WC attracted the attention of Sergeant C and pointed out the offending vehicle, which the former identified as a 'white XD'. WC saw the police vehicle do a u-turn, follow the offending vehicle up Clarinda, through the intersection of Church and Clarinda, then further along Clarinda and left into Bushman. The police vehicle had its flashing lights activated, then its sirens. At no stage did the other vehicle attempt to pull over.

The pursuit

After the vehicle was brought to his attention, Sergeant C activated his radar and obtained a ground speed of 95 kph as the vehicle travelled north in Clarinda. The police vehicle, with Senior Constable P seated in the front passenger seat, made a U-turn and the vehicle continued to accelerate as it proceeded north in Clarinda, before turning left into Bushman. At that stage, they were perhaps 50 metres behind him. First the flashing lights and then the siren were activated.

As the vehicle passed through the Bogan street intersection it slowed to about 60 kph and then proceeded straight through the intersection, accelerating rapidly and pulling away from the police vehicle quite rapidly. At this point, Sergeant C said in his record of interview that the offences for which he was pursuing the vehicle were excess speed and manner dangerous for the speed in Clarinda Street at that time of night.

The vehicle proceeded west in Bushman, topped a crest where the police temporarily lost sight of it and at this stage, Sergeant C notified a pursuit via VKG radio. The vehicle was then 250 metres ahead of them. It crossed the Condobolin Road, doing 60 to 70 kph through the give way sign, causing a vehicle travelling on the Condobolin Road to slow, and then actually stop to allow the police vehicle through.

They travelled along Middleton until the intersection of Brolgan Road, when the offending vehicle was observed to have lost control as it turned right into Brolgan. It was then on the northern kerb of the footpath, and then swung around to continue west in Brolgan, before travelling for about 50 metres at 30 to 40 kilometres an hour.

At this point Sergeant C was able to give a description of the vehicle - a white Falcon sedan, as he saw it - and its location. Having got to within a hundred metres of him, C attempted to give the radio the vehicle's number, but because of the reflection of his headlights, he was unable to read it. He gave one number which was incorrect, then immediately corrected it, but the radio identified the vehicle as a blue 83 model Falcon, whereas he perceived that the vehicle he was following was white, causing C to assume that he had given an incorrect registration number.

The vehicle accelerated away again doing a hundred kph in a 60 zone. C continued to keep VKG notified as to his position, providing unprompted details of himself and his gold certification. Although the driver, he provided this information because his partner, Senior Constable P, was unfamiliar with the streets. Once they hit the 80kph zone near Austop, the other vehicle accelerated away again up to speeds of 140 kph. At this time, the police

vehicle was perhaps 150 metres behind. C notified VKG that he (the offender) had had 'a few little turns' but was doing OK now and was able to maintain it. From Austop, C attempted to keep the vehicle in sight, maintaining a constant speed of 140 kph at a distance of some 300 metres, not trying to get close. He lost sight of him over a crest and continued to follow, notifying VKG as they were approaching the "S"s near the Mexican style house.

As the police vehicle came around the bend, it drove straight into a huge cloud of dust and debris that reduced visibility down to the bonnet. C stopped immediately, and found that the other vehicle was on fire and up against a tree. C retrieved a fire extinguisher and was running over to the vehicle with it in order to extinguish the blaze when a second police vehicle containing Officers C2 and K arrived. A short time later, estimated to be in minutes, a third and fourth vehicle arrived. Arrangements were made for emergency services to be notified.

The other police vehicles involved

Sergeant C2 and Senior Constable K were patrolling in Church Street in Lachlan 100 when they became aware of Lachlan 201 travelling north in Clarinda with its flashing lights activated. A short time later, they heard the pursuit called. They followed using a slightly different route at first, then travelling along Bushman, Middleton and finally Brolgan. As C moved around the next bend, they were passing Austop, a distance Sergeant C2 estimated to be 1 kilometre behind. He has since measured out the distance at 1.3 kilometres. They caught glimpses of the vehicle from time to time up ahead. At no stage did they ever see the offending vehicle. When they arrived at the scene, C was in the process of running towards the crashed vehicle with a fire extinguisher.

After they had travelled about 5 kilometres out of Parkes, VKG called for backup for Lachlan 201, and K replied that 'We are right behind them'. If this were interpreted literally, both C2 and K said that it was not correct, because at no stage did they get closer than a kilometre to C's vehicle. By this K said that he intended to mean that he 'was behind them and backing them up'. At the railway crossing, Senior Constable K said that they were some 1 1/2 to 2 kilometres behind. (R 1, Q 14). Neither Sergeant C2 nor Senior Constable K saw any other vehicles behind them. C2 saw none in his rear vision mirror and after K heard that the vehicle had crashed, he climbed into the back of the vehicle to search for a fire extinguisher. He saw no evidence of any vehicle behind.

Both C2 and K interpreted their role as backup - to give assistance in searching for and arresting possible offenders. They had no idea at that stage who they may be dealing with and for what offences. At no stage did they see themselves as forming part of the pursuit, even in a secondary role, and their vehicle was not a categorised pursuit vehicle.

Sergeant B was working with Constable W and the Duty Officer, Sergeant G when Constable W heard the pursuit called and notified the other two. B and W left the station in Lachlan 15 and G left in Lachlan 10. Lachlan 15 activated warning beacons and sirens whilst in Currajong Road. B heard C

on the VKG and estimated that the latter was about 5 kilometres in front. After they heard that the vehicle pursued by C had crashed, he turned off the siren but left the beacons flashing. They travelled another 4 to 5 kilometres before B saw the beacons of 201. B and W were travelling in a Holden rodeo 4 wheel drive caged vehicle. They saw their role as backup and to detain possible offenders since they were the only ones travelling in a vehicle equipped to do so.

Sergeant G, the Duty officer left in Lachlan 10 at about the same time as Lachlan 15 and travelled in close proximity behind them. He heard C call the pursuit and remembers Bushman Street being mentioned. He activated warning lights and sirens and noticed that Lachlan 15 similarly had theirs activated. As he drove, he heard C on the VKG saying he was passing Austop and estimated that he was then about three kilometres behind. As he passed Austop, maintaining visual contact with Lachlan 15, G heard VKG calling for backup for C and heard K respond. He also responded saying that he was 5 kilometres behind. However, his response is not on the tape and must have been overridden by the operator when he was transmitting. He got no closer than 300 metres to Lachlan 15 whilst travelling in Brolgan Road. He arrived at the scene at virtually the same time as Lachlan 15.

Blood alcohol readings

The police were breath tested and were found to have a nil blood alcohol concentration. Sergeant C admitted in his record of interview that he was taking prescribed medication, Zoloft, an antidepressant in a very low dosage. According to Professor S, there is no reason to suppose that his driving ability would have been affected by this drug in any way.

The deceased was found to have a blood alcohol concentration of .123 grams of alcohol in 100 millilitres of blood. According to Professor S, this would certainly have affected his driving ability. Further, the realisation that he was over the limit may have been a factor in causing him to try to escape from the police. 'What occurred thereafter appears to have resulted from a combination of alcohol-induced speeding behaviour coupled with an alcohol-induced reduction in his perceptual, cognitive and coordinative functions'.

Consideration of the evidence

The Acting Deputy State Coroner (hereinafter referred to simply as 'the Coroner') commented that there was a wide discrepancy between the estimates of time and distance given by the various civilian witnesses who were called to give evidence and that this was not unusual: perceptions can be different depending on the distance from which one is viewing an event, and the mind can tend to constrict or expand times and distances quite innocently when consideration is given to them after the event.

The Coroner said that he was satisfied that the evidence of the police officers as to the proximity of C's vehicle to H's vehicle and the relative positioning and spacing of the police vehicles was to be preferred. He said that there were a number of reasons for this conclusion. In the first place, the evidence of those who suggest that the police vehicles were travelling virtually in

convoy right behind the H's vehicle, and that the first police vehicle was close enough to be towing the first police vehicle did not accord with the evidence of the overwhelming majority of the other civilian witnesses.

The evidence of C3, who viewed events from Austop was that the police vehicle appeared to be following, making no attempt to catch up. He said that the headlights of the police vehicle did not light up the back of the pursued vehicle. The Coroner said he thought that C3 was a particularly reliable witness.

The evidence of Mr. W was that the police vehicle was 400 metres behind but no closer, and that the car seemed to be going a lot faster and was pulling away. He and Mr. V heard remarks over the train's radio to similar effect. A number of named witnesses all estimated a distance of approximately 400 metres between the F and the first police car at this stage of the journey. In fact, C himself puts the distance at 300 metres, which the Coroner accepted because of a police officer's greater experience and skill in estimating speeds and distances - a daily occurrence for a highway patrol officer.

The Coroner said that he preferred and accepted this evidence to that of those who suggested a closer distance not only because of its weight, both qualitative and quantitative, but because of what happened immediately after. When C came around the bend, he drove into a dust storm caused by H's vehicle leaving the road, and spinning around on the verge before it crashed. C then brought the police car to an immediate halt. This was confirmed by the tape, the transcript of which forms part of Exhibit 2. The remarks were spontaneous and formed part of a running narrative. By their very nature, they eliminated any suggestion of recent invention. The Coroner accepted them as an accurate depiction of what occurred. In fact, Senior Constable P, who was unfamiliar with the area, thought that they had turned onto a dirt or gravel road.

In other words, had C been any closer, he would have witnessed H's vehicle actually commence to leave the road, rather than witness the immediate aftermath. As it was, visibility was reduced to the bonnet after they came around the bend and the police vehicle was showered with dust and debris. Later inspection revealed that the police vehicle was undamaged. Further, the Coroner did not accept that an experienced highway patrol officer would place his own and his partner's lives and well being at risk by travelling virtually on the tail of a pursued vehicle at a speed of 140 kph. The expert testimony of Mr. S, an accident reconstruction expert, also corroborated the fact that the police vehicle pulled up in the vicinity of the crash site and not past it, which would have been the case had he been travelling right behind the offending vehicle.

So far as the distance between the second police vehicle driven by Sergeant C3 and C's vehicle is concerned, the Coroner said it was noteworthy that by the time they pulled up, C had time to stop his vehicle, report on the radio, help P to get the fire extinguisher out of the boot, and was actually running towards the crashed vehicle when they stopped. The Coroner accepted C3 and K's estimate of a kilometre behind, later measured out at 1.3 kilometres. At their estimated speed, this represented some 30 seconds in time. One would also have expected their vehicle to be covered in dust had they been right behind the first police vehicle.

The Coroner also accepted that the remark "we're right behind them" was not literally correct, but rather was intended to convey the information that they were already providing backup to the pursuing vehicle. Further, after hearing C's remark that the vehicle had crashed and was on fire, K still had time to crawl into the back of the still moving police vehicle to search for their own fire extinguisher. And so far as the distance between his vehicle and Lachlan 15 and 10 is concerned, he saw no evidence of any vehicles (in the form of headlights) behind them.

Sergeants B and G and Constable W were actually back in the police station, some 1 1/2 to 2 kilometres away, when they heard C signal a pursuit in Bushman. It defied logic, said the coroner, to think that the caged police vehicle and the four wheel drive could have out sped the much more powerful highway patrol vehicle, which was already doing 120 kph, so as to be able to catch up and be only momentarily behind, as some witnesses had suggested. The distance between them would only have increased once C got onto the open road. Under these circumstances, the Coroner accepted the police officer's estimate of approximately 5 kilometres behind when C was passing Austop.

The Coroner emphasised that the fact that he preferred the evidence of some witnesses over others did not mean that he was inferring that anyone was not being other than frank with the court:

It must be borne in mind .. that when a judge makes a factual finding by preferring one witness's account of a conversation to another *(the Coroner interpolated here: or one witness's version of events to another)* it does not mean that the judge has found that the witness whose evidence was not preferred was lying, any more than it means that the judge has found that the other witness was telling the truth. It means no more than that the judge has reached a conclusion on the balance of probabilities which version is more likely than not to be correct: *Mikaelian v CSIRO [1999] FCA 541 (Federal Court, Sydney, Hill J, 31 May 1999):*

The Coroner then went on to consider some of the issues raised during the inquest by the family, that is H's mother and N, his de facto wife.

Issues

1. Why were there so many police vehicles involved?

The Coroner accepted that the second, third and fourth police cars were providing backup for Lachlan 201 and were not engaged in the pursuit as such, even in a secondary role. He was satisfied that the police did not know who they were dealing with or how many occupants there were in the offending vehicle, and once the offending vehicle headed onto Brolgan they were travelling at night in remote area on a country road.

It was reasonable, he said, that they should have given backup to their colleague in these circumstances in the form of extra personnel to search for and attempt to locate anyone who decamped from vehicle. So far as B and W were concerned, theirs was the only vehicle equipped to carry prisoners if anyone was arrested at the scene. It was also reasonable that Sergeant G as the Duty Officer should be present for the same reasons.

2. Should a pursuit have been initiated?

The Coroner said that there had been the suggestion that this was only a traffic offence and that the police response was over the top, being more appropriate to an armed robbery or a major drug offence. At one stage, H's mother referred to the speeding aspect - doing 95 in a 60 kph zone. However, the Coroner said that H's offence was not one of simple speeding. It was a serious offence of driving in a manner dangerous to the public, serious enough to merit the concern of responsible citizens that H might seriously harm or kill others who happened to be in the vicinity on that evening.

The Coroner said that there was sometimes a tendency in the community to regard traffic matters as not really all that serious. However, he said that driving in a manner dangerous to the public was an offence so serious that, apart from a fine and licence disqualification, a first offence carries with it the potential for a prison term of up to nine months and if it is a second major offence in five years (as it was in this instance, bearing in mind H's previous conviction for driving with the prescribed concentration of alcohol, an offence committed in substantially the same circumstances to the present), the offender is facing a gaol sentence of up to twelve months.

The police officers were not aware of H's state of intoxication at the time. However, had the opportunity arisen his manner of driving would have led to him being breath tested. Because of his previous conviction, he would then also have been facing another potential gaol term for this, his second time prescribed concentration of alcohol offence, of 12 months (possibly concurrent), and the disqualification of his motor vehicle driver's licence in these overall circumstances for up to 5 years. The Coroner said that the point he was making is that on the overall scale of things, these were very serious offences indeed.

Under the circumstances, the Coroner had no criticism to make of any of the police for their response on this occasion.

3. Should the pursuit have been called off earlier? Were police procedures and guidelines for pursuits followed?

H's mother said in her written submission that the pursuit should have been called off once speeds of 100 kph were reached in the township of Parkes. The Coroner said that he did not agree, and that, having received a complaint from responsible citizens about the dangerous manner of Peter's driving in the main street, they would justifiably have been the subject of much criticism had they simply left a driver carrying on in that fashion continue to do so around the town. There was no guarantee that he would have ceased doing so, and having regard to his immediately preceding behaviour, the Coroner said that the probabilities were that he would not have. Once the police vehicle activated its lights and sirens, H's option was to pull over, and this he elected not to do. In fact, he could have pulled over at any stage of the pursuit but at no stage did he do so.

