Report by the

NSW State Coroner

into deaths in
custody/police operations.

2008

(Coroner's Act 1980, Section 13A.)

NSW Office of the State Coroner
NSW Attorney General's Department

ISSN No: 1323-6423

The Honourable John Hatzistergos
Attorney General of New South Wales
Parliament House
Macquarie Street
SYDNEY NSW 2000

31 March 2009

Dear Attorney,

Pursuant to *Section 12A(4), Coroners Act 1980,* I respectfully submit to you a summary of all *Section 13A* deaths reported and inquests held by the State Coroner or a Deputy State Coroner during 2008.

The most pleasing aspect of this report is that there were no known Aboriginal or Torres Straight Islander deaths reported to the coroner as a result of a death in custody or police operation for the year, 2008.

Section 13A provides:

(1) ***A coroner who is the State Coroner or a Deputy State Coroner has jurisdiction*** *to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died or that there is reasonable cause to suspect that the person has died:*

(a) While in the custody of a police officer or in other lawful custody, or while escaping or attempting to escape from the custody of a police officer or other lawful custody, or

(b) as a result of or in the course of police operations, or

(c) while in, or temporarily absent from, a detention centre within the meaning of the Children (Detention Centres Act 1987, a correctional centre within the meaning of the Crimes (Administration of Sentences) Act 1999 or a lock-up, and of which the person was an inmate, or

(d) while proceeding to an institution referred to in paragraph ©, for the purpose of being admitted as an inmate of the institution and while in the company of a police officer or other official charged with the person's care or custody.

(2) If jurisdiction to hold an inquest arises under both this section and section 13, ***an inquest is not to be held except by the State Coroner or a Deputy State Coroner.***

Inquests into these deaths are mandatory and can only be heard by the State Coroner or a Deputy State Coroner.

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

Deaths during the course of a 'Police Operation' can include shootings *by* police officers, shootings *of* police officers, suicide and other unnatural deaths.

Deaths occasioned during the course of a police pursuit are always of concern to the State Coroner and, like deaths in the latter categories; these critical incidents are thoroughly investigated by independent police officers from an independent Local Area Command.

The figure of 24 deaths reported to the Coroner pursuant to Section 13A is the lowest recorded number of deaths since statistics have been kept.

24 *Section 13A* deaths were reported in 2008, representing the lowest number of deaths since statistics have been kept.

48 matters were completed by way of inquest, compared to 23 in 2007. In many inquests constructive and far-reaching recommendations were made pursuant to *Section 22A, Coroners Act 1980*.

36 cases await inquest, compared to **58** in 2007. Many of these matters are in the investigative stage or set down for inquest in 2009.

The Deputy State Coroners and I have put considerable effort into reducing the delay in finalising Section 13A deaths as any recommendation that may flow from an inquest could save further lives in the future. The reduction in the number of outstanding cases and the increase of the number of inquests held in 2008 will continue.

I submit for your consideration the State Coroner's Report, 2008.

Yours faithfully,

Magistrate Mary Jerram
(State Coroner NSW)

STATUTORY APPOINTMENTS

Under the 1993 amendments to the *Coroners Act 1980*, only the State Coroner or a Deputy State Coroner can preside at an inquest into a death in custody or a death in the course of police operations. The inquests, the subject of this report, were conducted before the following Coroners:

NSW State and Deputy Coroners 2008

INSERT PHOTO

From left**: Deputy State Coroner's MacMahon & Dillon, State Coroner Jerram, Deputy State Coroner's Milovanovich & MacPherson.**

MAGISTRATE MARY JERRAM

New South Wales State Coroner

1983	Admitted as a Solicitor of the Supreme Court of New South Wales.
1983	Industrial Legal Officer Independent Teachers Union.
1987	Solicitor and Solicitor Advocate for Legal Aid Commission.
1994	Appointed as a Magistrate for the State of New South Wales and a Coroner.
1995	Children's Court Magistrate.
1996-98	Magistrate Goulburn.
2000	Appointed Deputy Chief Magistrate.
2007	Appointed NSW State Coroner.

MAGISTRATE CARL MILOVANOVICH

Deputy State Coroner

1968 Department of the Attorney General (Petty Sessions Branch)

1976 Appointed a Coroner for the State of New South Wales.

1984 Admitted as a Solicitor of the Supreme Court of NSW

1990 Appointed a Magistrate for the State of New South under the Local Courts Act 1982.

2002 Appointed as NSW Deputy State Coroner.

MAGISTRATE MALCOLM MACPHERSON
Deputy State Coroner

1965 Department of the Attorney General (Petty Sessions Branch).

1972 Appointed a Coroner for the State of New South Wales.

1986 Bachelor of Legal Studies Macquarie University.

1987 Admitted as a Solicitor of the Supreme Court of NSW.

1991 Appointed as a Magistrate for the state of New South Wales.

2006 Appointed as New South Wales Deputy State Coroner.

MAGISTRATE PAUL MACMAHON

Deputy State Coroner

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

MAGISTRATE HUGH DILLON
Deputy State Coroner

1983	Admitted as Solicitor.
1984-5	Worked as Legal Projects Officer, NSW Council of Social Service.
1986-96	Worked as Lawyer in government practice, principally with NSW Ombudsman's Office and Commonwealth Director of Public Prosecutions.
1996	Appointed a Magistrate of the NSW Local Court.
2007	Appointed Visiting Fellow, Faculty of Law, UNSW. Also appointed a part-time President of Chief of Defence Force Commissions of Inquiry (Defence Force inquests).
2008	Appointed NSW Deputy State Coroner.

Contents

Introduction by the New South Wales State Coroner

Overview of deaths in custody/police operations reported to the New South Wales State Coroner in 2008

Summaries of individual cases completed in 2008

Appendices

Introduction by the New South Wales State Coroner

What is a death in custody?

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

1 the death wherever occurring of a person who is in prison custody, police custody, detention as a juvenile or detention pursuant to the (Commonwealth) Migration Act, 1958.

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

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

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

Section 13A, *Coroners Act* expands on this definition to include circumstances where the death occurred:

1. while temporarily absent from a detention centre, a prison or a lock-up; as well as,

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

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

This is a matter for determination by the Coroner after all the evidence and submissions, from those granted leave to appear, has been presented at the inquest hearing.

---

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

The Department of Corrective Services has a policy of releasing prisoners from custody prior to death, in certain circumstances. This has generally occurred where such prisoners are hospitalised and will remain hospitalised for the rest of their lives. Whilst that is not a matter of criticism it does indicate a "technical" reduction of the actual statistics in relation to deaths in custody. In terms of *Section 13A*, such prisoners are simply not "in custody" at the time of death.

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

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

A death as a result of or in the course of a police operation is not defined in the Act. Following the commencement of the 1993 amendments to the *Coroners Act 1980*, New South Wales State Coroners Circular No. 24 contained potential scenarios that are likely deaths 'as a result of, or in the course of, a police operation' as referred to in *Section 13A* of the Act.

The circumstances of each death will be considered in reaching a decision whether *Section 13A* is applicable but potential scenarios set out in the Circular were:

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

After more ten years of operation, most of the scenarios set out above have been the subject of inquests.

The Deputy State Coroners and I have tended to interpret the subsection broadly. We have done this so that the adequacy and appropriateness of police response and police behaviour generally will be investigated where we believed this to be necessary.

It is most important that all aspects of police conduct be reviewed even though in a particular case it may be unlikely that there will be grounds for criticism of police.

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

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

We will continue to remind both the Police Service and the public of the high standard of investigation expected in all coronial cases.

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

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

> *The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty, and it is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion, and satisfies the community that deaths in such places are properly investigated*[2]*.*

I agree also with Mr Waller that:

> *In the public mind, a death in custody differs from other deaths in a number of significant ways. The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution. When the death is by deliberate self-harm, the responsibility is seen to rest largely with the institution. By contrast, a civilian death or even a suicide is largely viewed as an event pertaining to an individual. The focus there is far more upon the individual and that individual's pre-morbid state. It is entirely proper that any death in custody, from whatever cause, must be meticulously examined*[3]*,*

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

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

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

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

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

The DOI is required immediately to notify the State Coroner or a Deputy, who are on call twenty-four hours a day, seven days a week.

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

The DOI is also required promptly to notify the Commander of the State Coronial Investigation Unit, a specialised team of police officers under the umbrella of the Homicide Unit who are responsible to the State Coroner for the performance of their duties.

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

Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit and the coronial medical officer or the forensic pathologist. A member of the Coroner's Support Section must attend the scene that day if the death occurred within the Sydney Metropolitan area and, when practicable, if a death has occurred in a country district. The Support Group Officer must also ensure that a thorough investigation is carried out. He or she will continue to liaise with the Coroner and with the police investigators during the course of the investigation.

The Coroner, if warranted, should inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during it. If the State Coroner or one of the Deputy State Coroners is unable to attend a death in custody/police operations occurring in a country area, the State Coroner may request the local coroner in the particular district, and the local coronial medical officer to attend the scene.

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

In cases involving the police

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

In these situations Counsel (in consultation with the Coroner having jurisdiction) will give attention to the investigation being carried out, oversee the preparation of the brief of evidence, review the conduct of the investigation, confer with relatives of the deceased and witnesses and, in due course, appear at the mandatory inquest as Counsel assisting the Coroner. Counsel will ensure that all relevant evidence is brought to the attention of the Coroner and is appropriately tested so as to enable the Coroner to make a proper finding and appropriate recommendations.

Prior to the inquest hearing, conferences and direction hearings will often take place between the Coroner, Counsel assisting, legal representatives for any interested party, and relatives so as to ensure that all relevant issues have been addressed.

In respect of all identified *Section 13A* deaths, post mortem experienced forensic pathologists at Glebe or Newcastle conduct examinations.

Responsibility of the coroner

Section 22, *Coroners Act 1980* provides:

(1) The Coroner holding an inquest concerning the death or suspected death of a person shall at its conclusion. record in writing his or her findings. As to whether the person died, and if so:

(a) the person's identity,
(b) the date and place of the person's death, and
(c) except in the case of an inquest continued or terminated under section 19, the manner and cause of the person's death.

In general terms *Section 19* provides:

1. if it appears to the Coroner that a person has been charged with an indictable offence or the coroner forms the opinion that evidence given in an inquest is capable of satisfying a jury that a person has committed an indictable offence and that there is a reasonable prospect of a jury convicting the person of the offence; and

2. the indictable offence is one in which the question whether the known person caused the death is in issue the Coroner must suspend the inquest.

The inquest is suspended after taking evidence to establish the death, the identification of the deceased, and the date and place of death. The Coroner then forwards to the Director of Public Prosecutions a transcript of the evidence given at the inquest together with a statement signed by the Coroner, specifying the name of the known person and particulars of the offence.

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

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

The role of the coronial inquiry has undergone an expansion in recent years. At one time its main task was to investigate whether a suicide might have been caused by ill treatment or privation within the correctional centre. Now the Coroner will examine the system for improvements in management, or in physical surroundings, which may reduce the risk of suicide in the future. Similarly in relation to police operations and other forms of detention the Coroner will investigate the appropriateness of actions of police and officers from other agencies and review standard operating procedures.

In other words, the Coroner will critically examine each case with a view to identifying whether shortcomings exist and, if so, ensure, as far as possible, that remedial action is taken.

Recommendations

The common law practice of Coroners (and their juries) adding riders to their verdicts has been given statutory authorisation pursuant to *Section 22A* of the *Coroners Act 1980*. This section indicates that public health and safety in particular are matters that should be the concern of a Coroner when making recommendations *(S.22A(2))*.

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

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

Recommendations arising from a number of inquests of Section 13A deaths were made during **2008.**

Some of these recommendations include:

To the Commissioner of Police:

1. That the conditions of the powers granted to police by the Safe Driving and Pursuits Policy, and their resultant responsibilities, be clarified to all officers in New South Wales, and that all officers be required to undertake further education in that Policy, in accordance with the comments of the NSW Ombudsman, and in particular in regard to pursuits, forthwith.

2. That the Commissioner allows Local Area Commanders to make adaptations of the Policy for local conditions, but ensure that officers are fully instructed in those adaptations.

3. That there be no disciplinary action against Constable Innes for conduct in providing information to the family of Vanessa Hardy, and consideration be given to his courage in giving honest evidence, and his compassion for the family.

4. That Aboriginal Community Liaison Officers be incorporated in to procedures after any critical incident involving an Aboriginal person, and that the role of the ACLO be clearly defined, to include the requirement that an ACLO accompany any senior officer providing information to next of kin.

1. Face shields

All Local Area Commands provide to all police personnel who are required to carry 'Personal Protection Equipment Kits', the current face shield as recommended and specifically identified by the Operational Safety Training Unit of the NSW Police Force.

2. Basic life support update to NSW Police Force

All operational police be advised of the recent updated guidelines for basic life support/CPR, and in particular that:

i. the current compression/ventilation ratio is now 30:2 (30 compressions to 2 ventilations/breaths) for infants, children and adults;
ii. the recommended compression rate is 100 compressions per minute;
iii. if for some reason the rescuer is unable to ascertain whether a pulse is present and/or is unable to provide ventilations/breaths, implementation of compressions is recommended ("compressions are vital").

3. Pocket Face Masks (including Laerdal type)

All Local Area Commands implement an auditable checking system so as to ensure that all operational police vehicles are equipped with all mandatory safety and First Aid equipment including the contents of the Police First Aid Response Kits (including pocket face masks with a one valve).

TO THE POLICE MINISTER AND COMMISSIONER OF POLICE

I recommend that the following protocol is to apply to all critical incidents where the Healthy lifestyle section is unable to attend and take the required blood samples from the police involved in such incidents as soon as possible but preferably within two hours following the incident.

All involved officers are to be conveyed to an appropriate medical facility (hospital, medical centre, doctors surgery) where an authorised medical practitioner (Doctor or registered Nurse) will take the required blood sample.

All care should be taken to ensure that the police officers who are conveyed to and from the medical facility, do not discuss with their fellow officers the relevant incident at any time.

It shall be the responsibility of the officer in charge of the critical incident investigation (or an officer of that team delegated by the officer in charge) to ensure that all blood samples obtained from the police involved are appropriately preserved so as to allow their later analysis.

To the Minister for Roads and Traffic:

- That a safety barrier, designed to prevent or significantly impede jumping from the Northbridge Suspension Bridge, be erected by the RTA as soon as is practicably possible taking into account the relevant planning issues.

That any such safety barrier be designed to take into account the bridge's significant heritage and architectural values and to harmonise with them.

Contacts with outside agencies

During 2008 the State Coroner's office maintained effective contact with the following agencies:

- New South Wales Department of Forensic Medicine (Department of Health);
- Division of Analytical Laboratories at Lidcombe (Department of Health);
- Aboriginal Prisoners and Family Support Committee (New South Wales Attorney General's Department);
- Aboriginal Deaths in Custody Watch Committee;
- Indigenous Social Justice Association;
- Aboriginal Corporation Legal Service;
- Aboriginal and Torres Strait Islander Commission;
- Australian Institute of Criminology in Canberra;
- Office of the State Commander New South Wales Police Service;
- Department of Corrective Services;
- Corrections Health.
- Emergency Management Australia.
- NSW Crown Solicitors Office

Close links were also maintained with Senior Coroners in all other states and territories.

OVERVIEW OF DEATHS IN CUSTODY/POLICE OPERATIONS REPORTED TO THE NEW SOUTH WALES STATE CORONER DURING 2008.

All deaths pursuant to Section 13A, *Coroners Act 1980*, must be investigated by the State Coroner or a Deputy State Coroner.

Table 1: Deaths in Custody/Police Operations, which occurred in 2008.

These were cases of deaths in custody and cases of death as a result of or in the course of police operations reported to the State Coroner in 2008.

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	**23**	**14**	**37**
1996	**26**	**6**	**32**
1997	**41**	**15**	**56**
1998	**29**	**9**	**38**
1999	**27**	**7**	**34**
2000	**19**	**20**	**39**
2001	**21**	**16**	**37**
2002	**18**	**17**	**35**
2003	**17**	**21**	**38**
2004	**13**	**18**	**31**
2005	**11**	**16**	**27**
2006	**16**	**16**	**32**
20 07	**17**	**11**	**28**
2008	**14**	**10**	**24**

Aboriginal deaths which occurred in 2008

Of the 24 deaths reported during 2008 pursuant *to Section 13A, Coroners Act 1980*, it is most pleasing to note that there were no known aboriginal deaths reported to the coroner as a result of a death in custody or police operation.

This is the first year since figures have been maintained in NSW that this result has occurred.

Table 2: Aboriginal deaths in custody/police operations during 1995 to 2008.

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

Deaths investigated by the State/Deputy State Coroners during 2008

During the year, 48 'Death in Custody or Police Operation' mandatory inquests were finalised.

Findings were recorded as to identity, date and place of death, and manner and cause of death

Circumstances of death

Persons who died in custody/Police Operations in 2008: -

3 by taking their own life by hanging
3 from a motor vehicle accident
3 from gun shot wounds
1 from strangulation
1 from ingestion of objects
2 from injuries received as a result of a jump/fall

11 by natural causes

Unavoidable delays in hearing cases

In 2008 the State Coroner and the Deputy State Coroners completed 48 inquests of deaths reportable by Section 13A. This greatly reduced the outstanding number of these matters, which had been accumulating over the last few years.

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

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

It is settled coronial practice in New South Wales that the brief of evidence be as complete as possible before an inquest is set down for determination. At that time a more accurate estimation can be made about the anticipated length of the case. It has been found that an initially comprehensive investigation will lead to a substantial saving of court time in the conduct of the actual inquest.

In some cases there may be concurrent investigations taking place, for example by the New South Wales Police Service Internal Affairs Unit or the Internal Investigation Unit of the Department of Corrective Services. The results of those investigations may have to be considered by the Coroner prior to the inquest as they could raise further matters for consideration and perhaps investigation.

SUMMARIES OF INDIVIDUAL CASES COMPLETED IN 2008.

Following are the written findings of each of the cases of deaths in custody/police operations that were heard by the NSW State Coroner, Senior Deputy State Coroner and the Deputy State Coroners in **2008.** These findings include a description of the circumstances surrounding the death and any recommendations that were made.

1433/01
Inquest into the death of Darren Ryan at Silverwater gaol on the 11th August 2001. Finding handed down by Deputy State Coroner Dillon on the 25 March 2008.

The deceased has been identified as Darren James Ryan and that is not in contest. He died on 11 August 2001 at the Auburn District Hospital.

The cause of death according to the medical evidence is drug toxicity. There were possible complications but the most probable cause of death the consequences of drug toxicity with the possibility of contribution by his condition, which was diabetes melitis that would have a significant effect on him.

The one interesting issue I think that has been raised and it has been carefully dealt with by the detective who investigated this matter, and in my opinion very thoroughly and fairly, is whether there was some foul play by unknown members of the Department of Corrective Services. That issue was raised I think in an entirely speculative and possibly mischievous fashion by members or a member of Mr Ryan's family. But to go back a step, Mr Ryan was a 39-year-old male who had a lengthy criminal history. Also the evidence shows I think had a lengthy history of use of illicit drugs, certainly there is powerful evidence to show that he had been using illicit drugs from about the age of 13 or 14. His criminal history shows that he had been using drugs for a lengthy period and his cellmate also gave evidence to the police investigating death that he had "been getting some shit" which Mr Locklear, the cellmate, took to mean purchasing illegal drugs. That is utterly consistent with what in fact happened and that despite the evidence or the claims of Ms McPherson who says that Mr Ryan was not addicted to drugs.

At around 9.24 a correctional officer, Mr Owen, was sent to knock-up alarm warning Mr Owen that Mr Ryan had had some sort of incident. It was a possibility at that stage that Mr Ryan had lapsed in some sort of diabetic coma.

When medical staff arrived they were unable to locate a pulse or any sign of breathing and started resuscitation therapy. He was transferred to the Auburn Hospital and the next day he died.

The best evidence appears to me to show that Mr Ryan in gaol was obtaining drugs on a regular basis.

Certainly there is evidence that he was being provided monies from his family enabling him to do that. It is a circumstantial situation of course but the evidence shows that he was asking for money and he was being given it, the money being placed in his account which enabled him very clearly, if he had access to it and wished to do so, to purchase drugs in gaol. I think it is a matter of common knowledge that despite the efforts of the Department that drugs are available in gaol to those who wish to purchase them and despite the efforts of the Department to search for drugs and eliminate them from gaols. It is also a matter of common knowledge that a large number of the inmates in New South Wales gaols and no doubt gaols all over the world are there because of their drug habits and their desire to use drugs; Mr Ryan was one of those.

There was a suggestion made by Mr Ryan's de facto wife that he was in the process of suing the Department of Corrective Services for some sort of breach of a duty of care owed to him. Police investigated that claim and have found no evidence that he had in fact brought an action against the Department. Even if he had intended to sue the Department but had not got around to it, it seems extraordinarily implausible that someone in the Department would take it upon him or herself to assassinate Mr Ryan by injecting him with drugs, to use the vernacular to give him a hotshot. This seems an astonishingly implausible scenario.

Nevertheless that is the claim that Ms McPherson made, she, however, when questioned by police was unable and questioned on a number of occasions and given many opportunities I should say, and has provided absolutely no basis for her claim or her belief if she does hold such a belief. Nor has she attended Court here today to provide any substantiation of that claim. She also told the police he was not addicted to drugs but rather used drugs when his peers influenced him and their finances permitted him to do so.

I am not quite sure why she thinks that he was not addicted to drugs if he being influenced by his peers used drugs and would buy drugs when his finances permitted him to do so and when she was the person who was providing him the finances which did permit him to do so, it seems a rather self delusory sort of thing to suggest.

Almost certain Mr Ryan was addicted to drugs. Certainly he liked to use them in any event whether he was addicted to them or not and he sought occasion to purchase them and use them.

This was always going to be a bad thing to do to himself, not only because of the possible effects of those drugs but because he suffered diabetes melitis which of course was a very significant illness or condition from which he suffered, and to combine diabetes melitis with the use of illicit drugs was to walk on very, very thin ice indeed in my opinion.

He was taking a risk with his own life, whether he knew that he was taking such a risk I do not know but he was certainly taking a very great risk with his own life.

In my opinion the cause of death was drug toxicity and the manner of death was that he self injected and overdosed on those self injected drugs. No doubt his condition of diabetes melitis also contributed to his death ultimately. So I make the following formal findings

Formal Finding:

THAT THE IDENTITY OF THE DECEASED IN THIS CASE WAS DARREN JAMES RYAN. THAT HE DIED ON 11 AUGUST 2001 AT THE AUBURN DISTRICT HOSPITAL. IN FIND THAT THE CAUSE OF DEATH WAS MOST LIKELY TO BE THE CONSEQUENCES OF DRUG TOXICITY WITH POSSIBLE COMPLICATIONS FROM DIABETES MELITIS OR HYPOGLYCAEMIA. IN MY OPINION THE MANNER OF HIS DEATH WAS ALMOST CERTAINLY THAT HE OVERDOSED ON SELF-INJECTED DRUGS.

I WOULD MAKE A FURTHER COMMENT THAT I FIND NO EVIDENCE THAT HE WAS MURDERED BY DRUG INJECTION BY ANY PERSON AND IN PARTICULAR BY ANY MEMBER OF THE DEPARTMENT OF CORRECTIVE SERVICES.

1754/03
Inquest into the death of Vanessa Louise Hardy at Bourke on the 12 October 2003. Finding handed down by State Coroner Jerram on 18 December 2008.

In 2007, the then Deputy State Coroner, Magistrate Milledge, sought to reopen the inquest which she had held into the death of Vanessa Hardy, and had terminated under s. 19 of the Coroners Act, on the basis of her opinion that the evidence showed that a known person had caused the death of Vanessa.

That person, Joseph Shillingsworth , was subsequently charged with negligent driving causing a death, pleaded guilty, and was sentenced to a term of imprisonment. As he had served his sentence and been released, Magistrate Milledge at the strong request of Vanessa's family, wished to reopen or continue the inquest in order to examine some issues which had not been resolved at the time of the termination, specifically surrounding the actions of certain police officers and the Police Safe Driving, or Pursuit, policy.

The intention to reopen was considered by Rothman J of the Supreme Court and consequently, I, as State Coroner, reopened the inquest at Brewarrina on

October 14, 2008, and ably assisted by Mr Saidi of Counsel and Ms Cheryl Drummie from the Crown Solicitors Office.

Mr Shillingsworth was represented by Mr Wilson of counsel, the Police Force by Mr Haverfield of counsel, the three police officers by Mr Madden and the parents and family of Vanessa by Mr Hancock of counsel.

Further evidence was heard for three days at Brewarrina Courthouse.

Vanessa and another friend had been drinking at a party outside Brewarrina and were offered a lift home by Mr Shillingsworth, who himself had been drinking quite heavily and was considerably intoxicated, and both driving an unregistered car and himself unlicensed. Furthermore he was aware that there were outstanding warrants against him. Vanessa took the back seat and her friend the passenger seat.

As they entered the outskirts of the town about 3 am, two police, Constables Symington and Innes, who were in a patrol vehicle on general duties, saw the red Falcon driven by Shillingsworth, and signalled it to stop. Mr Shillingsworth, who gave honest and credible evidence to the court, admitted that he had panicked, refused to stop, and drove off at speed. His evidence was that he realised the police car was following him, and speeded up further, advising his passengers to put on their seat belts.

Unfortunately, Vanessa did not, possibly being asleep on the back seat. In an attempt to shake off the police, Shillingsworth took a dirt road, which, having observed it on a view was clearly little more than a track, through the scrub. It is a road which all agreed should not in good conditions be driven upon at much more than 40 kph. Conditions were anything but ideal: it was a pitch-black night; there was a lot of wildlife about,

Shillingsworth was highly intoxicated, and his car was throwing up a great deal of dust on the sparsely gravelled road. Furthermore, believing himself to be chased, he admitted to reaching speeds up to 100 kph.

The two officers called in a third, Senior Constable Prescott, prior to Shillingsworth turning on to the dirt track. He, Prescott, took over the pursuit, and ordered the two in the other police vehicle to circle round to the end of the track in an attempt to block, or cut off, the red car. As Shillingsworth approached that point, still at high speed, he lost control of the vehicle, which rolled. Vanessa was thrown through the rear window and died, probably immediately, of multiple injuries.

THE ISSUES

- ***Was there a valid reason for the police initially to seek to stop Shillingsworth's car or to pursue it?***

- ***Was there in operation in the area a "No Pursuits Policy", and if so where were its boundaries, and did the actions of the police breach that policy".***

- ***What was the general police policy in relation to pursuits and safe driving, and could it be altered by Local Area Commanders?***

- ***Was Senior Constable Prescott in fact 'in pursuit' of Shillingworth? Did he activate the siren and flashing lights of the police vehicle? Did he gain speeds as high as did Shillingsworth?***

- ***Was the VKG properly informed by any of the police officers of what was occurring, and did the operator of VKG advise accordingly?***

- ***Primarily, did the fact that the police acted as they did, cause the actions of Shillingsworth which resulted in Vanessa's death?***

- ***Of less broad import, but of huge effect for Vanessa's family, could or should they have been notified earlier than they were of the accident, and given an opportunity to see their daughter at the scene of her death?***

THE EVIDENCE

The two police officers in the first police car claimed that they were attempting to stop Shillingsworth for a random breath test. All three police then claimed that after he refused to stop they were entitled to follow him.

The evidence in regard to the policy operating in the area for safe driving and pursuits was sparse, and conflicting. Boyter…. Senior Sergeant Wilkinson claimed that there was no pursuits policy within the levy banks surrounding a township in the Darling River command.

He further said that there was no pursuit if police merely followed a car without warning lights. S/Con Preston said that he had heard 'rumours of a no pursuit policy' but thought it applied more to Bourke than to Brewarrina. In cross-examination according to the transcript tendered to me of the first inquest, he further said that he thought it applied to duty Officers, but not to Highway Patrol officers such as himself.

He claimed that he was following the car, but not in pursuit, and that while he agreed there had been no known traffic offence committed other than an attempt to avoid a breath test, a random breath test was the sole purpose of the chase.

Constable Innes gave evidence that he couldn't remember being taught any Safe Driving Policy at the Police Academy from which he had graduated only…. previously, other than that there had been a one day practical driving course.

Both Senior Constable Sutton and Senior Sergeant Wilkinson had given evidence that they had never heard of any ‘no pursuit’ policy within the city limits.

Preston’s evidence as to the chase itself was self contradictory, and not credible. In his original evidence he agreed that he had his lights and siren on when he entered the dirt track after Shillingsworth’s car.

He later denied having his siren on, or that he was in pursuit, and claimed he turned his lights off for that reason. He gave evidence that his speed was between 20 and 30 kpm, and that he maintained that same speed, but then agreed that it was ’60-90 and up to 100 kph’. The Investigator, Mills, confirmed that estimated speeds were up to 110 kph.

It is clear from the VKG tape that his siren was on when he told VKG that he was on the dirt track. He also changed his evidence as to visibility from ‘only 6 to 10 feet’ to ’10 to 20 meters’, and at one point to 25-30 meters.

Constable Symington, Preston’s wife, was the passenger in the police car driven by Probationary Constable Innes. She claimed limited knowledge of the incident and its details, but disputed that they were involved in a pursuit, and said that there were no lights other than the taillights of Preston’s car.

She then testified that actually she had no clear recollection of whether the lights were on or off. She estimated Shillingsworth’s speed as he passed their waiting car, followed closely by Preston’s, as 100 kph.

Constable Innes, on the other hand was firm that the warning lights were on Preston’s vehicle, and still were when he pulled up beside his, Innes’s vehicle. He too confirmed speeds by Shillingsworth and Preston of up to 100 kph.

The local police Education Officer Nicole Martin was herself was unsure as to what the safe driving policy for the command was, and whether it contained a no pursuits local directive or policy. She certainly was not involved in training the local command police in any safe driving policy.

Browning, who inducted Innes advised him of the no pursuit policy within the levee banks of Bourke and not to exceed 80 kph in the hours of darkness outside the town, but did not think the policy extended to Brewarrina.

Vanessa’s mother, Mrs Hardy, made a strong and moving statement to the court.

Apart from the terrible loss and distress still felt by the whole family, she was angry that they had not been told immediately of the accident, and that they were never told of any action taken against the police involved other than an

attempt to do so by Constable Innes many months later before he left the Command.

Ultimately the court was provided with the Commissioner's Safe Driving Policy. It is clear that that policy is intended to operate statewide, and that Local Area Commanders are not empowered to alter or adapt it for local conditions in any way without the express permission of the Commissioner.

CONCLUSIONS

There was no valid reason for police to attempt to stop Shillingsworth, and even less to pursue him when he refused to stop.

The red Commodore could have been easily identified the next day given the smallness of the town. The driver was not exceeding the speed limit at the time his car was first noticed by police.

There were passengers in the car. It was 3 am and pitch dark, and the chase reached high speeds on a dirt road through scrub sheltering kangaroos and other wild life. To follow a car in those conditions put not only Shillingsworth and his passengers at risk, but also the police in the waiting car (note that their evidence was that the police car shook as the Commodore went by).

There is clear conflict in the evidence regarding just what Safe Driving Policy was operative in the Darling River command at the time, what that Policy was, and whether the Local Commander could alter or adapt it to local conditions.

The lack of knowledge amongst police of the directives or rules and to this day the confusion between police about which policy or guidelines apply, is horrifying. It is made clear from evidence provided to this inquest that only the Police Commissioner can approve changes to the Policy and that it is in fact clearly set out.

Preston advised VKG that he was not in pursuit. VKG itself does not seem to have responded appropriately and called off the chase, although the tyranny of distance and difficult transmission may have made the information received by VKG unclear, apart from full information not necessarily being given out.

There was no argument eventually from any party that the chase constituted a pursuit. The Macquarie dictionary defines 'pursue' as follows: 'to follow, to close upon, to go with, to attend'.

The police involved took all those actions. Lights and sirens were used at least to some point on the dirt track, and probably up until the final crash (according to the evidence of Constable Innes). Constable Preston was not truthful about this in his original evidence. I accept that of Innes, but am doubtful about the vagueness in memory or observation of Constable Symington.

Whatever the policy, and regardless of the legitimacy of any local alteration, in all the circumstances given, the actions of the police,

and in particular Senior Constable Preston, were lacking in common sense, foolish and without basis (in terms of preventing a serious crime). Ultimately, those actions contributed to causing a fatality.

