Report by the NSW State Coroner

into deaths in

custody/police operations

for the year 2015.

(Coroners Act 2009, Section 23)

NSW Office of the State Coroner
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The Hon. Gabriel Upton MP
Attorney General and Minister for Justice
Level 31 Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

10th March 2015

Dear Attorney,

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

I attach a hard copy and an electronic copy of the 2015 report.

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

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

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

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

Yours faithfully,

Magistrate Michael Barnes
(NSW State Coroner)

2015 Overall Summary in Brief

- 41 *Section 23* deaths were reported to the State Coroner in the calendar year 2015, which is an increase of 14 deaths from 2014.

- In 2015 the State Coroner and the Deputy State Coroners completed 36 *Section 23* inquests.

- Six more inquests were conducted in 2015 than were conducted in 2014.

- As at the 31st December 2015 there are 65 unfinalised *Section 23* deaths compared to 55 at the same time in 2014.

- Just under 50% of the deaths reported in 2015 were as a result of natural causes, natural cause deaths continues to be the substantive cause of death recorded for those persons who die in custody or as a result of a police operation as opposed to non natural causes of death.

- Seven Aboriginal deaths were recorded in 2015 which is an increase of 5 deaths from the two deaths reported in 2014. Six of these deaths occurred in custody and one as a result of police operation. Four as a result of natural causes and three as a result of non natural causes.

- 36 of the 41 overall deaths for 2015 were male.

- One of the males died in detention at the Villawood Detention Centre

- Of the 36 male deaths, 32 of them were over the age of 30 years.

- Five of the 41 overall deaths reported were female, four out of the five female deaths were under 30 years of age.

- Four of the five females died from non natural causes.

- 21 of the 26 persons who died in custody were serving a sentence and four were on remand.

- One of the deaths in custody occurred at Villawood Detention Centre by way of natural causes.

STATUTORY APPOINTMENTS

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

NSW State and Deputy Coroners 2015

His Honour Magistrate MICHAEL BARNES

NSW State Coroner

1982- 1987 Solicitor in private practice

1987 -1990 Principal Solicitor, Aboriginal Legal Service

1990-1993 Principal Legal Officer, Criminal Justice Commission

1993-1999 Chief Officer, Complaints Section, Criminal Justice Commission

2000-2003 Head, School of Justice Studies, Queensland University of Technology

2003-2013 Queensland State Coroner

2013 Appointed NSW Magistrate

2014 Appointed NSW State Coroner

His Honour Magistrate HUGH DILLON

Deputy State Coroner

1983 Admitted as Solicitor.

1984 Legal Projects Officer, NSW Council of Social Service.

1986-1996 Worked as Lawyer in government practice, principally with NSW Ombudsman Office and Commonwealth Director of Public Prosecutions.

1996 Appointed as a Magistrate of the NSW Local Court.

2007 Appointed Visiting Fellow, Faculty of Law, UNSW. Appointed a part time President of Chief of Defence Force Commissions of Inquiry (Defence Force Inquests).

2008 Appointed NSW Deputy State Coroner.

His Honour Magistrate PAUL MACMAHON

Deputy State Coroner

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

Her Honour Magistrate CARMEL FORBES

Deputy State Coroner

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

Her Honour Magistrate SHARON FREUND

Deputy State Coroner

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

Her Honour Magistrate TERESA O'SULLIVAN

Deputy State Coroner

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

Her Honour Magistrate HARRIET GRAHAME

Deputy State Coroner

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

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Introduction by the New South Wales State Coroner

What is a death in custody?

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

- the death, wherever occurring, of a person who is in prison custody, police custody, detention as a juvenile or detention pursuant to the Migration *Act 1958* (Cth);
- the death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper *care* whilst in such custody or detention;
- the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and
- the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

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

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

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

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

Intensive Correction Orders

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I also agree with Mr Waller that:

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

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

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

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

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

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[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.*

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

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

Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit and the Forensic Pathologist. The Coroner, if warranted, should inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during the inquest.

If the State Coroner or one of the Deputy State Coroner's is unable to attend a death in custody/police operations occurring in a country area, the State Coroner may request the local Magistrate Coroner to attend the scene.

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

In cases involving the NSW Police

When informed of a death involving the NSW Police, as in the case of a death in police custody or a death in the course of police operations, the State Coroner or the Deputy State Coroner's may request the Crown Solicitor of New South Wales to instruct independent Counsel to assist the Coroner with the investigation into the death.