The suggestion that the pursuit should have been called off once the pursuit progressed onto the Brolgan Road is based upon the premise that the vehicle had been identified, and that the police could have proceeded by way of arrest

and charge at a later date. However, the vehicle was never properly identified. The tape showed clearly some confusion about the registration number, and then, once it seemed that this was established, the description of the vehicle. On the information supplied, VKG said that the vehicle was not reported (stolen) and that it was an '83 Falcon sedan blue'. Sergeant C said 'Sorry, radio, I must've given you the wrong number. We got a white XP Falcon sedan.' The confusion over the vehicle's colour was also reflected in the evidence of a number of the civilian witnesses.

The Coroner was satisfied that the police in the other vehicles never in fact saw the pursued vehicle. Mrs H also said in her statement that her son was known to police and they could have come back and arrested him later. However, he was certainly not known to these police.

In his review of the investigation and the actions of the police, Acting Inspector C expressed concern that nowhere was it indicated in the statements provided that consideration had been given to calling off the pursuit. However, in his statement dated 16 July 1999, Senior Constable P2, the VKG operator, said that he gave consideration to many factors to determine whether to terminate the pursuit or to allow it to continue, bearing in mind the Police Service Safe Driver Policy.

He said that he took into account that the police vehicle was a Category 1 vehicle, that C had a gold licence, the weather conditions and that no other vehicles were involved apart from the police vehicles. He said that the person calling the pursuit appeared calm, and that the calls were made clearly and precisely and that all requests were met. The breach for which the person being pursued was a serious one, driving in a manner to the public, and that the driver of the pursued vehicle appeared to be driving satisfactorily on the information supplied apart from 'a few little turns' earlier. The offending vehicle was now 'going along at 140 where he can maintain it'.

His decision to allow the pursuit to continue was made with these considerations in mind 'together with the absence of any real danger to pursuing police or public. The identity of the offender or his vehicle also was not positively determined.

Sergeant G, the Duty Officer, did not advert specifically in his earlier statement to what consideration he gave to terminating the pursuit. In a supplementary statement dated 22 February 2000, he said that as the pursuit developed, he monitored the progress of both vehicles, the path of the pursuit and the traffic conditions, and constantly evaluated the pursuit with these factors in mind.

The Coroner found that here, there was nothing specific which occurred which may have prompted a decision to call off the pursuit. There were no other vehicles on the road. Sergeant C appeared calm. It was he who had to give the responses to VKG because his partner was new to the area and did not know where he was. On his evidence and the evidence of witnesses that the Coroner accepted, he was following along not making any attempt to catch up but simply to follow at about the speed H's vehicle was doing.

Whilst in the witness box, Acting Inspector C made the point that he had never said that the chase should have been called off, simply that there was no mention made of consideration being given to this in the brief. In fact, in Constable P2's statement, there was.

All things considered, the Coroner had no criticism to make of the police for not calling off the pursuit. He was satisfied that Sergeant C had not identified the vehicle in question following the confusion about the vehicle's colour. Had it been identified, and in particular with a local address, consideration may well have been given to calling the pursuit off. Once the vehicles had progressed into Brolgan Road, the Coroner said he was satisfied that Sergeant C was merely maintaining his distance behind H's vehicle, making no attempt to overtake it, and in this regard, he also accepted the evidence of certain civilian witnesses to the same effect. The Coroner was also satisfied that C remained calm at all times, and that the weather, road and general traffic conditions did not merit any decision to call of the pursuit. He was also satisfied that the Commissioner's guidelines as to pursuits were followed, and in particular the Safe Driving Policy.

The Coroner said that police have to make a value judgment according to circumstances prevailing at the time as to whether to call off a pursuit, and the gravity of the offence is one factor which they would consider in this regard. If the police called off every pursuit simply because a person fled the scene, then a lot of serious offences and offenders would go undetected and unpunished. The Commissioner has laid down stringent guidelines for the conduct of pursuits and the Coroner was satisfied that they were followed on this occasion. The Coroner said that the legislature had also acknowledged the gravity of the damage that persons who themselves flee police vehicles in pursuit can cause. Section 52A of the Crimes Act 1900 provides that a person who is driving in a dangerous manner and/or under the influence of intoxicating liquor and causes death or grievous bodily harm to someone whilst driving the vehicle to escape a police pursuit, events for which there was significant potential from H's manner of driving in this case, is guilty of the offence of aggravated dangerous driving and liable for imprisonment for up to 14 years.

To the deceased's mother and fiancée and the members of their families, the Coroner said he was sorry they had lost their son, their son-in-law, and husband. He said it was always a great sorrow to lose someone close, particularly someone who in all other respects than when he consumed alcohol, and became consumed with anger and stepped into a motor vehicle, was a thoroughly decent young man.

However, the Coroner said that it must be realised that, unfortunate and tragic as it was, there was no one else to blame for the tragedy that occurred on this evening than H himself. The confusion about the number plate and the colour of the vehicle were innocent contributing factors. Whatever grievance H may have thought had at the party, he thereafter reacted quite inappropriately by then stepping into his motor vehicle and driving in the manner he did, thereby causing a grave potential danger to other road users who happened to be on or about Clarinda Street on that evening.

Once the matter was reported to the police in the manner it was, they would have been failing in their duty had they not reacted in the manner they did. H had the opportunity to pull over at any time. He never did. No doubt the alcohol he had consumed affected his judgment in this regard, as suggested by Professor S. In this context, his decision to outrun the police could be seen as a continuation of the quite unreasonable anger he displayed at the flat, and which manifested itself in his manner of driving in Clarinda Street.

Finally, the Coroner commended Senior Sergeant B and the other members of his critical incident team for the excellent quality of the brief they prepared, which was completely thorough, objective and professional.

Consideration of possible recommendations

This inquest heard some 40 witnesses over four days of evidence. A significant proportion of that time, if not most of it, was taken up with disputes about how far each the various vehicles involved in this matter were distant from each other. Senior Sergeant B, as part of his thorough investigation was obliged to interview over 30 civilian witnesses about the town in order to ascertain, so far as it could be ascertained, where each of these vehicles were at various places and various times in relation to each other. The variations between the estimates given were patent.

The Coroner said that all this effort, time and expense, might have been avoided if the various police cars had been fitted with video cameras, in the same way as the ERISP has removed much of the opportunity for disputes about records of interview. Apart from their obvious evidentiary value and financial savings where court evidence is concerned, video cameras would afford protection to members of the public and to police officers alike in providing a first hand record of events which may be the subject of later dispute.

The Coroner said that he had been informed during the hearing that the installation of video cameras in police cars has been under consideration for some time, but that for some reason, apparently budgetary, progress has stalled. He was informed that all of the steps preliminary to installation, had been taken, contracts had been awarded and a supplier identified. All parties supported a recommendation for the installation of these 'patrol data recorders' in all police vehicles. The Commissioner supports the concept, but is without the necessary funds. According to a working document entitled 'Patrol Data Recorder Project (In Car Video), dated 24 April 1998, Australia (with the exception of South Australia) is the only major country in the world without them.

For the above reasons, and with his experience in this case in mind, the Coroner said he intended to recommend to the Minister and the Commissioner of Police that video cameras be installed in all police vehicles without further delay. The Coroner said he would phrase his recommendation in terms of 'as soon as practicable' because he realised that there may still be some preliminary matters to take care of. However, the import of the recommendation was that they be installed without delay. The Coroner said that budgetary considerations are important. However, as against this, the forensic and financial savings involved would considerably offset the expense involved.

Findings

That [the deceased] died at about midnight on the evening of 5 and 6 June 1999 on the Brolgan Road near Parkes from multiple injuries sustained then and there when the vehicle in which he was travelling collided with a tree following a police pursuit.

Recommendations

That the Minister for Police and the Commissioner of Police take whatever steps are necessary to ensure that the Patrol Data Recorders (In Car Video cameras) are installed in all police vehicles as soon as practicable.

1475 of 1999

Male 36 years died on 19 July 1999 on the exit ramp off the Hume Highway into Jugiong. Finding handed down on 14 March 2000 at Glebe by Dr Elwyn Elms, Acting Deputy State Coroner (hearing at Yass)

Brief facts

This was a death in the course of a police operation under s 13A (2)(b) of the Coroners Act 1980. The deceased, Mr K, was pulled over whilst driving his vehicle along the Hume Highway near Jugiong for the purpose of a random breath test after committing a minor traffic offence. He passed this test, and was then questioned. The police said they became suspicious and proceeded to search his vehicle, apparently with the deceased's consent. A stage was reached during the search when the police sought to search a bundle of clothing wrapped with rope in the boot. The deceased's co-operation abruptly ceased and he drove off at high speed. The police gave chase. The deceased turned off his lights and was doing an estimated 140 to 160 kph when he turned off the highway at the Jugiong exit ramp. Ho rolled his car and suffered fatal injuries in the process. The pursuit was short - an estimated 1250 metres. The bag in the boot was subsequently found to contain in excess of 3 kilograms of cannabis.

Issues

1. Whether the police were justified in questioning K and then searching his vehicle after the original reason for pulling him over - to conduct a random breath test - was successfully concluded in his favour. Was a legitimate power being used for an ulterior purpose?

2. Whether there was anything untoward in the manner of pursuit.

Circumstances of death

K had been noticed by Senior Constable A driving somewhat erratically, though not dangerously, north on the Hume Highway near Coolac. A radioed ahead to Senior Constable F who was sitting in a radar equipped highway patrol vehicle about 3.6 kilometres south of the Jugiong exit ramp, and continued to follow until A's vehicle had passed the highway patrol vehicle. The radar detected the speed of A's vehicle at 117 kph in a 110 kph zone. F moved out to give chase, overtaking A's vehicle (a four wheel drive) in the process.

The Acting Deputy State Coroner found that A was justified in following the deceased's vehicle for the distance he did without pulling him up sooner, because his original estimate of the vehicle's speed was made at a time when A was stationary, and he did not thereafter have the opportunity to obtain a better estimate. He therefore decided to enlist the support of a vehicle equipped with radar to do a radar speed check on the offending vehicle. Furthermore, A was travelling on his own at night on a country road, and did not know who he could be dealing with.

K's vehicle is pulled over by police

F activated his flashing lights and pulled K's vehicle over at the intersection of the Hume Highway and Kitticarrara Road Jugiong.

F told K that he had been stopped for the purpose of a random breath test. He was asked "Will you blow into this tube?" At first he did not supply a sufficient sample. He blew again, and this time supplied a sufficient sample with a negative result. He was asked for his licence, for details of the car – a rental car hired at Wagga Wagga – where he was going, for what purpose and for how long.

A small toiletries bag was noticed on the back seat, and the police said they became suspicious because K appeared to have no more luggage. He was asked where were the rest of his clothes, and then "Will you hop out of the vehicle and open the boot?" (The form of words is slightly different in F's handwritten notes: "Do you want to get out and open the boot?").

In the boot, there was an overnight bag and a bundle of clothing with rope tied around it. F went back to the front passenger's side of his vehicle armed with K's licence and car rental papers to make an inquiry through VKG radio concerning K's identity and antecedents. A asked him what was in the overnight bag. K replied some dirty videos and some papers. A asked to have a look at the other item – the bundle of clothes. K said that it may take some time, it was difficult to open. A said that was all right, whereupon K asked if he had a search warrant and then slammed down the hatch, moving to his car and saying that he was going to call his solicitor. He got into the driver's seat and without warning, revved the engine hard in first gear and took off under full acceleration.

Issues

1. ***Whether the police were justified in questioning K and then searching his vehicle after the original reason for pulling him over - to conduct a random breath test - was successfully concluded in his favour. Was a legitimate power being used for an ulterior purpose?***

The Acting Deputy State Coroner found that the police were entitled to pull K over for a random breath test. It was his manner of driving which brought him to their attention, but the factor of speed was not thought to be of any significance. A did not have confidence that his own estimate would be likely to stand up in court without corroboration, and F did not think 117 in a 110 kph zone would have merited pulling up the vehicle on its own account. In fact speed was not even mentioned as a reason for pulling the deceased over.

However, the Acting Deputy State Coroner went on to say that the fact that a driver may have been pulled over for a random breath test is not a licence for the police to subject the driver to further questioning on extraneous matters, and then, as a result of the answers received or if they otherwise become 'suspicious', to search his vehicle, at least without making known to the driver concerned the nature of their power for doing so. This is particularly so once the reason for the exercise of the original coercive power which places on the driver an obligation to comply (s 4E of the Traffic Act 1909 at the time) has come to an end in the successful completion of the test with a negative result.

In the present case, stress was laid on the fact that the police were merely seeking K's permission to search the vehicle and that he willingly complied and cooperated with the police in answering their questions. In his COPS entry the Officer in Charge of the inquiry, said: "Whilst speaking to the deceased Police became suspicious and requested permission to search the vehicle. This was agreed to and the deceased unlocked the rear hatch door."

However, the Acting Deputy State Coroner found that what had occurred in this case was the utilisation of the original statutory power, which had been employed for legitimate purposes, the occasion for the use of which had now come to an end, to achieve an ulterior end, namely the questioning of the deceased about other matters followed by a request to search his vehicle and certain of its contents.

Ms Pinch, Counsel assisting the Acting Deputy State Coroner, drew attention to the identical nature of the terminology used in each case: "Will you blow into this tube?" (exercising the statutory power under s 4E of the Motor Traffic Act) and, moments later, "Will you hop out of the vehicle and open the boot?" (a purported invitation to consent devoid of statutory power). Any citizen, regardless of whether he had a criminal record or not, could be forgiven for not appreciating that there was any distinction.

Under s 357E of the Crimes Act 1900, a member of the Police force may stop detain and search "any vehicle in which he or she reasonably suspects there is any thing stolen or otherwise unlawfully obtained or any thing used or intended to be used in the commission of an indictable offence". However, the Acting Deputy State Coroner found that in the circumstances of the present case, questioning cannot be used for a purpose beyond the statutory power exercised under s 4E of the Traffic Act 1900 (a legitimate end) purely in order to string together pieces of information for the purpose of raising a reasonable suspicion under s 357E of the Crimes Act 1900 (an illegitimate end based on the exercise of the original power) unless and until the citizen has been made aware that the occasion for the exercise of the original power is now at an end.

In the present case, the officers said that their suspicion was initially raised by the fact that the deceased was a single occupant in the vehicle, he was from South Australia (apparently vehicles from South Australia had been used to convey drugs into New South Wales), he was in a rental vehicle, and he had only a toiletries bag in the back seat in the car. Hence the 'request' for him to open the boot and display his luggage.

The Acting Deputy State Coroner was not satisfied that these factors would have been sufficient to constitute "grounds in the eyes of the reasonable man for the suspicion which the (police officers) formed. It was not to the point that the (police officers) genuinely believed that (they) had reasonable grounds": *Streat v Bauer (SC of NSW, 13686/96, Smart J, 16 March 1998).* Accordingly, they were not entitled to bolster the 'suspicion' which they had formed in their own minds by a search of the deceased's vehicle.