I accept that the Hardy family have been very upset at the time taken for them to be notified of Vanessa's death. A police officer and an Aboriginal liaison officer should have been dispatched as quickly as possible to their home so that they may have been able to see Vanessa at the scene. It appears that there was no question of her identity, nor of her immediate death, and some compassion or thought for their feelings might have been more generously given.

Certainly, Shillingsworth was in fact intoxicated, and there were warrants against him. The car carried stolen plates. Police knew none of those facts at the time of first seeing his car; they had not identified him.

Nor were any of those factors per se necessarily endangering to the public at that time. He was not exceeding the speed limit, and despite the alcohol, was so close to home that it might reasonably have been expected that all would otherwise have arrived safely. Of course he should have stopped.

Of course he should not have been driving. But the facts speak for themselves: had he not been pursued, he would not have gone into the bush, nor reached the speeds which caused the car to overturn.

Furthermore, as has been said several times throughout these proceedings, 'the only thing more dangerous than a drunk driver is a drunk driver being pursued". Mr Shillingsworth has paid the price for his behaviour, and patently retains a strong sense of guilt and sadness.

Police pursuits are very serious matters indeed. To allow them gives police the right to engage in conduct, which could otherwise be criminal. It is a very important grant of any power in our society, which should be respected by all police officers for what it is, with an obligation on officers to exercise that power responsibly.

The policy is there, not just to give rights to police, but also to protect others, not only passengers such as Vanessa, but even lawbreakers like Shillingsworth. The rules regarding pursuits need to be crystal clear and diligently followed, or there may well come a time when an officer who does not follow them, or by some conduct permits pursuits to be called or continued by lack of information given, could be subject to criminal proceedings. A death such as Vanessa's must not occur again.

I intend to make recommendations, as I am entitled to do under s. 22 of the Coroners Act, that police review the Safe Driving and Pursuits Policy, and ensure that all police officers are retrained and educated fully as to its guidelines and their responsibility with the power given to them thereby.

I also intend to make a recommendation in regard to Constable Innes, who has apparently attempted months after the death, to bring some comfort to the Hardys by giving them some information in breach of guidelines. Although it was inappropriate, it is my view that Innes acted entirely in good faith out of concern for the family. He should not be further punished for that, particularly given that had he not been prepared to give his evidence in conflict with his colleagues, we may never have been able to establish the truth of what happened.

There is also a need to encourage a greater use of the skills of Aboriginal Liaison Officers in critical incidents. Their role should be incorporated as a matter of course, and be more defined.

Formal Finding:

That Vanessa Louise Hardy died at 3.40 am on October 12th, 2003, at Karinda Road, Brewarrina, as a result of Multiple Injuries received by a motor vehicle collision in which she was a passenger, during a police pursuit.

Recommendations

To the Commissioner of Police

- **That the conditions of the powers granted to police by the Safe Driving and Pursuits Policy, and their resultant responsibilities, be clarified to all officers in New South Wales, and that all officers be required to undertake further education in that Policy, in accordance with the comments of the NSW Ombudsman, and in particular in regard to pursuits, forthwith.**

- **That the Commissioner allow Local Area Commanders to make adaptations of the Policy for local conditions, but ensure that officers are fully instructed in those adaptations.**

- **That there be no disciplinary action against Constable Innes for conduct in providing information to the family of Vanessa Hardy, and consideration be given to his courage in giving honest evidence, and his compassion for the family.**

- **That Aboriginal Community Liaison Officers be incorporated in to procedures after any critical incident involving an Aboriginal person, and that the role of the ACLO be clearly defined, to include the requirement that an ACLO accompany any senior officer providing information to next of kin.**

845/04
Inquest into the death of Maxwell Phillips at Bathurst on the 1st August 2008. Finding handed down by Deputy State Coroner Milovanovich on the 27 March 2008.

Maxwell Phillips was aged 34 years died from head and chest injuries following motorcycle accident during a Police pursuit.

The deceased was observed in the early hours of the 1/8/2004 to be intoxicated at licensed premises at Bathurst. Following an altercation in the hotel, he was asked to leave. He was observed to by heavily intoxicated at that time and was warned not to drive his motorcycle. A short time later Police arrived at the hotel and were informed of the presence of the deceased who at the time was seated on his motor cycle in the hotel car park. At about this time the deceased started his cycle and rode off in the presence of the Police.

The Police followed the deceased with a view of stopping him for a random breath test. After following him for a short distance in the township of Bathurst, during which time a check of his registration details were obtained, Police activated their lights with a view of stopping the deceased to administer a random breath test. The deceased failed to stop and accelerated harshly, pulling away from the Police. The Police were driving a Category 4 caged Holden Police vehicle. This type of vehicle is not authorised for pursuit purposes. The Police vehicle increased its speed, however, radioed VKG to the effect that they were not in pursuit. Estimates given by Police were that the cycle increased its speed to up to 180klms per hour. Police continued to follow the vehicle contrary to the Safe Driving Policy Guidelines and have stated that they reduced their speed to the speed limit and were not in pursuit. At the end of a long straight, the deceased lost control of his cycle and crashed through a wire fence, sustaining fatal injuries.

The main focus of the Inquest was the compliance or otherwise of the Police Safe Driving Policy and the speed of the pursuing Police vehicle. The Inquest determined from independent evidence that the speed of the Police vehicle, as indicated by the officers involved in the pursuit, was unreliable. A time and distance study determined the average speed of the Police vehicle over a distance of 5.6 kph to have been 112 kph. A re-enactment of the route travelled by Critical Incident Investigators determined that, travelling at the nominated speed limit; the journey would have taken 6 minutes and 20 seconds. The time logs from VKG suggested that the actual journey over the same distance on the night in question took 3 minutes and 30 seconds.

While the Inquest recognised that the deceased had contributed to his death by driving at excessive speed and with a blood alcohol level of 0.188.

The Court was satisfied that Police had driven far in excess of the prevailing speed limit and while indicating that they were not in pursuit, they were deemed to be still pursuing the vehicle by definition of the Safe Driving Policy. The Court also noted that the Supervisor of the pursuit and the VKG operators should have made independent decisions as to whether a pursuit was in progress by eliciting more information from the Police officers involved in the pursuit.

Such information, regarding speed and location may have triggered a decision by the VKG Operator or Supervisor to direct immediate termination and to immediately cease following the cycle. The Coroner made no formal recommendations, however, did support that appropriate and regular training of Police in regard to the Safe Driving Policy and the responsibility of Supervisors should be considered and re-enforced by the Commissioner of Police.

The Coroner was mindful that recent recommendations had been made by Deputy State Coroner, Magistrate MacMahon in regard to the Safe Driving Police and any ambiguity that might exist.

Formal Finding.

That (the deceased) died on the 1/8/2004 at the intersection of Marsden Lane and Limekilns Road, Bathurst, in the State of New South Wales, from head and chest injuries sustained there and then, when the cycle he was riding left the road.

1495/04/1496

Inquest into the death of Caroline Gray and Charles Woodhouse at Barham on the 25 August 2008. Finding handed down by Deputy State Coroner MacMahon on 13 February 2008.

Ms Gray and Mr Woodhouse had been married and resided at Rocky Plain, near Cooma NSW. The relationship failed and Ms Gray had moved away from the Cooma area to Barham NSW. Ms Gray had also entered a new relationship. Property issues had not been resolved between Ms Gray and Mr Woodhouse following their divorce and this was to be the subject of pending proceedings in the Family Court of Australia.

The evidence suggests that Mr Woodhouse left his home saying that he was going to Canberra for an appointment with his solicitor to discuss the property proceedings. Mr Woodhouse had expressed concerns that he would be required to sell his property at Rocky Plain following the conclusion of those proceedings. Instead of going to Canberra he travelled to Barham arriving early in the morning of 25 August 2004.

At about 8am on 25 August 2004, shortly after Ms Gray's partner left for work, Mr Woodhouse approached her home. There was an argument between them on the front lawn of the property.

Mr Woodhouse had a rifle with him. The evidence established that Mr Woodhouse shot Ms Gray and then shot himself. As a result of the injuries sustained both Ms Gray and Mr Woodhouse died.

Post mortem examinations established that the direct cause of death in each case was gunshot wound. The Coroner was satisfied that the evidence established that Mr Woodhouse travelled to Barham with the intention of killing Ms Gray and then taking his own life.

The death of Ms Gray and Mr Woodhouse was classified as a death in a police operation. This was because neighbours had observed a man with a firearm arguing with Ms Gray and reported that fact to the police. As a result, at the time of the deaths, a police officer was in attendance at the scene. In addition a question arose as to Mr Woodlouse's possession of the rifle.

The Inquest examined the manner in which police responded to the information provided to them as well as the manner in which the critical incident was investigated. The Coroner considered that the police response in respect of each matter was appropriate.

The Coroner also made a number of recommendations in accordance with Section 22A, Coroners Act 1980.

Formal Findings:

Caroline Jane Gray died on 25 August 2004 at 48 Wakool St Barham. The cause of Ms Gray's death was gunshot wounds to her chest and head inflicted on her with the intention of taking her life by a person since deceased.

Charles Edward Woodhouse dies on 25 August 2004 at 48 Wakool St, Barham. The cause of Mr Woodhouse's death was a gunshot wound to the head which was self inflicted with the intention of taking his own life.

Formal Recommendations:

- **that Section 211A, Police Act be reviewed to require that all police involved in police operations where a death occurs be mandatorily tested for drugs and alcohol consumption,**

- **that the State of New South Wales bear the cost of the forensic cleaning of crime scenes where a death has occurred, and that**

- **That Sergeant Jeffery Elliott, the police officer who responded to the request for assistance on 25 August 2004, be recognised for the bravery and professionalism that he showed in the performance of his duties on that day.**

1574/04
Inquest into the death of Michael Brown at Grafton Gaol on the 9 September 2004. Finding handed down by Deputy State Coroner MacPherson on the 18 February 2008.

Michael was a 43-year-old inmate of Grafton Correctional Centre serving a sentence of 9 months imprisonment imposed on him at the Local Court Penrith on 31 March 2004 for Offences of Driving Whilst Disqualified and Driving with High Range Prescribed Concentration of Alcohol.

At about 1.30pm on the 8 September 2004 Michael was seen by clinic staff at the Centre to obtain his daily dose of methadone, which he regurgitated and informed staff that he had been unwell for the preceding three days.

After receiving some medication to alleviate his symptoms he was again seen at 8.50pm on the 8 September by clinic staff where he informed them that he was feeling worse. As a result he was transferred from the Centre to Grafton Base Hospital under escort.

Michael arrived at the Hospital after having been assessed by Dr. Calvey as having pneumonia. He was given oral antibiotics because a cannular could not be inserted and he was given oxygen therapy.

He was observed at various times over the next few hours and at 10.15 am on 9 September 2004 he was found in the ward suffering a cardiac arrest. Michael was resuscitated and transferred to the High Dependency Unit of the Hospital where he suffered a further cardiac arrest and unfortunately could not be revived by Hospital staff and life was pronounced extinct at 1.50pm on 9 September 2004.

A subsequent post mortem gave cause of death as bronchopneumonia.

A report was obtained from Dr. Peter Gianoutsos MB ChB FRACP FCCP, Consultant Thoracic Physician, on the care and treatment of Michael and he concluded that "*All proper medical treatment was afforded once Mr. Brown was transferred from Grafton Correctional Centre to Grafton Base Hospital*" and further that, "*All care and treatment provided were appropriate given the circumstances."*

As a result of the evidence of the specialist and the findings at post mortem the Inquest concluded that Michael died of natural causes and that no criticism could be made of the care Michael received either at the Correctional facility or the Hospital.

Formal Finding:

I find that Michael Dennis Brown died on 9 September 2004 at Grafton Base Hospital of bronchopneumonia.

1721/04
Inquest into the death of Phillip John Pettigrove at Long bay Gaol on the 1st October 2004. Finding handed down by Deputy State Coroner, MacMahon on 21 October 2008.

Mr Pettigrove was a resident of Victoria who was temporarily living in the Forster /Tuncurry area in July 2004 with a friend Stephen Rose. Mr Pettigrove had previously been diagnosed as suffering from chronic schizophrenia, poor vision and profound deafness. He had had multiple admissions to psychiatric institutions in Victoria.

Mr Pettigrove suffered a psychotic episode and was admitted to the Manning Hospital for treatment. His condition stabilised and the treating medical practitioners concluded that it was appropriate to discharge him into the care of Mr Rose to be transported back to Victoria in order to receive further treatment. He was discharged on 21 July 2004.

Whilst in transit near Dubbo during a convenience stop Mr Pettigrove killed Mr Rose. He was arrested and bail was refused. He was considered to be a risk to himself and held in a safe cell at Bathurst CC.

On 23 July 2004 he was transferred tot he MRRC and once again held in a safe cell whilst undergoing risk intervention team (RIT) assessments.

On 4 September 2004 Mr Pettigrove's condition was considered to have stabilised sufficiently to be transferred to the Long Bay Prison Hospital. He underwent further RIT assessments and on 27 September 2004 he was considered to be a risk to himself and returned to a safe cell until 30 September 2004.

An assessment on 30 September 2004 considered that it was appropriate for Mr Pettigrove to vacate the safe cell. During the course of the assessment Mr Pettigrove had not expressed any suicidal ideas however some concern was held for the safety of other persons who might occupy a cell with Mr Pettigrove. As such Mr Pettigrove was returned to a cell by himself.

On the evening of 1 October 2004 Mr Pettigrove was locked in his cell. When it was opened on the morning he was found to be deceased. The cause of Mr Pettigrove's death was hanging and the evidence available established that Mr Pettigrove had taken his own life.

At Inquest the assessment of Mr Pettigrove' propensity for self-harm by Health and Correctional staff together with the decision to house him in a cell by himself were examined. On the basis of the evidence available at the time those decisions were considered to be appropriate.

During the course of the Inquest an issue arose as to the conditions inmates experienced whilst housed in a safe cell. The Coroner made a recommendation that, as closely as possible having regard to the prison environment, the conditions experienced by an inmate when housed in a safe cell should reflect the conditions provided in public mental health facilities.

Formal Finding:

I find that Phillip John Pettigrove died on or about 1 October 2004 in Room 39 of Wing 12 Area 2 Hospital, Long Bay Gaol. The cause of his death was hanging which was due to the actions of Mr Pettigrove that were taken with the intention to take his own life.

Recommendations:

- **To the Commissioner, Department of Corrective Services and the General Manager, Justice Health.**

- **That the policies relating to the use of safe cells and the regime applicable for persons who are to occupy such cells be reviewed so that as near as possible, having regard to the Corrective Services environment, such cells meet the standards applicable to secure wards in psychiatric units of public hospitals.**

583/05
Inquest into the death of Benjamin David Walford at Lightning Ridge on the 10th April 2005. Finding handed down by Deputy State Coroner MacPherson on the 28 March 2008.

Any sudden and unexpected death is a tragedy but more so when it involves our children. You would have to have a heart of stone not to be moved by the sight of Benjamin's family and his mate George Radakovic attending every day of this Inquest into the circumstances surrounding Benjamin's death and having to relive that terrible day over and over again. Benjamin was obviously a special boy. That much is clear when you see his family and read the comments in the book that the school put together after Ben's death.

In trying to come to terms with Benjamin's death Sophia Brown, on behalf of the Walford Family, I think was trying to say that it didn't matter to the family that Benjamin's death was treated as a critical incident by police or that this was a 13A(1)(b) matter because an on duty police officer was involved.

They just wanted to know how the person who was driving the vehicle that struck Benjamin felt, what impact did Benjamin's death have on him as a person not as a police officer.

I am not being critical of Nathanial Luck when I say this. No doubt he was following the advice of his Association in participating in the record of interview that followed a particular form, but from the families point of view if one stands back and puts themselves in the families shoes, then commencing the record of interview by saying you would exercise your privilege against self incrimination and that you would only participate in the interview because you had to under the Police Service Regulations, gives the impression to the family that one either has something to hide or that one is unaffected by the death.

The evidence of Superintendent Stanley Single was that he was concerned enough about the emotional state of Nathanial Luck that he contacted a support person from Walgett Police Station to attend and the now Superintendent Michael Willing who conducted the record of interview who spoke about Luck's demeanor. Finally he appeared here at the Inquest where he withdrew his objection to give evidence and be cross-examined. He gave evidence of the effect that Benjamin's death had on him. He did not leave after giving evidence and he was here when Sophia spoke of her and her family's pain at the loss of their beloved Ben.

They are not the actions of someone unaffected by Benjamin's death.

The Role of the Coroner.

At the outset counsel assisting set out the role and function of coroners. It was done not so much for the benefit of learned counsel but more for the family and friends of Benjamin who may not appreciate and understand that while Coroner's do have wide powers, they are limited by the very statute, which empowers them. (The Coroner's Act, 1980)

The primary role of a Coroner in regard to a death is to determine the identity of the deceased, the date of death the place of death and the manner and cause of death. The Coroner is required to make formal findings, which will be recorded at the Registry of Births Deaths and Marriages. In making formal findings as to identity, date, place, manner and cause of death the test is on the balance of probabilities (what is more probable) and when the requisite test cannot be met, the Coroner would return an open finding.

Coronial proceedings are Inquisitorial. They are neither criminal, civil, or adversarial and it is not the role of the Coroner to attribute fault or make findings in relation to negligence or duty of care, they are issues that sit more comfortably in the civil jurisdiction. In fact it should be stated that a Coroner is prohibited from indicating in his/her formal findings that any known person has committed an offence. (Section 22(3) Coroners Act 1980).

There is often a perception and sometimes an expectation, particularly from the next of kin, that a Coroner in presiding over an Inquest will provide some measure of justice to the deceased, next of kin and next of kin's family. There is no doubt that a Coroner's role has been clearly identified as being one that places a responsibility on the Coroner to protect the interests of the deceased however, concepts of justice are limited to the responsibility the Coroner has to ensure that the evidence is examined with a view to determining whether any person has committed an indictable offence in relation to the death.

In the case of Benjamin's death there is no evidence that any person has committed an indictable offence. The Coroner can make recommendations in relation to a death to prevent a similar tragedy from occurring. (Coroner's Act 1980, Section 22) They are only recommendations, however, both the Walgett Shire Council and the Lightning Ridge Miners' Association Limited have indicated they are willing to consider any recommendations. These recommendations are made in light of the report of the expert, Fred Schnerring, Consulting Engineer, the answers given to questions put to him at the site on the first day, and answers to questions put in cross-examination.

Factual Background

On Saturday 9 April 2005 Ben had stayed over at George Radakovic's house as they were mates and would often stay at each other's houses. George and Ben would often go bike riding on the outskirts of Lightning Ridge.

On Sunday 10 April 2005 the boys decided to fix a bike owned by Ben's sister, Jennifer's boyfriend Colin Price by fixing the chain so they could both go for a ride. After fixing the bike up they both rode the bikes around the three-mile and the back of the Newtown Hotel at the bike track for one to one and half hours.

They then decided to go to Darren Smith's place at the airport to show him the bike that they had repaired and painted which necessitated them crossing the main highway, Bill O'Brien's Way. It was about 4pm.

George was in front approaching the intersection and he slowed because he knew the highway was coming up and at that point Ben rode past him and did not slow down. George then looked to his right saw a white 4wheel drive vehicle that we now know was being driven by Nathanial Luck a Detective Senior Constable.

George says he was near the cattle grid, which has since been removed, when Ben rode out onto Bill O'Brien Way into the path of the 4wheel drive vehicle which struck the motor cycle Ben was riding.

George says he did not see Ben looking out for traffic before he went onto Bill O'Brien Way but he says he speeded up to try and warn or stop Ben before he went onto the highway.

He said in his statement that he thought the accident happened because either Ben had forgot to look for cars, or that he saw the car at the last moment and thought that he could get across the road in time.

He said that whenever they rode together they always rode safely and that Ben was not a show off and that they would never play games of trying to beat cars across the roadway. He said, “This was just an accident.”

Although he saw the white 4-wheel drive vehicle he did not see the maroon car until it pulled up beside Ben.

Heather White was the driver of the maroon vehicle, a Ford Festiva with Victorian number plates. She says that she was not quite doing 100 kph when she saw the 4-wheel drive vehicle being driven by Nathanial Luck.

She had her mother Jean Goldfinch and daughter Laura White in the vehicle with her. She says that she saw a bus stop on the right hand side of Bill O’Brien Way and she describes seeing two motor cycles “They were hiking it…they looked like they were racing one another.”

We now know that what she saw was George trying to catch up to Ben to stop him from entering the highway and I am satisfied that the boys were not racing one another.

She said that when she saw them they were very close to the roadway where she says the front bike, being ridden by Ben, drove onto the roadway without slowing down. She says the white Ute seemed to swerve a bit to try and avoid a collision and she described the time it took as “instantaneously”.

In her evidence yesterday she drew a plan showing how the 4-wheel drive vehicle swerved right and then left to try and avoid Ben’s bike. She also said that the 4-wheel drive vehicle slowed down.

The evidence of George Radakovic and Heather White both support the evidence of Nathanial Luck that young Benjamin just rode out onto the highway in front of the 4-wheel drive vehicle. Luck says he was doing just under 100 kph and he saw the motorcycles at the last moment tried to take evasive action but struck Ben’s bike.

He stopped he went back and he rendered assistance by helping Heather White do CPR until the Ambulance arrived.

A Traffic Engineering Investigation into the accident involving Benjamin and Senior Constable Luck was commissioned on instructions from the Crown Solicitor’s Office. The comprehensive report was compiled by Fred Schnerring a Consulting Engineer and his findings, summary and conclusions are contained on pages 18 and 26 of that report.

He concluded that the speed of the Police Toyota Hilux probably was no more than about 100kmh and that the speed of Benjamin's motorcycle was probably no more than 60kph.

He said that any higher speeds probably would not have allowed sufficient time for Detective Senior Constable Luck to swerve to the right.

He concluded that impact with the bike occurred on the westbound side of Bill O'Brien Way.

He concluded that had Detective Senior Constable Luck not swerved he probably would have avoided impact with Benjamin's motorcycle,

However, he had George's motorcycle to contend with and as Fred Schnerring says on page 24 of his report that while a strategy of maintaining speed and not swerving could have avoided a crash with Ben's motorcycle and allowed George's motor cycle to pass behind the police car, such a strategy of threading the eye of a needle, especially when the gap between the two motorcycles was apparently closing, could be considered reckless.

Benjamin's death was a tragic accident and no fault of Detective Senior Constable Luck who had to make a split second decision in circumstances where two motorcycles were involved. Why Ben drove onto Bill O'Brien Way into the path of the police vehicle we will never know. It may be that he forgot the highway was there. It may have been that he saw the red maroon car and knew he could make it across the highway safely but did not see the white 4-wheel drive vehicle.

In the aftermath of Ben's death we heard evidence that Detective Senior Constable Luck had access to counselling through work. I do not mention this as any criticism of Officer Luck because the service is provided as part of his employment. Heather White said she had access to counselling through her work and I noticed when I read the book Ben's school had produced as a tribute to Ben it mentioned that counselling was provided for Ben's schoolmates. The only people it seems that missed out and who desperately need it even today are the Walford family and they are still waiting.

We have been able to use the expertise of Fred Schnerring in suggesting ways in which the intersection now called the Ben Walford Crossing can be improved and made safer. He points out that the intersection of the six mile, with Bill O'Brien Way is not obvious enough either to traffic travelling on Bill O'Brien Way or the Six Mile Road.

While I was standing at the crossing on the first day of this Inquest it was clear that the Six Mile in particular and the Three Mile to a lesser extent, were busy roads for a town the size of Lightning Ridge where there are limited opportunities for young people to amuse themselves and motor bike riding is understandably very popular. Bill O'Brien Way is the major thoroughfare connecting Lightning Ridge to the Castlereagh Highway.

There are four key recommendations which should be put in place and will not put either the Council or the Miners Association to any great expense but will enhance the safety of people using these roads, including young people like Benjamin and George, tourists and others who are unfamiliar with Lightning Ridge and its environs.

The first and most obvious is to reduce the road speed from 100 kph to 80 kph 300 metres from the intersection towards the Castlereagh Highway. The evidence of Fred Schnerring in that regard was that if that was the speed on the 10 April 2005 then the accident may not have occurred and if it did the injuries may not have been fatal.

The second recommendation is that there should be an Intersection Approaching sign placed somewhere between 140 and 240 metres on the western side of the intersection between Bill O'Brien Way and the Six Mile.

The third key recommendation is that there should be an Intersection Approaching sign on the Six Mile and Three Mile roads the distance from Bill O'Brien Way to be worked out with traffic engineers.

The fourth key recommendation is that *Single Barrier* line markings be placed *200 metres* west of Bill O'Brien Way changing to *Double Barrier Centre Lines 50 metres* from and leading into the intersection with the Six Mile and Three Mile roads.

There are a number of other suggestions that I will have conveyed to the Council and the Miner's Association for their consideration. They are (1) A Staggered T Intersection although the Walford family is understandably concerned that should the Three Mile Road be moved it may interfere with Benjamin's memorial and they would prefer that not to happen (2) A Roundabout (3) Bitumen for 50 to 100 metres from Bill O'Brien Way into the Three Mile and Six Mile Roads (4) A Median Strip and Signs on Three Mile and Six Mile roads and (5) Ripple Strips on Bill O'Brien Way leading into the intersection with the Three and Six Mile roads.

Finally, although there is a Give Way sign facing traffic entering the highway from the Six Mile in place now there was no sign there on the 10 April 2005. Although it is not one of the four key recommendations of Fred Schnerring I believe that the give way signs should be replaced by Stop Signs.

The Walford family pointed out that they have been miners in Lightning Ridge for many years and they do not want changes made to the intersection that would create confusion or interfere with the business of mining.

The issue for this Inquest to deal with was whether any information could be obtained from the police vehicle about speed and whether brakes were applied.

This issue came about because I had been involved in an Inquest dealing with a car being struck by an XPT at a level crossing in Baan Baa and an expert Greg Tanti had a program that could read data from the motor vehicle in relation to speed braking etc.

Counsel for the Police Commissioner has indicated that Police will implement a policy in relation to critical incidents involving police where management of the motor vehicle is in issue of impounding the vehicle and retrieving the data if it is available and can be retrieved.

We now have a statement from Greg Tanti it was given over the phone and transcribed and will now form part of this Inquest. Essentially it confirms that even with the 2003 Hilux driven by Officer Luck information could have been retrieved depending on the severity of the collision.

It seems to me that in light of this information I should make a recommendation that in fatalities involving police vehicles where the management of the motor vehicle is in question that the vehicle should be immediately impounded and towed away for examination of the vehicles Electronic Control Unit.

The statement by Greg Tanti indicates that police vehicle examiners are being currently trained by him to use his program to download information from vehicles ECU and that training is in it's early stages and is ongoing.

FORMAL FINDING

I FIND THAT ON THE 10 APRIL 2005 AT BILL O'BRIEN WAY LIGHTNING RIDGE BENJAMIN DAVID WALFORD DIED FROM THE EFFECTS OF MULTIPLE INJURIES SUSTAINED WHEN THE MOTOR CYCLE HE WAS RIDING CAME INTO COLLISION WITH A MOTOR CAR BEING DRIVEN BY DETECTIVE SENIOR CONSTABLE NATHANIAL LUCK.

RECOMMENDATIONS UNDER SECTION 22A CORONER'S ACT

TO MINISTER OF POLICE, LIGHTNING RIDGE MINERS ASSOCIATION AND WALGETT SHIRE COUNCIL.

SEE PARAGRAPHS 36, 37, 38 AND 39.

I FURTHER RECOMMEND THAT IN FATAL COLLISIONS INVOLVING A POLICE VEHICLE WHERE THE MANAGEMENT OF THE POLICE VEHICLE IS IN ISSUE THAT THE POLICE VEHICLE BE IMMEDIATELY IMPOUNDED AND TOWED AWAY FOR EXAMINATION AND DOWNLOADING OF INFORMATION FROM THE POLICE VEHICLES ELECTRONIC CONTROL UNITS.

1093/05
Inquest into the death of John Keith Lang who was reported to the Coroner as probably deceased on or about the 4th May 2005, location unknown. Open finding handed down by Deputy State Coroner Milovanovich on the 15 May 2008.

The deceased was a single male who was employed as a Postman and had resided in the Kenthurst area of northwestern Sydney. He was one of five children, both his parents being medical practitioners. At the time of his disappearance on the 4th May 1985 Mr Lang had no criminal record, however, evidence adduced during the Police investigation determined that he had been involved in criminal activity, primarily associated with the stealing and re-birthing of motor vehicles.

On the 4th May 1985 Mr Lang and an associate travelled in separate motor vehicles, one of which was stolen, to an area described as a dirt track off Singleton Road, near Colo in the State of NSW. Subsequent admissions to the Police by Mr Lang's associate have confirmed that they travelled to this area for the purpose of stripping motor vehicle parts off a vehicle that Mr Lang had stolen early that day.

At around 3.30am on the 4th May 1985 while returning from the Colo area, with stolen motor vehicle parts clearly visible in the rear of the utility Mr Lang was driving, Police stopped the vehicle. When questioned in regard to the motor vehicle parts, Mr Lang and his associate informed Police that they had removed those parts from abandoned motor vehicles in the Colo area. At this stage neither Mr Lang nor his associate made any admission to have stolen a motor vehicle. They were both taken to Windsor Police Station where it was agreed that Mr Lang would accompany Police to the Colo area and indicate the abandoned vehicles. His associate remained at Windsor Police Station.

At about 5.00am on the 4th May 1985, Mr Lang travelled in a Police vehicle with two Police officers to the location at Colo. Police were directed down a dirt track and observed a number of abandoned vehicles, however, could not confirm details due to their location and lack of light. A decision was then made to return to Windsor Police Station. A short time later, while travelling on the dirt track and while the Police vehicle slowed, Mr Lang exited the rear of the Police vehicle and ran off into bushland. Constable McCue gave chase but his ability to see Mr Lang was hampered by darkness and he was guided simply towards the direction from which he could hear noise. Constable McCue during this chase fell over a rock ledge and injured his back and knee. Both Police Officers then returned to Windsor Police Station. On the following day, Sgt Tallis and another officer returned to the scene at which it was believed that Mr Lang had exited the Police vehicle and searched the surrounding bushland. They could find Mr Lang or any evidence that he was injured.

At that time Police believed that Mr Lang had made good his escape and he was circulated as wanted in regard to the motor vehicle larceny offences.

The evidence presented at Inquest would suggest that Mr Lang did make good his escape from the bushland at Colo and that he returned to a property at Kenthurst for a short time. Two witnesses have corroborated seeing him some time on the 4th May and one witness believed that when she last saw him he left the Kenthurst property while in possession of a firearm. Mr Lang was known to have possessed firearms.

The disappearance of Mr Lang in 1985 was not treated as a critical incident and it was prior to the enactment of Section 13A of the Coroners Act, 1980. The evidence indicated that Mr Lang was reported as missing by his sister some time late in 1985, however, no records of that report could be located. His sister made enquiries in 1998 as to the progress of the missing person investigation, at which time it was noticed that he did not appear as a missing person. Accordingly he was again reported as a missing person, however, when reported as missing in 1998 it was not identified that at the time of his disappearance he was perhaps in lawful police custody.

His suspected death was reported to the Deputy State Coroner in 2005 and a full brief of evidence was called for. The investigation that was conducted over the past 2-3 years included a thorough search of paper work, a search of the area where Mr Lang went missing as well as searches using a cadaver dog at the Kenthurst property. All enquiries with various agencies, banks, medical records etc, have failed to identify that Mr Lang has accessed any of those agencies. His death is not registered nor is their evidence that he left the country. The Coroner determined that on the balance of probabilities Mr Lang was deceased.

The suspected death of Mr Lang was deemed by the Coroner in 2005 as being a death falling within the provisions of Section 13A of the Coroners Act 1980. The Coroner was satisfied on the evidence that Mr Lang was in lawful custody at the time that he escaped from Police, however, as there was evidence that he was alive on the following day, his death was not a death in custody per se.

Formal Finding:

That John Keith Lang is deceased and that he died on or some time after the 4th May 1985. As to the precise date of death, place of death or the manner and cause of death from evidence adduced I am unable to say.