This course of action is considered necessary to ensure that justice is done and seen to be done.

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

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

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

In respect of all identified Section 23 deaths, post mortem experienced Forensic Pathologists at Glebe or Newcastle conduct examinations.

Responsibility of the Coroner

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

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

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

> **78 Procedure at inquest or inquiry involving indictable offence**
> (cf *Coroner's Act 1980*, s 19)
>
> (1) This section applies in relation to any of the following inquests:
>
> (a) an inquest or inquiry held by a Coroner to whom it appears (whether before the commencement or during the course of the inquest or inquiry) that:
>
> (i) a person has been charged with an indictable offence, and
>
> (ii) the indictable offence raises the issue of whether the person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.
>
> (b) an inquest or inquiry if, at any time during the course of the inquest or inquiry, the Coroner forms the opinion (having regard to all of the evidence given up to that time) that:
>
> (i) evidence is capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence, and
>
> (ii) there is a reasonable prospect that a jury would convict the known person of the indictable offence, and
>
> (iii) the indictable offence would raise the issue of whether the known person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.
>
> (2) If this section applies to an inquest or inquiry as provided by subsection (1)(a) the Coroner:
>
> (a) may commence the inquest or inquiry, or continue it if it has commenced, but only for the purpose of taking evidence to establish:

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

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

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

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

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

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

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

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

Role of the Inquest

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

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

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

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

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

Recommendations

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

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

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

Unavoidable delays in hearing cases

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

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

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

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

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

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

AN OVERVIEW OF SECTION 23 DEATHS REPORTED TO THE NSW DURING 2015.

Table 1: **Deaths in Custody/Police Operations, for the period to 2015.**

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

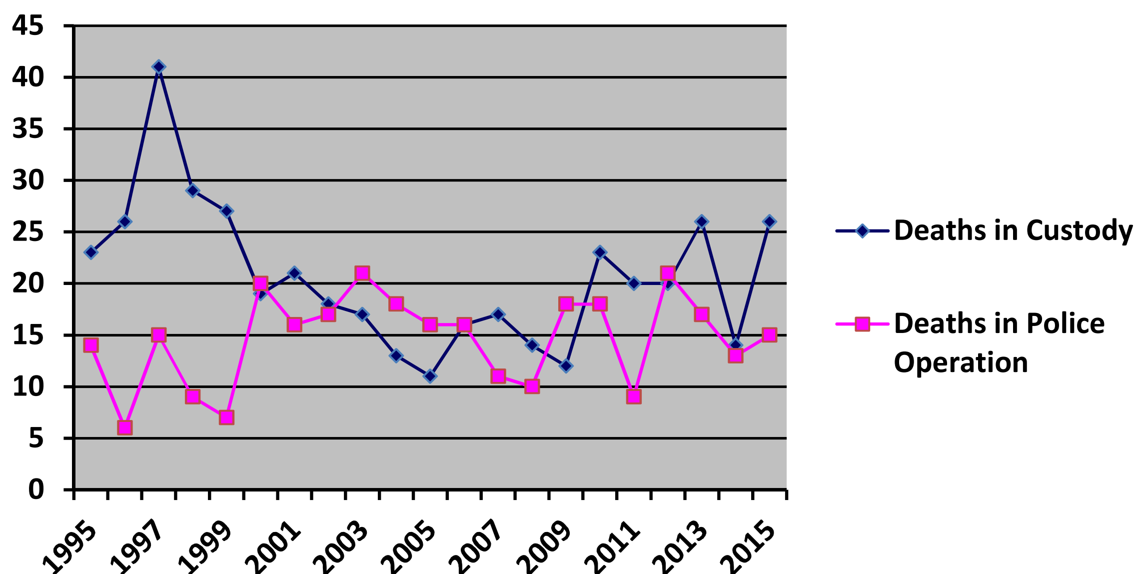
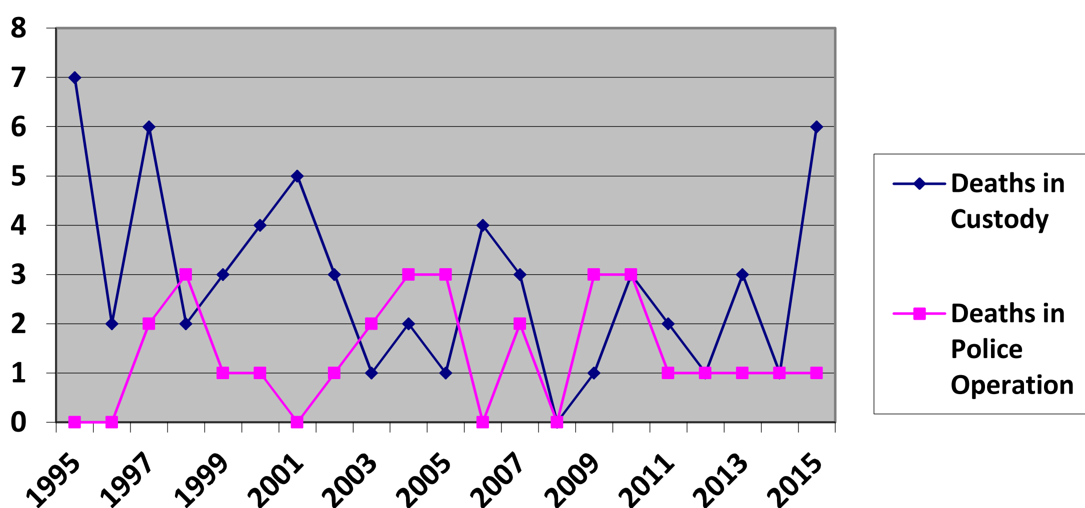