He also held that the other statutory powers which are relevant to police powers in this context: s 37(3)(b) of the Drug Misuse and Trafficking Act 1985 - the power to stop detain and search 'any vehicle in which the member reasonable suspects there is any prohibited plant or drug ... and s 10 of the Police Powers (Vehicles) Act 1998 – a senior police officer may authorise another police to search a vehicle or class of vehicles if the former believes ' the vehicle (or vehicle of the specified class of vehicles) is being used in or in connection with the commission of any indictable offence" – were not relevant on the facts of this case. The former was not relevant because on the evidence they had, the police officers had no grounds for suspicion that there was (specifically) any prohibited plant in the vehicle, though it subsequently turned out that there was. The latter was not relevant because no senior police officer authorised the search.

A said in his oral evidence that on the evening in question, he felt that he was exercising his powers at all times and that he did not think that he needed the deceased's consent to conduct such a search. F, on the other hand, said that first he was exercising his powers, then relying on the deceased's co-operation following which he then formed a reasonable suspicion.

The Acting Deputy State Coroner went on to say that our system of law places great emphasis on the freedom of the individual, which is only to be abrogated in quite specific circumstances – generally those approved by the legislature. The powers exercisable by police officers under s 4E of the Crimes Act 1900 are one example. It is not acceptable that the driver of a vehicle who is apprehended for a minor traffic offence should be subject to further questioning and a search of his vehicle once the original statutory reason for his apprehension has expired, unless it is brought home to him in some fashion that the original reason for his apprehension is at an end and that henceforth he is being questioned and asked to do things on a basis distinct from the reason for his original apprehension.

No magic formula or form of words is necessary. It is not necessary to caution the driver that he does not have to say anything because that situation only arises in the case of possible self-incrimination, and a police officer is entitled to make inquiries. But it is necessary to bring home to the driver that the reason for pulling him over (eg to conduct a breath test) is now at an end, and that henceforth it is intended to ask him questions on other matters. Whether what is said is sufficient will depend upon the circumstances of each case.

The relevant principles are set out in the Police Service's Code of Practice for CRIME, Exhibit 6 in the proceedings, page 39, dealing with police powers to 'stop, detain and search': "In determining whether you have reasonable suspicion consider all the circumstances of each situation... Your decision

must be objective... Do not detain someone using these powers for the purpose of questioning. Do not stop or detain someone against their will to find grounds on which to base your suspicion. You must have the suspicion beforehand. Before searching you may question someone about what gave rise to your suspicion. However, they do not have to answer." The Acting Deputy State Coroner said that what might more explicitly be spelled out is that legitimate powers used for one purpose – conducting a breath test – cannot be used for another – question, detain and search – unless it is made plain to the citizen where one power stops and the other starts, particularly where the person's consent is a prerequisite for the actions being taken.

The police officers may well have had reasonable cause for suspicion under s 357E after F's licence checks on the deceased were complete, because these would have revealed that he had a prior drug history, although even here these checks were made after the original cause for his apprehension was complete. He had complied with the request to supply a sample of his breath, the result was in his favour and he was then free to go.

The Pursuit

After K suddenly departed the scene under full acceleration, Senior Constable F, who was seated in the front passenger seat of his vehicle doing his VKG checks, ran around to the driver's side and followed in hot pursuit. He was attempting to put on his seat belt at the same time, which he managed to do after a while with some difficulty having regard to the acceleration of the police vehicle. He activated his flashing lights and siren.

He was an estimated 300 metres behind the deceased's vehicle that he lost sight of momentarily as it went over the brow of the hill, but then saw that it had turned off the Hume Highway down the Jugiong exit ramp. At this stage K was doing an estimated 140 to 160 kph and had turned his lights off. F could still pick up the path of the vehicle with the aid of his headlights reflecting off the taillights of the deceased's vehicle.

The deceased's vehicle then veered left, went up an embankment, and rolled sideways three to four times before coming to rest on the roadway. Coincidentally, it was at this time when F, after the difficulties with his seat belt, was activating his radio to notify a pursuit when the results of his VKG check on the deceased came through and were intercepted by A. After the vehicle rolled, the deceased was thrown out onto the roadway, and suffered serious head injuries. A came across this scene moments later. F called for an ambulance and then, when it was obvious that there were no signs of life, notified a fatality. Strewn about the scene was the bag of clothing tied up with rope that had attracted the attention of the police in the boot of the deceased's vehicle and a number of $50 and $100 notes. The bag was subsequently found to contain in excess of three kilograms of cannabis.

The chase was extremely short – an estimated 1250 metres according to the Officer in Charge of the Inquiry. It took only 30 to 40 seconds in all. F had a gold certificate entitling him to participate in pursuits and A had a silver certificate entitling him to participate in pursuits in a secondary role. No other vehicles were in the immediate vicinity at this time, and had there been,

F said that he would have constantly reassessed the situation with a view to calling off the pursuit in the event of any danger to the public.

In short, there is nothing in the manner of the pursuit that merited any criticism of the police officers. The decision to flee was entirely K's. The police were entirely justified in giving chase having regard to his manner of driving alone at this point alone and apart from any issues of reasonable suspicion. K was in a vehicle with which he was unfamiliar in an area he was unfamiliar with his headlights off and travelling at a speed estimated at between 140 and 160 kph. F never got closer than 300 metres behind the deceased's vehicle. The pursuit was short. F was just about to notify a pursuit when the deceased's vehicle rolled. There was no actual danger to the public which merited the pursuit being called off.

Under s 51 of the Road Transport (General) Act 1999, the Commissioner of Police may authorise the use by police officers of a tyre deflation device that causes the deflation of the tyres of a vehicle, for use by police to stop or assist in the stopping of a vehicle in connection with the pursuit of the vehicle by police. This section reflects the former s 24 of the now repealed Traffic Act. I was informed that the use of such devices, pursuant to which a device is placed on the roadway ahead of the oncoming vehicle, is still under trial. Such a device would not have been of assistance in the present case because K had brought his vehicle to a halt, and then later sped off while inquiries were still being made.

During the hearing, Sergeant F said that there is a device known as a 'stop stick' which can be placed ahead of the front wheel of a vehicle which has been halted in such a position that a tyre will be deflated if the driver drives off. It will not halt the vehicle's progress altogether, but it will slow its path. Such a device would have been of considerable assistance in the circumstances. The Coroner was informed that it does not form part of the present trial. In his view its use should be evaluated, and he intends to make a recommendation accordingly. If in use at the time, it may have served to save K's life. There are, of course, many factors to consider, not the least of which is expense, because, to have overall utility, it would need to be carried in a considerable number of highway patrol vehicles, if not all of them.

Formal Finding

That [the deceased] died at 8.08 pm on 19 July 1999 from head injuries when he lost control of the vehicle he was driving at the exit ramp off the Hume Highway near Jugiong following a police pursuit

Recommendations

1. That the Police Academy include as part of its course of instruction to trainees for the NSW Police Service the distinction between their coercive powers (such as the power to conduct a random breath test, or their powers s 357E of the Crimes Act 1900) and occasions when they are asking a member of the public to comply with requests for information or to search which depend for their efficacy upon the person's consent. Otherwise, circumstances may arise where a legitimate use of power is used for an

illegitimate end with the result that evidence may be rejected by a court in the exercise of its discretion as improperly obtained. A copy of this judgment should be forwarded to Sergeant M of the NSW Police Academy, Goulburn, for this purpose.

2. That the Commissioner of Police disseminate a similar caution (regarding the distinction between coercive powers and questioning or searches which depend for their efficacy upon the citizen's consent) to his officers in the field through the Police Service's normal educative channels.

3. That the Minister for Police, in conjunction with the NSW Police Service, consider the evaluation and assessment of the tyre deflation device known as a 'stop stick' with a view to the trial of such a device by members of the NSW Police Service, either as part of the trial of tyre deflation devices pursuant to s 51 of the Road Transport (General) Act 1999 or generally. If necessary, the period mentioned in s 51(3) of that Act should be extended for this purpose.

907 of 1999 **Male aged 35 years died on or about 1 August 1999 at Lithgow Correctional Centre, Lithgow. Finding handed down on 15 June, 2000 at Lithgow by Janet Stevenson, Senior Deputy State Coroner**

Circumstances of death

I was incarcerated on the 21 May 1989 for offences of break and enter. His earliest release date was the 19 August 1999. The deceased had a long-term drug habit and upon release was required to participate in a drug rehabilitation program.

Mr. I was compliant whilst in gaol and rather quiet. There was no evidence whether whilst he was in gaol, or with his family, that he was suicidal. He last saw a drug counsellor on the 26 July and this was to discuss the terms of his parole.

On the 31 July the deceased was in cell 188 with another prisoner. However on this date the cellmate left to attend an escort, leaving the deceased 'one out'. On the 1 August Mr. I was heard by other prisoners to make a comment in relation to a football program he was watching as he apparently was unhappy with the result. No one was seen to leave or enter the cell during the evening.

At 8am there was a change of shift of prison staff. As is the regular pattern, prison officers attended their monthly union meeting. Upon letting go the prisoners when officers returned to duties, Mr. I's cell was opened and he was seen to be in a foetal position on his bed face down. It was thought a faint pulse was felt. Medical staff were contacted and whilst waiting for them, the deceased was turned onto his back. He was thereupon found to be rigid and purple in colour.

There was a make shift syringe in the hand of the deceased. Under his hand was a small resealable bag. Other bags were located containing heroin. A torn bed sheet was located outside the window of the deceased that hung to the window of the cell below. The use of such sheet is consistent with a 'mail delivery' system used in the gaol. Not surprisingly the prisoners in the cell below denied any knowledge of the sheet or it's usage.

At post-mortem no signs of physical injury were noted. Mr. I had a reading of 0.4mg/l of morphine in his blood. This is within the fatal range.

Inquest

At inquest there was a factual finding of no foul play on the apart of any person. It appears the deceased has accidentally overdosed whilst alone in his cell.

Yet again, the Inquest was unable to say how the deceased obtained the heroin. The regular union meeting of the prison officers gave ample opportunity for prisoners who had drugs to distribute these by means of the 'sheet/mail' system.

Findings

That [the deceased] died on the 1 August, 1999 at Lithgow of the toxic effects of morphine administered by his own hand whilst an inmate at Lithgow Correctional Centre.

1736 of 1999

Male aged 43 years died on 18 August 1999 at Prince of Wales Hospital, Randwick. Finding handed down on 25 August 2000 at Glebe by Jacqueline Milledge, Deputy State Coroner

Mr. K, a 43 year old male, was received into custody at the Metropolitan Remand Centre on 31 May 1999. He was an unsentenced prisoner having been remanded in custody for the murder of his wife.

Mr K appeared before the Central Local Court on 30 May 1999 and was released pursuant to Section 33 (1)(a) Mental Health(Criminal Procedure) Act to be conveyed to Caritas Hospital, Darlinghurst, for the purpose of a Psychiatric Assessment. He was to return to Court on or before 2 June 1999.

The assessment by Dr. C found no signs of mental illness but Dr C opined " He will need a further assessment in custody to monitor his mental state. He is high risk of depression and self harm".

Assessment and response at Metropolitan Remand Centre

On 31 May he was assessed on admission by a registered psychiatric nurse. All questions were answered by Mr K in such a way as not to alert her to any issues of self harm. She noted on the file that the prisoner was to be referred to the Risk Assessment Intervention Team (R.A.I.T) , firstly as a matter of policy as he was facing a capital offence and that (he) "Denies suicidal thoughts. Appears stressed and agitated." She asked for him to be seen "ASAP". Mr K was seen the next day by the team.

On 3 June 1999 Consultant Psychiatrist Dr L consulted with Mr K. During the first consultation Dr L states "I conducted a general review of the case, noting a range of stresses and pressures upon Mr K.....his general health and state of mind were reviewed. I concluded that there had been a three to four month history of depressive symptoms which were of mild to moderate intensity."

Dr. L had a further 2 consultations with the deceased and found that whilst there was a three to four month history of a depressive reaction it was of moderate severity it appeared to be improving. Mr K was to revisit Dr L in a further two weeks, however he was moved to another facility for medical tests and did not keep that appointment.

Prison Officer O'C was the Case Officer for Mr K. He met frequently with Mr K and always found him cooperative.

Mr K's physical examinations

During the first consultation with Dr L, Mr K complained of a number of physical ailments. He complained about burning sensation in his testes, headaches, leg aches, urinary and bowel concerns, chest pain, lack of energy, a lack of fitness and unable to sleep. Dr L states none of these problems would give rise to a psychotic illness.

The medical file a Mr K shows consistent attention to his physical ailments by nursing and medical staff. On 18 July 1999 Mr K was transferred to the Metropolitan Medical Transit Centre to undergo a series of tests.

On the 16 August, about one hour before he was found hanged in his cell, he had seen Dr M at the Metropolitan Medical Transit Centre clinic. Dr M questioned Mr K about the history of his ailments and Mr K explained that these problems presented from the time he killed his wife. Mr K became tearful.

Dr M diagnosed a possible urinary tract infection and prescribed medication.

Events surrounding the finding of Mr K and his subsequent death

After his clinical consultation with Dr M, Mr K was returned to his cell he was sharing. Mr T and Mr K had been cell mates for 'a couple of weeks'. Mr T believed he was depressed and unhappy about his crime, "crying sometimes". Mr K told Mr T that he won't be getting out, which prompted Mr T to tell him that life was worth living. Whilst it appeared to Mr T that he might take his life, he was not 100% sure and believed he was only talking about it.

Mr T suggested to Mr K he speak to welfare or the psychiatrist, but he told Mr T he was beyond help.

On 16 August when Mr K was returned to the cell in 12 Wing after clinic, Mr T was absent at the dentist.

On T's return the cell door was opened, Mr K was found hanging by shoelaces from the grill of the window. Mr T ran from the cell to summon help while Officer B supported Mr K awaiting help. Other officers came to his assistance and approximately one minute later Officer F entered the cell and used Officer C's own pocket knife to cut Mr K free. Officer C states that this is the second time his own knife had been used in this way. The '911 tool' was not immediately available for use.

CPR was immediately applied and at the time Dr M presented to assist, a nurse was ventilating Mr K. Dr M found that his pupils were dilated and non

responsive. There was no spontaneous respiration, his heart sounds were audible and he had a good pulse. Resuscitation continued until paramedics arrived. Within twenty minutes Mr K was taken to the Prince of Wales Hospital.

Sadly on 18 August 1999, Mr K died in the intensive care unit of the Prince of Wales Hospital.

The Coroner is concerned that the appropriate response tool the '911 tool' was not being carried by any of the responding officers

Issues

1. Family concerns regarding failure to detect Mr K's intention to suicide

When Mr K first appeared at court at Central, he was sent to Caritas Hospital for psychiatric assessment by Dr C. The one page report stated that there was a high risk of depression and self harm. It appears from the evidence that this report was not noted by staff at 'intake', it is suggested that it was not part of the inmates file on presentation.

Like the family, the coroner is concerned that this information was not available on intake.

The Coroner is however, despite the absence of Dr C' letter, satisfied that Registered Psychiatric Nurse McK, ensured the protocol was followed for 'capital offence' prisoners and Mr K was referred for assessment to the RAIT for urgent referral. Mr K was seen in a timely fashion by the team and on referral to Dr L. His ongoing consultations with the psychiatrist Dr L was interrupted by his movement to the Metropolitan Medical Transit Centre for an ultrasound and other tests.