1303/05
Inquest into the death of Michael George Angus Llewelyn at Campbelltown. Finding handed down by Deputy State Coroner Milovanovich on 20 June 2006.

The deceased had a history of depression and mental health issues for a period of some 5 years before his death. The deceased due to his depression and suicidal ideation became a regular caller to the NSW Police and Emergency Services. In the two year period between 2004 and 2005 the deceased made no less than 54 phone calls seeking assistance or indicating a desire to take his own life. On 26 separate occasions between June 2002 and November 2005 the deceased was scheduled by the NSW Police under Section 24 of the Mental Health Act.

On the 19/11/2005 the deceased phoned Police and informed them that he intended to take his own life. Police and Ambulance responded and it was ascertained that the deceased had not harmed himself and indicted that he had no intention to do so. Shortly after, the deceased again made numerous phone calls to the Police and on this occasion he was arrested and charged with public mischief. He was released on bail with conditions that he was not to telephone the Police of Emergency Services unless in was in relation to a genuine emergency.

On the 23/11/2005 the deceased contacted Campbelltown Hospital and was put through to the Ambulance Emergency Operator (000). In the conversation the with the 000 operator, the deceased advised that he had taken 60 to 80 Colgout tablets and about 40 Progout tablets. This information was relayed to an Ambulance electronically onto a Mobile Data Terminal.

An Ambulance responded and attended the address of the deceased. At the same time, Police also responded to the 000 call and also made their way to the deceased premises. The Ambulance arrived first and the deceased was spoken to and he produced two empty bottles of Progout medication.

The deceased was placed into the Ambulance and the senior Ambulance Officer then phoned the Poisons Information Centre to obtain advice in regard to the drug Progout. It was of subsequent significance that the Ambulance personnel did not question the deceased as to his earlier assertion that he had taken both Colgout and Progout.

This information was displayed on the Mobile Data Terminal, however, the Poisons Information Centre was only advised, and gave advice, in regard to Progout. Progout is non-toxic and the information provided by the Poisons Information Centre was that the deceased would not suffer any ill effects. Police at the scene were advised by NSW Ambulance that even if the deceased had taken medication his vital signs and the information provided by the Poison Information Centre indicated that he was fit to be taken into custody.

Police then made a decision to arrest the deceased for breaching his bail and that he would be charged with a public mischief offence.

The deceased was then taken from the Ambulance and conveyed to Macquarie Fields Police station and entered into custody. During his period in custody at Macquarie Fields Police Station the deceased was observed to use the toilet on numerous occasions and to have suffered from vomiting and diarrhoea.

At 6.00am on the 23/11/2005 Police called for an Ambulance, as the deceased appeared to be unwell. Ambulance personnel responded and examined the deceased and again the Poisons Information Centre was contacted and advice sought regarding the possible effects in regard to the ingestion of Progout.

As on the previous occasion, earlier in the morning when Ambulance personnel assessed the deceased, no information was provided by the deceased that he had taken Colgout and Progout. Again the Poisons Information Centre was contacted only in regard to the drug Progout and the information provided was again similar to the information provided earlier, viz, that the drug should have no dangerous effects other than vomiting and diarrhoea.

At approximately 9.00am the deceased was transferred from Police Custody to the custody of the Dept of Corrective Services and was conveyed to the Court Cells at Campbelltown Court. Upon arrival he was again assessed and it was determined that he was not well.

On this occasion the deceased informed the Justice Health Nurse that he had taken Colgout and Progout. The Justice Health nurse recommended hospitalisation and Police were contacted and requested to convey the deceased to hospital. Police collected the deceased and he was taken to Campbelltown Hospital. The deceased was admitted to the Emergency Department and shortly thereafter to ICU. The deceased passed away at approximately 7.00 pm on the 24/11/2005.

A final post mortem report determined that the deceased had died from Colchicine Poisoning (Colgout). There was no doubt that the deceased had ingested both Colgout and Progout as he had stated in his initial phone call to 000.

A Critical Incident Investigation was conducted by Police and a Root Cause Analysis was conducted by NSW Ambulance. NSW Police (in the opinion of the independent reviewing Officer) determined that the bail conditions placed on the deceased on the 19/11/2005 were probably inappropriate in view of the known mental health history of the deceased.

The review was also critical of the Police in not investigating more fully the assertion by the deceased that he had taken an overdose of medication.

The review was critical of the Police in assuming that the deceased was being untruthful in regard to his assertion of taking medication, albeit, that that view may have been reasonable in view of the past unfounded assertions by the deceased that he had or would self harm.

NSW Ambulance determined that there had been a break down in communication in that the drug Colgout, which the deceased had initially indicated that he had taken, was not subject to inquiry from either the deceased or the Poisons Information Centre. The root cause analysis made a number of recommendations, which have now been implemented into Protocols.

In view of the recommendations made by the independent Police investigation and the NSW Ambulance Root Cause Analysis the Coroner was of the view that formal recommendations were not necessary. The Coroner did, however, make a number of informal recommendations.

They included a recommendation to Counsel representing the interests of the NSW Police Commissioner that the circumstances surrounding the death of the deceased be considered as a suitable case study for implementation in Police training when dealing with persons with a known history of mental illness.

The Coroner also recommended that the directives now contained in Protocol 48 of the NSW Ambulance Service be disseminated to NSW Police. The Coroner was also of the view that a copy of the Coroners commentary and findings be forwarded to the Minister for Health (Mental Health) in view of the 26 prior admissions of the deceased under the Mental Health Act.

The Coroner also requested that the Registrar write to the Director, Poisons Information Centre suggesting that the unwritten Policy of recommending hospital admission after an allegation of self-ingestion became a written policy and be disseminated to related agencies.

The Coroner formed the view that the deceased had not taken the medication Colgout and Progout with the intention of taking his own life.

Formal Finding.

That (the deceased) died on the 24th November 2005 at the Campbelltown Hospital, Campbelltown in the State of New South Wales, from Colchicine Poisoning and that the other conditions contributing to death include a severe fatty liver and coronary atherosclerosis.

195/06
Inquest into the death of Brett Adam Sparks at Darlinghurst on the 6th February 2006. Finding handed down by Deputy State Coroner MacPherson on the 14 May 2005.

At about 10.10pm on Monday, 6 February 2006 Brett Sparks entered the Royal Sovereign Hotel, 306 Darlinghurst Road Kings Cross.

He purchased a beer and went to the lounge at the rear of the hotel. After a short time, Brett then went to the pool table, however, not being a local, he was unaware that at the time a pool competition was in progress.

Brett had words with one of the pool players left some money on the pool table and went to the back of the hotel and sat down.

The patron Brett had words with went and spoke to Brett and as a result of that conversation Brett had a confrontation with that patron and several others who got involved.

As a result he was asked to leave the hotel which he did returning moments later rushing into the bar knocking over an old gentlemen near the pool table and rushing towards the patron who had words with earlier and who had gone into the ladies toilets.

Brett was then restrained by up to 8 patrons who waited for Police to arrive. Sergeant Ginnestra arrived and subsequently handcuffed Brett Sparks who then collapsed, the handcuffs were removed and ambulance called.

Other Police arrived and a Laerdal mask was searched for in the police vehicles without success.

Ambulance and rescue squad police arrived and it was noted that Brett Sparks was not breathing and had no pulse.

He was conveyed to St. Vincent's Hospital where life was pronounced extinct. The Inquest heard evidence from a number of persons including the persons involved in the restraint.

It was clear that at the time Brett Sparks was handcuffed, that is in custody, he was alive and that he died shortly after.

Brett Sparks had an alcohol addiction and mental health issues and had also ingested cocaine.

The cause of death was found to be cardiorespiratory arrest in association with a struggle including asphyxial components, cocaine ingestion and alcohol intoxication together with focal coronary artery disease.

S. 22A RECOMMENDATIONS

Face shields

All Local Area Commands provide to all police personnel who are required to carry 'Personal Protection Equipment Kits', the current face shield as recommended and specifically identified by the Operational Safety Training Unit of the NSW Police Force.

Basic life support update to NSW Police Force

All operational police be advised of the recent updated guidelines for basic life support/CPR, and in particular that:

i. **the current compression/ventilation ratio is now 30:2 (30 compressions to 2 ventilations/breaths) for infants, children and adults;**
ii. **the recommended compression rate is 100 compressions per minute;**
iii. **if for some reason the rescuer is unable to ascertain whether a pulse is present and/or is unable to provide ventilations/breaths, implementation of compressions is recommended ("compressions are vital").**

Pocket Face Masks (including Laerdal type)

All Local Area Commands implement an auditable checking system so as to ensure that all operational police vehicles are equipped with all mandatory safety and First Aid equipment including the contents of the Police First Aid Response Kits (including pocket face masks with a one valve).

510/06
Inquest into the death of Ian Trevor Bradford at Boolaroo on the 5th May 2006. Finding handed down by Deputy State Coroner Milovanovich on the 31 October 2008.

Ian Trevor Bradford was a 52-year-old male who at the time of his death resided at 13 First Street, Boolaroo. It is understood that Mr Bradford was a local of the Boolaroo area having grown up and completed his primary and secondary education in that area.

Mr Bradford had been in a relationship with Fay Hilton and fathered two children and it is understood that he had been in a relationship with Ann Baker for approximately 4 and half years before his death.

Mr Bradford at the time of his death was not working and was in receipt of a unemployed/disability benefit. The evidence would suggest that he had dealings with the Police in the past and was known to have been a heroin user as well as other prescription and prohibited drugs. At that time of his death he was on a methadone programme and the evidence would suggest that he was no longer using heroin, however, did occasionally use amphetamines and prescription medication.

On Friday 5th May 2006 at about 6.15am a witness (Scott Duncan) observed a body floating in Cockle Creek below the Five Islands Bridge, Boolaroo. Police were called, a crime scene was established and subsequently the person was identified as being Mr Bradford.

THE ROLE OF THE CORONER.

The death of Mr Bradford was reported to me by telephone on the 5th May 2006. At that stage it was known that Mr Bradford had been arrested the previous night and had been in Police custody up until his release around midnight on the 4th May 2006.

At the time his death was reported to me, it was in the early stages of the investigation and it was not known whether it was the Police, or some other person or persons that may have been the last to have seen him alive. It was also evident from the information provided that Mr Bradford was found deceased, floating in water a short distance away from where he had been arrested the previous night and a short distance away from where Police dropped him off after being released from custody.

As the on call Coroner I was required to make a determination at that time as to whether the death of Mr Bradford fell within the category of being a death in custody or a death in a Police Operation. I formed the view, on the available information that his death was neither a death in custody, nor a death in a Police Operation, however,

I directed that the investigation should assume critical incident protocols and that the investigation should be conducted by a senior ranking Police Officer attached to a different Local Area Command to that of the Police involved in Mr Bradford's arrest and release.

As the Coroner responsible for investigating Mr Bradford's death I instructed Chief Inspector Humphries to ensure that the Police Officers be interviewed as soon as possible and that a video re-enactment be conducted at the first available opportunity. I also made arrangements for Mr Bradford to be conveyed to the Newcastle office of Forensic Medicine and authorised a full post mortem to be conducted applying suspicious protocols.

I also requested that Mr Maurice Taylor, Information & Support Officer attached to the Office of the State Coroner contact Ann Baker (identified as the senior next of kin at the time his death) and inform her of the Coronial process, investigation process and to provide her with information and support if required.

Mr Bradford's death was a reportable death under the provisions of the Coroners Act 1980 for a number of reasons. Firstly his death was sudden and unexpected, the cause of his death was unknown and therefore no death certificate could issue and most importantly the manner and cause of his death required a full investigation.

The role of the Coroner in regard to every reportable death is to determine the identity of the deceased, the date and place of death and the manner and cause of death. When an inquest is held, the Coroner is required to return a formal finding under the provisions of Section 22 of the Coroners Act 1980. The Coroner also has a duty to examine the evidence surrounding the circumstances of death in order to determine whether the death is suspicious and whether any known person or persons have committed an indictable offence in relation to the death.

In that regard the Coroner must have regard to the provisions of Section 19 of the Coroners Act 1980, which requires the Coroner to examine the evidence to see whether the evidence is capable of satisfying a jury, beyond reasonable doubt, that a known person or persons have committed an indictable offence in relation to the death of the deceased. The Coroner also is required to consider whether the evidence is such that there is a reasonable prospect that a jury would convict a known person or persons of an indictable offence in relation to the death.

BACKGROUND.

The Police investigation into Mr Bradford's death involved the interviewing of a number of Police and civilian witnesses as well as obtaining other documentary evidence, which included telephone records, custody management records, charge sheets, crime scene examinations, photographs, post mortem results, analytical results and expert pharmacology evidence.

It would appear from the statement of Ann Baker that on Thursday 4th May 2006 Mr Bradford travelled to Newcastle in the morning in order to obtain his methadone from the chemist.

Upon his return Ms Baker and Mr Bradford visited the Teralba Bowling Club, arriving at about 11am and staying until approximately 2.45pm when they were collected by Ms Baker's mother and then had lunch. Ms Baker has stated that neither of them consumed any alcohol while at the Bowling Club.

At about 4.00pm Ms Baker's mother drove Mr Bradford to a Doctor and then a chemist at Wallsend in order for him to pick up his prescription of Serapax.

Ms Baker states that they were returned home and then took the children to McDonald's at about 6.30pm and returned home about 7.00pm in order to cook dinner. Ms Baker in her statement recounts a telephone conversation she had with a Donna Convery at about 7.15pm that night.

In that phone conversation Ms Baker states that she was told that a person by the name of John Hinks (Jonksy) was known to do break and enters and if he found out that Mr Bradford was residing away from his home that his property may not be safe. According the statement of Ms Baker a discussion then took place about Mr Bradford returning to his home to lock up and it was discussed as to whether they should wait until Ms Baker's mother returned home.

It would appear that Mr Bradford made the decision that he would ride over to his home on his bike and according to Ms Baker he left sometime between 9pm and 10pm. That was the last time she saw him alive. Ms Baker has given a description of the clothing that Mr Bradford was wearing when he left which included a description of long navy pants (thin fabric).

There is no evidence of any sightings or any evidence of the movements of Mr Bradford from the time he left Ms Baker's residence until he is sighted and then arrested by Police. We know from the charge papers that Mr Bradford was arrested at 10.50pm. In the statement made by Ms Baker on the 5/5/2006 she stated that she believed that Mr Bradford had left her home sometime between 9pm and 10pm.

In her oral evidence at this Inquest she now believes that he may have left much earlier and possibly as early as around 7.00pm.
There is some evidence that might support the fact that Mr Bradford in fact left Ms Baker's home some time shortly after 6.00pm. That evidence relates to her memory that he phoned her shortly after leaving her home. The call charge records of Mr Bradford's mobile phone record that he made a telephone call at 6.19pm to the number described as 0403815728. Ms Baker has stated that she had two mobile phones at the time and that that number could have been hers. Accordingly it is probable that Mr Bradford left Ms Baker's address some time after 6.00pm and phoned her at 6.19pm.

On the assumption that those times are correct it would appear that Mr Bradford's movements from sometime shortly after 6.00pm on 4/5/2006 until 10.50pm on 4/5/2006 are unknown. That time period is approximately 4hours and 50 minutes.

No evidence has been adduced that would suggest that anybody saw Mr Bradford and accordingly it is pure speculation as to what he may have done. Ms Baker has stated that he may have gone back to his premises and she recalls that the following day she found his home locked, however, the television was on.

It is possible that Mr Bradford may have returned home and changed some of his clothing and this may explain the fact that Ms Baker believed that when she last saw him he was wearing navy cargo pants.

We know that when Mr Bradford was found in Cockle Creek he was wearing beige or light coloured trousers. The fact that his movements prior to his arrest are unknown it is also possible that Mr Bradford may have obtained and consumed a quantity of drugs before his arrest and possibly after Police took him back to Five Islands Bridge.

THE ARREST OF MR BRADFORD.

The evidence indicates that Senior Constable Nicholson and Constable Hepplewhite were both serving Police Officers working out of Toronto Police Station, which forms part of the Lake Macquarie Local Area Command. On the 4th May 2006 they both commenced their shifts at 6.00pm and were rostered for general duties in a Police caged truck, which had the call sign, Lake Macquarie 20.

Some time before 10.50pm Sen Cst Nicholson & Cst Hepplewhite were patrolling in the Police caged truck and were driving across the bridge and construction area known as Five Islands Bridge. Both officers observed a push bike leaning up against a concrete barrier and shortly thereafter observed a male person, described as wearing a baseball cap, in and around one of the caged areas of the construction site.

The Offices stopped the Police vehicle and walked in the direction of where they last saw the male person. At first he could not be sighted and they continued walking and then heard a sound coming from around a piece of construction machinery.

Sen Cst Nicholson has stated that he observed a male person that appeared to be fiddling with and being in close proximity to the item of machinery. Officers then approached the male person and questioned him as to what he was doing. The male person stated that he was examining the seat or suspension and the Police noticed that a compartment in the unit had been disturbed and considered the actions of the male person as being suspicious. It is apparent from the interviews conducted with both offices that they formed a preliminary view that the male person was attempting to steal property and consequently they informed him that he was under arrest.

The evidence would suggest that Police then attempted to handcuff the male person and both officers have stated that during this process, possibly due to the uneven terrain, all three of them ended up on the ground for a very short time.

There was no suggestion that the male person was resisting arrest or being unco-operative and made assertions that he was not doing anything wrong and was only looking at the seat suspension. The Police Officers made a decision to take the male person back to Toronto Police Station for formal identification and processing. It would appear that the Police had made a decision that the male person would be charged; he was cautioned and eventually entered into custody at Toronto Police Station.

Police have explained that they could not issue a Field Court attendance notice, as the male person had not been formerly identified. At Toronto Police Station the male person was identified as Mr Bradford and was handed over to the Custody Manager, Sgt Jury. The custody records, which are contained at Tab 40 of Exhibit 2 (Brief of Evidence) indicates that Mr Bradford was arrested at 22.50 on 4/5/06, conveyed at 22.55 from the scene and arrived at Toronto Police Station at 23.05. The custody records also indicate that after processing and charging, Mr Bradford was released from custody at 23.50 on 4/5/2006. The Court has heard some evidence in regard to the nature of the charges preferred against Mr Bradford, and although of no real consequence, it was explained why Mr Bradford was eventually charged with the relatively minor offence of Entering Enclosed Lands.

It is understood that during the period that Mr Bradford was in custody at the Police Station he was permitted to make a phone call to his partner Ms Baker. Ms Baker confirms that she received this call and after speaking to both Mr Bradford and a Police Officer was informed why he was at the Police Station that he had been charged and would be released shortly. Ms Baker has stated that she requested that the Police bring him home and she has stated she was informed that the Police would do that. Sgt Jury, the Custody Manager, has confirmed in his oral evidence that he advised both arresting officers that they should convey Mr Bradford home in due course and Mr Bradford was told to wait.

It would appear that around midnight on the 4/5/2006 Sen Cst Nicholson & Cst Hepplewhite, the original arresting officers, departed Toronto Police Station with a view of taking Mr Bradford home. It is not entirely clear whether the Police knew that the pushbike they had seen prior to the arrest of Mr Bradford was in fact his bike.

There is no indication in the interview conducted with both officers that Mr Bradford had made any disclosure to them about his pushbike. It would appear, however, that by the time Police left Toronto they were aware that he wanted to go back to the Five Islands Bridge in order to collect his bike.

At Q.114 Sen Cst Nicholson was asked “O.K. did he tell you that was his bike” A. “He didn’t say it was his bike, but I asked him when we got there, he said he was on a bike”…and “then he said, I don’t know where I left me bike and so we told him where his bike was and he said yeah well that’d be mine”. Q.118 “so you put him in the back of the truck?, when leaving here? A. Yeah. Q and where did you take him to. A. back to his bike”

Both officers have given evidence in their recorded interviews that they drove to the area where they had previously seen the pushbike. They stated that they drove onto the incorrect side of the road with a view of getting the bike, placing it in the back of the truck and then driving Mr Bradford home. It is at this point that the Police say that Mr Bradford indicated that he would ride his bike home. Sen Cst Nicholson in his interview at Answer to Question 123 stated “we were going….to pick the bike up….put it in the back and drive him home…so we opened the back door to let him know what was going on and he said…no I am alright…I’ll ride home….so we asked him again…are you sure your right to ride home…and he says yeah…I am right to ride home”.

The evidence of both officers is that they then left Mr Bradford at the location of where his bike was and they returned to the area at which they had stopped earlier in the night to look for a set of lost car keys. They located the lost keys and Sen Cst Nicholson has stated that he observed a person riding off in the distance, which he presumed was Mr Bradford.

The two officers then continued with other general duties and at tab 67 of the Brief of Evidence there is a record of radio communications between Lake Macquarie 20 and the VKG Operator in regard to general duties performed after Mr Bradford was dropped off. It is not known, nor could it be established from Police investigations what Mr Bradford did after being dropped off near his bike.

No witness has come forward to say that they saw him or spoke to him after midnight of the 4/5/2006. It would appear that he has ridden his bike a distance of some 300-400 metres to the point where it was subsequently found. Mr Bradford’s body was found floating in Cockle Creek a distance of some 400 metres from where the Police last saw him on the road bridge.

LOCATION OF THE BODY AND CRIME SCENE EXAMINATION.

As previously stated the body of Mr Bradford was seen by Mr Scott Duncan at about 6.15am floating in the water in Cockle Creek. He called Police and they attended the scene shortly thereafter. Subsequently Crime Scene investigators arrived, the area was declared and sectioned off as a crime scene and investigations began.

The detailed crime scene examination and examination of the body of Mr Bradford is more fully outlined in the statement of Senior Constable Sarma Rumbachs, an investigator attached to the Newcastle Crime Scene Section. Sen Cst Rumbachs took numerous photographs of the crime scene, property and the deceased.

When Mr Bradford was removed from the water he was wearing a pair of beige coloured long trousers, which were around his knees and a pair of socks, and "Roughland" brand boots on his feet. He had no other clothing on his upper body. Mr Bradford's clothing was searched and Police located and photographed the following items;

- 25 blister packet of Murelax 30 mg tablets with 2 tablets remaining in the packet
- A roxy brand blue coloured Velcro wallet, which contained, money, coins, identification documents and other personal items (all photographed).

An examination of the surrounding area located a number of personal items and clothing, they being;

- A grey long sleave top. Wet and turned inside out.
- A pair of dark coloured underpants (wet)
- A red coloured neck strap
- 5 keys attached to the neck strap
- A black and silver object, possibly a remote control attached to the strap
- A blue and white Shimano brand baseball cap (wet)
- A "V" energy drink glass bottle.
- A drink bottle containing a small amount of liquid.

Also located in the area was a black coloured stereo speaker which was located on the dirt road between the items of clothing and the baseball cap and Police also observed a number of cigarette butts, some appeared old and some more recent. Sen Cst Rumbachs completed an examination of Mr Bradford's body and noted there was visible froth on his lips and the mouth opening. She observed small abrasions on the back of his left hand, abrasions on the lower left arm, on the back of the right hand and an abrasion on his left buttock. Police found no other evidence at the crime scene that may have indicated that some form of struggle or altercation took place.

Mr Bradford's body was subject to a post mortem examination on the 6th May 2006 by Dr Kasinathan Nadesan. The Doctor provided the Coroner with a full post mortem report, including toxicology analysis and that report forms part of the formal documents marked Exhibit "1". For the purposes of these findings I do not propose to reproduce, in any detail, what Dr Nadesan has said in his written report or his oral evidence. Briefly, however, Dr Nadesan has formed the view that death was due to Drowning and he explained the significance of the froth in the mouth, airways and the oedema in the lungs as being consistent with salt water drowning.

Dr Nadesan also expressed the opinion that there was no evidence to support that Mr Bradford has sustained any injury, which may have contributed to his death and described the abrasions as minor and possibly ones that may have been caused by Mr Bradford coming into contact with rocks or other objects in the water.

Dr Nadesan also noted that Mr Bradford had no alcohol in his blood, however, had 0.4mg/L of methadone, 0.3 mg/L of Methylamphetamine and 1 mg/L of Oxazepam.

THE POLICE INVESTIGATION.

Having examined the material contained in the brief of evidence and the oral testimony of those witnesses called, I am satisfied that the Police conducted a thorough and comprehensive investigation.

It was apparent that the Police, correctly treated Mr Bradford's death as being suspicious, until such time as forensic evidence indicated that death was probably due to misadventure and drowning. Notwithstanding that the Police had this forensic evidence they nevertheless followed up on checking Mr Bradford's last movements, speaking to his acquittances and followed up any concern or issue raised by family or members of the public.

It is known that Det Chief Inspector Humphries, a long serving and very experienced Police Officer was appointed as the Independent investigator into the death of Mr Bradford.

In the first two months of the investigation into Mr Bradford's death, Chief Inspector Humphries had completed most of the investigative work and would have completed the submission of the final report to the Coroner, had it not been due to a complaint made by Ms Baker. On the 7th July 2006, Ms Baker wrote to Mr Maurice Taylor, Information & Support Officer, Westmead Coroners Court and expressed a number of concerns.

That letter forms part of the brief of evidence and I do not propose to restate its entire contents, other than to say that she complained that C/Inspector Humphries was offensive to her and threatened her if she continued to ask questions. Ms Baker stated in her letter that this purported conversation with D/Inspector Humphries "made her think even more than I already did, that something else had taken place that night when Ian had died". I am not aware whether Ms Baker appreciated that the nature of her complaint would be brought immediately to the attention of the Coroner and that the Coroner would have no alternative, in order to ensure a perception of a fair and transparent investigation, to have C/Inspector Humphries replaced as the investigator.

Accordingly Det Sen/Sgt Godfrey was appointed to complete the investigation and he worked on completing the brief up until the time he proceeded on sick leave and then Sgt Oliver completed the final outstanding matters and arranged for the Inquest to be listed.

C/Inspector Humphries has submitted an additional statement dated 29th October 2008 in which he denies that he ever had a conversation with Ms Baker along the lines of her assertion in her letter.

C/Inspector Humphries has expressed the view that Ms Baker may not have been pleased with him due to the position he took in regard to disputed property items and her comments may have been motivated to have him removed from the investigation. The Coroner's role is not to arbitrate or make findings of fact on issues such as those as there is an appropriate complaint mechanism. In any event, while I have a personal view in regard to Ms Baker's assertions, the fact remains that C/Inspector Humphries had already completed most of his investigations in a thorough and impartial manner before the allegation was made and Ms Baker has not been able to provide any logical reason or motive as to why C/Inspector Humphries would make such a statement. It's more probable that he didn't.

OPINIONS AND THEORIES AS HOW MR BRADFORD DIED.

The Police in their report to the Coroner are of the view that Mr Bradford's death was due to misadventure and that for some reason that cannot be determined with any degree of certainty, that he either entered the water or fell into the water and drowned. Other theories, rumours and innuendo have also surfaced, which include the following.

NSW Police Officers were involved in Mr Bradford's death.

The primary proponent of this theory is Ms Baker and to some extent Mr Watson. It is understood from the evidence of Ms Hilton, that while she still has some concerns regarding the fact that Cst Hepplewhite has not given evidence and that a video tape was not recording in the Charge Room, she no longer believes that Police were involved in his death. The reality is not that Ms Baker, nor any other person has provided any meaningful evidence or motive as to why Police would be involved in Mr Bradford's death. The belief stands contrary to all the forensic evidence and is a bizarre allegation to make against two officers who had no prior dealings with Mr Bradford. There is no suggestion that Mr Bradford was treated badly, that he had past or pending complaints against either officer or the evidence in fact suggests the contrary, that is, that Mr Bradford was dealt with kindly, even to the extent of being offered a lift home. Sight should also not be lost of the fact that Mr Bradford was charged with a very minor offence (Trespass) and he was only in custody for less than one hour.

Victim of a Gay or Homosexual assault.

This theory has only surfaced by virtue of the fact that Police were aware that an area not far from where Mr Bradford's body was found was a known area frequented by homosexuals. The fact that Mr Bradford's body was found close to this area and the fact that when found his trousers were around his knees with no underwear, perhaps perpetuated the theory or rumour that he may have been a victim of some form of gay bashing. While an open mind should be kept in regard to all possibilities, this theory is not supported by any evidence and in particular there is no evidence of an assault or injury. If Mr Bradford had been involved in some altercation, one would think that injuries would have been detected.

In addition the location of some of his personal effects and the manner in which they were positioned, would suggest that they had been removed and placed there voluntarily.

Mr Bradford entered the water with a view of accessing the pontoon.

This theory should not be dismissed entirely. Sight should not be lost of the fact that Mr Bradford was arrested while trespassing and in close proximity to where he was located machinery was positioned on a pontoon. The only way of getting to that machinery would be via entering the water.
I understand that both Ms Baker and Ms Hilton have expressed the view that Mr Bradford disliked the water and particularly that area due to the possibility of bull sharks in the water and also the fact that he had lost a close friend from drowning in that vicinity.

That said, however, sight should not be lost of the fact that Mr Bradford was caught by Police interfering with equipment and therefore we know he had a propensity for such actions.

While I agree that it would be bizarre to enter cold water in the winter months of May and particularly with socks and boots, however, we must remember if we place any weight to the expert opinion of Dr Judith Pearl that Mr Bradford may well not have been thinking rationally at the time. Despite his knowledge and familiarity of the area, he may have believed he could walk or swim across to the pontoon. If his judgment was affected by what we now know was in his system, it is not that surprising that he may have felt less inhibited to enter the water. Such a possibility could explain why some of his clothing was on the ledge.

Entered the water to cool down.

Dr Pearl, a very experienced Pharmacologist with particular experience in regard to the use and affectation of prohibited and prescription medication gave evidence at this Inquest. Dr Pearl explained how methadone, when taken with Amphetamines and in conjunction with Oxazepam can have a number of side effects. In particular she referred to the phenomena of the drug taker experiencing a severe bout of body heat, notwithstanding that the ambient temperature at the time might be low. She gave examples of drug users taking off their cloths in icy conditions because of this affect.

She proffered the opinion that Mr Bradford may have been feeling extremely hot and decided to either cool himself by splashing water on himself or even decided to enter the water. While we cannot be certain if this is what happened, it is at least a scientific explanation as to why Mr Bradford may have entered the water. Similarly, the evidence of Dr Pearl should also be recalled in regard to her opinion as to the degree of affectation by virtue of the cocktail and quantity of drugs in Mr Bradford's body.

It is accepted that Mr Bradford had a high tolerance for prescription medication and the fact that he had been using them for many years would increase his tolerance level.

That said, however, we know that at the time of his death he had, notwithstanding his tolerance levels, a high reading for methadone and amphetamines.

We also know that he gave 3 tablets from a fresh Serapax box to Ms Baker before leaving and when found deceased only 2 tablets were left. This would suggest that Mr Bradford had possibly consumed 20 tablets before his death.

The amount of drugs, and more importantly, the combination of those drugs, in the opinion of Dr Pearl would have greatly affected Mr Bradford's judgment. It is entirely possible that he either entered the water of his own free will or that he may have fallen in. If he had fallen in it may well explain why his shirt and underpants were wet.

There are two possibilities, he fell in and come out of the water and then removed his shirt and underpants and then re-entered the water, or he entered or fell into the water and removed his shirt and underpants while in the water and placed them on the ledge. He may have then got into difficulty with his trousers around his ankles and the weight of wet socks and boots.

OTHER IDENTIFIED ISSUES.

Police Duty of Care in regard to taking Mr Bradford home.

I am not aware of any policy, nor was any brought to my attention that Police have a duty or responsibility to return persons who have been arrested to their home. Common sense would suggest that any such decision would be made according the circumstances, the available resources and possibly the attitude and demeanour of the person involved.

It is accepted that it is good public relations for the Police to take a person home and it is community spirited initiative that should be commended. That said, however, I reject totally that Police ever have a duty of care to transport a person released from custody to their home. It should be remembered that Police have a very onerous responsibility in terms of their obligations in regard to persons in custody. The assessment of persons in custody requires regular checks on their welfare and the need to provide medical attention if necessary. Similarly, Police are not permitted to release a person from custody if there may be concern for the welfare of the person due to affectation by alcohol, drugs or any other reason.