Table 2: Aboriginal deaths in custody/police operations 2015.

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



Circumstances of deaths of persons who died in Custody/Police Operations in 2015:

20 x Natural Causes

2 x Hanging

6 x Gunshot or Firearm

4 x Drugs/Alcohol

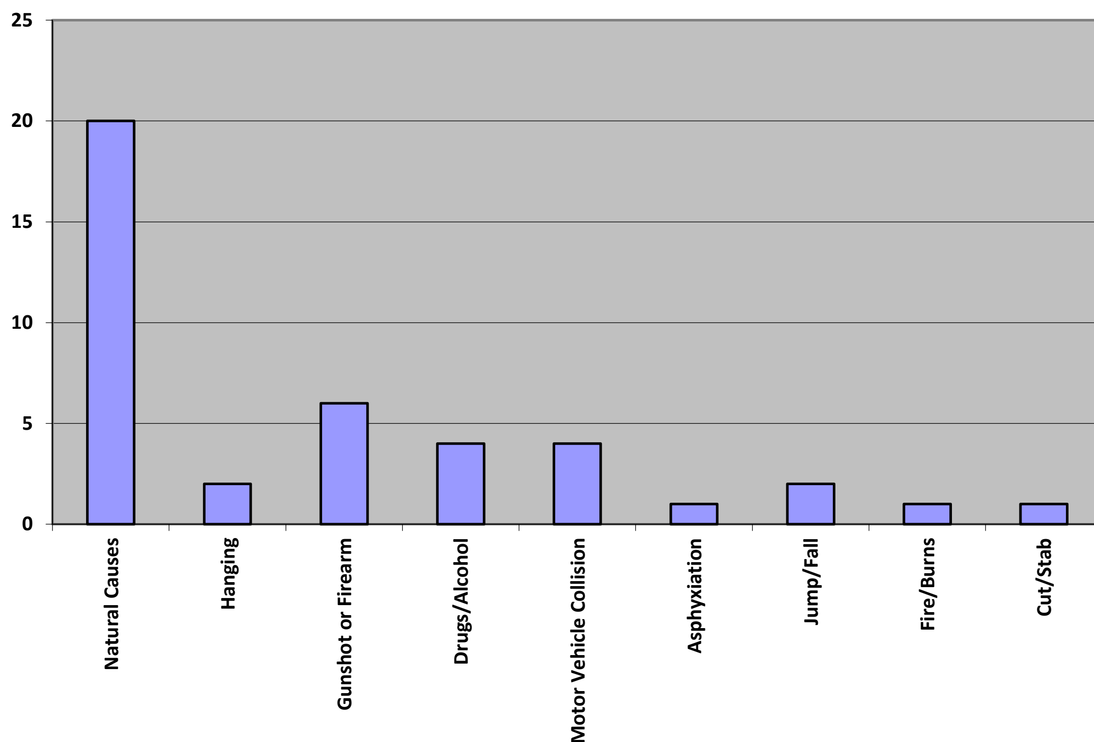
4 x Motor Vehicle Collision

1 x Asphyxiation

2 x Jump/Fall

1 x Fire/Burns

1 x Cut/Stab



SECTION 23 INQUESTS UNDERTAKEN IN 2015

Following are the written findings of each of the cases of deaths in custody/police operations that were heard by the NSW State Coroner or Deputy State Coroner in 2015. These findings include a description of the circumstances surrounding the death and any recommendations that were made. **Please note:** Pursuant to Section 75(1) & (5) of the *Coroner's Act 2009* the publication of the names of persons has been removed where the finding of the inquest is that their death was self inflicted, unless the Coroner has directed otherwise. ***The deceased names will be referred to as a pseudonym.***

	Case No	Year	Name	Coroner
1	474054	2009	Skye Sassine	DSC MacMahon
2	436872	2010	William Crews	SC Barnes
3	389486	2011	AA	DSC Freund
4	58625	2012	Ismail Housman	DSC Truscott
5	247660	2012	AB	DSC MacMahon
6	83234	2012	Jean Govinden	DSC MacMahon
7	59259	2013	Tracy Lee Brannigan	DSC MacMahon
8	98426	2013	Nick Karayiannis	DSC Dillon
9	98427	2013	AA	DSC Dillon
10	123760	2013	AB	DSC Forbes
11	153360	2013	AA	DSC Forbes
12	159048	2013	Dean Krasser	DSC Freund
13	200685	2013	Jake Innes	DSC Dillon
14	222036	2013	Trent Lenthall	DSC Forbes
15	246399	2013	AA	DSC Dillon
16	265085	2013	AB	DSC Forbes
17	286184	2013	Adam Southwick	DSC Forbes
18	304282	2013	James Ciappara	DSC MacMahon
19	331891	2013	Leif James	DSC Forbes
20	365275	2013	AA	DSC Freund
21	387501	2013	Aaron Magarry	DSC Freund
22	389043	2013	Farin Daley	DSC Truscott
23	22127	2014	JX	SC Barnes
24	38053	2014	Jason Rea	DSC MacMahon
25	83267	2014	Sean Waygood	SC Barnes
26	88509	2014	AC	DSC Dillon
27	161167	2014	AA	SC Barnes
28	166723	2014	Brian Carman	DSC Dillon
29	174768	2014	AA	DSC O'Sullivan
30	192992	2014	Dylan Maher	DSC Grahame
31	221203	2014	Neal Richardson	DSc Truscott