It would have been appropriate for Dr L to have been notified of his movement to the MMTC so that he could use his judgement and understanding of Mr K to determine whether he should contact his patient for 'follow up'.

On two occasions Dr M, General Practitioner, provided a certificate suggestion placement in a 'one out' cell. The first certificate stated 'one out cell or non smoker', the second certificate simply stated 'one out cell'. This latter certificate was dated the day of Mr K's hanging. He had only been seen by Dr M shortly before his death and the Department did not have time to consider the recommendation. I am not satisfied however that his placement with another inmate contributed in anyway to his decision to end his life, in fact it was at the time he was returned to his cell in 12 wing, and on being alone, that he took the opportunity to bring about his demise.

Dr L states Mr K was showing signs of improvement and I accept that, unfortunately the counselling ceased on his movement to the MMTC and this may have contributed to his depression.

2. Family concerns regarding the use of moveable furniture, hanging points and shoelaces

Mr K was found hanging from the window grill by shoelaces. Mr T states an upturned table was found at his feet. This was probably used for access to the hanging point. A small wooden stool was also in the cell.

Acting Deputy Governor stated that the table and stool were used for the inmates to use at meal time or letter writing. He also gave evidence that inmates during 'buy up' can purchase a variety of joggers with shoelaces. He also stated that the prison also issues joggers with laces.

The Coroner is not satisfied that more could not be done to eliminate shoelaces from the prison scene. She knows that there has been an earlier recommendation by the State Coroner for the use of velcro fastening shoes for 'at risk' inmates. She is also aware that the Department's Operations Procedural Manual was updated to ensure the strict removal of laces from 'at risk' inmates as a result of this recommendation.

This policy was operative at the time of Mr K's incarceration, but he was not classified 'at risk' and therefore restricting access to shoelaces was not considered.

Finding

That [the deceased] died on 18 August 1999 in the intensive care unit of the Prince of Wales Hospital, Randwick. He died within 2 days of being found hanged in 12 wing, Metropolitan Medical Transit Centre, self inflicted with the intention of taking his own life.

Recommendations

1. That all court papers should be endorsed clearly if a prisoner is 'at risk' and the warrants endorsed similarly.
2. That inmates assessed by a psychiatrist/psychologist or RAIT as exhibiting symptoms of major depressive illness should not have access to moveable furniture or shoelaces in cell areas.
3. That should an inmate being treated by the psychiatrist or RAIT team be moved to another facility, the RAIT team is to be notified immediately of the move and they in turn should notify the treating psychiatrist.

1910 of 1999

Male person aged 34 died on 10 September, 1999 at Grafton. Finding handed down on 10 August 2000 at Grafton by Jacqueline Milledge, Deputy State Coroner

Mr Y a 34 year old male was killed during a police pursuit driving a stolen motor vehicle in the Grafton region. The manner of death brings this matter within Section 13A of the Coroner's Act, as death was occasioned during a police operation.

At the start of the inquest the family of Mr Y were not concerned with the police response to Mr Y and the manner of pursuit, however, as the evidence unfolded, both the Coroner and the family formed the same opinion regarding

the extensive 150 kilometre pursuit, which saw police vehicles and Mr Y's car engaged in extremely dangerous manoeuvres.

The family were also concerned that the Mental Health System had abandoned the family and their mentally ill brother, Mr Y, as there was no appropriate community care for Mr Y. They stated that, even though the family had told mental health workers he was not taking his medication and further exacerbating his mental illness by alcohol dependency, they refused to have him admitted to an appropriate institution. Evidence of this was given by Mr Y's brother and supported by other family members.

No evidence was received from the mental health teams or Health Department during the course of this inquest as the issues relating to manner and cause of death focussed in this instance on the police pursuit and the protocols relating to the NSW Police Safe Driver Policy. The evidence from the family of Mr Y, did however, provide a valuable insight into the disposition of Mr Y, the driver of the stolen car.

The Facts

At approximately 11.45pm, 9 September 1999, a red Camry station wagon, was left open, unattended, with keys and engine running, outside an automatic teller machine. Mr Y was seen by the custodian of the Camry walk down the street and jump into the driver's seat.

Police were alerted and the stolen car was circulated via police radio. The car was easily identifiable as it had the trade mark 'Coca Cola' emblazoned on its sides.

A police sergeant driving the 1st police vehicle sighted the stolen car and called for assistance. Whilst that call was being made, a 2nd and 3rd police vehicle offered assistance.

The 'pursuit' of the stolen car saw the vehicles travel 150 kilometres and lasted about one hour and fifteen minutes. The pursuit ended tragically when Mr Y's vehicle crossed to the incorrect side of the roadway and collided 'head on' into a semi-trailer travelling in the opposite direction.

All witness accounts suggest that Mr Y's action was deliberate and considered, however I am not satisfied that he intended to take his own life or the life of anyone else.

The Issues

Over the entire course of the pursuit, all drivers posed a risk to the public. The police had to engage in alarming manoeuvres to 'keep up' with the stolen car and this was of great concern to one truck driver witness who believed that not only were the lives of the pursuit drivers at risk, but also the public.

The driver of the stolen car exceeded speed limits, roundabouts were taken the wrong way, a truck overtaken in hazardous conditions, red lights ignored, manoeuvring to the incorrect side of the road into oncoming traffic, speeding through built up areas. The driver of the truck that Mr Y targeted stated that no matter where he moved to avoid the collision the stolen car followed 'head on'.

The speeds reached and the style of driving caused the duty inspector to call an end to the pursuit. All this meant to the pursuing police was that lights and sirens were to be extinguished and that the stolen car could still be followed.

All police expressed this view and it was erroneously held. The intent of the Safe Driving Policy is to ensure that all police engaged in these incidents understand the strict protocols that attach to pursuits. In this instance the document failed. The definition of 'pursuit' and the definition of 'terminate' failed to impress on the police that a 'termination' of a pursuit simply means 'stop following'. Whilst the definitions in the policy appear, on the surface, to be clear in meaning, it was obvious that all police failed to embrace the 'stop following' concept. Police training did nothing to address what appeared an accepted and widely used practice amongst all police.

Their entrenched misunderstanding of the directive to 'terminate', exacerbated the danger, as the stolen vehicle was still being followed by the police vehicle **but without the use of warning devices ie lights and sirens.** This meant that the public were unaware of the dangers that confronted them.

Naturally all police involved in the pursuit were appropriately certified, however, Mr Y had no such expertise behind the wheel. We learnt he had a deep hatred of police, needed medication for treatment of his mental illness and was known to engage in substance abuse. Admittedly this was not known to police at the time, however it does show, in hindsight, that the stolen car, engaged in extremely dangerous manoeuvres, was being driven by an incompetent driver.

The coroner could not accept that there was a need for this pursuit to have endured for as long as it did, given the real danger it posed to other road users and indeed the police themselves.

It was an opportunistic taking of the vehicle. There were no warnings attached to the car ie it was not involved in robbery or any other serious incident. The car was easily identifiable due to the signs on the side.

The coroner stated that the retrieval of that stolen car with Coca Cola emblazoned on its sides was not worth the emotional and psychological impact that was visited on all those involved in the pursuit and subsequent death of Mr Y. The coroner accepted that there will need to be continued involvement of police in pursuits, however, there must be a balance between the need to continue a potentially dangerous police activity and the serious and possible fatal consequences that may flow from it.

The impact of Mr Y's tragic death was felt not only by his family, but it had a deep effect on the many police officers involved that night.

Finding

That [the deceased] died at 1.15 on 10 September 1999 near Cowper on the Pacific Highway, as a result of the motor vehicle he was driving, travelling onto the incorrect side of the Highway into the path of a semi-trailer. The deceased suffered multiple injuries and died instantly on impact.

Recommendations

1. That tyre-deflating devices be introduced for use by the NSW Police Service immediately.

2. That the NSW Police Service undertake a review of the safe driving policy 1999, to ensure the following:

a) The definition of "pursuit" includes all instances where a police officer in a vehicle follows a moving vehicle for the purpose of stopping and/or apprehending the occupants of that vehicle when the driver of that vehicle is attempting to avoid apprehension or appears to be ignoring police directions to stop.

b) The definition of "terminate" to mean "stop following".

c) The subject vehicle of a pursuit which has been terminated will not be the subject of another pursuit except with the prior approval of the Duty Operations Inspector (DOI), Senior Communications Officer (SCO) or Supervisor. Such approval is to be given only after information additional to that available at the time of the termination of the previous pursuit has been provided.

d) That the manner of driving of the offender, particularly any instances of erratic or dangerous driving, be included specifically as a matter upon which the primary response vehicle must provide frequent updates to the DOI, SCO or Supervisor.

e) If the primary response vehicle does not provide these updates, the secondary response vehicle has a duty to do so.

f) That officers engaged in pursuits which result in fatality or serious injury, not be required to undertake any operational duties until after the prescribed debriefing session.

g) That every police officer entitled to engage in pursuits be provided with a copy of the safe driving policy and that annual training in all aspects of the safe driving policy be provided to all officers engaging in pursuits on an annual basis.

1899 of 1999 **Male aged 36 years died on 11 September 1999 at Crest Park Parade, Queanbeyan. Finding handed down on 31 March, 2000 at Queanbeyan by Dr Elwyn Elms, Acting Deputy State Coroner**

The deceased was riding his motor bike in the main street of Queanbeyan, when he came under the notice of the police after committing a traffic offence. The police activated their warning lights and sirens and signalled a pursuit. After a short pursuit, lasting only 2 minutes over 2.5 kilometres, during which they lost sight of the deceased, they came across his bike which had apparently lost control, ultimately colliding with a stationary semi-trailer.

Issues

Were the police justified in initiating a pursuit?

1. The circumstances of the pursuit

The deceased (K) was observed by Sergeant I and Senior Constable K on his cycle in Monaro Street Queanbeyan at about 3.44 am on 11 September 1999 talking to a group of people near the taxi rank opposite the Royal Hotel whilst they were on patrol in the area. In driving off, K's rear wheel lost traction with the roadway causing it to 'fishtail'. He then raised the front wheel of the roadway and accelerated away.

Senior Constable B and Constable H were also patrolling the area in a police caged truck, Queanbeyan 19. For a short time, they were talking to I and K when the latter's vehicle, a General Duties sedan with the call sign Queanbeyan 12, pulled alongside them in Monaro Street. B and H also saw the cycle fishtail as it drove away. They did not see the front wheel raised in the air, which H attributed to the fact that they were almost directly behind the cycle, whereas I and K were viewing the incident from an angle. Subsequent inspection of the roadway did not reveal any tyre or burn marks where the cycle is said to have lost traction with the road surface. Nevertheless, the Coroner accepted that this and the raising of the front wheel did in fact occur.

The cycle accelerated away in Monaro Street. Either I or K activated the police vehicle's lights and siren, and I immediately signalled a pursuit from his stationary position, and followed. The bike drove down Monaro Street that becomes Farrar Place in the vicinity of the police station. At this point, he was observed by Senior Constable S from the police station doing approximately 100 kph, this being in a 60 kph zone in the vicinity of the city centre at a point only some 250 metres from where other witnesses saw the cycle in a stationary position. S also saw the police vehicle in pursuit.

I activated his siren and flashing lights. He said that the offence for which he was pursuing the cycle was driving in a manner dangerous. The Acting Deputy State Coroner (hereinafter called the Coroner) noted that riding or driving in such a manner as to cause sustained loss of traction to a tyre of a vehicle is an offence regarding which the legislature has of recent times enacted special laws to the effect that such an offence can result in the impounding of the vehicle.

The cycle continued accelerating until Farrar Place becomes Canberra Avenue, turned left into Tharwa Street and then drove into Crest Park Parade, where he topped a crest and the pursuing police vehicle lost sight of him. They also topped the crest and drove down Crest Park Parade where the road curves to the right.

There was an issue as to whether K in fact realised that he was being followed. Having regard to his full-face helmet and the roar of the cycle's engine and the distance between the vehicles, the various police officers who were asked to venture an opinion said that it was possible that he didn't. K was also heading to the place where he had arranged to spend the night. On the other hand, there is the piercing nature of the siren to be considered,

admittedly from some distance behind. For the purposes of the inquest, the Coroner proceeded on the basis that K was aware of the police vehicle's presence.

Constable K said that she looked down side streets to see if she could see the cycle, without success. Then she and I both saw what appeared to be, and in fact was, the tail light of the cycle up ahead. They stopped the vehicle adjacent to the cycle but did not immediately see K's body lying beside it and between the cycle and the tray of a semi-trailer. They thought that the rider had abandoned the possibly stolen cycle and decamped. They then became aware of his presence. K pulled down his dark jacket from the position where it was covering his white helmet. I called for an ambulance. A short time later ambulance officers attended, and were satisfied that K was deceased. Life was formally pronounced extinct at 6 pm at Queanbeyan Hospital. Blood tests later revealed a blood alcohol reading of .149 grams of alcohol in 100 millilitres of blood, a reading at which, according to Professor S, his riding ability would have been 'markedly degraded'.

During the pursuit, I had signalled the speed of his vehicle to VKG in Tharwa Place as 80 kph. The cycle was at no stage travelling less than 100 kph. I's own speed varied between 90 and 100 kph. At times when going around roundabouts, he was doing only 30 to 40 kph, which was the safest speed at which he said he could negotiate them. The cycle was able to attain much higher speeds by virtue of its greater manoeuvrability.

2. Was there any impact between the bike and the police vehicle?

One of the issues the inquest had to deal with was whether at any stage the police vehicle came into contact with the cycle, thereby possibly causing it to crash. The Coroner was satisfied that it did not. First of all, there is the evidence in statement form of the various civilian witnesses in the area. The Coroner then reviewed the evidence in statement form of a number of civilian witnesses whose evidence was unanimously to the effect that the police vehicle was significantly behind the cycle.

The scientific evidence corroborated this evidence. After the incident which resulted in K's death, Sergeant I requested that the police car be impounded. Minor paint scrapings were noticed on the front bumper bar. These were examined by a Forensic Scientist to see whether they shed any light on this issue. He concluded:

'The microscopic examination of the rubber from the rear tyre of the motorcycle revealed it to be black in colour, and very soft and pliable. The appearance of the residues from the bumper of the vehicle revealed them to be grey/black in colour and considerably harder in texture. The microscopic examination did not reveal any evidence to support the proposition that the material on the vehicle came from the motor cycle tyre'.

The forensic scientist used infra red spectroscopy in order to effect a comparative analysis and this came up with the same result. He concluded: "No evidence was found to support the proposition that the police vehicle had come into contact with the bike".

The Coroner was satisfied that at all material times other than when the pursuit began, the police vehicle was no closer than 200 - 300 metres representing about 10 seconds in point of time.

3. Was the Safe Driving Policy followed?

Under the Police Service's Safe Driving Policy, high speed urgent duty and pursuit driving are a last resort. "It shall only be engaged when the gravity and seriousness of the circumstances require such action and there are no other immediate means of responding".

Further, "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".