The decision at almost midnight on the 4/5/06 to take Mr Bradford home was a sensible and appropriate decision. The Court has been told that it was quite, Police were available and it was not far away. If Police had for whatever reason decided not take Mr Bradford home, their obligation in my view, would go no further than to contact a family member to arrange pick up, organise transport or allow access to a phone to ring a taxi. The Police are not a taxi service and while the initiative, as in this case, to take Mr Bradford home was commendable, Police may very well be cautious in the future if allegations, as in this case, are made.

The decision to take Mr Bradford to pick up his bike was reasonable. He was no longer in custody and despite the assurances given to Ms Baker that Police would take him home, they could not force him to get into the Police Truck with his bike, if he elected to ride home. With the benefit of hindsight perhaps the Police could have been firmer in insisting that Mr Bradford come with them, however, they could not lawfully compel him against his own will.

Should his bike have been picked up when he was arrested.

Again, with the benefit of hindsight, perhaps the answer to this question is yes. That said, however, it is not entirely clear whether the Police positively identified that the bike they saw was in fact Mr Bradford's bike.

There is an inference from the evidence that the Police may only have put two and two together that it was his bike, when he asked to be returned to the bridge to pick it up.

Constable Hepplewhite not giving evidence.

It is understood that the Ms Baker and Ms Hilton would have liked Cst Hepplewhite to give evidence and I agree with them. The reality is that Cst Hepplewhite is not fit to attend court and the Court has been provided with Medical Certificates to that effect. The Court has given detailed reasons, pursuant to Section 31 of the Coroners Act 1980, as to why a decision has been made not to call Constable Hepplewhite.

It should also be noted that Cst Hepplewhite was the junior of the two officers and both he and Sen Cst Nicholson provided a full electronic interview and walk through within a very short time after the incident.

SUMMARY

There is no evidence that any identified person was responsible or in any way contributed to the death of Mr Bradford. There is no forensic or scientific evidence that would suggest that he was the victim of an assault. The only undisputed evidence is that he died directly as a result of drowning, albeit, that Dr Nadesan has noted that cirrhosis of the liver and an enlarged were other significant findings at the time of the post mortem. Dr Nadesan has also stated that those findings may have contributed to death, however, his professional opinion has not changed that the primary cause of death was due to Drowning.

The aim of any coronial inquest is to determine, from the available evidence, the manner and cause of death. That responsibility requires the Coroner to not only examine the medical cause of death (in this case drowning) but also how and why the person drowned. Sadly, for the family and friends of Mr Bradford, despite the best efforts, sometimes all the answers are simply not there.

It should be stated firmly, that just because there may remain unanswered question, that does not, nor should it, perpetuate theories and hypothesis, which are masked with suspicion, unless there is evidence to support it.

A Coroner can only make findings on the available evidence and has an obligation to return a finding that is consistent with the evidence, rather than a finding that might sit more comfortably with some.

Ultimately, I am of the view that Mr Bradford's death was a tragic accident. An examination of all the evidence strongly supports that Mr Bradford drowned after either entering the water of his own free will (and with the rider that he was well affected by drugs) or that he fell into the water. As to how Mr Bradford entered the water will never be known, however, the evidence would suggest that his loose fitting trousers which were found around his ankles, the wet socks and boots would have severely restricted his ability to either swim and no doubt contributed to him drowning.

There is no dispute as to the identity of the deceased or the place of death. As to the time and date of death, at best it would appear that Mr Bradford was last seen alive around midnight on the 4/5/2006 and he drowned sometime between midnight on the 4/5/2006 and 6.15am when he was sighted in Cockle Creek. I propose to return a finding that he died on the 5/5/2006.

FORMAL FINDING.

That Ian Trevor BRADFORD died on the 5th May 2006, at Cockle Creek, Five Islands Bridge, Boolaroo in the State of New South Wales from Drowning.

587/06
Inquest into the death of David Barker at Yanderra on the 24 May 2006. Finding handed down by Deputy State Coroner Milovanovich on 10 November 2008.

The deceased was driving a four-ton flat bed truck, which impacted with an Armco railing on the Hume Highway, Yanderra. The deceased was not injured in the incident; however, his vehicle was partly resting on the Armco railing and was partly protruding into Lane 1 of the Hume Highway.

The deceased contacted Police to report the accident and Police responded and attended the scene. As the truck was protruding in lane 1, the Police placed the fully marked Police vehicle, with warning lights activated a distance of some 30 metres to the rear of the truck.

A tow truck arrived and positioned itself behind the Armco railing and in front of the protruding truck with a view of lowering the tilt tray and recovering the vehicle. Shortly after another Police vehicle arrived and positioned itself a distance of some 100 metres to the rear of the first Police vehicle, again with warning lights activated.

At about the time the two Police Officers commenced to exit from the second Police vehicle a Kenworth B Double truck collided with the rear of the second Police vehicle. The result of this impact, catapulted the Police vehicle, which ultimately struck the deceased causing fatal injuries.

The incident was deemed to be a death in a Police Operation and critical incident investigation protocols were put in place. One issues at Inquest was to examine whether protocols between the NSW Police and the RTA had been followed in regard to notification and ensuring sufficient warning devices and notice to oncoming vehicles. From the evidence it was apparent that the driver of the Kenworth Truck had ample line of site and could have avoided the collision. The driver of the Kenworth Truck was subsequently charged with summary offences and those matters had been finalised at the time of Inquest.

The Coroner determined that there was no need for any formal recommendations.

Formal Finding:

That (the deceased) died on the 24th May 2006 on the Hume Highway, Yanderra in the State of New South Wales from multiple injuries sustained there and then when struck by a motor vehicle.

666/06
Inquest into the death of Bradden John Mcintyre at Port Macquarie on the 6 May 2006. Finding handed down by Deputy State Coroner MacPherson on 3 April 2008.

Bradden John McIntyre died in the early hours of the morning of the 6 May 2006 from multiple injuries suffered when the Holden utility he was driving left the road when negotiating a roundabout at the intersection of Clifton Drive and Hasting River Drive Port Macquarie and collided with a power pole splitting the vehicle in two. His death was a reportable death to the Coroner his death fell within the provisions of Section 13A of the Coroners Act 1980. That section states that when a person dies in circumstances of a Police Operation or Police Pursuit, the death must be reported to the Office of the State Coroner and by virtue of Section 13A an Inquest is mandatory.

The Role of the Coroner.

The primary role of the Coroner at every Inquest is to examine the evidence and make formal findings pursuant to Section 22 of the Act as to the identity of the deceased, the date of death and the manner and cause of death. It would appear that those statutory obligations, in this case, are not contentious. It is also the responsibility of the Coroner to examine the evidence to determine whether any known person has committed an indictable offence in relation to the death. An indictable offence in relation to a death ordinarily will be the offence of murder, manslaughter or gross criminal negligence.

If a Coroner forms the view that the evidence is capable of satisfying a jury as to the commission of an indictable offence and that the Coroner is of the view that there is the prospect that a jury will convict that known person, the Coroner is required to suspend the Inquest and refer the matter to the Director of Public Prosecutions for consideration of criminal charges in relation to the identified charge and known person. In this case, there is no evidence that would require the Coroner to consider suspension in accordance with Section 19 of the Coroners Act 1980.

In relation to the Police Pursuit, the Coroner also has an obligation to examine the circumstances leading to death and whether the Police have complied with the Safe Driving Policy and any other directives in relation to the pursuit of possible offenders.

The findings of the Coroner in regard to every death under Section 13A are required to be included in an annual report to the Attorney General, which is tabled in Parliament.

The Coroner also has power pursuant to Section 22A of the Coroners Act 1980 to make recommendations. Recommendations are usually made on issues that touch upon public health and safety or in regard to procedures and protocols that may avoid similar deaths in the future.

In regard to this death there has been a number of questions asked of the Officer in Charge, Inspector McKenna and other police involved in the pursuit about the protocols involved in pursuits. The Safe Driving Policy and Draft Safe Driving Policy from New South Wales, the policy applying the Victoria and Queensland have been tendered in evidence with a non-publication order made in respect to each Manual.

Notwithstanding the very sensible submission by counsel assisting in relation to the definition of pursuit in the New South Wales Police Safe Driving Policy, it seems to me that, as there were no issues in this inquest in relation to the pursuit, apart from some technical breaches of no real moment, and each of the officers involved were aware of the Policy as it applied to pursuits, I cannot make any recommendations. I do however, suggest that the body that has drawn up the draft policy look at the matters raised by counsel assisting and look at the Victorian and in particular the Queensland Safe Driving Policy before the Draft becomes 'The Policy'.

The Issues

A. ***The NSW Police Safe Driving Policy and whether there was compliance with it.***

B. Management of the Critical Incident Investigation and compliance with critical incident protocols

C. Was any Police Vehicle involved in a Collision with the deceased's vehicle during the pursuit?

D. Was Port 30's presence in the roundabout at the intersection of Clifton Drive and Hastings River Drive a factor in the deceased's crashing his motor vehicle

E. Should I make any recommendations in terms of Section 22A of the Coroner's Act 1980

F.. The NSW Police Safe Driving Policy and whether there was compliance with it.

Bradden McIntyre and his friend Matthew Chignall went to a hotel after work about 7.30pm on Friday 5 May 2006. Chignall says they walked to the hotel because they knew they would be drinking.

At some stage the separate and meet up again at the Down Under Night Club in Short Street, Port Macquarie, at about 1am and according to Chignall they stay there about an hour and then leave.

They both got into Bradden McIntyre's Holden Utility registered number RPM-737 where two security guards James New and Dane Hockley both say the men were loud boisterous and clearly affected by what appeared to be alcohol.

They then observe Bradden McIntyre accelerate away and then return some minutes later driving in an erratic manner including feinting towards some people getting into a cab. The time was about 3.25am

There is no doubt that Bradden McIntyre was driving at that time in a manner dangerous to the public.

At about that time Constables Tuckwell and Griffiths were stationary in Short Street outside the Down Under Night Club performing general duties in a fully marked Mitsubishi Triton 4WD Police Vehicle (Category 4) call sign Port Macquarie 30.

Parked next to officers Tuckwell and Griffiths were Sergeant Brill and Senior Constable Broomby who were in a fully marked Holden Commodore sedan (Category 1) call sign Port Macquarie 35.

We heard evidence from Snr. Constable Broomby that he held a silver license and was also licensed to operate V8 police vehicles in pursuits and he was the driver of Port Macquarie 35 with Sgt. Brill the observer.

All those officers see Bradden McIntyre's silver Holden Ute travel through the roundabout at the intersection of William and Short Streets Port Macquarie. Because of the manner of driving the officers suspected the driver to be under the influence so Officers Tuckwell and Griffith drove after it and activated lights and later on siren.

The Policy States that a pursuit commences when “an attempt by a Police Officer in a motor vehicle to stop and apprehend the occupant of a moving vehicle when the driver of the vehicle is attempting to avoid apprehension or appears to be ignoring Police attempts to stop them.”

The Policy further states that a “pursuit is deemed to continue if you FOLLOW the offending vehicle or continue to attempt to remain in contact with the offending vehicle, whether or not your Police vehicle is displaying warning lights or sounding a siren”.

Bradden’s vehicle turned into Hollingsworth Street, which was not unusual the officer said because persons affected by alcohol or drugs sometimes take longer to respond and pull over. However it became obvious that the vehicle was not going to stop and Constable Tuckwell called ‘urgent’ and informed VKG that the vehicle had failed to stop and requested that Sgt. Brill and Snr. Constable Broomby take over the pursuit in Port 35.

The caged vehicle Port 30 with officers Tuckwell and Griffiths in did follow the silver Ute for a short distance and were technically part of the pursuit although one has to say some distance back from Port 35. In my view no criticism can be made of the officers they acted as quickly as they could in all the circumstances.

Whilst I was concerned before Snr. Constable Broomby gave evidence that at times he travelled on the wrong side of the road following the silver Ute his actions were explained and understandable when he took us on the drive through recorded on the DVD.

The other police vehicle involved in the pursuit OSG 60 with five occupants I accept did call VKG that is the evidence of the driver Detective Snr. Constable Deas and the observer Snr. Constable Brunyee and that they must have called at the same time as Port 30 or 35 were talking to VKG and so there call did not register. In any case VKG told all other traffic except Port 35 to get off the airways.

I am not going to go over the pursuit it is covered in the extensive and detailed brief professionally put together by Detective Inspector Peter McKenna who was the leader of the Critical Incident Investigation Team.

B. Management of the Critical Incident Investigation and compliance with critical incident protocols

There was evidence that he was telephoned and informed that he was the lead the Critical Investigation Team late on the morning of the 6 May 2006 because there had been some confusion as to which Local Area Command would be involved. However, as he said it did not hamper his investigation of the crash at all.

I mention this because one could not help but be impressed by Snr. Constable Broomby not only for his handling of this dangerous and dynamic situation that was unfolding in front of him but also his realisation when he knew Bradden McIntyre was deceased that this was a critical incident and that a crime scene should be established and the vehicles left where they were to be examined.

He had to make split second decisions and was careful not to exacerbate the situation. As he said in his evidence this was not a high-speed chase. The actions of the deceased precluded him from achieving any great speeds apart from one small section where he reached speeds of between 90 and 100 kph.

Counsel assisting in fact worked out from the VKG recording and the distances travelled that the average speed was about 66kph that could hardly be described as a high-speed car chase.

C. Was any Police Vehicle involved in a Collision with the deceased's vehicle during the pursuit?

There was some evidence from Ms. Cavanagh and Mr. Chignell, which suggests that one of the police vehicles contacted the deceased's vehicle. Chignell was a most unsatisfactory witness. He did not mention anything to police at the time he was interviewed he just said he mentioned it to his family.

Ms. Cavanagh is in a different category but there was a lot going on at the time. She was observing the scene from some distance. The streetlights were out as a result of the crash. Her view must have been obstructed. She never actually saw any vehicle impact with Bradden McIntyre's vehicle she just said she saw some damage to a police 4WD and that the vehicle was driven away.

Her evidence that she saw the police vehicle move from the crime scene being directed by men in overalls can be explained in my view, by the movement of Port 30 from near to the accident site back to the roadway nearer to Ms. Cavanagh's house

D. Was Port 30's presence in the roundabout at the intersection of Clifton Drive and Hastings River Drive a factor in the deceased's crashing his motor vehicle

The evidence in relation to what caused Bradden McIntyre's motor vehicle to lose control and collide with a pole is clear and confirmed for me during the drive through with Snr. Constable Broomby. As he described the last moments of Braden McIntyre the deceased's vehicle hit the median strip and you see the black tyre scrub marks he left behind. For those marks to be left like that the collision with the median strip must have been significant.

After he hit the median strip he then hit the left hand kerb so hard it fractured his offside front tyre the vehicle went sideways and given his stage of intoxication that I will refer to shortly, according to Snr. Constable Broomby he then accelerated to try and get out of the drift. All that did was exacerbate the situation the car became airborne and then stuck the power pole hard enough to split the Ute in two and black out all the streetlights.

The evidence in relation to his manner of driving was more than one would expect for some affected by just alcohol. Rather than weaving across the road his movements according to the witnesses was jerky. Snr. Constable Broomby thought he was being aggressive towards police but Sgt. Brill did not share his view but said the driving was unusual for a drink driver.

As it turns out the toxicology results show that Bradden McIntyre had a cocktail of drugs as well as the alcohol on board although Dr. Judith Pearl said that the alcohol played the greatest role in his manner of driving.

In the vehicle was a considerable quantity of LSD and much more than one would expect for self-use. In fact Ms. Smidt said that the most she saw him with at any time were 20 units

I agree with counsel for the Police Mr. Hood that we were given an insight into his behaviour behind the wheel of a car when affected by alcohol and drugs when his former partner Ms. Smidt gave evidence about a crash he had in someone else's motor vehicle at a time when affected by alcohol and drugs and when he had the same passenger in the motor vehicle Mr. Chignall.

In other words he acted in the same foolhardy dangerous fashion on a previous occasion when affected by alcohol and drugs but the outcome was different, no one was killed.

Therefore, although Sgt. Brill and Snr. Constable Broomby were aware of the presence of Port 30 somewhere to their right in the roundabout at the intersection of Clifton Drive and Hastings River Drive, it's presence had no influence on the manner of driving of Bradden McIntyre or was a factor in him loosing control of his motor vehicle.

There was a minor matter that really has no bearing on this Inquest. A security guard Mr. McKinnon gave evidence that he was 'summonsed' by the police to assist in the pursuit. I am satisfied that did not happen. I am satisfied that what he interpreted as being summoned was the action of Snr. Constable Brunyee in OSG 60 putting the temporary flashing light on the roof of the unmarked Magna. The Snr. Constable describes the same movement McKinnon gives evidence about and at that time he had not activated it because it would have shone inside the vehicle.

Finally the action took place at the same intersection that McKinnon said he saw a policeman in a wagon gesture to him.

Should I make any recommendations in terms of Section 22A of the Coroner's Act 1980 ?

Evidence was given that drug testing of officers in Regional New South Wales after critical incidents is problematic because of the time it takes for an employee of NSW Police Healthy Lifestyles to attend.

In some instances that could amount to days and any test taken after a few hours would seem to be pretty useless as most recreational drugs would have been metabolised by then.

In the circumstances it seems to me that a recommendation should be made to enable a blood sample to be taken in Regional areas of New South Wales by someone other than an employee of the New South Wales Police Healthy Lifestyles.

Very helpfully counsel appearing for the Police Mr. Hood has reduced what he says is a practical protocol for Police to follow in Regional New South Wales who are involved in critical incidents and I thank him for his assistance.

FORMAL FINDING

I FIND THAT ON THE 6 MAY 2006 BRADDEN JOHN McINTYRE DIED OF MULTIPLE INJURIES SUFFERED WHEN THE VEHICLE HE WAS DRIVING LEFT THE ROADWAY AT THE INTERSECTION OF CLIFTON DRIVE AND HASTINGS RIVER DRIVE PORT MACQUARIE AND COLLIDED WITH A POWER POLE.

RECOMMENDATIONS UNDER SECTION 22A CORONER'S ACT

TO POLICE MINISTER AND COMMISSIONER OF POLICE

- I RECOMMEND THAT THE FOLLOWING PROTOCOL IS TO APPLY TO ALL CRITICAL INCIDENTS WHERE THE HEALTHY LIFESTYLE SECTION IS UNABLE TO ATTEND AND TAKE THE REQUIRED BLOOD SAMPLES FROM THE POLICE INVOLVED IN SUCH INCIIDENTS AS SOON AS POSSIBLE BUT PREFERABLY WITHIN TWO HOURS FOLLOWING THE INCIDENT.

- ALL INVOLVED OFFICERS ARE TO BE CONVEYED TO AN APPROPRIATE MEDICAL FACILITY (HOSPITAL, MEDICAL CENTRE, DOCTORS SURGERY) WHERE AN AUTHORISED MEDICAL PRACTITIONER (DOCTOR OR REGISTERED NURSE) WILL TAKE THE REQUIRED BLOOD SAMPLE.

- ALL CARE SHOULD BE TAKEN TO ENSURE THAT THE POLICE OFFICERS, WHO ARE CONVEYED TO AND FROM THE MEDICAL FACILITY, DO NOT DISCUSS WITH THEIR FELLOW OFFICERS THE RELEVANT INCIDENT AT ANY TIME.

- IT SHALL BE THE RESPONSIBILITY OF THE OFFICER IN CHARGE OF THE CRITICAL INCIDENT INVESTIGATION (OR AN OFFICER OF THAT TEAM DELEGATED BY THE OFFICER IN CHARGE) TO ENSURE THAT ALL BLOOD SAMPLES OBTAINED FROM THE POLICE INVOLVED ARE APPROPRIATELY PRESERVED SO AS TO ALLOW THEIR LATER ANALYSIS.

669/06
Inquest into the death of Peter Clifford Harvey at Bathurst on the 9 June 2006. Finding handed down by State Coroner Jerram on the 17 September 2008.

Peter Harvey came to the attention of Bathurst Police when he contacted Bathurst police Station on the 9th June 2006 at 10am identifying himself and informing police that he was at the top of Mount Panorama, McPhillamy Park and further indicating he was intending to take his own life by firearm.

Station staff continued to speak and negotiate with Mr Harvey on the phone for over an hour in an attempt to build a rapport with him. At the same time police attended his locality and placed a perimeter around the area of McPhillamy Park.

At 10.40am the telephone call was terminated in order that police could then speak Mr Harvey at the scene. Mr Harvey was in a campervan and at around 12pm he was observed by police to leave the van and stagger around. Information provided to the police by his psychiatrist suggested that if Mr Harvey was drinking alcohol and taking his prescribed medication would pass out. The police observed the Mr Harvey for over an hour at which time he had laid near a tree. After some time police approached and found him deceased next to the tree with a .22 calibre rifle.

The cause of death as determined by the post mortem report is 'Gunshot Wound to the Head', consistent with self-inflicted by the rifle located in situ. Alcohol and a number of prescription medications were detected in his system, the pathologist commenting that the drugs and the alcohol would have likely to have interacted with each other to impair his mental status and their combined effects could have caused his death had he not suffered a fatal gunshot.

Formal Finding:

I find that Peter Clifford Harvey died just after noon on 9 June 2006 at McPhillamy park, Mount Panorama, Bathurst, of a gun shot wound to the head, self inflicted but evidence doesn't allow me to find whether with intent to end life or accidentally.

Recommendation:

I recommend to the Police Commissioner that refresher courses be held for all local area commanders particularly in rural areas, to ensure that there is clarification and knowledge of the various roles and actual lines of authority, required and flexibility maintained, in all incidents of high risk.

735/06
Inquest into the death of James Stuart Monroe at Kirkconnell on the 25 June 2006. Finding handed down by Deputy State Coroner Milovanovich on the 30 January 2008.

The deceased was sentenced to 7 and a half years imprisonment in regard to an offence of manslaughter, with a non-parole period of four years and the earliest release date being 27th March 2007.

The deceased had been diagnosed with high cholesterol levels at the age of 14. At the age of 29 he suffered a myocardial infarction, which resulted in by-pass surgery.

He was seeing a specialist cardiologist who had recommended a strict medication regime to reduce cholesterol, as well as a low fat diet and moderate exercise. The deceased heart condition required careful monitoring otherwise his life expectancy would be compromised.

At Inquest the family were concerned that his medical care and treatment was not optimal while in custody at Junee Correctional Centre (a privately managed correctional centre). He remained at Junee until the 29th March 2006 and was then transferred to the Kirkconnell Correctional Centre.

The Coroner examined the medical records and it would appear that the deceased was subject to regular medical check ups and one appointment with a cardiologist while at Junee was not kept, the reasons are unknown. Similarly when transferred to Kirkconnell the deceased was again subjected to regular medical check ups, including the taking of blood.

In May of 2006 a medical appointment was organised for the deceased with a Cardiologist at Long Bay Gaol, however, the deceased, cancelled this appointment in writing. The evidence at Inquest suggested that the deceased prepared his own meals.

On the 25th June 2006 the deceased voluntarily participated in a game of soccer. He was seen at one stage to be running awkwardly while participating in the game and shortly thereafter assumed the position of gaol keeper. Shortly thereafter he was seen to collapse. Clinical staff administered CPR until the arrival of the Ambulance; however, the deceased could not be revived. A post mortem examination determined the cause of death as being Coronary Artery Thrombosis.

The family and their legal representatives made submissions to the Coroner that the care and treatment the deceased received while in Correctional custody was not optimal and that it was a relevant factor in determining manner and cause of death.

The Coroner was of the view that the medical condition of the prisoner did require a higher level of supervision, however, the Coroner indicated that his formal finding would be restricted to identity, date of death and manner of cause of death.

The Coroner was of the view that if the family had further concerns regarding the prisoners care and treatment, that they are matters more appropriate for investigation by the Health Care Complaints Commission. The Coroner made no formal recommendations, however, suggested that the Legal representatives of the Department of Corrections and Justice Health should refer a copy of the brief to Junee Correctional Centre.

The Coroner also indicated that he would refer a copy of the coronial file to the Health Care Complaints Commission.

Formal Finding.

That (the deceased) died on the 25th June 2006 at the Kirkconnell Correctional Centre, Kirkconnell in the State of New South Wales, from Coronary Artery Thrombosis.

944/06
Inquest into the death of Brett Lyons at Randwick on the 24 June 2006. Finding handed down by Deputy State Coroner Dillon on the 17 June 2008.

Mr Lyons, a 44 year old man, was serving a three-year sentence at Long Bay Correctional Facility when he died on 24 June 2006 in the Prince of Wales Hospital. He had suffered from cirrhosis of the liver due to Hepatitis C and some slight brain damage, which he had received as a result of an assault upon him in 2002. A post mortem examination found that the cause of his death was “complications of intracerebral haemorrhage”.

In the few hours before his death, Mr Lyons had been observed by other prisoners pacing around the yard talking to various inmates. This was apparently out of character. At about 7.30pm, Mr Lyons was seen by another inmate in what appeared to be a disorientated state, unable to answer questions and mumbling incoherently. A few minutes later, an inmate heard the sound of Mr Lyons falling to the floor and found him lying in his cell. At that time he appeared to having seizures.

He was examined by a Justice Health nurse and conveyed to Prince of Wales Hospital where a CT scan revealed an intracranial haemorrhage.

He was unconscious on arrival at hospital and remained comatose until he died the next morning.

A police investigation of the circumstances surrounding Mr Lyons's death revealed no suspicious circumstances. An inquest was conducted in accordance with s.13A of the *Coroners Act 1980.*

Formal Finding

Mr Brett Lyons died on 24 June 2006 at Prince of Wales Hospital, Randwick. The cause of Mr Lyons's death was an Intracerebral Haemorrhage. A contributing condition was Cirrhosis of the liver (Hepatitis C). The manner of his death was by way of natural causes following his collapse at the Metropolitan Program Centre, Long Bay.

1169/06 /537/08
Inquest into the death of Herbert William Kermode at Woy on the 30 September 2006. Finding handed down by Deputy State Coroner Dillon on the 26 September 2008.

Late in the afternoon of 30 September 2006, Mr Kermode, an 89 year old man, was found by police floating face down in the Woy Woy Baths. He had drowned. No one saw him enter the water or saw him moving in the water. It was immediately evident to police who found him that he was dead and no attempt was made to revive him.

On the morning of 30 September, his daughter and a nurse from the nursing home in which he resided had telephoned the 000 emergency service and reported their fears that Mr Kermode may have travelled from Sydney to Woy Woy to take his own life. Shortly afterwards, police found Mr Kermode time in Woy Woy and spoke to him for some but were persuaded by him that the concerns of his daughter and the nursing home for his safety were misconceived. It seems that he deliberately and skilfully misled the police. In fact, he was intent on taking his own life.

An inquest was required, pursuant to s.13A of the *Coroners Act 1980,* because Mr Kermode's death had occurred during the course of police operations. Among other things, the inquest examined the question whether police at Woy Woy Police Station had conducted their assessment of Mr Kermode's mental health and intentions in an appropriate fashion.

Other issues of concern raised during the inquest concerned resuscitation protocols for drowning victims and a question whether there had been undue delay in removing Mr Kermode's body after he was discovered. Mr Kermode had been in the company of police before his death for a considerable time.

An experienced and careful Senior Constable and a relatively junior Constable spent about 45 minutes speaking to Mr Kermode in the police station.

They were attempting to assess whether he was a danger to himself or others. If they had formed the view that he was, it had been their intention to exercise their powers under the *Mental Health Act 1990* and take to him a psychiatric hospital for assessment as an involuntary patient.

During these conversations his daughter and a nurse from the nursing home were also contacted by police. They both had the opportunity to speak to Mr Kermode. He emphatically denied that he had any suicidal intentions and provided a plausible alternative explanation for having left the nursing home that day.

After closely considering whether to detain Mr Kermode pursuant to s.24 of the Mental Health Act, the police were persuaded that he was not suicidal and posed no danger to himself or to others. They decided that it was appropriate to allow Mr Kermode to return to the Woy Woy railway station to catch a train back to Sydney. The police officers were aware that Mr Kermode had made an arrangement with his daughter that he would call her from Strathfield station and she would collect him from there.

Mr Kermode walked to the Woy Woy railway station and spent some time sitting on a platform. Whether he had simply walked to the station to lay a false trail in case the police watched him or whether he waited there making up his mind we cannot know. CCTV footage depicts him walking away from the train station towards the shopping centre about 35 minutes after leaving the police station. What happened next is, to some extent, a mystery. We do not know whether he went directly to the Baths or spent some time in Woy Woy before doing so.

At a time that cannot be ascertained with any precision, Mr Kermode entered the Woy Woy Baths and drowned. When he did not return by train as arranged, his daughter telephoned police and suggested that he might have gone to the Baths. Police acted on this information immediately and went straight there. Mr Kermode's body was found floating near a ladder which descended from the boardwalk.

It was readily apparent when police arrived that Mr Kermode was no longer alive. Police called for assistance from the State Emergency Service in landing his body but this took an unfortunately long time. No attempt was made to resuscitate Mr Kermode.

Mr Kermodes's case is unusual in that he was an elderly man, a widower of almost 90 years of age, with his mental faculties largely intact, who seems to have concluded that he if he had to live in a nursing home he had no desire to live. He appears to have made a rational decision to take his own life and he employed his wits to ensure that his family and friends did not prevent him from doing so.

The inquest revealed that the police had made a serious and reasonable effort to assess his mental health. In his reasons, Deputy State Coroner Dillon not only did not find any misconduct or negligence on the part of police officers in relation to that process of assessment, he found that they had had insufficient lawful basis (on the evidence then available to them) to detain Mr Kermode an involuntary mental health patient.

The case highlighted some of the complex problems faced by General Duties police in dealing with mentally ill or potentially self-harming people. Geriatric mental health issues add further layers of complexity. An Interdepartmental Committee including the Police Force and Dept of Health has ongoing responsibility for developing co-ordinated policies relating to mental health issues. Deputy State Coroner Dillon referred his reasons, with recommendations, to the IDC for consideration.

He also took the view that, notwithstanding the reasonableness of the police response in this case, further specific training would be beneficial for police officers who have a frontline public health role under the *Mental Health Act.* He also made recommendations concerning an approach to apparent drownings and training in resuscitation techniques.

Formal Finding:

That Herbert William Kermode died on 30 September 2006 by drowning in the Woy Woy Baths and that his death was intentionally self-inflicted.

Formal Recommendations:

1. *To the Interdepartmental Committee on Mental Health*:

- **That it consider the reasons for findings made in this case, review the current protocols and police training programs in relation to mental health with a view to providing general duties police with better guidance and training in understanding of the psychology of suicide, and the signs of suicidal ideation and behaviour.**

- **That the IDC consider how best to inform police about, and encourage their reliance upon, professional mental health services when dealing with mentally ill persons, especially those who may be suicidal.**

- **That the IDC, in addressing training issues, consider the special problems of geriatric mental health revealed by this inquest.**

2. ***To the Commissioner of Police***:

- **That, in the course of their training in resuscitation techniques, police officers be trained as a standard operating procedure that where there is no compelling reason to do otherwise, an apparently drowned person in water ought be landed as quickly as possible, his or her vital signs checked and resuscitation attempted.**

- **That, in the course of police training in resuscitation techniques and first aid, officers be given formal instruction in the application of the Australian Resuscitation Council's guidelines concerning drowning victims.**

1061/06
Inquest into the death of Glenn McMillan at Lithgow on the 4 September 2006. Finding handed down by Deputy State Coroner Milovanovich on the 18th March 2008.

The deceased had a long history of criminal activity as a juvenile and as an adult.

He had been imprisoned on a number of occasions and had escaped from custody on two occasions. In September 2006 he was arrested and charged with a number of serious offences and was bail refused at Katoomba Local Court on 1/9/2006. In view of the deceased two previous escapes and non-association classification he was treated as a high security risk.

The deceased was taken into custody at Bathurst Correctional Centre late in the afternoon of the 1/9/2006. A full reception and screening of the deceased was not undertaken, however, he was assessed as withdrawing from drugs and was placed in the Acute Crisis Management Unit in a safe cell with 24-hour CTV observations.

The deceased was again assessed on 2/9/206 by Justice Health and on the 3/9/2006 the Department of Corrections considered that the deceased could no longer be kept at Bathurst due to his high security level.

A decision was made that the deceased would be transferred to Lithgow Correctional Centre. On the 3/9/2006, Justice Health again reviewed the deceased and formed the view that the deceased could be discharged from the detoxification unit of the Acute Crisis Management Unit.