32	226574	2014	Joseph Gumley	DSC Truscott
33	229687	2014	Kelvin Gardoll	DSC Forbes
34	239934	2014	Allan Gillard	DSC Dillon
35	253769	2014	Robert Britten	DSC Truscott
36	64664	2015	Paul Gatien	DSC Dillon

1. 2009 of 474054

Inquest into the death of Skye Sassine finding handed down by Deputy State Coroner MacMahon at Glebe on 15 May 2015.

Skye Sassine (born on 26 May 2008) died on 31 December 2009 at Liverpool Hospital, Liverpool in the State of New South Wales. The cause of her death was head injury that she sustained when the motor vehicle in which she was a passenger was struck at high speed by a motor vehicle which, at the time, was the subject of a police pursuit.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009: To the Commissioner of Police

That amendment's be made to the NSWPF Safe Driving Policy (SDP) to:

1. Provide that where a death occurs during the course of, or following a police pursuit, the driving of the officer(s) in the pursuing vehicle(s) during the pursuit itself, and any preceding period of urgent duty or catch up, be reviewed by a Safe Driving Panel to assess the compliance of the driver(s) with the SDP.

2. That a Safe Driving Panel, having assessed the driving of an officer (s) in such circumstances, prepare a written statement of the matters considered, **the conclusions it has reached and the reasons for any recommendation it has made.**

3. Such statement of conclusions, recommendations and reasons be retained in the records of the Safe Driving Panel and a copy provided to the officer the subject of the review.

4. That the role of Police Aviation Support Branch (PASB) in circumstances of **urgent duty or pursuit be reviewed in order to clarify such role so as to ensure** that such role can be reasonably undertaken having regard to the capacity of **available technology and resources.**

5. Having clarified the role of PASB officers in circumstances of urgent duty or pursuit, appropriate training should be provided to members of the PASB and other police officers likely to be involved in such situations such as communication operators, VKG Supervisors and Duty Operations Inspectors.