"Police officers are under no legal obligation to initiate a pursuit and in many circumstances the safety to the community and police will dictate that no pursuit be initiated. Similarly when a pursuit is considered by police to be dangerous it shall be terminated".

"When engaging in a pursuit, police shall 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".

When he was asked what factors he took into account in initiating the pursuit, bearing in mind that pursuits are an option of last resort, Sergeant I initially referred only to the offence, driving in a manner dangerous - a reference to the wheel's loss of traction with the roadway in the main street of Queanbeyan.

However, after further questioning he referred to the road conditions, the light traffic and to the fact that at no stage was he in a position to identify the alleged offender - he never got close enough to be able to get a registration number. He was, of course, a hundred metres back when the pursuit started. He was unable to identify the vehicle involved, and he activated his lights and sirens, which should have alerted the cyclist to his presence. He may have been overcautious in signalling a pursuit before one had really got under way.

He did not know at that stage, particularly after activating his sirens and flashing lights, that the offender was not going to stop. The Coroner accept that police officers will act according to their training and instincts in these situations, particularly when no danger to the community is perceived to be a factor. When a pursuit starts and the siren and flashing lights are activated in order to attract the offender's attention, the latter has the option of pulling over. Once such factors enter the equation - he does not pull over, the vehicle is identified or there is a danger to the police, the offender or others in the community who may happen to be on the roadway that evening - those factors are taken into account in deciding whether or not to call the pursuit off.

I called the pursuit at the first available opportunity. Senior Constable K thereafter responded to the questions that were asked by VKG. I had passed the tests for a gold classification, but was still recorded as silver. In his record of interview, he said that he had applied for gold, but this was not approved by his station commander. Being classified silver, he was entitled to participate in pursuits in the type of vehicle he was travelling in.

The speeds he attained were those that were necessary, but not excessive under the circumstances. K reported the speed at 80 kph in Tharwa. I said that he was doing 30 to 40 kph around roundabouts. The highest speeds he attained were 90 to 100 kph. He did not see the rider come to grief once they had come over the crest of the hill. The pursuit itself was short, lasting only some two minutes over a distance of 2.5 kilometres.

All things considered, the Coroner was satisfied that the procedures in the Safe Driving Policy were adhered to, bearing in mind all the above factors, and in particular the nature of the offence, the fact that the police never got close enough to be able to identify the vehicle, and the traffic conditions prevailing at the time which did not involve other members of the community, although they may have done so potentially.

4. Why were the family not notified earlier?

The accident happened at 3.46 am. The family were not apparently notified until about 8.00 or 8.30 am. Inspector B gave evidence that, since this matter was equated with a death in police custody, there was a great deal to be done in securing the accident scene. This may have led to the result that the family were not notified earlier than would have been the case if the death had occurred in other circumstances. K was not formally pronounced as deceased at Queanbeyan Hospital until 6 am.

The Coroner said that it was desirable that the family of a person who has died in such circumstances be notified at the earliest available opportunity. However, he could understand the circumstances that had led to the delay on this occasion

Consideration of possible recommendations

The Coroner noted that in a recent inquest 1122 of 1999 concluded at Parkes on 24 March 2000, he had made a recommendation that Patrol Data Recorders (In Car Videos) be installed in all police vehicles. All parties concurred in that recommendation. In so recommending, he commented upon the time, energy and expense occasioned by the investigating police having to do a doorknock of all houses in the area of the pursuit, and how this might be avoided were there a first hand record of the pursuit per medium of an In-car Video recorder.

But he said that there was an even more cogent reason why, in his opinion, such cameras should be installed, this being the public confidence in the administration of justice and law enforcement in this state. Members of the family of a person who has died in these circumstances are naturally concerned to have the best evidence as to the manner and cause of (in this case) their son's or husband's or father's death.

There is the concern, said the Coroner, that no matter how thorough the investigation, and how cogent the statement evidence obtained, family members may walk away dissatisfied with the results obtained. He noted that such concerns had been raised in an explicit or implicit manner in the last two inquests he had conducted concerning police pursuits. The Coroner said that it would go a long way towards addressing such concerns if there was a contemporary record of the events as they occurred by means of video film for all to see.

There had been a discussion in the Parkes matter as to whether the recommendation should be as regards all police vehicles or simply Highway Patrol Vehicles. The consensus favoured the former. The Coroner was comforted that the recommendation did also, bearing in mind that the police vehicle involved in this case was a General Duties vehicle.

During the hearing, Sergeant F from the NSW Police Academy said that no studies had yet been conducted in this State as to the effectiveness of police pursuits in the context of profiling high-risk offenders, that is those offenders who are prepared to take high risks in seeking to evade police pursuits. The Coroner said that he would make a recommendation that such a study be undertaken.

Findings

That [the deceased] died at 3.46 am on 11 September 1999 in Crest Park Parade Queanbeyan of the combined effect of head and chest injuries sustained then and there when the motor cycle he was riding left the roadway following a police pursuit.

Recommendation

That a formal study be undertaken by the Police Service of the profile of those offenders who take high risks in evading police pursuits.

Formal Comment

That the Minister of Police and the Commissioner of Police take whatever steps are necessary to ensure that Patrol Data Recorders are installed in all police vehicles as soon as practicable, as recommended in the Inquest concluded at Parkes on 24 March 2000.

1903 of 1999

Aboriginal male aged 37 years died on 11 September 1999 at Bathurst Correctional Centre. The finding was handed down on 19 May 2000 at Bathurst by Dr Elwyn Elms, Acting Deputy State Coroner

A group of aboriginal inmates were playing touch football on the X-Wing rear oval. Somewhere between 5 and 10 minutes into the third game, it was noticed that one of the inmates, S was down. At first, the other inmates thought he was just having a breather. After a short while, it was realised that the situation was more serious and the inmates asked Correctional Service Officers in the near vicinity to call the clinic for medical assistance.

Issue

Whether that assistance took too long to arrive.

Chronology

The Acting Deputy State Coroner (hereinafter referred to simply as 'the Coroner') found the relevant chronology to be as follows:

12.30pm Officer K drives Officer R to her post at 5 Tower; drives to post outside gaol - 45 inmates allowed onto X-Wing Rear oval to play football.

approx 1.30	Deceased fall to ground.
1.34	mate notifies R in Tower that 'guy injured' on the oval.
1.35 - 1.40	Officer B in control room receives telephone call from in Tower.
	B notifies Activities Officer C (*she says time 1.40 pm).*
	C and Officer M make way through sterile area to Oval - time elapsed two to three minutes. Inmate tells C to 'get the medical staff'.
	Inmate notifies Officer K outside fence that 'one of the blokes gone down'. Notifies R in Tower 'We've got a prisoner down'. She replies 'We know about it. It's under control.'
	B in tower notifies Nurses S and L in clinic to attend oval (*they say call received at approx 1.30 pm; Officer B says approx 1.35 pm).*
	S gets backpack. Officer B asks two female officers to bring stretcher from clinic.
	Area Manager T hears call from control tower requiring clinic staff to attend oval (*he says approx 1.40 pm).*. Enters Clinic. There for less than a minute. Emerges with Nurses S and L. Sees Activities Officer C.
	C returning from oval hears call over radio for security staff to collect two nurses from clinic and to attend rear oval.
	Officer B in Control Room sees C returning from oval. Asks C whether ambulance required. She uncertain.
	C arrives at clinic as Nurses S and L emerge from clinic. They follow C to main oval.
1.40	B in Control Room receives second call from R asking who was attending.
1.41	B calls ambulance not knowing whether one required or not.
Between 1.36 & 1.45	Officer K outside fence positions himself to get better view - inmate surrounded by other inmates. Looks at watch "few minutes sees T,S,L.B and C, "hurrying towards" group of prisoners. later" Sees them attend inmate on ground.
1.45	Ambulance Officers M and C receive call that Ambulance required.
1.47	B in Control Room radios to Area Manager T on main oval - informed that inmate unconscious. Second call to ambulance.
	T radios Area Manager 'C" to supply staff from X-Wing to man the X-Wing double gates to facilitate prompt ambulance access. Contacts control, tells them to get ambulance to enter via X-Wing. Goes to double gates separating X-Wing from rear oval - speaks with officers to ensure ambulance access.

Conversation re gates overheard by Officer K on radio.

1.49 Ambulance arrives at X-Wing gates. Drives through first set of gates after they were opened. Has to wait 'a few minutes' at second set of gates until they were physically opened by staff. Ambulance Officer M and ex-inmate A say 5 - 6 minutes before second set of gates opened.

1.55 Ambulance drives onto oval. Attend inmate and place him in ambulance.

1.59 Ambulance departs X-Wing gates.

2.15 Ambulance arrives at Bathurst Base Hospital.

2.23 S pronounced deceased.

Circumstances of death

The Coroner found that there was a delay in the order of five minutes and probably even longer before the other inmates called for assistance. In the initial stages, no one thought the problem to be anywhere near as serious as it in fact was, and it was only when it was realised that S had a slow pulse and his breathing was irregular that a decision was made to call medical staff.

When the clinic staff were called, they were not informed that they were responding to an emergency. When Activities Officer C arrived at the oval, she was asked simply to 'Get the medical staff'. Nurse L assumed they were responding to a sporting injury, but they took the backpack anyway because they took that everywhere when they responded to a call. It contained a variety of materials which as it so turned out were vital in the attempts to resuscitate S. One of those was Narcan. They also took an oxyvivor and a mobile stretcher.

Estimates varied as to the time it took for the clinic staff to reach S. R, an inmate, said it was ten minutes from the time he commenced giving the deceased mouth to mouth and twenty minutes from the time he first saw that someone was down on the oval. Assistant Superintendent T said that all up the journey would have taken four to five minutes. They had to pass through some eight gates, six of which had to be locked and unlocked. One officer had to run ahead and unlock those gates to allow free passage through. They were not running, but moving at a fast walk.

Nurses S and L estimated that the journey took in the order of ten minutes. The Coroner was satisfied that this was something of an overestimation. The Officer in Charge, Senior Constable M, walked the route and found it took four minutes and two seconds to walk the route to the top of the oval. All interested parties, including S's family, had the benefit of walking the route on a view on the first day of hearing, and had the opportunity to appreciate at first hand the distance from the clinic to the oval.

Officer B in the Control Room did not log the actual time he notified clinic staff to attend the oval. Assuming that this occurred on the basis of the evidence of other witnesses at between 1.35 and 1.40 pm, the Coroner was satisfied that they arrived at 1.45 pm or shortly thereafter. Bearing in mind the distance they had to travel and the number of locked gates they had to

traverse, Nurse S bearing an oxyvivor and backpack and another member of the party wheeling a stretcher, the Coroner was satisfied there was no undue delay.

He did not accept that the initial call to the clinic was made as early as 1.30 pm (evidence of Nurses S and L) as this conflicted with other objective evidence as to the time at which S fell and the delay which occurred thereafter before nursing staff was called. He was also satisfied that there was no undue delay in calling the clinic, and said that Officers R (in the Tower) and B (in the Control Room) acted with commendable promptitude. Officer K (in the car outside the wall) also did all that could be expected of him, armed as he was only with a radio and not a phone. He was also hampered by the mesh surround in getting a clear view as to what was actually happening on the oval.

The inquest heard evidence from Dr. C who performed the post mortem. He said the cause of death was ischaemic heart disease due to coronary atherosclerosis. The post mortem revealed severe narrowing of all three coronary arteries at their origin by mildly calciific atherosclerosis. The left anterior descending and right coronary arteries were particularly narrowed by atherosclerosis with pinhole size openings to their lumen, in lieu of a 3 to 4 mm diameter opening which one would expect. There was also severe narrowing of some of the tributary vessels.

Put simply, S's heart was being starved of oxygen, and he succumbed whilst under the stress of playing football. His irregular breathing, taking gasps firstly every few seconds and then every 30 seconds or so signified that he was in extremis when he was on the ground, and that even if he had collapsed in the emergency ward of a hospital, he would have been unlikely to have been resuscitated. Even if there was some delay in the clinic staff getting to the oval, and on the evidence before him the Coroner was satisfied there was no unreasonable delay, the probabilities were that S was beyond help in any event.

Traces of morphine were found in S's system: less than 0.05 mg per litre in the blood (preserved), which is not in the toxic or fatal range, and 0.9 mg per litre in the urine. According to the post mortem report, 'This suggests the deceased used heroin some time (within hours) of his death, however, the blood level is very low for morphine and probably resulted in no ill effects'. The fact that the morphine was in S's urine meant it was being excreted from his system and is consistent with an ingestion of the drug some hours before.

No puncture mark was found, but this could have been masked by the plastic tubes inserted into both elbows for resuscitation purposes.

The Coroner raised comment on the discrepancy in the evidence given by the Correctional Services Officers and the Ambulance Officers concerning whether the ambulance was delayed in entering the gaol. Officer B in the Control Tower said he controlled the opening of the gates to X-Wing, and was able to press the appropriate controls to enable those gates to open just as the ambulance arrived.

Ambulance Officer M said they had to wait a 'short time' at these gates. The Coroner said that there may be no necessary discrepancy here, and even if

there was, it was not significant. Of more moment was the delay while the second gates leading to the oval were opened. Ambulance Officer C said they had to wait a 'few minutes' at these gates. Officer M says the delay was in the order of five to six minutes. Inmate A also referred to a delay of about five minutes. According to the chronology, the ambulance arrived at those gates at 1.49 pm. Nurse S said it 'arrived' (on the oval) at about 1.55 pm, when they applied the monitors as CPR was continued.

Correctional Services staff say there was no delay at these gates, and in fact they were open to allow the ambulance direct passage. Those who attended the view in the presence of the coroner were informed as much, and Officer C later gave oral evidence to similar effect. The Coroner was satisfied there was a delay at these gates, which was unfortunate having regard to the ambulance's emergency mission.

Assistant Superintendent T seemed to have done all he could to ensure that that both sets of gates were opened in timely fashion. Nevertheless, there appeared to have been some hiccup at the final gate possibly associated with the manning of the gates. The Coroner did not see this as a matter for formal recommendations. The delay did not contribute to Mr. S's death, and Officers B and T did what they could to prevent obviate any delay. The coroner said that he would anticipate that staff would be vigilant in the future in allowing prompt access to an ambulance in similar circumstances.

The Coroner also said that it may have been of assistance if Officer K who was in the car outside the oval had access to a mobile phone and a list of emergency telephone numbers by means of which to call an emergency service such as the ambulance direct, instead of relaying a message second hand through the Control Tower. Had this occurred on this occasion, it would not have saved Mr. S, but it may serve to save someone in other circumstances. The Coroner did not make a formal recommendation to this effect, but left it as a comment made by him to be considered by the department.

Finding

That [the deceased] died shortly after 1.30 pm on Saturday 11 September 1999 on the X-Wing rear oval at the Bathurst Correctional Centre from ischaemic heart disease due to atherosclerosis.

247 of 2000[1]

Male aged 27 years died on 23 September, 1999 at Cliff Road, North Wollongong. Finding handed down on 24 October 2000 at Kiama by Janet Stevenson, Senior Deputy State Coroner

The deceased B was a fit young man of 27 who had participated in various sporting activities concentrating during the past few years on gym participation. During the past seven years he had had bouts of depression and attempts at suicide. His depression was increased over recent times due to an injury sustained at work which caused severe pain and a separation from his wife. He was also apparently using steroids from time to time - his body had the appearance of a person who had at times used steroids.