The deceased was transported under strict security to Lithgow Correctional Centre, where again he was not processed through the Reception Area, but taken directly to a cell in the Security Unit. The deceased was assessed while in the cell by a Correctional Officer and a staff member from Justice Health who formed the view that the deceased was not suicidal and was suitable for placement in Cell 243, which was a "one out" cell.

The deceased requested a meal and prison clothing at around 6.00pm on the 3/9/2006 and was then locked into his cell. The deceased was found shortly after 8.00am on the 4/9/2006 hanging. The deceased had fashioned a ligature from a singlet, which he secured to a shower railing and used his weight to place pressure on his neck and carotid arteries, which led to death by hanging.

There were no suspicious circumstances surrounding the death. No suicide note was left and during the last telephone conversation that the deceased had had with his defacto he was future orientated and gave no indication that he would self-harm.

The Department of Corrections conducted an internal investigation into the placement and assessment of the deceased and found that both Bathurst and Lithgow Correctional Centres had failed to complete a full screening and reception of the deceased. It was noted that the deceased was a high risk inmate and that he was taken into custody late on Friday afternoon and that the full reception process was not available at Bathurst or Lithgow until the following Monday.

The Coroner noted that the internal investigation report had suggested that if the full screening process could not have been conducted at Bathurst or Lithgow the deceased may have been more appropriately placed at the Metropolitan Remand Centre. The Coroner did not make any formal recommendations, however, did request that the Department of Corrective Services and Justice Health review their policy in regard to the placement of high risk inmates when taken into custody over a weekend in centres where a full reception process is not available.

Formal Finding.

That (the deceased) died on or about the 4th September 2006 at the Lithgow Correctional Centre, Lithgow in the State of New South Wales from hanging, self-inflicted with the intention of taking his own life.

1201/06
Inquest into the death of Vicki Catherine Latham at Liverpool on the 20 September 2006. Finding handed down by Deputy State Coroner Milovanovich on the 10 January 2008.

The deceased had a medical history of hypertension and was a smoker. In June 2006 the deceased was charged with a number of Centrelink fraud matters. The deceased was convicted and sentenced to 6 months imprisonment to be served by way of Home Detention. Her sentence commenced on the 12th September 2006 and was due to expire on the 11th March 2007.

Probation & Parole assessed the deceased as being suitable for Home Detention. The deceased was a registered nurse and continued working while serving her sentence of Home Detention.

On the 19th September 2006 the deceased was found in her bedroom unresponsive.

She was conveyed by Ambulance to Liverpool Hospital and was diagnosed as having a cerebral infarct and her prognosis was poor. The deceased was pronounced life extinct on the 20th September 2006. Dr Jennifer Davidson issued a death certificate unaware that the deceased was a serving prisoner and that her death was a reportable death to the Coroner pursuant to Section 13A of the Coroners Act. Police became aware of the death on the 12th October 2006 and reported the death to the Coroner.

At this stage the deceased had already been buried and accordingly no post mortem examination was conducted.

The Coroner was satisfied that there were no suspicious circumstances and that the deceased had died from natural causes. The Coroner made a finding as to the cause of death as being consistent with the cause of death certified by her treating Doctor.

Formal Finding

That (the deceased) died on the 20th September 2006 at Liverpool Hospital, Liverpool in the State of New South Wales from a Large Posterior Cerebral Infarct, Atrial Fibrillation and Hypertension.

1210/06
Inquest into the death of Mouawad Rahme at Silverwater gaol on the 14 October 2006. Finding handed down by Deputy State Coroner Milovanovich on the 18 April 2008.

The deceased was a married man with 5 children who had migrated to Australia from Lebanon in 1977. In 2005 his demeanour commenced to change in that he was having constant arguments with his wife, which led to domestic violence proceedings being instituted. The deceased also had one episode of self-harm when he drank poison and was admitted to Rozelle Hospital. Following his release the family relationship continued to deteriorate with the deceased often threatening to harm his wife as well as committing suicide.

In 2005 the deceased poured petrol throughout the family home and destroyed it by fire while on an apprehended violence order. He admitted his guilt and was sentenced to 3 years imprisonment from 3/5/2005 with a non-parole period of 1 year and 3 months. He was eligible for release on parole on the 3/8/2006. During his period in custody the deceased on two occasions had expressed suicidal ideation and was placed on a mandatory risk intervention team. In May 2006 his parole officer spoke to him in regard to the preparation of reports for his upcoming considerations for release on parole. His parole officer had indicated that it was not likely that his parole would be supported as he had done little in terms of seeking counselling and had no insight into the crime he had committed. The deceased blamed his wife for his imprisonment and continued to threaten to harm her upon his release. Following two parole board hearings, the last on the 13/10/2006, his parole application was refused. The deceased was legally represented at the parole board hearing and aided with an interpreter.

In view of his previous suicidal ideation a warning was placed on his file for further risk assessment following refusal of parole.

Justice Health saw him on the 13th October 2006 following the refusal of his parole and he did not express any further suicidal ideation. On the 14/10/06 he had a visit from his family and it is understood that the visit became heated. He was last seen returning to his cell at about 11.40am. His cell partner was not in the cell when the deceased returned. At around 1.40pm his cell partner attempted to enter the cell and found that it had been locked from the inside. He sought Correctional Staff assistance in order gain access to the cell and the deceased was then found hanging from a ligature fashioned from a bed sheet. Emergency assistance and CPR failed to revive the deceased. No suicide note was left. A post mortem examination determined the cause of death was due to hanging.

The Coroner was satisfied that all appropriate risk assessments had been conducted on the deceased when issues had either been raised by the deceased or following the refusal of parole in accordance with the warning placed on his prison file. The deceased did not communicate his intentions to any person. The Coroner was satisfied that there were no suspicious circumstances.

No formal recommendations were considered necessary.

Formal Finding

That (the deceased) died on the 14th October 2006 at the Silverwater Correctional Centre, Silverwater in the State of New South Wales from hanging, self-inflicted with the intention of taking his own life.

1278/06
Inquest into the death of Allison Luisa Croke at Madden Plains on the 30th October 2006. Finding handed down by Deputy State Coroner Milovanovich on the 4 August 2008.

On the 30/10/2006 the deceased contacted 000 and sought assistance in relation to a concern she had in regard to boyfriend who had hired a motor vehicle and had been consuming "pills" and alcohol. She provided Police with her location and a Police vehicle responded to the location indicated. Police arrived at the given location but could not identify any relevant vehicle, however, did observe a vehicle leaving the area which they followed until it drove into a driveway. Police believed that this was not the subject vehicle and continued to circulate in the area.

Shortly after Police observed a Corolla vehicle stationary and decided to execute a U turn with a view of stopping the vehicle. The vehicle then accelerated harshly to a speed of approximately 90 kph with Police in pursuit. During the pursuit the Corolla vehicle collided with a parked vehicle and shortly thereafter

Police terminated the pursuit due to possible danger to other road users. The total pursuit covered a distance of approximately 1 klm and lasted for approximately 40 seconds.

Shortly after the termination of the pursuit Police received a further 000 call from a motorist who had observed a vehicle travelling at high speed on F.6 Freeway, loose control and left the carriage way and rolled. Police and Ambulance responded with a view of searching the F.6 Freeway in the vicinity of the reported incident. Shortly after the vehicle was located with the deceased in situ in the front passenger seat with no signs of life and a male person, later determined to be the driver, with minor injuries.

Following Police investigations the driver of the vehicle was charged with a number of indictable and summary offences.

The driver of the vehicle was subsequently dealt with the District Court in regard to indictable charges and has been sentenced. The period in which any appeal could have been lodged has expired.

The Coroner was satisfied that the Police had applied the Safe Driving Policy and all relevant critical incident protocols. An independent review was conducted of the Police response and investigation and no matters were identified that may have required further comment or recommendation.

Formal Finding.

That (the deceased) died on the 30th October 2006 at Maddens Plains in the State of New South Wales from multiple injuries when the vehicle in which she was a passenger left the F.6 Freeway and overturned.

1834/06
Inquest into the death of Luke Morrison at Royal North Shore Hospital on the 25 November 2006. Finding handed down by State Coroner Jerram on 13 May 2008.

An inquest in to his death is mandatory under s. 13A of the Coroners Act as at the time of his death he was in the custody of police.

I have heard oral evidence from a large number of witnesses over four days, and admitted a great deal of documentation pertaining to Mr Morrison's death.

The Facts.

Soon after midday on 25 November, a Saturday, Luke Morrison (LM) was seen to drive his black Mercedes up Lindsay Lane and into Cowles Road, Mosman. There, while the car was still moving, he got out of it and started to run about in a clearly very agitated state, removing his trousers and running into private gardens and in to the busy road.

He called to passers-by for help consistently, and told Mr Lee, that he had taken cocaine. The car rolled in to a residential fence, fortunately without harming any person. Neighbours called the police, primarily concerned for his welfare because of his obvious distress and potential risk of being harmed by traffic.

Highway Patrol Officer Sergeant Walters was first to arrive having responded to a Code Blue call and being closest, while other police were on their way on Code Red. He described LM as very jumpy and disorientated, and at great personal risk. His initial belief was that he probably had a mental illness, and when he started to run from Sergeant Walters in to the street, the police officer tried to grab him and a struggle ensued.

Sergeant Reimer arrived and tried to assist Sergeant Walters to contain LM. The three men tripped on the gutter and on to the grass edging, and continued to struggle for 30 seconds to 1 minute. Sergeant Reimer was unable to operate his handcuffs.

Eventually, on the arrival of Senior Constable Fisher and Constable Lear, with S/Con Fisher's cuffs, LM was handcuffed behind his back, and with considerable difficulty, placed in the rear of the caged truck at 12.53.

He was kicking, thrashing, yelling and screaming. All four police believed that LM required detention under S 24 of the Mental Health Act, and Sergeant Reimer ordered that he be taken in the truck, as he was too violent to travel in a police sedan, to the Royal North Shore Hospital (RNSH) Emergency Department.

Both Sergeants, and Senior Constable Fisher stated that LM's behaviour was as violent, if not the most, as each of them had ever witnessed in many years of policing. Once LM was shut in to the truck, police spent 5 to 10 minutes obtaining details from witnesses in order to provide hospital staff with as much information as possible for assessment purposes.

Mobile phones had been used to film LM running about the street, and the car, both in situ and internally. In the car, police found syringes, bloody tissues, and white powder later analysed as cocaine.

An ambulance arrived, but it is unclear whether that was before or after the truck set out for the hospital. In any case, all police were vehement that LM could not have been treated by ambulance officers because of his violent behaviour.

S/Con Fisher notified the hospital of their imminent arrival. He had assumed LM was suffering from a drug-induced psychosis, LM having told him that he had taken cocaine, and noted that his kicking and yelling became worse during the trip to the hospital. He also requested back up at the hospital to assist in removing LM from the truck.

CCTV footage shows, very badly, the police truck arrival at the hospital (the first camera is apparently positioned so that its view becomes obscured by other vehicles, and is in the sun filming in to the shade of the arrival bay, and the second, inside the bay, was so dirty that the film was obscured except for the outer circumference).

The truck waited about 10 minutes, with LM still in the back screaming and kicking, for the second police truck to arrive. Nurse Mellish came out and attempted to speak to LM through the door of the truck, to reassure and calm him, but to no avail.

Dr Petransky looked at him and saw that he had several injuries to his face. He went to set up the drugs and equipment, which would be needed to sedate the patient once he was brought in to the hospital,

to ensure the safety of staff and patient, and allow medical staff to assess the patient medically. He, Dr Petransky, described LM as the most violent patient he had ever seen admitted.

After some 10 to 15 minutes, the truck doors were opened and two police officers took Elm's legs to pull him out. LM was struggling and kicking as wildly as ever, and as two security men and the other police tried to take his upper body, they lost their grasp and Elm's head and upper torso fell about a metre to the ground. According to Nurse Mellish, this occurred twice, although police and security only recall one drop.

Finally LM was carried by police and security officers the short distance through the doors and placed, still handcuffed, in Consult Room 4, which is the secure, isolation or observation room, containing minimal furniture and equipment, with a mattress on the floor. LM,
requiring restraint by 8 men, was initially placed on his side, but was so difficult to contain that he rolled on to his face, with his cuffed hands behind him so that medical staff could attempt to gain intravenous access with a canula to sedate him.

Nurse Mellish was tending to LMs head to ensure he did not bang it on the floor. Dr Petransky, assisted by Dr Rudas and supervised by the Emergency Department Director, Dr Macken, was unable to insert the canula at his first attempt because of LM's continuing movements.

At the second attempt a minute later, LM's vein 'disappeared', he was observed by Mellish and security staff to go still and cold, was rolled over and the cuffs taken off, and assessed as being in cardiac arrest. Despite all efforts at resuscitation and CPR, he was pronounced life extinct by Dr Macken at 2.14 pm.

Luke Morrison's History.

Three weeks before his death, LM had reported to police and to his wife a 'home invasion' in which he said he had been badly beaten and his house considerably damaged. After discharging himself from hospital, he told his wife that he realised that he had probably done the damage both personal and material himself after taking 'some bad cocaine'.

Two months before, he had been ordered from the hospital where his baby son was a patient, because of violent and disoriented behaviour.

Mrs Morrison told police, and later gave evidence to this court, that she became aware after marriage that her husband had a substantial and very long term drug habit or addiction (possibly more than 20 years) in particular to cocaine, but that she believed that he had not used drugs between the original hospital incident and the home damage.

She described some further bizarre and distraught behaviour in the days immediately preceding his death, which she attributed to his taking large amounts of cocaine, despite his denials.

The Post Mortem.

The pathologist found the cause of death to be cocaine toxicity, the analysis of combined cocaine and benzoylecgonine (its metabolite), detected in his blood reaching a level of 7.6mg per Litre of blood, that level being more than 7 times the potentially fatal dosage. She further noted multiple external bruises, abrasions and lacerations to his head, body and limbs, and a 60% narrowing left anterior descending artery focally and distally.

However, she also commented that 'the contribution of restraint during the attempts at treatment was difficult to quantitate, however, the level of cocaine present was above the fatal level, cocaine is cardiotoxic and may cause sudden death due to arrhythmias and restraint was required because of the effects of cocaine".

The Issues:

Whether the police officers used more force than necessary in restraining Mr Morrison, initially at Cowles Road, and, with security staff, in the observation room at the hospital.

Whether the time in which Mr Morrison was left in the truck, both at Cowles Road and in the hospital bay, was excessive.

Whether the fact that LM was dropped by police and security staff as he was removed, struggling wildly, from the police truck at the hospital, could have been avoided and/or contributed to his death.

Whether his death might have not have occurred had he not been held face down with his cuffed hands behind him on the observation room mattress, and whether again that restraint was excessive.

The Law

I am required under the Coroners Act to make findings as to the identity, place, date, cause and manner of Luke Morrison's death. As stated at the outset,
This was a mandatory inquest under s13A of the Act because Mr Morrison had been taken in to custody by police (for both his own protection and because he appeared to have committed offences) and remained in custody at the time he died.

The first three issues are, as Mr Jordan has submitted, very clear. It is to the cause and manner of death to which the issues above are directed.

Medical Opinions

Dr McCreith, the pathologist who performed the autopsy, gave as cause of death, 'cocaine toxicity'.

Dr Duflou, called as an expert to review the post mortem report, averred that his preferred and more precise formulation would be:

> *'Cardiorespiratory arrest during struggle including hypoxic components, cocaine ingestion and cardiovascular disease".*

In his opinion, hypoxia was a possible contributor to, though certainly not sole cause of death. Professor Fulde, who is the highly experienced Director of Emergency at St Vincents Hospital, differed from Dr Duflou in stating his undoubted view that Mr Morrison suffered a cardiac arrest,
due to the enormous amount of cocaine and the occlusion of his left anterior descending coronary artery found during post mortem (probably contributed to by the long term cocaine use, cocaine being a vaso-constrictor).

Dr Macken, the senior doctor in charge of the team, who was directing them throughout LM's entire time in the observation room, and who was clearly deeply distressed by the death, had been certain that the arrest was cardiac because of its suddenness and its unexpected nature.

He, like Nurse Mellish, who was protecting LM's head throughout, was sure that none of the restrainers placed their body weight upon LM in such a way that his breathing was restricted, and that because of his extreme struggling and shouting to the very moment of the arrest, he was not suffering from hypoxia or asphyxia.

Professor Fulde held the same view, stating that such 'maximal exertion' as he exhibited for the 5 minutes in the room was inconsistent with respiratory arrest, which would be preceded by a slowing of motion. It should also be noted that LM was producing maximal exertion from the first time he was seen on Cowles Road throughout his struggle with the police, his transport in the truck, and his being removed from the truck. In itself, all agreed that given the condition of his coronary artery as well as the huge amount of cocaine taken, the heart would have been subject to extreme pressure.

Police, security and medical witnesses all stated that LM"s violence was either the worst, or in the top 90%, ever witnessed. Because of this, there was overall agreement that he could not have been handled, or restrained, in any other way. He was clearly in a state, which was potentially dangerous to those around him. Despite this,

I am satisfied that all who dealt with him or witnessed him, were concerned most of all for LM himself, and his own safety, rather than intending any aggression towards him.

There were a number of bruises and lacerations noted at autopsy, which did not cause or contribute to LM's death. They were presumably incurred by his throwing himself about in the truck, and perhaps his unfortunate dropping as he was being removed from it. It further seems that he caused himself to be dropped because of his struggling but no injury seems to have been incurred thereby which was either serious or a contributor per se to his death.

It is notable that none of LM's known medical practitioners nor his wife had any knowledge of his heart disease. Evidence was that it may have been largely due to his long term cocaine use. Whether or not that was so, it certainly became a factor in his death following a potentially fatal overdose of cocaine. No real conclusion can be drawn from the detection of the drug diltiazem in his urine post mortem. I am satisfied that it played no part in the death.

Police and Timing:

In my view, the police were more than justified in taking Mr Morrison in to custody. Sergeants Reimer and Walters had to prevent him from running out in to fast and heavy traffic, and he was causing considerable concern to the residents and passers-by of Cowles Road.

Those residents all stated that the police handled the situation with great professionalism, but there was patently concern for their own welfare as shown by the calls to police, and the evidence given by some of them to the court.

The time, which elapsed from his arrest to his being treated, was 37 minutes. While some civilian witnesses at Cowles Road though it seemed unnecessary for him to have been kept in the truck for 11 minutes before the truck left, I accept that up to a point it was necessary for the accompanying police to gather as much information as possible to give to medical staff, given that they, the police, expected to present him for scheduling under s 24 of the Mental Health Act.

Perhaps they could have been radioed that advice as they drove by police who remained at the scene, but in any case, as with the time spent in the hospital bay, although it left LM untreated and with a longer opportunity to damage himself, there is absolutely no evidence that LM's death might have been prevented had he been treated earlier, and furthermore, the time which elapsed was, in Professor Fulde's opinion, not excessive and probably commendable in its speed. All medical experts agreed that the death was virtually inevitable in all the circumstances.

CONCLUSION

I have great respect for the expertise of Dr Duflou, the Chief Pathologist of the Department of Forensic Medicine here at Glebe. I understand his concerns about the possibility of LM's breathing being impaired by his 'trussed' position. However, unlike Drs Macken and Petransky, and Nurse Mellish, he was not present to observe that position, and each of those were adamant that LM was not exhibiting signs of hypoxia.

I note further that Dr Duflou asserted only that it was a possibility, for which there was limited evidence, that hypoxia was a component in the sudden arrest. He based that view partly on circumstantial evidence and partly on the fact that there were petechiae of the face and some bruising around the neck.

However, he agreed that petechiae can occur in circumstances other than pure respiratory distress, such as vomiting and other severe physical exertion especially in a face-down position.

It must be taken into account that LM had been heard colliding with the inside of the police vehicle for some time prior to removal, and photographs were tendered which showed evidence of extreme violence inside that truck.
Also not to be ignored are the two recent episodes prior to this date on which LM had proffered similar behaviour, particularly that of only 3 weeks previous, in which he apparently caused huge damage to himself and his home after ingesting a large amount of cocaine. In all, I could not come to any finding that hypoxia was a factor in the death of LM.

LM had a long history of cocaine addiction, a recent history of severe cocaine use and addiction, cardiac changes associated with long term cocaine use, had used an amount of cocaine in the fatal range immediately prior to coming to the attention of the Cowles Road residents (according to the material found in his car, the results of the post mortem toxicology and the puncture marks on his forearms), was exhibiting signs of severe cocaine intoxication in the hour before his death according to the evidence of Dr Perl and had exhibited those signs consistently over time.

Attempts at medical treatment as outlined to the court were appropriate and caring.

Formal Finding:

That Luke Morrison died on 25 November 2006 at the Royal North Shore Hospital at St Leonards, in New South Wales, as a result of Cardiac arrest, consequent upon a recent and fatal amount of cocaine ingestion With antecedent cause of cardiovascular disease probably contributed to by long term use of cocaine, following a lengthy struggle.

1859/06
Inquest into the death of Brenton Hasler at Tweed Heads on the 30 November 2006. Finding handed down by Deputy State Coroner MacMahon on 30 January 2008.

On Thursday 30 November 2006 police were conducting an operation on the Pacific Highway at Sextons Hill near Banora Point in northern New South Wales. The operation was directed, in part, at detecting unregistered and wanted vehicles. Automated Number Plate Recognition (ANPR) equipment was being used to assist in this process. S/C Mahaffy was the ANPR operator and S/C Hamilton positioned himself some 225 meters further north along the Pacific Highway at a stopping site. The stopping site was just south of Terranora Road. The operation commenced at about 0830.

S/C Bowmer was also to assist in the operation. The traffic was very heavy and on his arrival S/C Bowmer decided to facilitate traffic flow by arranging for the traffic lights at the intersection of Terranora Road and the Pacific Highway to be turned off and the traffic managed manually.

S/C Bowmer parked the police vehicle he was driving at the ANPR stopping site near that of S/C Hamilton.

As this was occurring a rider was travelling on the Pacific Highway on a Honda VFR 750 motorcycle. He was negotiating through the traffic and was overtaking vehicles on the nearside on the incorrect side of the edge line. This was contrary to the motor traffic laws. S/c Mahaffy, who advised S/C Hamilton, observed this. As a result S/C Hamilton stopped what he was doing and walked onto the road and directed the rider to stop.

The rider refused and accelerated away. S/C Hamilton yelled to S/C Bowmer to stop the rider and S/C Bowmer having returned to his vehicle followed him. By this time the rider was out of sight.

S/C Bowmer proceeded along the Pacific Highway looking for the rider. After examining a number of sidestreets S/C Bowmer observed a bike on Darlington Drive, Banora Point, just off the Pacific Highway. He exited the Pacific Highway and followed it. The bike rapidly increased speed and S/C Bowmer decided to commence a pursuit and did so with lights and sirens operating.

Shortly before the intersection of Lochlomond Drive and Darlington Drive the bike left the road and collided with a tree. S/C Bowmer came on the scene shortly thereafter and provided assistance to the rider. CPR was commenced and an ambulance was called. On arrival the ambulance officers found the rider to be unconscious, without pulse and not breathing. CPR was continued and he was taken to Tweed Heads Hospital however the rider was declared to be life extinct shortly after his arrival at the hospital.[4]

Elizabeth Alice Hasler subsequently identified the deceased as being her husband Brenton Craig Hasler.[5] On 2 December 2006 an autopsy was performed at the Department of Forensic Medicine, Newcastle, by Dr. K. Lee, a senior specialist forensic pathologist. Dr Lee found that the cause of Mr. Hasler's death was multiple injuries.[6]

Legislative Provisions.

The role and function of a Coroner is contained in section 22, Coroners Act, 1980 (the Act). That section, in summary, provides that at the conclusion of an inquest the coroner is to establish, on the basis of the evidence available, the identity of a deceased person together with the date, place and the cause and manner of their death.

[4] Life Extinct Certificate, Dr. B Beal, Tab 1.
[5] Identification Statement, Tab 2.
[6] Autopsy report, 2 April 2007, 10.at Tab 66.

Section 13 (1) (a) of the Act provides, in addition, that a coroner has jurisdiction to hold an inquest if it appears to the coroner that a person has died *a violent or unnatural death.* Section 13A (1) (b) also provides that a coroner who is the State Coroner or a Deputy State Coroner has jurisdiction to conduct an inquest where it appears that deceased *died, or there is reasonable cause to suspect that the person has died, as a result of or in the course of a police operation*.

Section 13A (2) provides that where the jurisdiction to hold an inquest arises under both section 13 and section 13A an inquest is not to be held except by the State Coroner or a Deputy State Coroner.

On the facts as set out above it is apparent that Mr. Hasler's death was one that came within the meaning of section 13(1)(a) in that it occurred as a result of injuries he sustained in circumstances that appeared to come within the definition *as a result of or in the course of a police operation*, in this case a police pursuit. As such either the State Coroner or a Deputy State Coroner is required to conduct the inquest into his death.

Issues for Inquest:

In this inquest the identity of Mr. Hasler together with the date, place and direct cause of his death are not in dispute. On the evidence available I am comfortably satisfied that Brenton Craig Hasler died on 30 November 2006 at the Tweed Hospital and that the cause of his death was multiple injuries sustained by him when the motorcycle he was riding left the road and collided with a tree. The manner, or circumstances, of Mr. Hasler's death was, however, the subject of examination in the course of the Inquest.

The issues inquired into during the course of the inquest were as follows:

- ***Was Mr. Hasler the rider of the motorcycle that failed to stop when directed to do so by S/C Hamilton?***
- ***Were the circumstances sufficient to justify the commencement of a pursuit?***
- ***What was the applicable police policy?***
- ***Did S/C Bowman comply with the policy, as he understood it, during the course of the pursuit and should he, at any time, have discontinued the pursuit?***
- ***What caused Mr. Hasler to lose control of the motorcycle and did the manner in which S/C Bowman conducted the pursuit cause, or contribute to, that loss of control of the motorcycle?***
- ***Following Mr. Hasler suffering his injuries was assistance provided to him in timely manner?***
- ***Were the NSW Police critical incident guidelines complied with?***
- ***Are there any recommendations that should be made in accordance with section 22A?***

The Evidence:

During the course of the inquest evidence was taken from the following witnesses

- Senior Constable Brett Andrew Mahaffy (the officer operating the ANPR equipment on the Pacific Highway),
- Senior Constable Troy Anthony Hamilton, (the officer who directed the rider of the motorcycle to stop),
- Michael Francis Murphy (a truck driver in traffic near the ANPR site at the time that the motorcycle rider was directed to stop),
- Sergeant Mark Anthony Garner (a police officer in traffic near the ANPR site at the time that the motorcycle rider was directed to stop),
- Bruce Roy Austen, (who was driving on Darlington Drive in the opposite direction to that of the Mr Hasler and Senior Constable Bowmer and saw the motorcycle lose control)
- Kellie John, (who saw the collision of the bike with the tree from her lounge window which overlooked the park in which it occurred),
- Mark Raymond Rabjones (who saw the incident from his driveway and provided assistance to Mr. Hasler following the collision)
- Senior Constable Paul Bowmer (the officer who conducted the pursuit of the motorcycle rider),
- Inspector David Richard Driver (the officer responsible for the investigation of the death of Mr. Hasler in accordance with the critical incident guidelines).

In addition statements from witnesses not called to give evidence, relevant police policy and guidelines, maps, vehicle inspection reports and diagrams were also made available.

Was Mr. Hasler the rider of the motorcycle that failed to stop when directed to do so by S/C Hamilton?

S/C Hamilton, after the rider of the bike failed to stop as directed, followed in the direction the rider had taken. He subsequently arrived at the site where Mr Hasler had been injured. During evidence he was asked whether Mr. Hasler's bike was the bike ridden by the rider that had failed to stop as directed. He thought that it had been and explained why he had come to that conclusion.[7] *Sergeant Garner, who had seen the bike on the Pacific Highway and had also seen S/C Hamilton direct it to stop. Sergeant Garner also attended the crash site and had the opportunity to observe Mr. Hasler's bike. He also was of the view that the bike was the same as that he had observed on the Pacific Highway and gave his reasons during the course of giving evidence.*[8] *I accept the evidence of S/C Hamilton and Sergeant Garner on this point and am satisfied that Mr. Hasler was the rider who failed to stop when directed to do so by S/C Hamilton at the ANPR stopping site that morning.*

Were the circumstances sufficient to justify the commencement of a pursuit?

[7] Transcript 06/11/2007, 81-82.
[8] Transcript 07/11/2007, 210.

Mr Hasler was directed to stop by S/C Hamilton and failed to do so. He then accelerated away. S/C Hamilton gave him the direction to stop as a result of information he had received from S/C Mahaffy. S/C Hamilton then yelled to S/C Bowmer stop the bike after which S/C Bowmer followed the bike. S/C Bowmer did not know why S/C Hamilton wanted the bike to be stopped and gave evidence that when he was able to stop the rider he intended to administer a random breath test while waiting for S/C Hamilton to attend. There was some debate during the course of the inquest as to when the pursuit of Mr. Hasler commended and I will return to that debate later however on the evidence it is my view that Mr. Hasler's failure to stop as directed by S/C Hamilton was sufficient to justify efforts to be taken to apprehend him notwithstanding the fact that the officer doing so might not initially know the reasons for S/C Hamilton's request that they do so.

In any event I accept S/C Bowmer's evidence that he observed Mr. Hasler accelerating his motorcycle in Darlington Drive to a speed that was well in excess of the speed limit applicable. I consider that at that point S/C Bowmer had sufficient cause based on his own observations, subject to the application of the relevant protocols, to seek to apprehend Mr. Hasler.

What was the applicable police policy?

The guidelines for police pursuits are contained in the NSW Police Safe Driving Policy (the Policy). [9] The policy deals with the qualifications and experience of police officers authorised to engage in a pursuit and the vehicles that may be used.

The evidence, which I accept, is that S/C Bowmer was appropriately qualified and experienced and his vehicle was also appropriately classified to conduct a pursuit.

The Policy, at Part 6, deals with *Urgent Duty and Pursuits.* An urgent duty is defined as being duty *'which has become pressing or demanding prompt action'.*[10] A pursuit is defined as commencing '*at the time when you decide to pursue a vehicle that has ignored a direction to stop'*[11] On the commencement of urgent duty or a pursuit the relevant officer is required to make certain notifications to senior officers at VKG and thereafter undertake those duties or the pursuit in accordance with any instructions given by the appropriate senior officer.

Evidence was given at the inquest that the Policy underwent and adjustment by the introduction of a Coded System of Safe Driving from 11 November 2005[12]. That system made it permissible for an officer to perform urgent duty '*without first informing police radio in the execution of a traffic stop.*

[9] Exhibit 3, Tab 69.
[10] NSW Police Safe Driving Policy, 29.
[11] NSW Police Safe Driving Policy, 30.
[12] Exhibit 5.

However, should the driver of the other vehicle attempt to avoid apprehension or appears to be ignoring requests to stop, and a decision is made to pursue the vehicle – then a pursuit has commenced'.[13]

At inquest there was a difference of opinion as to how the relevant policies were to be applied to the circumstances that occurred 30 November 2006. One view, that held by Counsel assisting and Inspector Driver was that when S/C Bowmer left the AMPR site with the intention of stopping Mr. Hasler a pursuit had commenced and, as a consequence, the obligations provided for in the guidelines came into force. The other view, the one held by S/C Bowmer and apparently other officers, was that he (S/C Bowmer) was able to commence urgent duty until he approached the motorcycle for the purpose of a traffic stop. If, having indicated to the vehicle that it was to stop, he formed the view that other vehicle was attempting to avoid apprehension or appearing to ignore his request to stop, he would have to decide, as he did in this case, if he was going to commence a pursuit. He was of the view that it was only at that time that he would have had to advise VKG that he was in pursuit.

In this case the motorcycle rider had refused to stop. I accept that S/C Bowmer did not know this however it must have been implicit in the circumstances of the ANPR operation and in S/C Hamilton's call to 'stop the bike'. That was the basis of S/C Bowmer's actions in following him. It was clearly the intention of S/C Bowmer to stop the rider. To follow him to administer a random breath test whilst awaiting S/C Hamilton's attendance seems to me to be somewhat artificial. I consider that on a reasonable interpretation of the policy the pursuit commenced at the time S/C Bowmer left the ANPR stopping site with the view of stopping the bike. On that interpretation he was at that time obliged to inform VKG of the pursuit and to implement the other instructions contained in the policy.