2. 436872 of 2010

Inquest into the death of William Crews finding handed down by State Coroner Barnes at Glebe on the 21st September 2015.

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

Introduction

1. *On the e*vening of 8 September 2010, Detective Constable William Crews and six other police officers entered the basement of a residential unit complex in Bankstown expecting to apprehend a drug dealer actively involved in drug trafficking. Detective Constable Crews was at the front of the search party when their target suddenly came out of a garage in the basement. Upon seeing the officers, the target produced a pistol and fired at them. Detective Constable Crews and another officer returned fire. Detective Constable Crews fell to the ground fatally wounded. It was later found that a shot from the drug dealer had struck his left arm, while a bullet from a colleague's gun had lacerated major blood vessels in his neck, causing un-survivable injuries. Detective Constable Crews lay dying on the floor of the basement, while his colleagues took cover in another part of the basement under the mistaken belief that the drug dealer continued to pose a danger to them. He died later that night in hospital.

2. The holding of an inquest into the death was essential but it could not proceed until the criminal charges arising from the fatal incident had been dealt with and any appeals resolved. As a result, the inquest did not commence until 4 years after the death.

The issues

3. In accordance with s81 of the Act, a coroner is required to confirm that the death occurred, and to find the identity of the deceased person; the place and date of the death; and its manner and cause.

4. In this case there was little or no doubt about the general particulars of the death. The inquest focused on whether it could have been prevented by better policing and whether any changes to police policies, procedures or training could reduce the likelihood of deaths occurring in similar circumstances. In particular:-

   - Were the policies and procedures of the New South Wales Police Force (NSWPF) in relation to the obtaining and execution of search warrants complied with for the purposes of the search of the premises concerned;

- Were those policies and procedures adequate and appropriate to protect the safety of police officers and the public;

- Did the conduct of any of the police officers participating in the preparation for the search or the search itself contribute to the death of Detective Constable Crews; and

- Did inadequate training of police officers participating in the preparation for the search or the search itself contribute to the death of Detective Constable Crews?

The evidence

Social history

5. William Arthur George Crews was born on 29 May 1984. He was 26 years old at the time of his death. He was the son of Sharon and Kelvin Crews, and the youngest brother of Benjamin Crews, Rebecca Lancaster and Kate Elliot. He is referred to by his family as Bill.

6. Bill Crews was described by his father as a person who loved life, his family, friends and colleagues. According to his father, Bill was competent and capable of whatever he put his mind to.

7. He grew up on the family farm in Glen Innes from the age of one. According to his father he enjoyed his years on the farm and embraced the country life and all that went with it: the work, horse riding, polo cross, hunting, shooting, motorbike riding and rugby.

8. He was a New South Wales Rural Fire Service volunteer from an early age, fighting numerous bushfires and attending motor vehicle accidents that occurred in the area. He continued to volunteer any time he was at home from university or Sydney.

9. After completing year 12 at High School, Bill attended Southern Cross University at Lismore and completed a three year degree in information technology after which he returned home for a short time and then went on to Sydney in search of employment in this field.

10. He worked for a short period as a barman and lived with either his brother or his sister who were already established in Sydney. One evening he rang his parents and said; *"I got in"*. They responded; *"Where"* and were most surprised but equally proud when he answered; "*The cops*".

11. He came from a family of former and serving police officers. His brother Ben is a current serving Senior Constable with the NSW Police Force. His father is a former police officer, as was his aunt and two of his uncles.

Policing history

12. William Crews joined the NSW Police Force in January 2007 as a Probationary Constable attached to Campsie Local Area Command. He was confirmed as a Constable in January 2008. On 22 August 2010 Detective Constable Crews was transferred to the Middle Eastern Organised Crime Squad where he worked in the Target Action Group.
13. Detective Constable Crews was described by his superiors as a keen, competent and pro-active team member. He was liked and respected by his colleagues who were impressed by his work ethic and enthusiasm. He was known to his colleagues as Bill or Crewsy.

14. At his funeral Commissioner of Police Andrew Scipione referred to Bill Crews as *“a highly regarded police officer who served his community with courage, honour, and distinction"*, and read out the following words provided to him by some of Bill’s closest workmates:

    Crewsy had an aura that drew people closer to him, and a personality that made everyone around him embrace life and work hard ... He was a natural leader, but more importantly he was also a team player, who always put other people's interests before his own. Whenever the serious work was on he was either leading the way; or right there behind you when you needed his support. The love and respect that Crewsy had for the job, his mates, and for his ever-growing family are characteristics that we thought were one in million.

