody
102	236119/19	29/07/19	Newcastle East	36	Police Op
103	239447/19	31/07/19	Taree	40	Police Op
104	248603/19	08/08/19	Parklea	59	In Custody
105	248603/19	09/08/19	Malabar	52	In Custody
106	252231/19	13/08/19	Malabar	76	In Custody
107	256729/19	17/08/19	St Leonards	53	Police Op
108	256729/19	19/08/19	Glen Innes	40	In Custody
109	259359/19	19/08/19	Randwick	33	In Custody
110	261510/19	21/08/19	Malabar	70	In Custody
111	269131/19	28/08/19	Malabar	33	In Custody
112	276007/19	03/09/19	Cessnock	37	In Custody
113	278264/19	05/06/19	Silverwater	42	In Custody

114	280398/19	08/09/19	Westmead	73	In Custody
115	281694/19	09/09/19	Randwick	54	In Custody
116	289826/19	16/09/19	Westmead	44	In Custody
117	289835/19	16/09/19	Malabar	42	In Custody
118	302386/19	26/09/19	Silverwater	55	In Custody
119	308628/19	01/10/19	Malabar	75	In Custody
120	308924/19	02/10/19	Penrith	33	Police Op
121	324097/19	14/10/19	Wellington	27	In Custody
122	323357/19	15/10/19	Malabar	80	In Custody
123	337389/19	27/10/19	Malabar	74	In Custody
124	345858/19	01/11/19	Erina	45	Police Op
125	351386/19	05/11/19	Gosford	20	In Custody
126	362566/19	18/11/19	Malabar	80	In Custody
127	388175/19	09/12/19	Berkshire Park	49	In Custody
128	388183/19	09/12/19	Randwick	72	In Custody
129	407715/19	28/12/19	Blacktown	60	In Custody

(Coroners Act 2009, Section 23)

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