[1] *Previously file No. 994 of 1999 (at Glebe)*

B had regular visits to medical practitioners including a psychiatrist and at the time of his death had been assessed as being non-suicidal

The evening before his death he had been with friends and had been drinking heavily (he was later found to have a blood alcohol reading of .264). His mood altered and he appeared depressed. B drove his friends home and then returned to his unit at about 4am.

At about 5.11am B rang his mother and stated he was going to jump from the balcony. Mrs. B told him she would immediately come to his unit. At about this time, a woman in a unit block across from Mr. B saw him attempting to hang himself and called '000'. Two police arrived at the unit occupied by the witness in an attempt to discover the exact location of Mr. B. They called out to Mr. B from the witnesses balcony, but it is uncertain whether or not he heard police. Mr. B stood on the balcony with a sheet around his neck and jumped off.

The police officers ran from the unit block occupied by Mr. B and after a short period located the exact unit. At this time other police arrived but none of the police were able to gain entry. They obtained an axe from a nearby occupant and were then able to gain entry.

Police risked their lives by leaning over the balcony in a dangerous fashion during their attempts to lower Mr. B from his unit railing to the unit below. In the lower unit were other police who 'caught' Mr. B and lowered him to the floor. Unfortunately Mr. B was not able to be revived. The time from the time of police arrival at nearby units to the time of attempting to resuscitate Mr. B was approximately 10 minutes. At post mortem the finding was one of: Hanging with a significant contributing factor of Alcohol Toxicity.

Issues

Mr. B's family raised the following issues:

1) Whether police should have called out to the deceased?

2) Whether police should carry equipment in their cars to break down doors?

It became clear at the Inquest it was unlikely the deceased would have seen or heard the police. The actions of police at all times were proper and rational under the circumstances. They also risked their lives in an attempt to save the deceased. It was considered in this matter that a recommendation as proposed by the family should not be made due to the unusual nature of the case.

Finding

That [the deceased] died on 23 September 1999 at Wollongong, by hanging with significant contributing factor of alcohol toxicity.

1197 of 1999

Female aged 29 years died on or about 15 October1999 at Mulawa Correction Centre Silverwater. Finding handed down on 3 August, 2000 at Westmead by Janet Stevenson, Senior Deputy State Coroner

Circumstances of death

The deceased Z was a 20-year-old single mother was serving her first prison sentence, of six months, for larceny and breach of Community Service Orders having been sentenced on the 11 October 1999.

No member of Ms Z's family attended court when she received her sentence.

Ms. Z was a heroin addict and had unsuccessfully attempted detoxification in the past.

She had a long term relationship from which she had a three year old son.

Ms. Z was housed in the Induction Unit at Mulawa, and on the evening of the 14 October was placed two-out with another prisoner who was six months pregnant. She had been assessed at the Unit as not being suicidal.

Shortly after 12.30am Correctional Officer T shone his torch into Ms. Z's cell and saw the deceased hanging from a bar above the doorway into the cell. Ms. Z had used her 'sloppy joe' as a noose. T raised the alarm, lowered Ms. Z to the floor and commenced resuscitation. A Correctional Health Nurse assisted the officer.

The cellmate had been woken and removed to another cell during early attempted resuscitation.

Resuscitation continued until the arrival of ambulance officers who indicated Ms. Z was deceased. She had not shown any signs of life during attempted resuscitation.

The cell mate was interviewed and advised that following 'lock-down' the couple had some conversation and seemed 'a bit sad' following a telephone conversation earlier that day with her boyfriend. Apparently Ms. Z could hear her young son in the background. This sadness was noted by other prisoners.

The cell mate went to sleep about 9.15pm and later woke about 10pm and saw Ms. Z pacing whilst smoking a cigarette.

The couple spoke and the conversation turned to suicide. The cellmate believed this was just a general conversation but did ask Ms. Z whether she was all right. Ms. Z 'laughed it off' and agreed she was fine. Ms. Z did not appear in any way effected by drugs and was not seen with any whilst in the company of the cellmate.

The cellmate then returned to sleep.

Following her death police searched the deceased's cell and found an unfinished letter dated 14 October at 2pm. This letter made reference to the assault of another unknown prisoner that concerned the deceased but made no mention of suicidal thoughts.

The boyfriend of the deceased states reference was also made to the assault when the deceased spoke to him the day before. He also states the deceased made no indication of suicidal ideation.

At post mortem the cause of death was found to be hanging. No drugs were detected in her blood or other specimens.

Issues

Hanging point used is identical in many prison suicides at Silverwater.

No evidence of foul play- appears that the deceased was depressed over receiving her first sentence and ensuing loss of access to her son.

Question of 'hanging points' is on going and has been the subject of a number of previous Inquests. Department of Corrective Services attempting to find alternatives but difficult situation .

No criticisms made of actions of any persons who had dealings with Ms. Z whilst she was in custody.

No formal recommendations made.

Findings

That [the deceased] died on or about 15 October, 1999 died at Mulawa Correctional Centre, Silverwater when she hanged herself with the intention of taking her own life.

1221 of 1999 **Male 59 years died on 21 October 1999 at East Kurrajong Road, East Kurrajong. Finding handed down on 24 March 2000 at Westmead by Janet Stevenson, Senior Deputy State Coroner**

Circumstances of death

B was a 59-year-old man who lived with his wife at East Kurrajong. He had been suffering depressions for a number of years. Mr. B's treating physician telephoned Mrs. B on the 21st October, 1999 as following a call from Mr. B's brother he was concerned about Mr. B's mental state. Following a discussion with the physician, Mrs. B and Mr. B had an argument that was not assisted by the consumption of alcohol by Mr. B.

Mrs. B left for work at 7pm and the relationship between herself and her husband was strained at that time. At about 8.32pm Mr. B telephoned '000' on two occasions after his wife left the home and indicated to the operator that he was suicidal. The operator contacted police and ambulance and attempted to talk to Mr. B. Mr. B indicated he was going to suicide but wanted the police to come to the house and 'clean up before mum gets home'.

Police attended the house at about 9pm and it appears once Mr. B has heard them at the door he placed a rifle in his mouth and shot himself. Police and Ambulance personnel heard 'gasping sounds', entered the premises, and found Mr. B recently deceased. A suicide note was found in the kitchen.

This matter can be classified as a 'technical matter' as the deceased was awaiting the arrival of police before shooting himself. There was nothing in the actions of police or other personnel which calls for any criticism but highlights the difficult and unpleasant aspects of day to day policing.

Finding

That [the deceased] died on 21 October 1999 at East Kurrajong of a gunshot wound to the head, self-inflicted with the intention of taking his own life.

1296 of 1999 **Male aged 29 years died on 14 November 1999 at Lithgow Correctional Centre, Lithgow. Finding handed down on 15 June 2000 at Katoomba by Janet Stevenson, Senior Deputy State Coroner**

Circumstances of death

The deceased was serving a sentence of 4 years and 3 months for armed robbery offences. This commenced from the 5 August 1997 so at the time of his death he had 18 months to serve. He was not known to have suicidal tendencies and was in good health. He apparently was an occasional user of heroin.

Until recently the deceased's two sons had been in the custody of their mother but recently were placed in the custody of the deceased mother's care (that is, the maternal grandmother's care).

On the 13 November at 11.41 Mr. F's sister visited him bringing with her his two sons. One of the children, the youngest, had not been seen by his family for two years. Following the visit, Mr. F was seen to be quite elated however this mood deteriorated and at 3.15pm he approached a Correctional Officer to permit him to go 'two out' with another prisoner.

This was agreed to and the deceased was placed with Mr. L. During the early evening, the men talked generally about matters and at 6pm the deceased produced a syringe and injected himself. He vomited a short time later.

The men continued to talk until 6.30pm when the deceased lay on his bed and began to snore. The snoring of Mr. F kept his cell mate awake with Mr. L falling asleep between 2am and 4am on the 14 November.

The following morning at 8.20am the 'let go' procedure commenced. Mr. L's cell door was opened and staff saw Mr. F asleep on the bed and Mr. L asleep on a mattress. Upon being called, Mr. L awoke but the deceased did not. Mr. F exhibited no signs of life and had been deceased for some time.

A search of the cell revealed only the used syringe. No other drugs or drug paraphernalia was located.

Post mortem findings

Acute Narcotism

Inquest Issues

Nil

Findings

That [the deceased] died on 14 November 1999 at Lithgow Correctional Centre, Lithgow of Acute Narcotism self administered.

2609 of 1999

Female aged 17 years died on 22 December, 1999 at Royal North Shore Hospital, St Leonards. Finding handed down on 28 April 2000 at Glebe, by John Abernethy, State Coroner

Circumstances of death

At about 9.10pm on 20 December 1999, the deceased was in the left front passenger seat of a vehicle which was being pursued by police after a radar speed check. The vehicle was being driven by a 19 year old female. Police radio at Newcastle was informed of the pursuit. Soon after police terminated the pursuit due to the manner of driving by the offending vehicle and informed police radio of the same. Some time later this vehicle crossed over to the incorrect side of the road, colliding with a vehicle travelling in the opposite direction.

Immediately upon impact the offending vehicle rolled onto its roof. A police officer at the scene and a member of the public removed the two female occupants prior to the vehicle igniting.

The deceased was taken to Gosford Hospital, then transferred to the Royal North Shore Hospital for treatment. The deceased had sustained a serious head injury and died on 22 December 1999.

Inquest

Advice has been received that person has been charged with an indictable offence in relation to the death of Ms. M. In those circumstances the inquest was terminated under the provisions of Section 19 of the Coroner's Act, 1980.

4 of 2000

Male aged 31 years died on 1 January, 2000 at St Vincents Hospital, Darlinghurst. Finding handed down on 31 October 2000 at Glebe by Jacqueline Milledge, Deputy State Coroner

This was an inquest into the death of Mr C, a thirty-one year old man who fell to his death from Level 14 of a Darlinghurst Hotel. Prior to him falling to his death, a drug affected Mr C had assaulted hotel patrons and staff and police were called for assistance.

When police arrived they briefly spoke to Mr C at his hotel door on Level 14, however, he suddenly slammed the door in their face, bolting and locking it behind him. When police were attempting to gain entry with a master key, he fell from the 14th floor balcony in an effort to escape them.

As a result of this, it was determined that this death was during a 'police operation' and therefore governed by the provisions of Section 13A of the Coroner's Act.

The Facts

Mr C and friends had secured a room in the hotel for New Years Eve. The group was partying and most were engaged in drug taking. Mr C was seen by witnesses to use many different drugs during the course of the night. One witness saw him 'snorting on a least two or three occasions'. His girlfriend stated she saw him use speed, cocaine, ecstasy, Valium and alcohol. Other friend said Mr C had use these types of drugs and more on other occasions.

The forensic pathologist states in his report '(the body) revealed toxic levels of methamphetamine in the blood'. He further opines 'methamphetamine levels as seen in this case are known to cause changes in ideation and behaviour in a percentage of individuals'. The deceased's friends confirmed that when he took drugs he became paranoid.

Prior to police arriving, Mr C had stripped naked. Argued with his girlfriend pushing her into a wall. Assaulted his male friend when he went to assist the young woman. Mr C ran into the corridor on the 14th floor and turned on a family of tourists, smashing the teenage sons head into the wall and breaking items on a trolley.

He assaulted a hotel staff member when he approached him to assist and other staff members were extremely frightened and concerned at his behaviour. Despite the obvious dangers, all hotel staff acquitted themselves very well indeed to ensure the situation was contained and patrons not put at risk.

When police arrived, an ambulance team was there to attend to Mr C's victims. One Constable was on street level watching Mr C pelt items from the balcony onto the street below where a large crowd had gathered.

Amongst the items thrown was patio furniture. Whilst this was happening other police had manoeuvred into the hallway outside his room attempting to conceal themselves. A senior officer knocked on the door and it was opened by a naked Mr C, who on glimpsing the hidden police in a lift mirror, told them to 'Fuck off' and slammed the door closed.

Police secured the master key, broke the chain lock and gained entry into the room. Mr C had barricaded the door to his bedroom where he accessed the balcony.

As police were pushing into the room Mr C was seen by others below to climb onto the balcony railing, lowering his body down and trying to swing his lower torso into the balcony below. Sadly he fell to the ground hitting his body on the railings of other balconies as he fell.

Witnesses described the fall as 'heavy' causing a crater effect in the garden where he came to rest. Mr C did not die instantly. The ambulance officers that were already on hand were able to attend to him and transport him quickly to hospital. Mr C died in hospital.

The Issues

The family had many issues relating to the death. All concerns were addressed during the course of the inquest.

Amongst other things, the family failed to accept that Mr C was a voluntary drug user. The autopsy findings and the evidence of his long standing friends clearly indicate he was a long term user of all types of drugs.

The family believed he had been pushed or thrown over the balcony. The police evidence is very clear that there was no one else in the room when he fell and that he was alone on the balcony when he made the decision to climb

down the balcony. The pathologist found no evidence of injury that would suggest force or an assault prior to the fall, other than the multiple injuries he sustained as a result of his descent.

Mr C's mother and aunt stated the delay in notifying them of the incident, led to Mr C dying in hospital without them being there. Police records show that the mother did not respond to the police visit and police had to take extra time locating a family member. They found the aunty living close by and informed her. The time of death recorded by the hospital suggests that even if the mother had responded at the earlier time, it would still have been too late to see her son before death.

The Coroner commended the hotel staff for the very good approach they adopted during this incident. One very thoughtful police officer re-assured staff that they were 'doing a good job' during the event. This sensible and generous acknowledgment by the constable did a great deal to help them cope in extreme circumstances. Not only was the police response timely and appropriate, but the coroner stated "the police that dealt with that incident are police that the constabulary can certainly be proud of".

Finding

That [the deceased] died at 3.08pm on 1 January 2000 at St Vincents Hospital. The cause of death being multiple injuries sustained when he fell from the 14th floor balcony of the Saville Park Suites, Oxford Street, Darlinghurst. It was death by misadventure when he tried to climb from the 14th floor balcony to the 13th.

Further comment

The Coroner is satisfied that the police response to the original incident was timely and appropriate.

48 of 2000

Male aged 67 years died on 9 January 2000 at Westmead Hospital. Finding handed down on 29 June 2000 at Westmead by Janet Stevenson, Senior Deputy State Coroner

Circumstances of death

The deceased was serving a sentence of life imprisonment for the murder of his wife. He was permitted day leave to stay with his daughter.

Mr. L had always used a walking stick whilst in custody due to an injury to his back in 1975. His health had deteriorated over the years he had spent in custody. He had limited skills in English but was able to communicate with staff. If he ever felt unwell he would present himself to nursing staff for medication. He was on medication on a full time basis for psychiatric problems.

On the 6 January the deceased was treated by nursing staff for a vomiting attack. This did not prevent him from taking his day leave on the 7 January as he was quite excited about this. (Such leave was a precursor to being paroled). The deceased left the correctional centre in a wheel chair as he found it difficult to walk. He was driven from the gaol by his daughter.