15. Detective Constable Crews was posthumously awarded a detective’s designation and received the Commissioner’s Valour Award, for conspicuous merit and exceptional bravery while on duty.

16. The police officers involved in the search warrant were members of the Middle Eastern Organised Crime Squad (MEOCS) which sits within the State Crime Command. As the name suggests, this is a specialist squad dedicated to investigating organised crime associated with persons described, generically, as being of “Middle Eastern” heritage, particularly in the south western suburbs of Sydney. It is not a tactical unit, that is, its members were not specifically trained in advanced methods of overcoming resistance or forcing entry into premises.

17. MEOCS commenced operation on 1 May 2006 and took over the responsibilities of Task Force Gain, which was formed in October 2003 in response to an increase in violence being exhibited by Middle Eastern organised crime groups in south western Sydney. MEOCS consists of three tiers of staff, namely, the Criminal Investigation Team, the Target Action Group (or TAG) and uniformed police (including Highway Patrol and General Duty officers).

18. The charter of MEOCS provides it should:

Conduct multi-level investigations into Middle Eastern Organised Crime Groups involved in Serious and Organised Crime with a focus on those groups who have a propensity to use violence to achieve their criminal ends.

19. The role of the Target Action Group is to support the investigative capacity of MEOCS strike forces, and its charter includes conducting approved investigations into Middle Eastern crime syndicates, including investigations and related operations concerning low and mid-level illicit drug distribution, firearm possession and supply, and crimes of violence.

20. In 2010, executing search warrants was a regular activity for members of the Target Action Group.

Events leading up to the search

Contact with the informant

21. Since 2009, Detective Senior Constable Dave Roberts had cultivated a relationship with a registered source who had on a number of occasions provided him with information about criminal activity relevant to MEOCS's charter. I have granted an application to suppress the name and identifying information about that source on the basis of public interest immunity. Accordingly, the informant was referred to throughout these proceedings and in the documentary material tendered as X.

22. Detective Roberts continued to contact X from time to time with a view to obtaining criminal intelligence. At about midday on 8 September 2010, he contacted X and agreed to meet with X. He took Senior Constable Richard McNally with him. Prior to his departure, Detective Roberts informed his supervisor, Detective Inspector Michael Ryan, that he was leaving the office to meet with X.

23. The meeting occurred at around 1:15pm. The officers collected X in an unmarked police vehicle from an agreed location and then drove to the unit complex at Cairds Avenue Bankstown because according to X a person known to X was continually committing drug crimes from those premises.

24. Detective Roberts drove and took the lead role in the discussions. Senior Constable McNally sat in the back seat alongside X and took notes during the meeting.

25. X indicated an occupant of the unit complex was dealing drugs from his garage. The garage was located in the basement of the building. X described the occupant as an Asian male in his 50s who drove a white Toyota Camry station wagon. X did not know the Asian male's name and referred to him as "Miagi". X said that the Asian male was dealing in substantial amounts of cocaine and heroin, being amounts no smaller than 3.5 grams at a time, and that the deals took place mainly in the evening.

26. X said that the Asian male had a practice of taking sellers and buyers to different garages to deal with them. X said the customers of "Miagi" included members of the Kalache family and the Hamze family.[4] X told them that two days earlier, on 6 September 2010 at about 11:00pm, X had been present at the unit complex and witnessed "Miagi" sell half a pound of cocaine to Bill Kalache in the garage in the basement of the complex. Payment to "Miagi" was made with three ounces of heroin and cash. According to X, Bill Kalache had attended the meeting with 3 carloads of associates.

27. The claim that members of the Kalache and Hamze families were involved with the Asian male was of significance to the officers because they were known to be Middle Eastern crime families, some members of whom had a history of involvement in serious crime including drug supply and violence. The officers were aware of intelligence that some members of these families potentially had access to firearms.[5] Detective Roberts was personally aware that at least one member of the Kalache family had a history of being aggressive towards police. Bilal ("Bill") Kalache had become aggressive towards police when Detective Roberts and Senior Constable Howes had arrested him in December 2008. Detective Roberts had arrested another member of the Kalache family in March 2010 and charged him with a series of firearms offences relating to the possession of unauthorised and illegally altered weapons.