As I indicated during the course of the inquest I am not, nor do I intend to be, critical of S/C Bowmer in respect of his interpretation of the policy. It is clear from the findings of other Coroners and the various interpretations placed on the policy during the course of this inquest that the issue of the interpretation of the policy has been a live one for some time[14]*. The introduction of the Coded System of Safe Driving in November 2005 does not, in my view, clarify the obligations of officers that find themselves in such situations. Indeed it is my view that it probably makes it more confusing by adding another element to the equation.*

The policy needs to be clear and unambiguous so that officers responsible for its implementation are able to act with confidence in situations that they are required to face in their duties. I propose to make a recommendation pursuant to section 22A on this subject.

---

[13] Coded System of Safe Driving ,2.

[14] See Decision of SDSC Magistrate Milledge in William Spence 1 July 2004 and DSC Magistrate Pinch in Colin John Holmes 29 November 2004.

Did S/C Bowman comply with the policy, as he understood it, during the course of the pursuit and should he, at any time, have discontinued the pursuit?

S/C Bowmer gave evidence that having entered Darlington Drive he observed the motorcycle ahead of him and formed the view that the rider was exceeding the speed limit. He also formed the view that the rider had probably seen him and was seeking to avoid apprehension[15]. At that time S/C Bowmer decided to commence a pursuit. He attempted to contact VKG to advice of the pursuit but was initially unsuccessful but was able to do so some 9 seconds later. From the VKG records it would seem that there was a period of 21 seconds form the first attempt to advise of the pursuit to the time that S/C Bowmer advised VKG of Mr. Hasler's collision and of the need for an ambulance[16]

The shortness of the pursuit is also emphasised by the recordings contained in the in-car video recordings from S/C Bowmer's vehicle. The pictures in that recording commence at 9.15.37 with a view of Mr Hasler's motorcycle 160-180 meters ahead of the police vehicle about to take a left hand bend. The motorcycle is then out of sight. At 9.15.51 a splash of water is observed (as Mr. Hasler's motorcycle passes through a stormwater drain).[17]

The inquest has had the opportunity to traverse the route that was travelled and to observe that part of the pursuit that was recorded on the in-car video. We have also had to evidence of a number of witnesses who observed aspects of the pursuit. A police pursuit is, in its nature, dangerous. It is required to be conducted with skill by the officer involved in order to ensure the safety of the general public who might be in the area (particularly-as in this case where it is a residential area), the police involved in the pursuit and, of course, those that are being pursued. As far as the manner in which S/C Bowmer conducted the pursuit is concerned the evidence establishes to my complete satisfaction that it was performed in a competent fashion and during its short duration no event occurred that would, in my view, have required it to be terminated.

There was, as I have indicated above, some delay in S/C Bowmer accessing VKG to advise that a pursuit had commenced however this was minimal and had, as far as I can see, no bearing on the course of the pursuit.
Counsel assisting has suggested that whilst she does not criticise S/C Bowmer she suggests that looked at in hindsight and taking into account all the now known circumstances perhaps the commencement of the pursuit by S/C Bowmer was not appropriate. I feel however that I must try and put myself into the circumstances that existed on 30 November 2006. I cannot second-guess S/C Bowmer. It seems to me that S/C Bowmer's do not warrant any criticism whatsoever.

[15] Bowmer transcript 7/11/2007 168
[16] Exhibit 3, Tab 19.
[17] Exhibit 3, Tab 17.

Having regard to S/C Bowmer's understanding of the policy, and having regard to the circumstances in which he found himself, I am satisfied that the NSW Police Safe Drive Policy was complied with.

Following Mr. Hasler suffering his injuries was assistance provided to him in timely manner?

What caused Mr. Hasler to lose control of the motorcycle and did the manner in which S/C Bowman conducted the pursuit cause, or contribute to, that loss of control of the motorcycle?

Mechanical defect did not contribute to the incident see evidence of Graeme Bruce Lawrie expert vehicle examiner 'there was no mechanical defect or failure with the vehicle that may have been a contributing factor towards the collision.'[18]

Mr Hasler lost control of the motorcycle when he was unable to negotiate the bend in Darlington Drive. (See evidence of Michio Justin McMillan)[19] '*It is obvious from the physical evidence available that the motorcycle rider, Hasler, has not anticipated or negotiated this bend. Hasler has braked hard and after skidding the motorcycle has left the road and mounted the raised concrete cutter onto the grass.*[20]'

Mr Hasler was travelling at a great speed. I accept the calculations of S/C Craig Stewart Norton that the motorcycle was travelling at between 129km/h and 135km/h as being indicative of that speed.[21]

Also:

Bruce Roy Austin, '*very, very fast*'[22]

Kellie John from her lounge-room:

'*I could hear the bike coming, I assumed it was a bike, it was very loud and so I turned around to look out my window because I was thinking-I could hear them coming very fast and I was thinking how are they going to slow down to go through the roundabout*'[23]

S/C Bowmer's pursuit did not contribute to the loss of control.

[18] **Statement 21/03/2007 para 23**
[19] Statement 28/12/2006 para 13 and 14.
[20] McMillan statement 28/12/2006 para 12.
[21] Norton statement 12/01/2007 para 8.
[22] Austin 6/11/2007 89
[23] John 6/11/2007 98 at 35

I have had the benefit of observing the in-car video and hearing the evidence of those who were present. It is undisputed that S/C Bowmer was travelling some distance behind Mr Hasler and at a slower speed.[24]

It is not suggested, and I find that it was not the case, that S/C Bowmer's driving or the manner in which he conducted the pursuit contributed to Mr Hasler losing control of the bike. I am satisfied that the cause of the collision was due to the motorcycle being ridden at excessive speed for the conditions and that on reaching the bend in the road Mr. Hasler was unable to negotiate it thereby losing control, mounting the gutter and thereafter continuing for some time until colliding with a tree.

Were the NSW Police critical incident guidelines complied with?

The relevant policy is the Guidelines for the Management and Investigation of Critical Incidents. That policy was tendered in evidence.[25] In accordance with the policy Inspector David Richard Driver was appointed to investigate the circumstances of Mr Hasler's death. That investigation was a detailed and thorough one and a number of recommendations were made that go to police procedures that should be given serious consideration.

The investigation identified a number of non-compliances with the guidelines. These are identified in Inspector Drivers report. They did not, in my view, affect the integrity of the investigation of Mr. Hasler's death. It is, however important that such guidelines be complied with strictly in all critical incident situations as compliance ensures that the best evidence is available for any review that subsequently takes place and, at a minimum will free officers involved from any unjustified criticism.

Formal Finding:

Brenton Craig Hasler died on 30 November 2006 at the Tweed Heads Hospital. Mr. Hasler's death resulted from multiple injuries he received when the motorcycle he was riding left the road at speed and collided with a tree during the course of a police

Section 22A Recommendation:
To the Commissioner of Police:

1. **That the NSW Police Safe Driving Policy and the Coded System of Safe Driving be integrated and reviewed and clarified with a view to ensuring that ambiguity as to the obligations officers who are required to engage in traffic stops, urgent duties and pursuits are removed.**

[24] Norton statement 12/01/2007 para 8.

[25] Exhibit 3 tab 70.

2. **That consideration be given to the inclusion of a knife in the equipment carried by highway patrol vehicles to assist officers who find themselves needing to free persons who might be trapped in motor vehicle collisions or other such situations.**

1883/06
Inquest into the death of Michael Kerney at Dubbo on the 1 December 2006. Finding handed down by Deputy State Coroner Dillon on 24 June 2
Michael Kerney

Michael Kerney was 23 year old man who died on 2 December 2006 following a motorcycle accident in Dubbo.

His motorcycle left the carriageway of a main road and hit a telegraph pole. He sustained fatal head injuries and other catastrophic blunt trauma in the collision.

Shortly before the accident, a Dubbo Highway Patrol car had been warned by another Highway Patrol car that a motorcycle was heading towards the second car at speed. The second car saw the motorcycle approach at approximately 80 km/h in a 60 km/h zone. It allowed the motorcycle to pass then turned to follow. It almost immediately lost sight of the motorcycle, which seemed to accelerate and disappeared over a rise. Moments later the police vehicle spotted Mr Kerney's bicycle on its side and him lying nearby motionless. An ambulance was called and Mr Kerney was transported to hospital urgently. He died of his multiple injuries shortly after arrival.

As the incident occasioning Mr Kerney's death had taken place during police operations, an inquest was held pursuant to s.13A of the *Coroners Act*.

In-car video footage produced by the Police Force showed the approach of the motorcycle, its rapid disappearance and the discovery of the motorcycle and Mr Kerney. It confirmed the police officers' accounts of the incident.

In making his findings, Deputy State Coroner Dillon found that there had been no fault on the part of the Highway Patrol police in the manner in which they had conducted their operations. Whether or not a pursuit had in fact begun was a question not argued at the inquest. In effect, there had been no pursuit. By the time the police car had completed its turn and begun to accelerate after the motorcycle, Mr Kerney had already disappeared from sight and, in all likelihood, had reached the corner at which he lost control of his motorcycle.

Formal Finding:

Michael Lee Kerney died on 1 December 2006 at Dubbo, NSW as a result of multiple blunt trauma, including severe head injuries, sustained when he lost control of his motorcycle which was travelling at excessive speed.

1901/06
Inquest into the death of Steven Lewis Caton at Westmead on the 6 December 2006. Finding handed down by Deputy State Coroner Dillon on the 19 June 2008.

On 3 December 2006, Mr Caton, who had suffered depression and other mental illnesses that had possibly been drug-induced, sent text messages to his step-father indicating that he intended to commit suicide. Mr Caton's stepfather notified police and a van was despatched to the house Mr Caton was visiting. The intention of the General Duties officers was to assess him and, in all likelihood, to detain him for assessment under the *Mental Health Act 1990* as an involuntary patient in a psychiatric hospital.

When the police arrived, Mr Caton was initially co-operative. Police spoke to him inside the house and escorted him outside towards the police caged truck. They did not search him inside the house partly because he was compliant with their directions at that stage and partly for reasons of safety. They considered that it would be better safety practice to search him at the rear of the vehicle before putting him inside. The police did not know at the time that they detained Mr Caton inside the house that he had secreted a steak knife on his person. It is not clear whether he managed to pick up the knife unobserved by police after they entered the house or whether was carrying the knife on his person at the time of their arrival.

When Mr Caton reached the back of the truck, he suddenly began to struggle violently. The police officers, to contain him, forced him into the back of the truck and closed the door. They immediately realised, however, that this had been done prematurely because he had not been searched for items, which he could use to harm himself or others. Within a very short time of the closing the door, the police opened it again and found him sitting inside the van holding the steak knife and exhibiting a large blood stain on his chest. Mr Caton refused to drop the knife and was sprayed with OC spray.

One of the officers then entered the van to remove Mr Caton who continued to hold the knife. Mr Caton was pulled out of the van to the ground where the knife was forced from his grip. He was subdued and an ambulance was called. Shortly after he was removed from the van, Mr Caton stopped breathing.

The police then commenced CPR until police reinforcements and an ambulance arrived. On arrival the ambulance officers followed the asystole procedures.

Mr Caton was transported to Hawkesbury Hospital then airlifted to Westmead Hospital where he underwent emergency surgery for his self-inflicted injuries. These included a left ventricular tear due to a stab wound in his upper left chest. Unfortunately, one of the consequences he suffered was a severe hypoxic brain injury due to the prolonged cardiac arrest he had undergone after stabbing himself. After consultation with his family, Mr Caton was placed in palliative care. He died in Westmead Hospital on 6 December 2006.

One principal issue explored during the course of the inquest was the question whether Mr Caton ought to have been searched in the house. On balance, the arguments presented for the police officers that it was in principle safer for them to search him near the back of the truck were accepted by Deputy State Coroner Dillon. It was conceded by the police that, with the benefit of hindsight, Mr Caton, although resistant at the back of the van, ought to have been searched before being forced into the rear of the vehicle.

Another issue explored in some detail was the adequacy of the training of officers in weapon less defensive techniques. Deputy State Coroner Dillon expressed concern that the levels of training and, therefore, the skill levels of general duties police in weapon less defensive technique may not be adequate to enable relatively junior general duties officers to carry out their duties safely. He queried whether Occupational Health and Safety policies ought take priority over ensuring that officers are trained in a sufficiently realistic way to enable them to protect themselves (and prevent harm to others due to inadequacy of their training).

Formal Finding:

Mr Steven Caton died on 6 December 2006 at Westmead Hospital. The cause of death was the consequences of a stab wound to his chest, self-inflicted, when in police custody.

Recommendations

- **That all trainees, probationary constables and general duties police receive training in the safe management of mentally ill persons who are taken into police custody, particularly those suffering major depression or psychotic mental illness.**

- **That training ought include theoretical and practical components. It is recommended that the training be given by skilled and experienced psychiatric nurses.**

- **That training of police officers in weapon less defensive techniques be made as realistic as possible, consistent with the Police Force's duty of care for its officers and those in its custody, to prepare officers for the challenges they face in dealing with strong or violent resistance to arrest or detention. To that end, it was recommended that the Operational Safety Training Unit be directed by the Commissioner to review its training syllabus in relation to weapon less defensive tactics to give priority to realistic training over Occupational Health and Safety concerns.**

1929/06
Inquest into the death of Kim Malouf at Vaucluse on the 15 December 2006. Finding handed down by Deputy State Coroner MacMahon on 27 June 2008.

Ms Kim Marie Malouf (who I will refer to as Kim) was born on 28 October 1962. She appears to have had no significant medical history until about 1982 when she suffered bouts of depression that required her to be hospitalised for a considerable period.

In 2001 Kim commenced a relationship with Paul Santamaria. This relationship resulted in the birth of a son, Tom Carl Santamaria, in October 2005. The relationship was dissolved shortly after the birth.

During the course of her relationship with Mr Santamaria Kim suffered further bouts of depression in particular in May 2004 and December 2005. Kim was diagnosed as suffering from major depression with melancholic features and possible mood congruent psychosis. Following treatment she would recover quickly. Treatment included twenty four-hour care and medication.

Kim was cared for during these times by her general practitioner, Dr. Susan Iland, and Dr. Rosalie Wilcox, a psychiatrist. Kim also received considerable care and support from members of her family including her brother Ian Malouf (who I will refer to as Ian).

The nature of Kim's illness was such that she could become unwell in a matter of days and would similarly respond to appropriate medication quite rapidly. Whilst affected she would be significantly debilitated having little, if any, insight into her medical condition and would suffer a loss of her sense of reality. At these times she would require care on a continuous basis.

When well Kim was able to lead a full life and made a substantial contribution to the lives of those around her. Unfortunately she lacked insight into to nature and seriousness of her illness and was not prepared to accept a long-term medication regime.

On 14 December 2006 Kim was in the midst of a depressive experience. She was very debilitated and, as had occurred before, her family rallied to her support. Her father and her brothers, Craig and Ian, spent time with her and a fulltime carer was employed to care for her and her son during the night.
Kim did not sleep at all that night and was observed by her carer to be in constant movement within the house.

On the morning of 15 December 2006 Kim left the house with her son. The carer thought that she was going to purchase cigarettes because she had run out. As she left Kim asked the carer not to tell her brother that she had left the house. The carer, however, immediately contacted Ian and informed him of what had happened.

At the time Ian was travelling to see Kim. He observed her driving with her son in the baby seat. Pulling up beside her they had a conversation during which Kim told her brother that she was going to get some cigarettes. Nothing appeared untoward at the time and they agreed that they would meet at her home and have breakfast together. Kim was, however, subsequently observed driving past her home. She went to Lighthouse Reserve, Vaucluse, part of the area commonly known in Sydney as *'The Gap,'* where she met her death.

Legislative Provisions:

The role and function of a Coroner is contained in section 22, Coroners Act, 1980. That section, in summary, provides that at the conclusion of an inquest the coroner is required to establish, should sufficient evidence be available, the identity of a deceased person, the date and place of their death together with the cause and manner thereof.

In addition Section 13 (1) (a) provides that a coroner has jurisdiction to hold an inquest if it appears to the coroner that a person has died *a violent or unnatural death.* Section 13A (1) (b) provides that a coroner, who is the State Coroner or a Deputy State Coroner, has jurisdiction to conduct an inquest where it appears that deceased *has died, or there is reasonable cause to suspect that the person has died, as a result of or in the course of a police operation*.

Section 13A (2) provides that where the jurisdiction to hold an inquest arises under both section 13 and section 13A an inquest is not to be held except by the State Coroner or a Deputy State Coroner. Section 14B(1)(b) requires that an inquest be held where a death comes within the provisions of section 13A.

Kim's death was one that came within the meaning of section 13A (1)(a) in that it occurred as a result of injuries she sustained in circumstances that occurred *as a result of or in the course of a police operation*. As such it is mandatory that an inquest examine the circumstances of Kim's death and either the State Coroner or a Deputy State Coroner conduct that inquest.

Section 22A also provides that a Coroner conducting an inquest may make such recommendations as they consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations is discretionary and relates usually, but not services provided by public instrumentalities.

Also of relevance are sections 44(3) and (4). Those sections provide, in summary, that where at the conclusion of an inquest findings are made that a death was self-inflicted no report of the proceedings shall be published unless the coroner holding the inquest is of the view that it is desirable in the public interest to permit a report of the proceedings to be published.

The events at Lighthouse Reserve:

Kim arrived at Lighthouse Reserve at about 08.00 and was observed by Diana Bracey and Ally Barrow, who were walking in the reserve, to be on the 'wrong side' of the fence. After observing Kim for a short time they became concerned for her welfare and Diana Bracey contacted '000' at 08.08 '*about a lady on the other side of the fence'.* At the time Kim appeared to be engaged in a conversation on her mobile phone (the conversation was with her brother Ian).

At 08.09.30 a VKG broadcast was made. The broadcast indicated a '*concern for welfare at the Gap'* and referred to *'a woman on the wrong side of the fence near the lighthouse'* The VKG broadcast was responded to by Sen Con Key, who was in Rose Bay 14, at 08.09.50 14 and by Con Weir and Con Johnson, who were in Rose Bay 15, at 08.10.40. Rose Bay 14 and 15 arrived at Lighthouse Reserve at about 08.15.

In the meantime Rene Alexander and Michelle Donde, who were also walking in the reserve, approached Kim and, because of their concern for her, tried to engage with her. They continued to do this until police arrived.

When Sen Con Key and Con Johnson arrived at Lighthouse Reserve Sen Con Key observed Kim on the cliff side of the fence talking to a woman on the correct side of the fence. At the time Kim was on a ledge of the cliff leaning against the back of the ledge.
The officers approached and introduced themselves to her and, from the correct side of the fence, encouraged her to move back off the ledge.

Sen Con Key described Kim's demeanour as being, *'agitated .. manic .. fast.. not rational.'*

Sgt H Barros, who had heard the VKG broadcast whilst travelling to Waverley Court, also arrived at Lighthouse Reserve at about 0823. As he did so he observed a male person get out of his car and run to the fence. That person was Ian who had become very concerned for his sister following his phone conversation with her and had gone looking for her.

Arriving at the fence Ian spoke to Kim saying; '*Kimmy its me, its your brother Ian. Don't do this Kimmy, Tommy is in the car, remember the same thing happened last year.'*

He then stood on the bottom rung of the fence and said *'I'm coming over'.* Sen Con Key prevented him doing so saying *'No sir, I can't let you go.'*

During this time Kim was moving towards to edge of the cliff and back again repeating over and over again that she '*was going to be blamed'.*

Sgt Barros, having retrieved the supervisors mobile from Sen Con Key and the police radio from Con Weir, moved back a distance and made a radio request for negotiators. Det Sen Sgt Fitzgerald and Det Sen Con Gallard, in Rose Bay 102 who had responded to the VKG broadcast from Paddington Police Station, arrived at about that time. Both were accredited negotiators but were not at the time 'on call'.

Det Sen Sgt Fitzgerald spoke to Kim. She introduced herself as a police officer and asked her to come away from the edge. At this time Ian then approached the fence again and was again prevented from doing so by Det Sen Sgt Fitzgerald who then took him aside to obtain information about Kim. Sen Con Key continued to speak to Kim. Then, without any further warning, Kim said words to the effect of *'I've got to go'* or *'I'm sorry I've just got to do it'* after which she jumped to her death.

Issues for Inquest:

As indicated above the findings that a coroner is required to make at the end of an inquest in accordance with Section 22 relate to the identity of a deceased together with the date and place and cause and manner of death. In this case I am satisfied as to Kim's identity. Following the recovery of her body Fr. Mel Cotter, a catholic priest who had known her for about 40 years, identified her and I accept that identification.

Dr. Paull Botterill performed an autopsy, at the Department of Forensic Medicine, Glebe on 18 December 2006, and provided a report dated 30 May 2007. Dr Botterill expressed the opinion that the cause of Kim's death was '*multiple blunt trauma'*. I accept Dr Botterill's opinion.

Concluding that a deceased person has died due to actions taken by them with the intention of taking their own life is one that is not reached lightly. In this case however having heard the evidence of each of the witnesses as to their observations of the events at Lighthouse Reserve on 15 December 2006 I am satisfied that Kim died as a result of actions taken by her with that intention. I also have no doubt that this was the consequence of the loss of her sense of reality that was caused by her illness.

I therefore propose to make findings pursuant to Section 22 that Kim Marie Malouf died on 15 December 2006 in the vicinity of Macquarie Lighthouse, Vaucluse as a result of multiple blunt trauma sustained when, with the intention of taking her own life, she jumped from a cliff in Lighthouse Reserve.

In the circumstances the main issues that were to be determined at inquest arose from the fact that Kim's death occurred during the course of a police operation (Section 13A (1)(a)) and whether or not any recommendations should be made pursuant to Section 22A.

The issues that were the subject of debate during the course of the inquest thus related to the following general matters:

- Did the actions of officers of the NSW Police Force contribute in any way to Kim's death,
- Did officers of the NSW Police Force respond in an appropriate and timely manner to the request for assistance for her made by members of the public,
- Were the NSW Police Force 'Guidelines for the Management and Investigation of Critical Incidents' ('the Guidelines') complied with following Kim's death,
- Are there any changes to the Guidelines that should be considered following a review of the circumstances surrounding Kim's death,
- Were the officers who were involved in the incidents surrounding Kim's death sufficiently trained to deal with the circumstances that they faced on arrival at Lighthouse Reserve on 15 December 2006,
- The appropriateness of the fencing provided by Woollahra Council in the area of Lighthouse Reserve, and
- The appropriateness of an education campaign to provide information for members of the public who have to deal with a person who is in distress on the 'wrong side' of the fence at Lighthouse Reserve or other similar locations.

The inquest had the benefit of hearing from a number of persons who were present at Lighthouse Reserve on the morning of 15 December 2006. Those witnesses were:

- Leonora Wilson, Michelle Donde and Rene Alexander who were walking in the reserve with their dogs,
- Leading Senior Constable Key, Sgt Henrique Barros and Det Sen Sgt Fitzgerald who were police officers who attended following the VKG broadcast, and
- Ian Malouf, Kim's brother.

In addition statements were tendered from a number of other civilian and police witnesses who were involved in the events of the morning.

Did the actions of officers of the NSW Police Force contribute in any way to Kim's death?

Section 13A (1)(a) applies to a death that *occurs either as a result of or in the course of a police operation*.

A police operation has a wide meaning. In this case the actions of officers from Rose Bay Police Station in seeking to assist Kim amounts to a police operation. It is therefore mandatory for an inquest to occur in order to review the actions of officers involved.

It is in the interest of both the NSW Police Force, the individual officers themselves and the public at large that this should occur.

Part of that review needs to assess whether or not the actions of the officers involved contributed in any way to the death of a deceased. Having regard to the evidence I am satisfied that the actions of each of the officers involved were appropriate and there is no evidence whatsoever to suggest that Kim's death was, in any way, caused by or a result of the actions of those officers either individually or as a group.

Did the NSW Police Force respond in a timely and appropriate manner to the request for assistance for her made by members of the public?

As mentioned above Rose Bay 14 and 15, containing general duty officers from Rose Bay Police Station, arrived at Lighthouse Reserve within 6 and 4 minutes respectively. Detectives, in Rose Bay 102, arrived within 13 minutes. This response time was, in my view, more than adequate.

On arrival at Lighthouse Reserve Sen Con Key was the senior officer and assumed the primary role of trying to coax Kim to return to the correct side of the fence. Other officers attended to the other persons present. Sen Con Key was not a trained negotiator.

The inquest had the benefit of receiving evidence from Det Chief Inspector Graeme Able the Commander, Negotiation Unit of the NSW Police Force, who outlined the basic principles that are applied in the conduct of negotiations in circumstances such as that faced by Sen Con Key on 15 December 2006. That evidence included details of training provided to general duties officers who might have to deal with situations prior to the arrival of accredited negotiators.

The inquest had the benefit of a number of independent witnesses as to the manner in which the police officers responded to the events of 15 December 2006. In addition the inquest had available to it an audio recording of a critical part of those events. The inquest was thus in a unique position to assess the appropriateness of the police response.

Having regard to the evidence available, the nature of Kim's illness and her location on the cliff ledge I have no doubt that there was nothing more that the officers could have done on the day to prevent her death. The actions of the officers were in my view most appropriate. Whilst not ignoring the contributions of each of the various officers involved that of Sen Con Key must, however, be given particular recognition.

Her response in what was no doubt a very difficult situation was both highly professional in relating to Kim whilst at the same time sensitive to the needs of Ian Malouf and the various members of the public who were present at the time. She is to be commended for her actions.

Having regard to the evidence I am satisfied that the response of the NSW Police Force was both timely and appropriate.

Were the NSW Police Force 'Guidelines for the Management and Investigation of Critical Incidents' ('the Guidelines') complied with?

Following the occurrence of a critical event the procedures set out in the Guidelines are to be followed. The Guidelines require that there be an independent investigation of the event by police officers of a Command other than that of the officers involved. The objects of the Guidelines are, in part, to ensure that the best evidence is available when the matter subsequently comes to inquest. It is in the interest of both the public and the police officers involved that this be the case.
In this case the fact that the incident was a critical incident was identified immediately and action was taken to implement the Guidelines.

The evidence available at inquest examined the manner in which the requirements of the Guidelines were implemented. I do not propose to go through that evidence in detail other than to say that, apart from a number of relatively minor departures that did not, in my view, affect the quality of the evidence available, the Guidelines were complied with. As a result the effectiveness of the investigation for the purpose of complying with the obligations of the Coroners Act was not compromised.

The Guidelines have, of course, been developed so as to ensure that the 'best evidence' is available at inquest. It is self evident that it is in the interest of the public, the NSW Police Force and individual police officers themselves that this should be so. Sometimes, for practical reasons, full compliance is not possible however in every case every endeavour must be made to ensure compliance.

Are there any changes to the Guidelines that should be considered following a review of the circumstances surrounding Kim's death?

The Guidelines require, for good reasons, that officers involved in an incident not communicate with each other concerning the events and be interviewed as quickly as possible. The compliance with these requirements must have regard to the needs of the officers where, as was the case here, the events were distressing and would no doubt have an effect on the involved officers. Each of the officers who gave evidence was asked whether or not they had discussed the events with other colleagues who had been involved.

They each denied that they had and expressed the view that they could not do so until the inquest had concluded.

The court is aware that the events of 15 December 2006 have negatively affected each of the officers involved with some requiring long-term sick leave. It was apparent at the time those who gave evidence did so that they remained affected by the events.

Dr. Murray Wright, a consultant psychiatrist who consults to the NSW Police Force Negotiation Unit and has extensive experience in treating police officers, both negotiators and general duties officers,

who suffer injury following traumatic events, gave evidence at the inquest. Dr Wright's evidence was to the effect that there was a real possibility that officers involved in such events would suffer psychological injury as a consequence of such involvement and that the best chance of avoiding, or reducing, such injury was for the officer to be debriefed, preferably in conjunction with other officers involved, as soon as possible but in any event not more than 72 hours after the event. This did not happen with the officers involved in the incident on 15 December 2006. Indeed each of those who gave evidence said, and I accept their evidence, that they had not discussed the incident believing that they were not allowed to do so until after the inquest had concluded.

It is in the public interest that following an event officers not discuss the details of an event with others involved until after they have given a statement or been interviewed. This will ensure that the evidence available is the best evidence and there is no possibility of contamination of evidence either intentional or otherwise. It is also in the public interest that officers not suffer injury as a result of the, sometimes distressing, matters that they are required to deal with during the performance of their duties. Indeed, having regard to the principles enshrined in the occupational health and safety legislation, the Commissioner has a statutory obligation to prevent such injury occurring. Achieving the balance between these two public interests is a difficult task.

At inquest Counsel Assisting submitted that the circumstances of Kim's death highlighted the need for amendments to the Guidelines and suggested that a recommendation should be made in accordance with section 22A to address the perceived problems.

The terms of the suggested recommendation were as follows:

1. "The NSW Police Force give consideration to whether officers involved in traumatic critical incidents should participate in a debrief with trained psychologists or psychiatrists with an understanding of operational policing within a 72 hour period of the incident.

2. That the NSW Police Force give consideration to amending the "Guidelines for the management and investigation of critical incidents" (Guidelines) to clarify the following ambiguities which have arisen during the course of the inquest:

If involved officers who became seriously distressed as a result of a critical incident can return home before participating in a recorded interview, and if so, for how long;

a) If officers are prohibited from discussing the events which give rise to the critical incident with people other than involved officers, investigators or potential witnesses to a coronial inquest until the inquest has concluded;

b) The time frame in which interviews with involved officers should usually be conducted in a manner similar to the guidance given with respect to alcohol and drug testing."

Counsel for the NSW Police Force submitted that such a recommendation was unnecessary as the Guidelines were currently under review and the balance between the competing interests that had to be drawn was one that was already the subject of consideration. No further information as to the proposed variations, if any, to the Guidelines was provided to the inquest.

In the circumstances, whilst recognising that the issues are important ones but at the same time not having details of the current review of the Guidelines, I do not consider it appropriate to make recommendations in accordance with section 22A on this matter other than to refer the evidence taken from Dr. Wright to the Commissioner for Police and recommend that the views contained therein be considered during the course of the review of the Guidelines.

The investigation of a critical incident includes the obtaining of evidence of the compliance, or otherwise, with the Guidelines. Where this issue is not dealt with in directed interviews or statements taken at the time it is necessary for it to be the subject of evidence at the inquest. Counsel assisting submitted that this could be avoided if the checklist for those conducting directed interviews were available that included compliance with those aspects of the Guidelines that are designed to ensure that evidence is not contaminated. This suggestion is a sensible one and I propose to recommend that the Commissioner give consideration to it as part of the current review of the Guidelines.

Were the officers who were involved in the incidents surrounding Kim's death sufficiently trained to deal with the circumstances that they faced on arrival at Lighthouse Reserve on 15 December 2006?

The evidence was that officers at the Rose Bay Police Station were regularly required to attend the Gap as part of their duties. Sen Con Key stated that she had been to the area more than a hundred times.

On 15 December 2006 a Standard Operating Procedure (the SOP) dealing with responses to the Gap for Rose Bay Local Area Command was in the course of preparation.

This SOP has since been proclaimed and is a significant advance in the provision of support to general duties officers who are called to assist persons at the Gap. The LAC is to be commended for its actions in the development of the SOP.

Counsel assisting suggested that as the attendance at the Gap was a regular activity of general duties officers at Rose Bay recommendations should be made pursuant to section 22A so as to ensure that all officers are conversant with the provisions of the SOP. Those recommendations also suggested there be mandatory annual training in, and that officers be required to acknowledge familiarity with, the SOP.

Counsel appearing for the NSW Police submitted that such a recommendation was unnecessary. I do not however consider that it is appropriate to make the recommendation suggested. I am not aware of the training budget available to the LAC nor am I aware of any other issues' that would make claims on that training budget.

As such I do not consider that it would be appropriate to recommend mandatory training. I do, however consider that I recommend that the LAC ensure that all officers have familiarity with the SOP is appropriate. I do not, however, think it is necessary that officers be required to certify their familiarity with the SOP.

The appropriateness of the fencing provided by Woollahra Council in the area of Lighthouse Reserve.