Due to the deceased's ill health, he immediately went to bed when he arrived at his daughter's. The next morning the deceased had become more unwell and an ambulance was called. When the ambulance arrived the deceased was unconscious and CPR attempted. Upon arrival at Westmead Hospital, Mr. L was placed in Intensive Care where he was found to have an acute myocardial infarct. An angiography and angioplasty were undertaken and it was found a right coronary artery was occluded.

The deceased was placed in coronary care overnight and later found to have had a further cardiac arrest. The deceased was pronounced life extinct at 3.30pm on the 9 January 2000. The post mortem finding was of Acute Myocardial Infarction due to Coronary Thrombosis.

Issues

Should Corrections Health have known of the deceased's heart condition?

Inquest

At Inquest it was ascertained that the deceased had never during his time in custody complained of any symptoms of heart disease although he had been in custody since 1987. The treatment afforded the deceased was proper and no criticisms could be levelled at any person in relation to the treatment of the deceased.

Findings

That [the deceased] died on 9 January 2000 at Westmead Hospital of Acute Myocardial ischaemia due to Coronary Thrombosis whilst on day leave from the John Maroney Correctional Centre, Windsor.

68 of 2000 **Male aged 21 years died on 16 January 2000 on the M5 Motorway, Ingleburn. Finding handed down on 13 March 2000 at Westmead, by Janet Stevenson, Senior Deputy State Coroner**

Circumstances of death

The deceased was a passenger in a white Isuzu truck that was travelling in a northerly direction upon the M5 Motorway at Ingleburn. A stolen Holden commodore was travelling at high speed in the same direction after avoiding a random breath testing station.

The stolen commodore veered right into an unidentified semi trailer and then left towards the Isuzu truck in which the deceased was a passenger. As a result the Isuzu has hit the guardrail and rolled onto its left side and then struck one of the concrete pillars on the Campbelltown Road over bridge. It is believed Mr. S died instantly as a result of injuries received in the accident.

Inquest

Advice has been received that a person has been charged with an indictable offence in relation to the death of S. In those circumstances the Inquest was terminated under the provisions of Section 19 of the Coroners Act, 1980.

463 of 2000 **Aboriginal male aged 19 years died on 3 March 2000 at Cessnock Correctional Centre, Cessnock. Finding handed down on 11 August 2000 at Cessnock by John Abernethy, State Coroner**

This 19-year-old single prisoner hanged himself on the afternoon of 3 March 2000 in his cell, 4334 of 4 Wing at the Cessnock Correctional Centre, Cessnock.

He had a history of self-harm and had attempted suicide on a number of occasions from a young age, though not in the recent past. He had spent much of his teenage years in Juvenile Justice facilities and latterly, prisons. In fact he had served a long sentence of 2.5 years as a Juvenile, for a serious offence. An additional period of 2.5 years had been imposed. The nature of that offence would have had a bearing on his relationships with other inmates at Cessnock, and also with those responsible for his safe custody. The prisoner served his first adult sentence during the second half of 1999, largely without incident. He was not in prison over Christmas, 1999.

On 31 January 2000 the prisoner received a sentence of 9 months (minimum term), with a period of 3 months by way of additional term. He had been received into custody, bail refused on 1 January 2000. He was due to appear at Maitland Local Court to face further charges on 6 March 2000. In essence, at the time of his death, the prisoner had served his one month sentence from 31 January 2000; he was serving a sentence of 9 months by way of minimum term, from 31 January and was due for release on parole on 30 October 2000. On completion of his custodial sentence he was due to serve the balance of his parole in respect of the serious offence committed as a juvenile. In practical terms, it is likely that the time served would have counted, especially if he were to have received a further sentence in respect of the pending matters.

The deceased had, some years earlier, been diagnosed as suffering from Attention Deficit Disorder and saw a variety of medical practitioners. He often harmed himself, usually by slashing his left arm, perhaps because of problems with other inmates, perhaps to attract attention, and certainly in order to obtain what he may have wanted at the time. Self-harm may also have been a way of relieving stress. The behaviour of the prisoner in this regard was most impulsive.

During his current term of imprisonment the prisoner spent two periods in the Acute Crisis Management Centre (ACMU), a small Wing housing only ten cells. The Unit is intended only for inmates who are deemed to be in crisis. It is intended to be used for short periods as it is Spartan in the extreme, consisting virtually of a series of "safe" cells fronted by "Lexan", a form of plexiglass. Prisoners are monitored or checked every ten minutes and have virtually no privacy. In the case of this prisoner there had been a number of incidents of self-harm and mutilation.

The prisoner first spent 17 days in the ACMU, and after assessment was discharged to Wing 4 Strict Protection on 17 February 2000. After 7 days a further incident of self-harm necessitated his re-admission on 24 February 2000. After assessment by the Risk Intervention Team he was again released

to 4 Wing Strict Protection on 3 March 2000. He took his own life on his return to a cell in 4 Wing, having declined to share a cell with another inmate.

This prisoner gave no indication to any of those who saw him on 3 March 2000, of an intention to take his life, a decision which was surely spontaneous. After his evening meal he took a bed sheet and fixed it to a metal support above the door. He took a milk crate which was being used as a bed leg and used it to stand on. The State Coroner was satisfied that the prisoner took his own life.

Issues

1. Aboriginality

The prisoner described himself as being of aboriginal descent. There was a suggestion from the family of aboriginality. The State Coroner took the view that it was appropriate to deem this case an aboriginal death in custody.

2. Notification of a Death to the Family

An officer of the Department of Juvenile Justice, working at the Mt. Penang Juvenile Justice facility, and who knew the mother of the deceased, obtained appropriate permission and telephoned the mother as a support person. Unknown to her the family had not been officially notified of the death and the telephone call upset the mother in particular. The Department of Corrective Services protocols involve personally informing the next of kin of a death, and this in fact occurred after some three hours had elapsed. The State Coroner was of the view that three hours was an acceptable period in the particular circumstances of this case. He felt that notification, officially, by telephone was not preferable to personal notification.

3. Death in Custody Protocols

All were carried out correctly.

4. Hanging Points

From photographs taken of the cell the coroner noted many hanging points, particularly at the shelving and bed, but also grilles at the door and window. The hanging point utilised by the deceased had been removed after the death.

The State Coroner said:-

"The hanging points are of considerable concern but I have been consulted in relation to hanging points generally and have recently received advice from the Commissioner, (in implementation of an earlier Coronial recommendation) that the Department is gradually taking steps to minimise hanging points. In particular there have been intense discussions with architects and planners of new and renovated prisons with a view to their elimination or minimisation. As I have so often said the Department must tread a "fine line" between prisoner safety and humanity. The punishment is deprivation of liberty and prisoners cannot be kept in cells so austere as to amount to cruel and inhumane treatment. I am satisfied, at this stage, that the Department is working hard to achieve that balance."

He noted that the bed was on milk crates because of persistent damage to the legs by prisoners. Steps were being taken to install firmer beds, but the problem was difficult to resolve completely.

5. Threats of Other Prisoners

The prisoner was satisfied that threats by at least one other prisoner would have amounted to stressors to the deceased. Even in protection prisoners could be "got at" by word of mouth.

6. The Decision to transfer the prisoner from the ACUM back to Strict Protection. Interaction between ACMU and Wing on transfer of a prisoner back to the Wing

The Coroner heard evidence from a psychologist of the Department of Corrective Affairs, from the prisoner's Juvenile Justice Supervisor and from the Acting Chief Executive Officer of the Corrections Health Services. He also heard from the Acting Director, Inmate Services and Programs, Department of Corrective Services. To an extent these witnesses provided corroborative expert evidence. On all the evidence he found the deceased to be a most impulsive young man who had been seen throughout his teenage years by a plethora of medical "experts", none of whom had treated him for long periods. He was satisfied that the prisoner needed a long period of intensive psychotherapy but doubted that he would be able to cope with such a program either within or outside the corrections system.

He was satisfied that the assessment of the ACMU was accurate and that the prisoner was over the acute phase of his crisis when transferred to a Wing. He appeared happy, active and in fact supportive of other prisoners. He appeared to be over the acute phase of his crisis. The prisoner agreed with the assessment that he could return to the Wing, and gave no indication at all that he might self-harm or take his life.

Whilst the Prisoner's case management file went with him to the wing, it was not seen by the Wing Officers on his landing. The Coroner found it unlikely that a reading of the Discharge Summary would have made any difference to the outcome.

Importantly the Coroner found that since this death the Governor of the institution has focussed more closely on the transfer of prisoners from the ACMU to the Wings and is, where possible, attempting to house all relevant inmates two out initially. He made the point that that can be difficult to arrange with Strict Protection inmates as they are few in number and their relationships with other prisoners can be a problem. The Coroner was satisfied that it is the intention of the Department to implement the Governor's strategy globally through a "Through Care" system whereby inmates such as the deceased will be given more intensive opportunities to develop problem solving skills on discharge from an ACM Unit. One strategy will be to transfer prisoners to the Waller Unit at the Long Bay Complex of Prisons; another will be to arrange more intensive counselling locally; yet another will be to embrace family and peer support to a greater extent. The State Coroner said, in this context:-

"To me, this is heartening and absolutely necessary if the Department is to continue to reduce its rate of deaths in custody as it has managed to do over the past twelve months.

7. Links with Juvenile Justice

In an earlier inquest (7.10.1999 - 1881 of 1998 (also a Cessnock case)) the State Coroner made the following recommendation in a case which also involved a 19 year old with extensive involvement with the Juvenile Justice System:-

"That the Department of Corrective Services and the Juvenile Justice Department formulate a written protocol for the sharing of critical welfare, safe custody and other relevant information with respect to any prisoner/young person who has come into the care of either agency, as a matter of urgency."

He noted that in this case, ad hoc information had been received from Juvenile Justice (sought by both CHS and DCS but not volunteered by JJ) whilst there had been none in the earlier case. He accepted the evidence of a senior official of the Department of Corrective Services and noted that at present ongoing discussions are being held between the DCS, CHS and JJ with a view to implementing appropriate protocols.

With a high incidence of Juvenile prisoners entering the adult system, the State Coroner saw it as vital that information sharing protocols be implemented as a matter of urgency. In view of his earlier recommendation he stopped short of making a further recommendation.

Finally the State Coroner found that an officer of the Department of Corrective Services may have released details of the "serious offence" in respect of which the prisoner had been incarcerated as a juvenile. He recommended that the Department investigate the matter and discipline the officer if necessary. He recommended that departmental spokespersons be reminded that such information is never to be released.

Finding

That [the deceased] died on 3 March 2000 in Cell 4334, 4 Wing, Cessnock Correctional Centre, Cessnock, by hanging with the intention of taking his own life.

Recommendation

That the Department of Corrective Services investigates the issue of whether or not a spokesperson of the Department gave details of juvenile criminality of an inmate to the press following the death in custody of Mr. L; that the Department of Corrective Services considers reminding all spokespersons that such information is not to be published.

453 of 2000 — A male of 30 years on 4 March 2000 died at Goulburn Correctional Centre, Goulburn. The finding was handed down on 25 August 2000 at Goulburn by John Abernethy, State Coroner

The deceased, a 30-year-old Caucasian male was convicted of a number of offences at Maclean Local Court on 12 November 1999. He was sentenced

police station and charged with three counts of assault. Police also obtained a telephone interim apprehended violence order which, inter alia, precluded the deceased from returning to his home. The deceased was granted bail.

On the morning of 11 March, 2000 the deceased's defacto again called police to report that the deceased was in the grounds of their home contrary to the telephone interim order. When confronted by police officers the deceased threatened to drink from a container containing arsenic if the officers came any closer. He then proceeded to do so and despite the timely action of officers in using capsicum spray and providing immediate transport to hospital the dosage consumed was lethal.

The deceased had a history of suicide threats and attempts. This fact was noted as a warning on the COPS System. However, neither of the police officers that processed the deceased following his arrest on 10 March 2000 noted that warning. The COPS System was also accessed on 11 March 2000 by the telephonist who took the call from the deceased's defacto. She did not note the warning either. Nor did she, as required by the standard operating procedure for communications groups re domestic violence, ask the caller about the mental state of the deceased. Consequently, the officers who confronted the deceased on 11 March 2000 were unaware of his suicidal tendencies.

Issues

1. Reading of Warnings Entered into the COPS System

The Coroner noted that it was clear from the evidence that two proficient police officers and one proficient civilian working as a telephonist/despatcher did not open up the warnings on the COPS System that applied to the deceased. Significantly, the warning spoke of suicide ideation, mental illness and violence towards police. The warning was of particular relevance given that this was a domestic violence matter. However, the Coroner noted that, on the evidence, this failure of personnel to read the warnings about the deceased in all probability made no difference to his taking his life. He had for a long time suffered from a variety of disorders and had either attempted or threatened suicide on many earlier occasions. The Coroner emphasised that the issue of reading warnings on the COP System was important as, more often than not, they were there for the protection of police themselves.

2. Domestic Violence Standard Operating Procedures (SOPS)

The relevant SOP in March 2000 contained a long list of requests which telephonists needed to make of a caller, including whether or not mental illness was an issue. The Coroner found on the evidence that the telephonist engaged in the call-out on 11 March 2000 did not make any request in relation to mental illness. The evidence also disclosed that the telephonist did not have the current SOPS in a handy position to use as a checklist. The Coroner indicated that while he would not make a recommendation on this issue he asked the Police Service to ensure that checklists were available. He also indicated that he wanted advice as to the implementation of this in due course. The Coroner did note, however, that the telephonist's failure to follow the SOPS did not alter the outcome of the matter.

In the course of the inquest the current Domestic Violence Policy and Standard Operating Procedures document was tendered. The Coroner noted that the document was deficient in that it did not clearly delineate the duties of police officers, telephonists and despatchers in Domestic Violence call-outs, so far as they may differ. He called for the document to be amended accordingly.

Finding

That [the deceased] died on 11 March 2000 at Tumbarumba District Hospital of arsenic poisoning ingested earlier that morning under a house at Tumbarumba, with the intention of taking his own life. The arsenic was ingested in the presence of two officers of the New South Wales Police Service who had been called to the premises.

Recommendations

1. That the New South Wales Police Service considers the feasibility of altering the COPS System so that wherever there is a warning against an individual, those accessing data about the individual must open (and read) that warning.

2. That the New South Wales Police Service considers making it mandatory that all users of the COPS System open and read warnings entered on the system when they are accessing the system.

3. That all Police and civilians using the COPS System be reminded of the need to read the text of warnings entered on the system.

4. That the New South Wales Police Service urgently amends its document "Domestic Violence Policy and Standing Operating Procedures" by listing therein not only the duties of police officers, but also the duties of telephonists and despatches.

298 of 2000 **Male aged 30 years died on 19 March 2000 at Silverwater Correctional Centre, Silverwater. Finding handed down at Westmead on 13 June 2000 by Janet Stevenson, Senior Deputy State Coroner**

Circumstances of death

The deceased was under minimum security serving a sentence for drug offences. He was due to be released on the 28 July 2000. At approximately 4pm on Sunday 19 March, 2000 the deceased was located by prison staff in the gym area, unconscious with head injuries. It appears that the prisoner has sustained a blow to the head with a rock that was located in close vicinity to the body.

Finding

Advice has been received that a number of persons have been charged with an indictable offence arising from the death of Mr M. In those circumstances the Inquest was terminated under the provisions of Section 19 of the Coroners Act, 1980.

312 of 2000 **Male aged 29 years died on 24 March 2000 at Luxford Road Shalvey. Finding handed down on 14 June 2000 at Westmead by Janet Stevenson, Senior Deputy State Coroner**

Circumstances of death

The deceased was the front seat passenger of a vehicle involved in a high speed police pursuit along Palmyra Avenue, Willmot. The vehicle turned into Luxford Road (on the wrong side of the road) and headed north.

The pursuit was terminated by police but the vehicle continued at high speed on the wrong side of the road. A short time later the vehicle collided with an oncoming vehicle at the intersection of Halmahera Street and Luxford Road, Lethbridge Park. As a result of the collision, the deceased was trapped by his legs and upper body against the dashboard and door of the front passenger side. Mr. C was taken to Mt. Druitt Hospital where he died at 5.10pm on the 24 March 2000.

Findings

As a known person was charged with an indictable offence arising from the death of Mr. C, the Inquest was terminated under the provisions of Section 19 of the Coroner's Act, 1980.

1107 of 2000 **Male aged 14 years died on 7 June 2000 at St George Hospital, Kogarah. Finding handed down on 29 September 2000 at Glebe by John Abernethy, State Coroner**

Mr T was a front passenger of a vehicle which had been allegedly stolen. Police sighted the vehicle on the 6 June and again on 7 June. ON sighting the vehicle on 7 June police commenced a pursuit. Some time later the pursuit was terminated by the Duty Operations Inspector. The vehicle allegedly continued at speeds in excess of 100km/h and crossed an intersection through a red traffic signal. The vehicle appeared to have lost traction on the uneven road surface, causing the vehicle to skid sideways until the passenger side collided with a telegraph pole. The deceased was trapped in the vehicle an had to be cut from the wreckage.

The deceased was later conveyed to St George Hospital, where life was pronounced extinct.

Finding

As a known person was charged with an indictable offence arising from the death of Mr. T, the Inquest was terminated under the provisions of Section 19 of the Coroner's Act, 1980.

884 of 2000 **Male aged 25 years died on 5 August 2000 at Pitt Street, Merrylands. Finding handed down on 31 October 2000 at Westmead by Janet Stevenson, Senior Deputy State Coroner**

Circumstances of death

On 5 August 2000, the deceased was the front seat passenger being driven in

Pitt Street Merrylands. The vehicle was sighted by a police patrol car which signalled it to stop. The vehicle accelarated and disobeyed a red traffic control signal, it then lost control and crashed into a tree on the footpath.

The deceased was severely injured and trapped within the vehicle. He apparently died within 3 - 5- minutes after the collision.

Inquest

Advice has been received that a person has been charged with an indictable offence in relation to the death of M. In those circumstances the inquest was terminated under the provisions of Section 19 of the Coroner's Act.

1800 of 2000

Male person aged 22 years died on 5 September 2000 at Elizabeth Street, Sydney. Finding handed down on 12 October 2000 at Glebe by John Abernethy, State Coroner

At about 9.00pm on Tuesday 5 September 2000, the Mr B was the driver of a stolen white Toyota Corona sedan, at the time being followed by police from the Endeavour Region Anti-Theft. The vehicle became stationary in King Street about 10 metres west of Elizabeth Street, Sydney.

Police approached the vehicle, a shot was fired striking the Mr B and causing his death.

Finding

Advice has been received that a person has been charged with an indictable offence in relation to the death of Mr B. In those circumstances the inquest was terminated under the provisions of section 19 of the Coroner's Act, 1980.

The following matters were referred to the coroner under section 13A of the Coroner's Act, 1980. Although technically the deaths did not take place whilst the deceased was in custody, the event which caused the death was whilst they were in custody.

700 of 1999 **Male aged 56 years died on 15 June, 1999 at Nepean Hospital, Penrith. Finding handed down on 15 June, 2000 at Westmead by Janet Stevenson, Senior Deputy State Coroner**

Circumstances of death

P has been sentenced to life imprisonment for murder in 1969. Since that time he had been allowed out of prison at various times on license but returned to custody when he had committed other offences. His sentence had been re-determined in 1998 to a term of 34 years expiring on the 11 October 2002 with an additional life term. An appeal was made regarding re-determination. On the 8 June Mr. P who was 'one out' was treated by Correctional Health Staff for the symptoms of influenza.

The following morning shortly after 'let go', their was a knock up call from Mr. P's cell. Nursing staff attended where he was found to be unable to talk, with eyes open and able to move his arms. He was transferred to Lithgow Hospital and later Nepean Hospital where he was placed in intensive care. He was diagnosed with Pneumococcal Meningitis and placed on life support. This was withdrawn on the 15th June and life pronounced extinct at 8.35am. Due to his imminent demise and in accordance with Section 25A of the Sentencing Act, 1989, the deceased had been granted parole on the day of his death.

Post mortem Findings: Pneumococcal Meningitis

Inquest Issues

Was this matter a 'Death in Custody'? Was parole granted to avoid the situation of a death in custody? Although technically, the death did not take place whilst the deceased was in custody, the event which caused his death occurred whilst he was in custody. He was 'released' from that custody whilst on life support at hospital and because he was shortly to die. This matter of parole was unusual though not improper. At a short Inquest, the actions of Correctional Health Staff were canvassed and actions taken by all staff were without criticism.

Finding

That [the deceased] P died on the 15 June 1999 at the Nepean Hospital, Penrith of Pneumcoccal Meningitis.

1030 of 2000 **Male aged 27 years died on 23 July 1999 at Gateshead. Finding handed down on 13 October, 2000 at Glebe, by John Abernethy, State Coroner**

On the evening of 23 July 1999, the deceased was drinking at a Hotel with members of a motorcycle club of which he was a member.

Mr L was last seen riding towards the Pacific Highway. On 25 July, Mr L was reported missing and later that evening, police officers were patrolling Oakdale Road when they noticed tyre tracks and bushes knocked down.

The police officers located the motorcycle and deceased in bushland.

Police from Newcastle Police Rescue and Hunter Crash Investigations attended the scene and the deceased was conveyed to Newcastle mortuary.

Finding

The Coroner is satisfied that this can be assessed as NOT being a section 13A death and is satisfied that the manner and cause of death are clear.

Inquest dispensed with on 13 October 2000 at Glebe by John Abernethy, State Coroner.

1778 of 1999 **Male aged 22 years died on 24 August, 1999 at Prince of Wales Hospital, Randwick. Finding handed down on 27 November 2000 at Glebe, by John Abernethy, State Coroner**

Preamble

Mr B was an inmate of the Metropolitan Medical Transient Centre (MMTC) prior to his death. As the name implies, the centre holds prisoners who are moving to and from the hospital.

Facts

He was granted unconditional bail whilst extremely ill, unlikely to survive and whilst a patient at the Prince of Wales Hospital, Randwick. In those circumstances his death is not for statistical purposes a death in custody though the Coroner has ensured that it was investigated as one. As the Coroner understands, the family of the deceased wanted him to die "out of custody".

The State Coroner is satisfied that the deceased received extremely competent and caring psychological counselling. He is also satisfied that any number of prisoners could have given the drugs to the deceased.

The Coroner States that Mr B did not commit suicide but probably took the drugs in order to be taken to the Long Bay Hospital - or at least for his own ends.

The State Coroner found that there is no issue of criticism of either the Department of Corrective Services or of any individual officer of these institutions.

Finding

That [the deceased] died on 24 August 1999 at the Prince of Wales Hospital Randwick, of hypoxic brain damage, following an overdose of prescription drugs (Venlafaxine, Propranolol and Amitriptyline) on 22 August 1999 whilst the prisoner was on remand in the Metropolitan Medical Transient Centre, Long Bay Complex of prisons.

This matter has been assessed at inquest as not being a death in custody as the prisoner died in the Prince of Wales Hospital, Randwick having, in extremis, being granted unconditional bail.

The next of kin were happy that the deceased did not die in custody.

Appendix 1:

Summary of inquests heard or terminated in 2000

File No.	Date of Death	Place of Death	Date Completed	Age	Manner of Death	Death in custody/ police operation	Place of Hg.
753/98	15/04/1998	Bellingen	20/04/2000	36	Hanging	Police cells	Pt Macq/Glebe
776/98	18/04/1998	Grafton	26/06/2000	39	Hanging	Prison	Grafton
856/98	22/04/1998	Silverwater	23/02/2000	22	Hanging	Prison	Glebe
872/98	01/05/1998	Silverwater	07/07/2000	20	Hanging	Prison	Glebe
1719/98	24/08/1998	Goulburn	04/04/2000	22	Stabbing	Prison	Glebe
2351/98	20/11/1998	Coffs Harbour	15/02/2000	39	Shooting	Polic Operation	Coffs Harbour
2423/98	01/12/1998	Goulburn	25/08/2000	34	Hanging	Prison	Goulburn
108/99	07/01/1999	Cessnock	02/03/2000	20	Hanging	Prison	Raymond Terrace
73/99	10/01/1999	Silverwater	31/08/2000	26	Drug overdose	Prison	Glebe
239/99	23/01/1999	Cessnock	03/03/2000	35	Suffocation	Prison	Cessnock
261/99	07/02/1999	Silverwater	31/08/2000	49	Hanging	Prison	Glebe
505/99	13/03/1999	Long Bay	15/11/2000	49	Anaesthetic	Prison	Glebe
558/99	19/03/1999	Silverwater	11/01/2000	23	Drug overdose	Prison	Westmead
559/99	15/04/1999	Silverwater	14/06/2000	28	Hanging	Prison	Westmead
1122/99	05/06/1999	Parkes	24/03/2000	19	Police Pursuit	Police Operation	Parkes
1475/99	19/07/1999	Jugiong	14/03/2000	36	Police Pursuit	Police Operation	Yass/Glebe
907/99	01/08/1999	Lithgow	15/06/2000	35	Overdose	Prison	Lithgow
1736/99	18/08/1999	Randwick	25/08/2000	43	Hanging	Prison	Glebe
1910/99	10/09/1999	Cowper	10/08/2000	34	Police Pursuit	Police Operation	Grafton
1899/99	11/09/1999	Queanbeyan	31/03/2000	36	Police Pursuit	Police Operation	Queanbeyan
1903/99	11/09/1999	Bathurst	19/05/2000	37	Natural causes	Prison	Bathurst
247/00	23/09/1999	Wollongong	24/10/2000	27	Hanging	Police Operation	Kiama
1197/99	15/10/1999	Silverwater	03/08/2000	29	Hanging	Prison	Westmead
1221/99	21/10/1999	East Kurrajong	24/03/2000	59	Gunshot	Police Operation	Westmead
1296/99	14/11/1999	Lithgow	15/06/2000	29	Drug overdose	Prison	Katoomba
2609/99	22/12/1999	St Leonards	28/04/2000	17	Police Pursuit	Police Operation	Glebe
4/00	01/01/2000	Darlinghurst	31/10/2000	31	Fall	Police Operation	Glebe
48/00	09/01/2000	Windsor	29/06/2000	67	Natural	Prison	Westmead
68/00	16/01/2000	Ingleburn	13/03/2000	21	Police Pursuit	Police Operation	Westmead
463/00	03/03/2000	Cessnock	11/08/2000	19	Hanging	Prison	Cessnock
453/00	04/03/2000	Goulburn	25/08/2000	30	Hanging	Prison	Goulburn
502/00	11/03/2000	Tumbarumba	14/12/2000	50	Poison	Police Operation	Wagga Wagga
298/00	19/03/2000	Silverwater	13/06/2000	30	Bashing	Prison	Westmead
312/00	24/03/2000	Mt. Druitt	14/06/2000	29	Police Pursuit	Police Operation	Westmead
1107/00	07/06/2000	Kogarah	29/09/2000	14	Police Pursuit	Police Operation	Glebe
884/00	05/08/2000	Merrylands	31/10/2000	25	Police Pursuit	Police Operation	Westmead
1800/00	05/09/2000	Sydney	12/10/2000	22	Gunshot	Police Operation	Glebe

Matters assessed as not being reportable to the coroner under s13A of the Coroner's Act, 1980.

700/99	15/06/1999	Penrith	15/06/2000	56
1030/00	23/07/1999	Gateshead	13/10/2000	27
1778/99	24/08/1999	Randwick	27/11/2000	22

Appendix 2:

Summary of deaths in custody/police operation reported to the NSW State Coroner for which inquests are not yet completed.

File No.	Date of death	Place of death	Age at death	Circumstances
948/95	22-05-95	Long Bay	24	Prison
778/97	30-04-97	Orange	20	Police Operation
1265/98	23-06-98	Long Bay	44	Prison
1328/98	05-07-98	Long Bay	36	Prison
1757/98	29-08-98	Silverwater	39	Prison
2217/98	01-11-98	Grafton	46	Prison
963/99	18-08-99	Silverwater	75	Prison
981/99	23-08-99	Silverwater	28	Prison
2096/99	10-10-99	Goulburn	29	Prison
2217/99	26-10-99	Bathurst	53	Prison
1304/99	12-11-99	Glossodia	24	Police Operation
1317/99	19-11-99	Silverwater	23	Prison
2491/99	03-12-99	Long Bay	25	Prison
2565/99	18-12-99	Queanbeyan	28	Police Operation
180/00	27-01-00	Tamworth	37	Prison
222/00	01-02-00	Randwick	65	Prison
258/00	07-02-00	Bondi	25	Police Operation
233/00	25-02-00	Silverwater	30	Prison
280/00	26-02-00	Bega	16	Police Operation
612/00	27-03-00	Bathurst	51	Prison
257/00	16-04-00	Thornton	33	Home Detention
414/00	18-04-00	Silverwater	21	Prison
441/00	26-04-00	Silverwater	39	Prison
836/00	29-04-00	Fishing Point	24	Police Operation
1100/00	05-06-00	Randwick	29	Police Operation
554/00	22-03-00	Canberra	18	Police Operation
1830/00	28-08-00	Cessnock	33	Prison
1751/00	20-08-00	Brewarrina	49	Police Operation
1879/00	18-09-00	Goulburn	20	Prison
1068/00	18-09-00	Lithgow	28	Prison
2028/00	12-10-00	Camperdown	25	Police Operation
1174/00	16-10-00	Prospect	48	Prison
2177/00	08-11-00	Tamworth	18	Prison
2181/00	10-11-00	Goulburn	29	Prison
1282/00	15-11-00	Lapstone	30	Police Operation
2092/00	23-10-00	Oberon	27	Police Operation
2093/00	23-10-00	Oberon	38	Police Operation
2274/00	26-11-00	Long Bay	64	Prison
2286/00	26/00/00	Malabar	33	Prison
2363/00	13-12-00	St Peters	18	Police Operation
2385/00	15-12-00	Loftus	46	Police Operation