The evidence presented at inquest clearly establishes that on 15 December 2006 Kim was determined to take her own life. I am also satisfied that she went to Lighthouse Reserve for that purpose. She had been to various locations associated with the Gap on numerous previous occasions. She may well have been to the Lighthouse Reserve itself. To access the cliff it was necessary for her to scale the fence that separated the public area from the cliff area. This raises the question of the appropriateness of the fence particularly as the Gap is recognised as an area that many persons attend who have the intention of harming themselves.

The nature of the fence to be provided at such sites is one that requires a balance between the need to keep persons away from a dangerous location, the desire not to block the magnificent views that attract residents and tourists to the area and the cost involved in providing fencing along an extensive coastline. The inquest had the benefit of a view of the site and of receiving evidence from David Shields the Manager, Public Open Space, Woollahra Council. Woollahra Council is responsible for the management of the 1 kilometre coastal strip from Gap Park in the north to Christison Park in the south. This area includes Lighthouse Reserve.

Mr Shields outlined the work that had been done as part of the preparation of what has become known as the 'Gap Master Plan'.

The preparation of this plan has involved extensive public consultation and has involved mental health experts, the Rose Bay Police, the Community Safety Committee, the counselling service 'Lifeline' and the public in general. The Plan involves the installation of a number of strategies designed to minimise self-harm. At Lighthouse Reserve this involves the replacement of the existing fence with one that is less accessible and slightly higher than that which existed at 15 December 2006. The work to replace the fence was being undertaken at the time of inquest and the changes to the fence could be examined at the time of the view.

Whether or not the changes to the design of the fence, had it been in place on 15 December 2006, would have made a difference in Kim's case will never be known. The Woollahra Council is, however, to be commended for the actions it has taken in developing the Gap Self-Harm Minimisation Plan.

The appropriateness of an education campaign to provide information for members of the public who have to deal with a person who is in distress on the 'wrong side' of the fence at Lighthouse Reserve or other similar locations.

A number of the civilian witnesses who gave evidence at the inquest expressed the view that they felt a moral obligation to assist Kim but that they felt untrained or unprepared to do so. Two witnesses did approach her and during the course of the inquest it was evident that there was a disagreement between them as to how she should be approached and what should be said to her. It was suggested that there should be a public education campaign to provide residents and others who use the headland facilities with training to enable them to respond in such circumstances.

The appropriateness, or otherwise, of such a public education campaign was the subject of evidence during the inquest. Det Sgt Fitzgerald, who was trained as a negotiator, was firmly of the view that the best advice to be provided to civilian witnesses was that they should call 'triple O' and do nothing more. This was because some things said in such circumstances, even if made with the best of intentions, might actually aggravate the situation.

No evidence was provided as to what the content of such a public education program might be, who it should be aimed at, who should conduct it or how it would be funded. As such it is not possible for me to make any relevant suggestion concerning this matter. The advice that when a person was observed on the 'wrong side' of the fence the observer should phone 'triple O' is a good one and I propose to make a recommendation that Woollahra Council consider including such advice as part of signage installed at various locations in the vicinity of the Gap.

Summary:

Kim's death was a tragedy. She suffered a serious illness that became chronic at various times for no apparent reason. When it did she was severely debilitated and, because of the loss of her sense of reality, it meant that she was in need of constant care. Kim's family recognised this and were unstinting in their efforts to care for her. On 15 December 2006 she was unfortunately able to elude the supervision that she required and this resulted in the tragic consequences that followed.

No doubt members of Kim's family will wonder whether or not there was anything more that could have been done by them. They need to be assured that there was not. As was recognised by Dr. Wilcox and Dr Iland the love and care that they, and in particular her brother Ian, showed for Kim and their response to her circumstances was exceptional. They are to be commended for their efforts on her behalf.

Section 44 (3) and (4).

Having regard to the fact that Kim's death occurred during the course of a police operation thus requiring a mandatory inquest and taking into account the view expressed by Kim's family that they had no objection to the reporting of the proceedings I consider that the publication of a report of the proceedings of the inquest into the death of Kim Marie Malouf is desirable in the public interest and therefore, pursuant to section 44(4), I permit a report of the proceedings to be published with the exception of those parts of the evidence of Det Inspector Able the publication of which was previously prohibited.

Formal Finding:

Kim Marie Malouf died on 15 December 2006 in the vicinity of Macquarie Lighthouse, Vaucluse as a result of multiple blunt trauma sustained when, with the intention of taking her own life, she jumped from a cliff in Lighthouse Reserve.

Section 22A Recommendations:

To the Commissioner of Police:

- **That during the review of the 'Guidelines for the Management and Investigation of Critical Incidents' ('the Guidelines') currently being undertaken the evidence of Dr. M Wright given at inquest be taken into consideration when formulating time-frames and protocols for the taking of directed interviews from and the conducting of debriefing conferences for involved officers especially where the critical incident has involved traumatic circumstances and there is the possibility of such officers suffering psychological injury.**

- **That during the review of the 'Guidelines for the Management and Investigation of Critical Incidents' ('the Guidelines') currently being undertaken a checklist for those conducting directed interviews be developed that includes the obtaining of evidence of compliance with those aspects of the Guidelines that are designed to ensure that the evidence of the officer has not been contaminated.**

To the Commander, Rose Bay LAC, NSW Police:

- **That action is taken to ensure that all officers within the command are familiar with the requirements of the 'The Gap Standard Operating Procedure'.**

To the General Manager, Woollahra Council:

- **That the Council give consideration to including as part of the signage erected in the area of the Gap a notice asking members of the public who observe persons of the 'wrong side' of the cliff fence to immediately advise the police by contacting 'triple O.'**

9/07
Inquest into the death of Hung Quach at Fairfield on the 30 December 2006. Finding handed down by Deputy State Coroner Milovanovich on the 9 September 2008.

Hung Quach was aged 32 years, died as a result of multiple injuries sustained in a motor vehicle accident during the course of a Police pursuit.

The deceased had a long criminal record and at the time of his death was a disqualified driver and was at the time on a suspended sentence for disqualified driving offences.

On the 30/12/2007 the deceased was observed driving a Red Honda Integra in the Cabramatta area. A police officer who was driving a fully marked Highway Patrol vehicle thought the driver may have been a disqualified driver and a radio check of the registration details confirmed an association with that vehicle an a person who was a disqualified driver. Police made a decision to stop the vehicle for the purposes of a random breath test and check on the bona fides of the driver.

The Police vehicle followed the offending vehicle and signalled the driver to stop by activating the Police lights. The vehicle did not stop and the Police vehicle continued to pursue to a point where the offending vehicle commenced to increase its speed and a pursuit was called into the VKG Operator. At this point the Police vehicle activated its lights and sirens.

A pursuit then commenced that last approximately 60 seconds during which period the offending vehicle increased its speed and was driven erratically in a 60 kph built up area.

Upon reaching the Cumberland Highway, the vehicle disobeyed red traffic control lights and crossed 6 lanes of the Cumberland Highway at speed. The Police vehicle then radioed VKG to advise that the pursuit was being terminated.

The evidence at Inquest and aided by the on board Video Camera in the Police vehicle corroborated the actions of the Police. The evidence, however, also indicates that while the Police vehicle had reduced its speed and deactivated the sirens, the Police vehicle continued to follow the offending vehicle and attempted and did remain in visual contact. The decision to continue to follow the offending vehicle was a clear breach of the Safe Driving Policy and both the driver and observer have been counselled and have undertaken further training.

The offending vehicle continued at speed and attempted to overtake another vehicle when it lost control at a speed of approximately 130 kph.

The vehicle rolled and struck a power pole resulting in the vehicle splitting in half, the deceased being ejected and a fire started in the main body of the vehicle.

The Police vehicle, which had followed the offending vehicle, arrived at the accident site within a short time frame of the accident. The deceased died at the scene.

At Inquest the Coroner was satisfied that the Critical Incident Investigation Team had identified breaches of the Safe Driving Policy and action had been taken to counsel, reprimand and re train the involved officers. Similarly, minor failings in the Critical Incident Investigation protocols were noted by the Coroner, but not of such significance that would have warranted formal recommendations.

The Coroner did not make formal recommendations, however, did request that Counsel appearing for the Commissioner of Police and the involved Officers convey to the Commissioner and the Police Training Unit the breaches of the Safe Driving Police for the purposes of ongoing education. The Coroner found that the deceased had a blood alcohol level in the high range and that the speed and manner of driving contributed to the accident.

Formal Finding:

That (the deceased) died on the 30th December 2007 in King Road, Fairfield West in the State of New South Wales from multiple injuries when the vehicle he was driving left the carriageway and impacted with a telegraph pole.

108/07

Inquest into the death of Raymond Marmara at Long Bay on the 18 January 2007. Finding handed down by Deputy State Coroner MacPherson on the 10 March 2008.

Raymond was diagnosed with having a mental illness when he was about twenty-one years of age. He lived in the Botany area by himself and was being looked after by the Community Mental Health Centre.

Like so many mentally ill people Raymond was not a management problem when he was taking his medication. In January 2002 he was taken to the Prince of Wales Psychiatric Unit under Section 24 of the Mental Health Act after threatening a shop owner with a knife. He was psychotic and required sedation.

After recon 30 January 2002 Raymond escaped from the Kiloh Centre and because of his violent behaviour the Community Mental Health Team and the Police were notified.

On 1 February 2002 he was seen returning to his house in Botany and two Police Officers followed Raymond into the kitchen of the residence where Raymond became aggressive and armed himself with a knife. Raymond was shot by one of the Officers when he attacked the Officers with a knife. Raymond was arrested and taken to Hospital for treatment.

He was charged but eventually on 5 April 2005, having been in custody at Long Bay Prison Hospital since his arrest, at the Sydney District Court Raymond was found not guilty because of his mental illness and was held under Section 39 of the Mental Health (Criminal Procedure) Act 1999, and detained in 'C' Ward in Long Bay Prison Hospital until his release by due process of law.

On 18 October 2006 the Governor signed an order for Raymond's continued detention.

Raymond was being treated intensively for his illness, paranoid schizophrenia and also an endocrine problem being primary failure of the testicles.
Raymond weighed 160 kgs at the time of his death and he was actively being encouraged to loose weight to prolong his life. Part of his illness related to his belief that he was not overweight.

At about 7.40 am on 18 January 2007 Raymond was found deceased in his cell and a subsequent post mortem determined that Raymond had died of natural causes namely, Generalised Bacterial Sepsis subsequent to Acute Prostatitis with Obesity and Schizophrenia being other conditions contributing to but not relating to the cause of death.

There were issues regarding the statements made by Richard Karalus, Catherine Capecci and Danny Palmer in relation to who had entered the cell first and found Raymond deceased. It is clear from the statements that lies have been told by the officers, however, despite that there are no suspicious circumstances and Raymond died from natural causes.

The Solicitor representing the Department informed the Court that Officer Karalus had been under considerable emotional strain that day and in retrospect should not have been at work. No further action was taken against any officer.

One further issue was that closed circuit television footage of the area was only stored for a short period of time, however, no recommendations were made in relation to storing because new accommodation for inmates will be completed and they do have storage facilities for CCTV footage.

Formal Finding:

I FIND THAT RAYMOND MARMARA DIED BETWEEN 17 JANUARY AND 18 JANUARY, 2007 AT THE LONG BAY PRISON HOSPITAL FROM (A) GENERALISED BACTERIAL SEPSIS) NATURAL CAUSES

(B) ACUTE PROSTATITIS

(II) OBESITY, SCHIZOPHRENIA

136/07
Inquest into the death of Kenneth James Martin at Lismore on the 26 January 2007. Finding handed down by Deputy State Coroner Milovanovich on the 10 April 2008.

The deceased was a 57-year-old married man who had no prior criminal record. In September 2006 the deceased was charged with driving a motor vehicle with High Range Concentration of alcohol. While on bail for the latter charge, the deceased was arrested again for driving with the High Range Concentration of Alcohol and with driving while suspended.

He appeared at Grafton Local Court on 11/12/2006 where he was fined for the first offence and sentenced to 9 months imprisonment with a non-parole period of 6 months for the second offence.

The deceased was taken into custody at the Grafton Correctional Centre on the 11/12/2006 where he was assessed as being at risk of self-harm due to the withdrawal effects of excessive alcohol use and the fact that this was his first incarceration. In the ensuing 3 days his medical condition began to deteriorate and he was transferred to Grafton Base Hospital.

His prognosis was very poor and was diagnosed with severe life threatening liver disease and medical staff at the hospital believed his death was imminent. Justice Health and the Department of Corrections advised the Parole Board of the prisoner's medical condition and his prognosis and a decision was made to release him on parole.

He was released on compassionate parole effective from 19/12/2006. Between the 19/12/2006 and 5/01/2007 the deceased's medical condition improved remarkably and concerns were raised that the deceased was well enough to discharge himself from hospital.

Accordingly on the 7/01/2007 the deceased's parole was revoked and he returned to the care of the Department of Corrections as a prisoner in lawful custody, albeit, that he remained in hospital.

On the 7/01/2007 the deceased was transferred to Lismore Base Hospital for further medical treatment. His condition remained stable until the 19/1/2007 when it suddenly deteriorated.

From the 19/1/2007 until his death on the 26/1/2007 the deceased was treated palliatively with non-resuscitation directive from the family. The deceased was found unresponsive on the 26/1/2007 and no resuscitation was conducted in accordance with the wishes of the family.

The death was considered as a death in custody and one falling within the provisions of Section 13A of the Coroners Act 1980. There were no coronial issues identified at the inquest, other than the next of kin expressing some concern that the release on parole and the subsequent revocation may have contributed to the deceased's death.

Formal Finding:

That (the deceased) died on the 26th January 2007 at Lismore Base Hospital, Lismore in the State of New South Wales from Gastrointestinal Haemorrhage, Oesophageal Varices and Alcoholic Cirrhosis of the Liver.

138/07
Inquest into the death of John Sayers at Tunks Park on the 22 January 2007. Finding handed down by Deputy State Coroner Dillon on the 22 April 2008.

Mr Sayers, a 37 year old unemployed man, committed suicide on 22 January 2007 by jumping off the Northbridge Suspension Bridge in front of two horrified police officers and a civilian witness who had tried to prevent him from doing so. He had suffered depression for a long period of time and had talked for some years about committing suicide. It seems that he had made prior attempts on his own life.

At about 6.10pm Mr Caton was seen by a passer-by looking over the bridge wall. Mr Sayers told the man that he intended to jump and asked him to give his wallet to police. The wallet contained identifying details. The witness tried to persuade Mr Sayers not to jump and also called 000. A police vehicle was despatched urgently to the location as a result, arriving a few minutes later.

As the police vehicle drew up behind him, Mr Sayers turned, looked at the police, and jumped onto the bridge wall. The civilian witness grabbed hold of him but was unable to restrain him. One of the police yelled, "Stop" but this had no effect on Mr Sayers who threw his wallet in their direction and rolled over the ledge.

Mr Sayers died of multiple injuries received when he landed in the park 50 metres below the bridge.

The inquest was a mandatory matter under s.13A of the *Coroners* Act because Mr Sayers died in the course of police operations. Nevertheless, the focus of the inquest was not on the conduct of the police officers, which was in all respects exemplary, but on the question of prevention of future accidents.

Police records produced for the period 1995-2007 showed that at least 14 jumps or threatened jumps had been reported. Apart from a number of suicide attempts, successful or otherwise, the bridge has been used for base-jumping. Below the bridge is a park used by schools and clubs for sports and by local residents for exercise, dog-walking and general recreation. The potential hazards to park users posed by jumpers from the bridge is self-evident and were pointed out by Deputy State Coroner Dillon in his findings.

Formal Finding:

John Michael Sayers died on 22 January 2007 at Tunks Park, Northbridge. The cause of his death was multiple injuries due to a fall from height and the manner of death was suicide

Recommendations

To the Minister for Roads and Traffic:

- **That a safety barrier, designed to prevent or significantly impede jumping from the Northbridge Suspension Bridge, be erected by the RTA as soon as is practicably possible taking into account the relevant planning issues.**

- **That any such safety barrier be designed to take into account the bridge's significant heritage and architectural values and to harmonise with them.**

140/07
Inquest into the death of Michael Hurley at Randwick on the 23 January 2007. Finding handed down by Deputy State Coroner MacMahon on the 4 April 2008.

Mr Hurley was arrested in February 2005 and bail refused. In February 2006 he was diagnosed as suffering from *'metastatic carotid paraganglioma'.* This condition resulted in Mr Hurley experiencing 'progressive paralysis about the legs with a sensory level about mid torso'. A MRI conformed the diagnosis. Specialist examination of Mr Hurley at the Prince of Wales Hospital advised that his tumour was rare and not one which chemotherapy or radiotherapy would be undertaken.

In April 2006 Mr Hurley was transferred to Long Bay where he remained until July 2006 when he was transferred to the Metropolitan Special Purposes Centre.

Because of his medical condition Mr Hurley was provided with a medical certificate that allowed him to return to his cell at any time.
In the latter part of 2006 it was found that Mr Hurley's tumour had metastasised to his left rib cage and he received radiotherapy treatment.

On the morning of 8 January 2007 when Mr Hurley's cell was opened he complained that he had fallen out of bed and called for medical treatment. A doctor and nurse examined him and following that examination he was to be taken to Prince of Wales Hospital for further examination. Whilst waiting to be transferred Mr Hurley was able to leave his cell and communicate with other prisoners. Mr Hurley was then taken to Prince of Wales Hospital.

On admission Mr Hurley gave a history of a fall on 7 January 2007 followed by severe neck pain, shoulder pain and difficulty swallowing. He was subsequently found to have a fracture at C3and C4 and associated pre-vertebral haematoma. He underwent surgery on 8, 12 and 15 January 2007. At surgery the fractures that Mr Hurley had suffered were found to have resulted from the weakening of the bones due to the metastatic tumour that he was suffering from.

Following surgery Mr Hurley's condition deteriorated and he entered into palliative care. Mr Hurley died on 23 January 2007.

An autopsy conducted following Mr Hurley's death found that the direct cause of his death was *metastatic paraganglioma.*

At Inquest the suggestion that there was some third party involvement in the circumstances that led to Mr Hurley's fall and his sustaining the injuries that resulted in his admission to Prince of Wales Hospital was investigated.

No evidence was found to support this contention. At the conclusion of the Inquest it was found that Mr Hurley died of natural cause process.

Formal Finding:

I FIND THAT MICHAEL HURLEY DIED ON 23 JANUARY 2007 AT PRINCE OF WALES HOSPITAL. THE CAUSE OF DEATH WAS METASTATIC PARAGANGLIOMA. THE MANNER OF DEATH WAS NATURAL CAUSES.

204/07
Inquest into the death of David George Pullen at Maroubra on the 3 February 2007. Finding handed down by Deputy State Coroner MacMahon on the 4 April 2008.

Mr Pullen was a 63 year old man who had been sentenced on 16/08/01 to a term on imprisonment on 14 years with a non parole period of 11 years.

Mr Pullen suffered from coronary artery disease, angina, chronic obstructive pulmonary disease, and arthritis to the hip and chronic back pain. He was being treated with various medications, which he received on a daily basis from the prison pharmacy.

On 2 February 2007 Mr Pullen was not observed to have been experiencing any personal difficulties and made no complaints to any of the correctional officers. He was locked in his cell at about 4pm with no complaints. On 3 February 2007 his cell was opened for morning muster at about 8.25am. Mr Pullen was found to be lying on his back near the door deceased.

An autopsy was performed by a pathologist attached to the Department of Forensic Medicine at Glebe who concluded that Mr Pullen had died from a natural cause that being an acute subrachnoid hemorrhage with antecedent causes of acute right intraparenchymal cerebral haemorrhage and hypertensive vascular disease. Mr Pullen's death was unexpected. The medical treatment of Mr Pullen whilst in custody was reviewed and considered to be appropriate.

Formal Finding:

I FIND THAT DAVID GEORGE PULLEN DIED ON OR ABOUT 2 FEBRUARY 2007 IN CELL 24, MSPC - AREA 4, LONG BAY CORRECTIONAL CENTRE. THE CAUSE OF DEATH WAS

1 (A) ACUTE SUBARACHNOID HAEMORRHAGE
1 (B) ACUTE RIGHT INTRAPARENCHYMAL CEREBRAL HAEMORRHAGE
1 (C) HYPERTENSIVE VASCULAR DISEASE

217/07
Inquest into the death of Cheryl Gysin-Jones (Brett Sparks) at Wagga Wagga on the 9 March 2006. Finding handed down by deputy State Coroner Milovanovich on the 16 January 2008.

Biological Male aged 59 years, with a number of alias names who has identified himself as female. Died at Wagga Wagga Base Hospital on 9th March 2006.

The deceased was identified to the Coroner as being Paul Theodore Gysin with a date of birth as 8/9/57, although he was recorded under some 36 alias names corresponding with the former date of birth. Medical records, however, suggest his correct date of birth was 8/9/47.

The deceased had a long criminal history and was an intravenous drug user. The deceased had been diagnosed with Acquired Immunodeficiency Syndrome as well as being positive to Hepatitis B and C.

The deceased was last imprisoned on the 22/10/2005 after being arrested on a warrant for breach of parole. The deceased was sentenced to further period of 11 months and 29 days with earliest release date being 20/10/2006.

When the deceased was arrested on 22/10/2005 the prisoner had a bottle of Ordine in his property.

This item was seized and recorded in the Police exhibits and transferred to the Dept of Corrections. It would appear that the prisoners property remained in a sealed bag while the prisoner was transferred, first from Police custody to Correctional custody at the Metropolitan Remand Centre, then to Long Bay Hospital and finally to Junee Gaol. The prisoner was received at Junee Gaol on 29/12/05.

There was no record of the prisoner's property being recorded on the computerised property system. It would appear that the prisoner's property remained in sealed bags until the 4/3/2006. On this day, it would appear that the prisoner's property was located and a decision was made to inspect, record and return to the prisoner those items the prisoner would be entitled to. There was no record of the bottle of Ordine being sighted or recorded. Ordine is a liquid base morphine and investigations determined that the bottle of Ordine had been lawfully prescribed and dispensed to the deceased prior to being taken into custody.

On the 7/3/2006 the prisoner became unwell with breathing difficulties. The prisoner was receiving methadone and other prescribed drugs in relation to his diagnosed immune deficiency.

While the prisoner was being transferred from the cell to the prison clinic a search of the prisoners person detected the Ordine bottle with fluid in it. The bottle was confiscated.

The prisoner's condition was monitored in the clinic; however, on 8/3/2006 nursing staff noticed that the prisoner was in respiratory distress.

Medical attention was given including two doses of Narcan and the prisoner was transferred to Wagga Wagga Base Hospital. The deceased condition continued to deteriorate and a decision was made to withdraw all active medication and keep the prisoner comfortable. The prisoner died on the 9/3/2006.

The death was reported to the Coroner as the deceased was in lawful custody at the time of death. A post mortem examination concluded that the deceased had died from Bronchopneumonia with other significant conditions contributing to the death, but not relating to the disease or condition causing it, as Acquired Immunodeficiency Syndrome, Emphysema and Opioid Toxicity.

At Inquest the primary issue for the Coroner was the circumstances under which the prisoner was able to have in his possession a bottle of Ordine. The Coroner determined, that on balance, the Prisoner most likely secreted the item in her clothing on the 4/3/2006 when her property was being examined in his presence.

There was no direct evidence to suggest that the deceased consumed part or any of the Ordine or that it may have contributed to death. The toxicology reports did indicate a high level of Morphine, however, this level was difficult to interpret by virtue of the fact that the deceased was on a methadone programme as well as other medications that metabolise into morphine.

The deceased was also being treated palliatively shortly before death and was medicated with morphine. Also of significance was the fact that the deceased had a compromised immune system in which the ordinary break down period for drugs may be different in an otherwise healthy adult.

The Junee Gaol is a privately run Gaol, however, responsible to the Commissioner for Corrective Services. The Dept of Corrections instigated an investigation in regard to the Ordine bottle and determined that there had been breaches of guidelines in regard to the timely and appropriate identification and recording of personal property.

A number of recommendations were made which have been implemented and accordingly the Coroner was of the view that further formal recommendations were not necessary. The Coroner was satisfied that there were no systemic failure and the failure to inspect the prisoners property may have been compromised by the fact that it had a hazard warning in view of the prisoners known medical history (AIDS).

Formal Finding.

That Cheryl Gysin-Jones died on the 9th March 2006 at Wagga Wagga Base Hospital, Wagga Wagga in the State of New South Wales from Bronchopneumonia with significant contributing factors being Acquired Immunodeficiency Syndrome, Emphysema and Opioid Toxicity.

225/07
Inquest into the death of Viet Hoang Nguyen at Cessnock on the 13 January 2007. Finding handed down by Deputy State Coroner MacPherson on the 19 December 2008.

This was a death in custody at Cessnock Correction Centre. Nguyen was 30 years of age and was serving a sentence of 12 months imprisonment imposed at Liverpool Local Court on 14 September 2006 to date from 17 August 2006.

Nguyen was given a non parole period of 8 months so his earliest date for release would have been 16 April 2007. Nguyen was involved in receiving methadone to combat a long-standing drug addiction.

About 7.20pm on Friday 12 January 2007 Nguyen was placed into his cell and when he was taken his breakfast at 6.40am on 13 January 2007 he was found deceased.

A subsequent post mortem disclosed that he had died from natural causes the specific pathology being described as CORONARY ARTERY VESSEL DISEASE.

There was no indication he was ill before being placed in the cell and the Forensic Pathologist stated that the condition he suffered from could lead to sudden death.

Formal Finding:

I FIND THAT VIET HOANG NGUYEN DIED ON 13 JANUARY 2007 CESSNOCK CORRECTIONAL CENTRE. DIED OF THE EFFECTS OF A NATURAL CAUSE NAMELY CORONARY ARTERY VESSEL DISEASE.

274/07
Inquest into the death of Karen Sarah at Randwick on the 15 February 2007. Finding handed down by Deputy State Coroner MacPherson on the 4 September 2008.

Karen Sarah was a 46-year-old inmate at Long Bay Correctional Centre. She was being held as a Forensic Patient under the Mental Health Act, having been committed for maliciously wounding her former partner in 2004.

At about 11.40am on Thursday 15 February 2007 Karen Sarah had been in the outside area of the hospital grounds of Long Bay Gaol where she was eating her lunch, consisting of a peanut butter sandwich.

At this time she was seen by Correctional Services Officers Brown, Menzel and Busmell to collapse.

A medical team was close by and it appeared to them that she was chocking on some food that was lodged deep in her throat passage.

Some food was removed by suction. Doctor Stewart and medical team members Ericson, McLeod and Ballence employed by the Department commenced CPR and at this time Karen Sarah went into cardiac arrest.

An Ambulance arrived at 12.09pm and several attempts were made to intubate her but the throat passage was blocked by food particles.

Two other Ambulance crews were pm the scene as backup.

Eventually Karen Sarah was taken to the Prince of Wales Hospital Accident and Emergency and arrived at 12.45pm Karen Sarah was intubated and attempts were continued to resuscitate her for the next hour and finally discontinued at 1.03pm.

Although the Post Mortem indicated that death was undetermined on the available evidence the Coroner was satisfied that death was due to cardiac failure as a result of asphyxia due to the accidental impaction of food in the larynx.

The Coroner was satisfied that all that could be done after Karen Sarah collapsed was done.

Formal Finding:

I find that Karen SARAH died on the 15 February 2007 at the Prince of Wales Hospital Accident and Emergency Ward of a Cardiac Arrest as a result of Asphyxia due to the Accidental Impaction of food in the Larynx.

439/07
Inquest into the death of Andrew John McDonald at Long Bay Gaol on the 12 March 2007. Finding handed down by Deputy State Coroner MacPherson on the 11 August 2008.

Andrew was a 54-year-old inmate who at the time of his death was on remand for 'Malicious wounding with intent to murder'. He was due to appear or at Court in relation to those charges on 11 May 2007.

Andrew had been held in custody at Parklea Correction Facility but was moved to Long Bay Hospital on 22 January 2007 due to prostate cancer.

Andrew had told his family that he had been told in November 2006 that he only had a short time to live because the prostate cancer had spread and that he did not expect to live past the middle of 2007.

Andrew was suffering severe pain and respiratory problems and he was kept in Long Bay Hospital until his release back to Parklea Prison 8 February 2007. On the 23 February 2007 Andrew was again returned to Long Bay Prison Hospital because his condition had worsened.

Andrew basically received palliative care and was last seen alive about 8.30pm on 11 March 2007 when he requested some food and consumed some jelly.

Around 8.25am on 12 March 2007 Dr. Veronica Stewart visited Andrew and saw his chest rising up and down slowly but Andrew was unconscious. She checked and was unable to hear any breathing

No attempts were made to resuscitate Andrew and life was pronounced extinct at 8.29am on 12 March 2007.

There were no care and treatment issues and clear that Andrew died from natural causes, specifically, Metastatic Carcinoma of the Prostate.

Formal Finding:

ANDREW JOHN MCDONALD DIED ON 12 MARCH 2007 AT LONG BAY GAOL OF METASTATIC CARCINOMA OF THE PROSTATE.

475/07
Inquest into the death of Edwin Thomas Street at Long bay Gaol on the 19 March 2007. Finding handed down by Deputy State Coroner MacMahon on the 28 April 2004.

Mr Street was an inmate of the Long Bay Gaol Hospital. He was serving a life sentence. He had been diagnosed as suffering from colorectical cancer.
At about 6.30pm on 18 March 2007 he was seated on the edge of his bed in his cell eating his meal when he fell forward hitting his head on a chair.

He suffered a haematoma to the left side of his forehead. He was subsequently transported to Prince of Wales Hospital for treatment. After treatment for the haematoma he was returned to the gaol hospital for observation. He was checked on a random basis by nursing staff.

When observed at 3am on 19 March 2007 he was observed to be alive. When checked again at about 3.15am he was found to be deceased.

An autopsy found that the direct cause of Mr Street's death was metastatic colonic Aden carcinoma and its consequence.

There was no evidence presented at Inquest to suggest that the medical care and treatment provided to Mr Street whilst in custody was inappropriate.
Mr Street died of natural causes.

Formal Finding:

Edwin Thomas Street died on 19th March 2007 at Long Bay Hospital. The cause of death was metastatic colonic Aden carcinoma and its consequences. The manner of death was natural cause.

479/07
Inquest into the death of Ben Robbins at Bargo on the 12 May 2007. Finding handed down by Deputy State Coroner Milovanovich on the 12 May 2008.

Ben Robbins was aged 29 years, died from multiple injuries in a motor vehicle accident deemed to be a death during a Police Operation.

The deceased was observed driving a motor vehicle towards a fully marked Highway Patrol vehicle in the early hours of the 12/5/2007 along Remembrance Drive, Bargo NSW. His speed was checked as being between 98 and 102 klm per hour in an 80-kph-speed zone.

The Police vehicle executed a three-point turn with a view of following and stopping the offending vehicle in relation to the alleged speeding offence. The Police vehicle was a fully marked Highway Patrol vehicle fitted with an onboard Video Camera.

When the Police completed their three point turn the warning lights on the Police vehicle were activated. The activation of the warning lights, automatically activates the on board video camera. The evidence presented at Inquest indicates that Police followed the offending vehicle,

however, the distance between the two vehicles was approximately 800 metres and at times the video depicts taillights for intermittent periods some considerable distance away. Police did not activate warning sirens, as they were not entirely sure whether the vehicle, some distance in front of them, was in fact the offending vehicle.

In terms of the Safe Driving Policy and the interpretation of what constitutes a pursuit, it is evident that a pursuit was not commenced nor radioed through to VKG.

Police continued to travel in the same direction as the vehicle they thought may have been the offending vehicle and when reaching a point on the roadway near some bends, observed a cloud of dust and then noticed a headlight in the bushes off the carriageway.

Police stopped their vehicle and they found a small sedan with extensive damage and a male occupant in the driver's seat that was critically injured. Immediate assistance was provided to the driver, ambulance and emergency services called, however, the driver passed away shortly after the arrival of the ambulance and paramedics.

The death was treated as a death falling within the provisions of Section 13A of the Coroners Act 1980 as being a death in the course of a Police Operation. All necessary critical incident protocols were invoked by the Police, including the separation of the involved officers, blood and urine testing and the commission of the independent investigation.

The Coroner found that the Police had acted appropriately and there had been no breach of the Safe Driving Policy. The Coroner found that the death of the deceased was primarily due to excessive speed and that prohibited drugs found in the deceased blood may have contributed to his inability to control the motor vehicle he was driving.

No formal recommendations were considered necessary.

Formal Finding

That (the deceased) died on the 12th May 2007 at Remembrance Drive, Bargo in the State of New South Wales from multiple injuries when the vehicle he was driving left the carriageway and collided with an advisory sign, guide and a tree.

562/07
Inquest into the death of Charles James Jones at Penrith on the 12 June 2007. Finding handed down by Deputy State Coroner Milovanovich on the 22 February 2008.

Charles Jones was aged 63, died from natural causes while in Corrective Services Custody.

The deceased was charged with sexual assault offences in 1985 and failed to appear at the District Court. Bench Warrants were issued and the deceased was arrested in Queensland in 2007. He was extradited to New South Wales on the 8/7/2007 to appear at the Parramatta Bail Court on 9/7/2007. On 9/7/2007 the deceased was bail refused and remanded in custody to appear on a future date.

The deceased was transported from the Metropolitan Remand Centre at Silverwater to the cells at Penrith Court on the 12th June 2007.

At 11.49am the deceased activated the distress button in his cell and was found was to be in distress with laboured breathing. Ambulance assistance was called for and the deceased was transferred to Nepean Hospital. The deceased subsequently passed away at Nepean Hospital.

A post mortem examination determined that the deceased had died from natural causes, being a ruptured abdominal aortic aneurysm due to atherosclerosis. The death was treated as a death in custody pursuant to Section 13A of the Coroners Act, 1980. The Coroner was satisfied that the deceased had died from natural causes and made formal findings as follows;

Formal Finding:

That (the deceased) died on the 12th June 2007 at the Nepean Hospital, Penrith in the State of New South Wales from ruptured abdominal aortic aneurysm due to atherosclerosis.

667/07
Inquest into the death of Sebastian Sabatini at Eastern Creek on the 12 July 2007. Finding handed down by Deputy State Coroner Milovanovich on the 24 November 2008.

Sebastian Sabatini was aged 28 years, died from chest and abdominal injuries after jumping from an overpass.

The deceased resided with his parents and had a history of mental illness and depression. The depression appears to have been associated with a number of failed relationships and business ventures.

On the 12th July 2007 the deceased was at his home and made a number of entries on is computer, which could best be described as suicide notes. Sometime in the early hours of the 12th July 2007 the deceased drove his vehicle to the "Light Horse" Interchange at the junction of the M2 and M7 Freeway.

At about 3.00am a passing interstate truck driver observed the deceased vehicle with its hazard lights on and then noticed the deceased sitting on top of the metal safety barrier. The motorist called 000 because of his concern for the welfare of the deceased and reported his observations.

Police responded and arrived at the scene at 3.28am and observed the deceased still seated on the safety barrier. Police approached the deceased and when approximately 50 metres from him engaged him in a short conversation.

Police asked the deceased to come down from the barrier, however, almost immediately he swayed backwards and then forwards falling some 20 metres to a grassed medium strip below.

Police immediately drove to the location of the deceased and attempted to provide assistance by means of resuscitation and an ambulance was called. Police noticed that the deceased had applied some form of masking or sticky tape to his mouth and nose. The deceased was conveyed to Blacktown Hospital where life was pronounced extinct a short time later.

Although there was some confusion at first as to whether the incident was to be treated a critical incident, it was eventually so determined and critical incident protocols put in place. The Inquest identified a number of breaches of the critical incident protocols, in particular, a failure to separate officers and a failure to ensure that independent versions be obtained by way of electronic interview. Apart from those issues the Police had acted appropriately, had responded in a timely manner and rendered all available assistance to the deceased.

It was apparent from the evidence that the deceased had planned his intention of taking his own life. He had left suicide notes. He had taken a milk crate with him in order to provide access to the safety barrier and it appears that he had taped his mouth and nose, possibly with a view of limiting his chances of survival from the fall.

The Coroner identified a number of issues associated with the welfare of officers, protocols for determining whether a matter was a critical incident or not and education and training issues. The Coroner did not make any formal recommendation, however, suggested that the identified issues be raised by Counsel representing the Police with the Commissioner of Police with a view of addressing the identified issues.

Formal Finding.

That (the deceased) died on the 12th July 2007 at Blacktown Hospital, Blacktown in the State of New South Wales from Chest and Abdominal Injuries sustained on the same date when he jumped from the M7 Motorway West Link Overpass, Eastern Creek in the State of NSW, with the intention of taking his own life.

717/07
Inquest into the death of James Thomas Baker at Helensburgh on the 28 April 2007. Finding handed down by Deputy State Coroner Dillon on the 22 August 2008.

On 28 April 2007, Mr James Thomas Baker, a man 53 years old, was killed in his car, a Holden Commodore, when he lost control of it at high speed at the intersection of Walker and Parkes Streets, Helensburgh, and collided with retaining wall beneath the Centennial Hotel.

An inquest was required by s.13A of the *Coroners Act 1980*, however, because Mr Baker's death occurred in the course of a police operation, namely, a pursuit, or what, in all likelihood Mr Baker perceived to be a pursuit, by police who followed him for some kilometres through roads around and in Helensburgh.

Deputy State Coroner Dillon concluded that the police officers in question were involved in a pursuit, a fact that that they dispute, but that they did not bear any responsibility for Mr Baker's death. The evidence at inquest demonstrated that Mr Baker made a number of unfortunate errors of judgment, which, in combination, resulted in his death.

On the evening of Friday 27 April 2007, Mr Baker and a number of other members of his extended family were present at the Helensburgh Workmen's Club. He appears to have arrived at the club between 9 and 9.30pm after drinking elsewhere earlier in the evening. He remained in the club drinking until closing time at about 1.00am on the Saturday morning. According to toxicology tests conducted after his death, Mr Baker had a prescribed concentration of alcohol reading of 0.196 at the time of his death.

The two officers who sighted his vehicle were on patrol in their police van driving north on the Old Princes Highway when Mr Baker's vehicle was seen emerging from Parkes St. They noticed Mr Baker's car turn left at what appeared to be an excessive speed from Parkes St onto the Old Princes Highway and travel south. The police turned around to investigate, following Mr Baker's car. Apart from the manner of driving, it appears that the car attracted the attention of police because a vehicle of similar nature had been reported as having been involved in a ram-raid some time previously. There is no suggestion, however, that Mr Baker or his vehicle had had anything to do with that crime.

Having u-turned, the police followed Mr Baker's vehicle a relatively short distance along the Old Princes Highway, through a roundabout at the intersection of the Old Princes Highway and Lawrence Hargreave Drive. Mr Baker then pulled to the left off the road and stopped for a short time outside his own house (a fact unknown to police at the time).

(Had Mr Baker alighted from his vehicle at that stage and entered his premises, police could not have taken action against him for drink-driving. Section 13(1) of the *Road Transport (Safety and Traffic) Management Act* allows an officer to require a motorist to undergo a breath test. Section 14 allows an officer to arrest a person who fails the test and s.15 allows a police officer to require a person who is so arrested to undergo a breath analysis. Section 17 of the Act places certain restrictions on an officer's general right to require a motorist to undergo a breath test. Section 17(d) states: "A police officer cannot require a person to undergo a breath test … at that person's home".)

As the police van drew up behind Mr Baker's vehicle, however, he u-turned, drove back up the Old Princes Highway, turned right at the roundabout into Lawrence Hargreave Dr, now travelling east towards the Helensburgh shopping centre. The police van turned to follow Mr Baker's car.

Mr Baker's car picked up speed once it was in Lawrence Hargreave Drive, probably in an effort to throw off the police. Mr Baker's Commodore was then about 100 to 150 metres ahead of the police vehicle, which was travelling at about 80 km/h with Mr Baker at that stage travelling at about 100 km/h and rapidly pulling away from the police van, which, being a diesel-powered vehicle accelerated only sluggishly.

The two vehicles then drove along Lawrence Hargreave Dr for almost a kilometre before Mr Baker's vehicle turned into Temple Rd, which is about 400m long and intersects with Walker St, one of the main roads into the Helensburgh town centre. As Mr Baker slowed to turn into Temple Rd, the police driver turned on the police vehicle's red and blue warning lights, hoping that this would cause Mr Baker to pull over.

Once Mr Baker had turned into Temple Rd, however, the police concluded that he did not intend to stop. They made a call by police radio for assistance from the Highway Patrol. The police van is not permitted under police policy to engage in traffic pursuits and may only engage in high-speed urgent duty driving in life-threatening emergencies. A Highway Patrol car was despatched but it was some distance away and never became involved in the pursuit. The police van, however, continued to follow Mr Baker.

As Mr Baker's vehicle was turning into Temple Rd, the police driver illuminated his warning lights "just to try and get him to stop for us" but not sound the siren. The police van lost the Commodore for a time before regaining sight of it across fields.

The police evidence is that they turned to follow Mr Baker's car which was by then travelling rapidly north on Walker St, the main road into Helensburgh but soon lost sight of it again over a crest.

After the police lost sight of the Commodore, they drove to the crest and started to explore side streets, reasonably believing that Mr Baker may have turned off the main road in a further attempt to elude the police car.

Walker St descends quite steeply from the crest in more or less a straight line for about 1100 metres to the roundabout opposite the Centennial Hotel at the intersection of Parkes and Walker Sts. An observer has a clear view from the crest to the roundabout.

When they reached the crest the police saw taillights about a kilometre ahead of them apparently travelling fast in a northerly direction. They assumed that one set of the lights were those of the vehicle they had been following. They decided to continue down the hill to follow those lights.

Down the hill a number of witnesses then saw at least some of what happened next. Several witnesses describe Mr Baker's vehicle travelling at very high speed up the main road towards a roundabout and the hotel. There was only one, however, who saw the whole incident. She said that she had turned and seen a white Commodore "travelling at very high speeds… driving in the middle of the road, but more on the wrong side rather than the right side." She thought that the car had been travelling "as fast as that car could go… really fast." In her oral evidence at the inquest she described it "flying" past her. She said that the car had driven straight into the retaining wall in front of the Centennial Hotel.

A short time later the police van arrived on the scene and a little later the Highway Patrol car. An ambulance was called but Mr Baker probably died on impact or very shortly afterwards of the multiple injuries he received in the collision.

One of the points of contention during the course of the inquest was whether the police van had, in fact, been engaged in a pursuit contrary to the Police Force's safe-driving policy. It was argued for the police officers that they had not been. As noted above, Deputy State Coroner Dillon took a different view.

He noted in his findings that the definitions applied by the Police Force contain within them certain ambiguities. He criticised certain elements of the policy document and recommended that it be clarified. On this question he said:

It has been argued by counsel representing them that the officers were not involved in a pursuit. He submitted that under the definition given in the Police Safe Driving Policy, there was no pursuit because the police had never decided to commence a pursuit. Although he conceded that they had been following the Commodore,

it was submitted that they were simply on an information-gathering operation while they awaited the arrival on the scene of a Highway Patrol vehicle which was authorised under the Police Safe Driving Policy to conduct traffic pursuits.

The definition in the Safe Driving Policy of a "pursuit" is as follows:

A pursuit commences at the time you decide to pursue a vehicle that has ignored a direction to stop.

An attempt by a police officer in a motor vehicle to stop and apprehend the occupant(s) of a moving vehicle when the driver of the other vehicle is attempting to avoid apprehension or appears to be ignoring police attempts to stop them.

A pursuit is deemed to continue if you FOLLOW the offending vehicle or continue to attempt to remain in contact with the offending vehicle, whether or not your Police vehicle is displaying warning lights or sounding a siren.

In my view, the argument for the Police Force is incorrect for a number of reasons.

First, a coroner is not concerned with police disciplinary issues or semantics but with facts. When I use the words "pursue" or "pursuit" I am using ordinary English words as they are commonly used. The *Collins Concise Australian Dictionary* (6th edn, 2004) offers the following relevant definitions of the word "pursue": "1. to follow (a fugitive, etc) in order to capture or overtake; 2. to follow closely or accompany;… 6. to follow persistently…". "Pursuit" is defined by that dictionary to mean "the act of pursuing".

In their records of interview with the Critical Incident investigators and also in oral evidence during the inquest, both Officers M and S gave frank and candid evidence that they had followed Mr Baker's vehicle with the intention of pulling it over. The main reason for doing so was that the car was being driven somewhat erratically, raising the possibility that he or she was affected by alcohol. Their intention was to subject the driver to a breath-test. To do so, they first had to apprehend him. On their own evidence they sought to catch up to the Commodore in Lawrence Hargreave Dr with that intention. That appears to fall well within the dictionary definitions. In plain English, the police van pursued Mr Baker's car. That their vehicle was too slow to catch up with Mr Baker's until it crashed is not to the point.

Second, the Police Force itself has attempted to define a pursuit for the guidance of police officers.

Counsel for the Police Commissioner and the two officers contended for a construction of the definition that was sequential and dependent on police officer making a decision to pursue a vehicle, the driver having ignored a direction to stop.

I disagree with that construction. So did counsel assisting, Mr Clark. In my opinion, the first and second paragraphs only read properly together if they are read as alternatives. The first sentence appears to be directed to situations where a police officer has given an unambiguous direction to a motorist to stop.

This might be done by a stationary officer at, say, a Random Breath Test site. It might also be given by police in a vehicle flashing their warning lights and blipping the siren of their car to another motorist. The second paragraph seems to be directed to the more confused and ambiguous situation where a moving police car in traffic seeks to apprehend the occupants of another vehicle which seems to be attempting to evade apprehension.

If [counsel for the police's argument is correct], the second paragraph of the definition appears to me to be entirely redundant. If two constructions of this nature are available (leave aside the question of which is the better), this suggests that the definition begins and continues ambiguously. That does not assist in providing clear guidance to police.

The first paragraph is also drafted in a circular fashion: in effect, police are said to be in pursuit when they decide they are in pursuit and are pursuing. I do not regard that as a helpful guideline to police or anyone trying to understand police policy.

The one-sentence second paragraph appears to me to be an incomplete sentence. It appears to read as an alternative to paragraph one. Thus the definition of pursuit as it appears in the Safe Driving Policy seems to me to be:

[1] A pursuit commences at the time you decide to pursue a vehicle that has ignored a direction to stop; [or]

[2] [A pursuit is] an attempt by a police officer in a motor vehicle to stop and apprehend the occupant(s) of a moving vehicle when the driver of the other vehicle is attempting to avoid apprehension or appears to be avoiding police attempts to stop them. If it is intended that paragraph 2 be an amplification of paragraph 1, the document does not make this clear but rather amplifies the ambiguity of the definition.

The ambiguity of the definition is further amplified by what appears to me to be a jumble of subjective and objective elements in the definition. In my opinion, whether or not a police vehicle is in pursuit of another car does not and ought not depend solely on whether the officer has used some sort of verbal formula in his or her own mind ("I have decided to pursue…"), because that opens up a giant potential loophole in the policy, but can and ought be tested objectively by reference to whether the police vehicle is following another vehicle and whether the purpose for following that other vehicle is to apprehend the driver or occupants of the vehicle being followed because (among other reasons) that vehicle appears either to have ignored a direction to stop or to be taking action to avoid apprehension.

That the police intended to stop and speak to Mr Baker about his manner of driving is admitted. Given his somewhat erratic driving out of Parkes St onto Lawrence Hargreave Dr, they almost certainly had reasonable cause to suspect that he may have been driving under the influence of alcohol or drugs. In any case, they were entitled to subject him to a random breath test and were intent on doing so and decided to pull him over. When he continued, they followed. If that is not a pursuit, I am not sure what else it could be.

The facts that Constable M turned to follow Mr Baker's vehicle shortly after the police first saw it, then turned again to follow him once he drove away from outside his own house, that Constable M turned on his warning lights in the vicinity of Temple Rd, that Constable S not only asked by radio for Highway Patrol assistance but told the radio operator that police would attempt to get a registration number (in the dark at 1.00am with the Highway Patrol car some distance from Helensburgh) and that the police vehicle followed in Mr Baker's wake all indicates an intention on the part of the police to "stop and apprehend the occupant(s)" of Mr Baker's vehicle.

It is apparent from the manoeuvres undertaken by Mr Baker – stopping outside his own house, u-turning as the police vehicle approached him from behind, turning down Lawrence Hargreave Dr, increasing speed as he went – that Mr Baker must have seen the police van as it went past him the first time on the Old Princes Highway and then, when it approached, decided to avoid being spoken to by police if he could get away from them.

Although the police were, of course, not to know it at the time, it is reasonable to conclude that, given his high blood alcohol reading at the time of the accident, he must have known he was well over the drink-drive limit and have become alarmed at the prospect of being arrested by police and losing his licence. Whatever his reasons for driving away from the front of his house where he had stopped, his actions certainly must have given rise to a belief on the part of the police officers that he was trying to get away.

By the police definition itself, as I construe it, as soon as the police truck turned to follow Mr Baker, officers M and S were engaged in a pursuit because they were following him in an attempt to apprehend Mr Baker who was apparently seeking to defeat that purpose.

Third, if I am wrong on that point, it is clear enough from the evidence of S/Con M that he turned on his warning lights at Temple Rd to indicate to Mr Baker that he must pull over and stop. In my opinion, that must be construed as a direction to stop. It was either not seen or ignored by Mr Baker. The police would have been within their rights to assume that Mr Baker was ignoring the direction because he showed no sign of slowing down but instead appeared to them to be accelerating away from them, apparently ignoring police attempts to stop him.

In my opinion, they correctly made that assumption and continued to follow him.

The third part of the police definition of a pursuit then becomes relevant: "A pursuit is deemed to continue if you FOLLOW the offending vehicle or continue to attempt to remain in contact with the offending vehicle, whether or not your Police vehicle is displaying warning lights or sounding a siren."

Here the police van followed Mr Baker's car with the intention, according to Constable S's radio message of obtaining a registration number. That implies an intention on the part of police to "remain in contact with the offending vehicle". It is irrelevant whether or not the police are actually able to remain in contact, the point is that they are following with that intention.

Finally, shortly after the event, the Police Force itself appears to have come to the commonsense conclusion that Officers S and M had, indeed, engaged in a pursuit. At the time of the incident, it was immediately treated as a "Critical Incident" because it was self-evident that Mr Baker had died in the course of a police operation. When Sgt P arrived on the scene to investigate the crash, he was told by the Inspector who had taken control of the crash site that there had been "a short pursuit". On 7 May 2007, the Police Professional Standards Unit sent a report about the incident to the State Pursuits Committee summarising the police version of the incident. The PSU appears to have inferred – in my view correctly – that the facts showed that Mr Baker had been pursued by police. That lends support to my own conclusion.

If, as I think they were, Officers M and S were engaged in a pursuit, under Police guidelines they were not entitled to be. Police policy specifically forbids the use of vans and other vehicles classified as "category 4 vehicles" from being used for traffic pursuits.

Whether these officers fully understand the Safe Driving Policy and its logical ramifications I do not know. I would not be surprised if they do not since [their counsel] was able to argue cogently but, in my view, wrongly that they had not breached the policy. If that is the case, they cannot be alone in their confusion. I do not think that they ought be subject to any disciplinary action when they appear to me to have been trying to follow a guideline that is inherently ambiguous, complex and confused.

I am conscious that for some years a considerable amount of work has gone into the development of the Police Safe Driving Policy and the definition of "pursuit". Praiseworthy as that effort has been, this case shows that the definition remains imperfect and can and does give rise to confusion.

In my opinion, the definition of "pursuit" as applied by police on the road is in urgent need of clarification and simplification by an expert versed in plain English to make it consistent with commonsense and safe driving, and with high professional standards in operational police work.

I have given thought to proposing a revised definition myself but I lack the requisite expertise in police traffic operations. I recommend that the Commissioner of Police address the issue by delegating the task to a person or committee with the combination of plain English and police operational skills. I have proposed above some ideas which might be given urgent consideration if the present ambiguities are to be removed. I note that in a previous inquest concluded on 22 February 2008, the matter of Brenton Craig Hasler, Deputy State Coroner MacMahon also found that police policy documents concerning safe driving and pursuits gave rise to ambiguities and recommended that the Commissioner review and clarify the Safe Driving Policy and Coded System of Safe Driving. Perhaps this second recommendation will give added momentum to that review.

Deputy State Coroner Dillon concluded that although, but for the police pursuit, James Baker probably would not have driven the way he did, it would be unfair to hold the police officers responsible for what happened to him. Apart from the fact that he was an intelligent, mature person with a great deal of motoring experience, capable of making his own decisions, there was no hot pursuit goading Mr Baker on. As far as Mr Baker would have been able to tell, the police had been left far behind back at Temple Rd. The connexion between the pursuit and the crash was too remote for any responsibility to attach to the police officers.

Formal Finding:

That Mr James Thomas Baker died at Helensburgh on 28 April 2007 after suffering multiple injuries when his motor vehicle collided with a retaining wall while travelling at high speed when he was under the influence of alcohol.

Recommendations

To the Commissioner of Police:

- **That the Police Force review of the Safe Driving Policy currently on foot amend the definition of "pursuit" so as to remove the ambiguities in the current definition and to provide for a clear and objective guideline in plain English. guideline in plain English.**

- **I further recommend that the definition be drafted by a person or committee applying the skills of Plain English and police highway operations.**

810/07
Inquest into the death of Darryl Clarkson at Muswellbrook on the 14 may 2007. Finding handed down by State Coroner Jerram on the 21 July 2007.

Darryl Clarkson was a 32 year old inmate serving a four year sentence at St Heliers Correctional Facility for mainly drug related and break and enter offences.

The facility is a minimal security prison with inmates being allowed to participate in work release programmes. The deceased had previously overdosed in his cell in 2006, which was noted on his records. The deceased was approved to work for Primo meats on this programme. On the day of his death the deceased was in the kitchen with other inmates . One of the inmates went looking for the deceased and upon entering the bathroom and found the deceased slumped over the toilet and unconscious. The alarm was sounded by the inmates and it took some 15 to 20 minutes for corrections officers to respond.

Ambulance attended and commenced CPR and he was later transferred to hospital whilst CPR was continually being applied. However he was pronounced deceased at the hospital.

The cause of death proffered by the pathologist was given as, 'Mixed Narcotic Drug Toxicity' and old and new track marks were noted on the deceased.

Formal Finding

I find that Darryl Raymond Clarkson died at Muswellbrook on the 14 May 2007 as a result of mixed narcotic, drug toxicity, self administered, but accidentally, a lethal amount.

845/07
Inquest into the death of John Frederick Malone at Albury on the 21 August 2007. Finding handed down by Deputy State Coroner Milovanovich on the 4th September 2008.

John Frederick Malone was aged 19 years, died from multiple injuries sustained in a motor vehicle collision.

The deceased had a long criminal history and was a disqualified driver as at the 21st August 2007. He had recently been convicted and sentenced to 7 months imprisonment, which on appeal was varied to a suspended sentence of 7 months. The deceased was disqualified from driving until 2010.

Albury Police had been undertaking operations in an area known as the Munga Bareena Reserve, East of Albury due to complaints regarding motor vehicle driving offences and the fact that the area was a known dumping ground for stolen motor vehicles.

In the early hours of the 21/8/2007 Police in a fully marked Police vehicle observed a white sedan make a turn into Munga Bareena Road. The number or identity of the occupants could not be determined. Due to the time of day (3.40am) and the location, the Police made a decision to stop the vehicle to ascertain its bona fides.

The Police vehicle completed a U turn and followed the vehicle with the intention of stopping it. Almost immediately the vehicle increased its speed and the Police then activated the Police lights. The vehicle further increased its speed and the Police then activated, lights and sirens. The vehicle continued to increase its speed and distance from the Police vehicle. The Police vehicle radioed VKG to inform that a pursuit had commenced and provided information regarding the location, speed of the offending vehicle, and call sign of the Police vehicle and direction of travel. During the course of the pursuit, which lasted 65 seconds, Police lost site of the vehicle and the Police vehicle reduced its speed, however, continued to travel in the same direction in which the vehicle was last seen travelling. Shortly thereafter Police came across the vehicle, which had impacted with a large tree on a sharp left hand bend. The driver of the vehicle was trapped with serious injuries and 4 other occupants had various degrees of injuries. He driver was released and taken to hospital, however, died within a short time.
The death was determined to fall within Section 13A of the Coroners Act 1980 and an independent Critical Incident Investigation Team was actioned.

The Inquest determined that the deceased was travelling at a speed in excess of 93 kph, that being the maximum speed that the curve could have been negotiated at, at the time of impact. The Inquest also determined that the deceased had a blood alcohol level of 0.165 and also cannabis and amphetamines in his blood. There was a suggestion at the Inquest that the Police vehicle had rammed or shunted the offending vehicle off the road. Independent Forensic Evidence from the Crime Scene examination, the Crash Investigation Unit and the Forensic Services Group found no evidence that the Police vehicle had had any impact with the offending vehicle. The four surviving passengers in the vehicle all made statements to the Police and none of them made any assertions that the Police vehicle had had any contact with the offending vehicle.

The Coroner was satisfied that the Police had complied with the Safe Driving Policy and Critical Incident investigation guidelines. The Coroner made no recommendations.

Formal Finding:

That (the deceased) died on the 21st August 2007 at the Albury Base Hospital, Albury in the State of New South Wales from Multiple Injuries when the vehicle he was driving left the carriageway on Munga Bareena Road and impacted with a tree.

1034/07
Inquest into the death of Donald Matthew McEwen at Long Bay Gaol on the 17 June 2007. Finding handed down by State Coroner Jerram on the 1 February 2008.

Donald McEwan was serving a sentence at long bay Gaol; he had been transferred to that institution from Grafton Gaol as he was suffering from emphysema and cancer of the lungs. The deceased was confined within the Long Bay Hospital.

On the night of his death his health failed dramatically and he was checked regularly by the nurse on duty. At 9.30pm it was noticed his colour was dreadful and cyanotic and despite the nurse applying the oxygen mask the deceased would remove it. At approximately 2.10am he passed away.

The post mortem recorded the cause of death as 'carcinomatosis'.

Formal Finding:

I find that Donald Matthew McEwan died at the Long Bay Hospital of

1a) Carcinomatosis
b) Bronchogenic Carcinoma- natural cause.

1490/07
Inquest into the death of David John McCormack at Halfway Creek on the 12 August 2007. Finding handed down by Deputy State Coroner MacPherson on the 21 December 2008.

David McCormack was an off duty Police Officer who was involved in a fatal motor vehicle accident as a result of taking evasive action to avoid a head on collision with a BMW Sedan registered number South Australian Registration VNW576 being driven by MARK BOMBARDIERI who was on the wrong side of road.

At about 1.50pm on 12/8/07 Bombardieri was travelling south along the Pacific Highway at high speed and Police in an unmarked Ford Falcon XR8 activated lights and siren and commenced to follow him

After a short pursuit Bombardieri turned off the Pacific Highway onto a dirt road and slowed down. Police drove up to Bombardieri who turned in front of the police and the front of the Police vehicle collided with the driver's side door of Bombardieri's vehicle.

Bombardieri then drove off in a southerly direction on the Pacific Highway where police lost sight of him.

At 2.15pm Bombardieri drove onto the incorrect side of the road heading towards oncoming traffic. David McCormack took evasive action by veering to his left however on bringing his car back onto the road McCormack has lost control and the vehicle has travelled onto the incorrect side of the road and collided with a semi trailer and has been killed instantly.

Bombardieri was charged with Aggravated Dangerous Driving causing death.

The Inquest was suspended under section 19 of the Coroner's Act 1980 on 21/12/07.

106/08
Inquest into the death of Michael Keft at Wyoming on the 16 January 2008. Finding handed down by State Coroner Jerram on 3 September 2008

Michael Keft was a 39 year old man separated from his wife some 18 months prior to his death. He had two young children from the union whom resided with the mother and former wife of Mr Keft.

Despite the separation an arrangement was agreed upon between the couple that Mr Keft would reside in the garage of the two-story house. This was allowed under the condition that he not consume alcohol and not to be abusive to either her or the children.

On the night of the 16th January 2008 Mrs Keft contacted Police to complain about the behaviour of Mr Keft who she alleges was drinking alcohol and abusing her through the floorboards of the house.

Police attended and were advised by Mrs Keft that she no longer wanted the deceased living at the residence. Police issued Mr Keft with a move along direction however he refused to comply and was then arrested by police.

Police conveyed Mr Keft to the Gosford Police Station and issued with him with an infringement notice, inquiries were made by police for temporary accommodation however Mr Keft refused the offer. He was advised not to return to the residence and was released from custody. Police applied for an interim Apprehended Violence Order on behalf of Mrs Keft and children.

Some hour or so later Mrs Keft again contacted police and advised them that he had returned and was asleep on the front veranda. Police spoke to Mrs Keft an hour later who stated he had left the veranda and she was unaware of where he had gone.

At 9.40am a police car crew attended the house and spoke to Mrs Keft who pointed out to police a bag belonging to the deceased in the back area of the house. Police then looked under the house and located Mr Keft hanging from a beam.

The death was treated as a death in a police operation and investigated accordingly.

Formal Finding:

I find that between 9.10am and 9.40am that Michael James Keft died on the 16 January 2008 at Elizabeth Street, Wyoming, as a result of hanging, self-inflicted with the intent to end his own life.

Recommendations:
To the Minister of Police Commissioner of Police

- **Ensure further and continuing education for all officers on protocols for domestic violence incidents, particularly at Brisbane Waters LAC being second only in NSW for number of Domestic Violence incidents.**

- **Ensure further and continuing education for all officers in protocol regarding critical incidents/ deaths, regarding following; where there is any possibility that life exists, all efforts are to be made to check vital signs and administer first aid. This should take absolute priority over the otherwise important duty to preserve a crime scene. In particular, regarding hangings (and noting that physical viewing is insufficient) the 4 basic rules:**

Cut down
Lay down
Remove ligature
Administer CPR.

Appendix 1:

Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed as at 31 December 2008

*** W denotes Westmead Matter**

No.	File No.	Date of Death	Place of Death	Age	Circumstances
1					
2	248/03	16-26/11/01	Unknown	52	In custody
3	1136/06	28/07/06	Malabar	19	In custody
4	1740/06	09/11/06	Darlinghurst	46	In custody
5	1757/06	11/11/06	Gosford	41	Police Op
6	759/06 (W)	02/07/06	Belmont	41	Police Op
7	749/07 (w)	31/07/07	Penrith	28	Police Op
8	1020/07	14/6/07	Old Bar	34	Police Op
9	1782/07	27/9/07	Malabar	31	In Custody
10	2172/07 (w)	28/11/07	Silverwater	26	In Custody
11	2195/07	3/12/07	Randwick	50	Police Op
12	2331/07	25/12/07	Randwick	32	In Custody
13	2357/07	28/12/07	Junee	35	In Custody
14	1231/07 (w)	25/12/07	Westmead	44	Police Op
15	58/08	11/01/08	Liverpool	35	Police Op
16	63/08	04/01/08	Main Arm	36	Police Op
17	166/08	27/01/08	Junee	44	In Custody
18	400/08	10/03/08	Ingleside	41	Police Op
19	418/08	12/03/08	Eastwood	22	Police Op
20	529/08	28/03/08	Wellington	37	In Custody
21	595/08	10/04/08	Junee	52	In Custody
22	541/08	23/05/08	Malabar	53	In Custody
23	567/08	28/05/08	Westmead	23	In Custody
24	669/08	19/06/08	Penrith	64	In Custody
25	1137/08	14//07/08	Malabar	80	In Custody
26	816/08	22/07/08	Silverwater	27	In Custody
27	1202/08	23/07/08	Newcastle	49	In Custody
28	1435/08	26/08/08	Goulburn	39	In Custody
29	1047/08	06/09/08	Windsor	40	Police Op
30	1048/08	06/09/08	Windsor	18	Police Op
31	1793/08	10/10/08	Belmont	43	Police Op
32	1969/08	28/01/08	Junee	50	In Custody
33	1647/08	23/09/09	Quirindi	40	Police Op
34	2219/08	21-22/11/09	Aldavilla	27	In Custody
35	2474/08	20/12/08	Penrith	25	In Custody
36	2523/08	27/12/08	Sydney	40	In Custody