28. Given their Middle Eastern heritage, the involvement of members of the Kalache and Hamze families in drug dealings at the block of units was of particular interest to officers in MEOCS, because it fell within their area of specialist operations. The Hamze and Kalache families were identified investigative targets of MEOCS because some members were known to be involved in crimes of violence and ongoing criminal activity.

Record of the meeting with X

29. For reasons which will become clear, exactly what was said about some things when officers Roberts and McNally met with X are material to an assessment of whether the search of the premises in Cairds Avenue was properly planned and executed.

30. While Detective Roberts spoke to X, Senior Constable McNally made a note of the conversation in his police notebook. That note is the only contemporaneous record of the information provided by X. The full context of the note is also significant when assessing an important matter in dispute, namely the meaning of the entry "<u>Gun</u>" in the note. The note is set out, in full, below:

31.

8/9/10 *1:15pm*

½ lb Cocain – 2 nights ago

Bankstown

Gun + cash,

Deals with Gangs

Bill Kalarchi's/Hamzy's

Asian male – Mayugi – 50-55

5-6 garages

Buyers in different garages

Roller door. First garage on left.

Kalachi gave Asian – Heroin few oz

Asian gave Kalachi – cocaine

TONI McNeice *16

*6

[Portion redacted]

8/41

Carmen St CAIRDS AVE!

41-43

AYL9ZP Mitsubishi outlander

Main bloke drives a white

QQY160 Magna wagon – Camry 84

Cocaine 1lb in the garage.

32. Both Detective Roberts and Senior Constable McNally say they recall asking X if "Miagi" was in possession of any firearms. In their inquest evidence the officers could not recall precisely what X had said about firearms. This is understandable given the passage of time. However, Senior Constable McNally said he was sure he was never told there was a gun at the premises. Detective Roberts recalled X said X had never seen "Miagi" in possession of a firearm, but could not rule it out.

33. This was significant, as the officers were not aware how many dealings X had previously had with the Asian male. Detective Roberts conceded in evidence that he only knew it was more than once.

34. The notation "Gun + cash" could indicate something was said about a gun and cash being present at the location, and "gun" was underlined because this was of very obvious importance. However, Senior Constable McNally said he wrote down "Gun" because he had asked if X had seen a gun and X replied that X had not. He said he underlined "Gun" because it was an important question for a risk assessment and the answer could determine how the job would proceed.[7] Further, he said he underlined it to indicate he'd asked whether there was likely to be one at the premises.

35. Given its significance, it is hard to comprehend why he did not simply write "No gun" or strike out the word "gun" which the officer conceded would have been just as easy. Nor does his explanation fit with the officer asking about the likelihood of cash being at the premises, which he said he did, and that word not being underlined.

36. When asked about his note, in an interview on 18 March 2011, Senior Constable McNally said that X may also have said words to the effect of "*you never know, he might have one in the unit*".[8] Detective Roberts also said that X may have made a comment to the effect that X "couldn't rule it out" (Miagi having access to a firearm). Detective Roberts thought the statement may have been made later, in one of his phone conversations with X. In evidence, Detective Roberts described the comment as a glib remark, perhaps made in exasperation because he had asked X so often about firearms. Senior Constable McNally gave similar evidence, stating that he considered the remark "off the cuff", and that:

    If I had any inkling that the bloke had a gun there's no way we would have done a search warrant like that.

37. X refused to give a statement to police. However, X told investigators during an interview at Revesby Police Station on 24 September 2010 that X had said to a police officer before the shooting that there could be "ammo" (which X said meant firearms) at the location because the Asian male was a big drug dealer.[9] X was a particularly evasive and unhelpful witness when called to give evidence at the inquest. X gave evidence in a closed court via audio visual link. To be fair to X, it is likely that X had a justifiable fear of being identified as having been a police informant. In any event, X's evidence was of little assistance and real caution must be exercised when relying on anything that X said that is not supported by other evidence.

38. I accept Senior Counsel Assisting's submission that Senior Constable McNally appeared, in general, to be making a genuine attempt to give truthful evidence. However, it is the case that his memory was not always reliable. In his WorkCover interview he suggested that he may have underlined "Gun" because of inquiries he later made on the COPs database and firearms registry which showed no guns to be registered to the Cairds Avenue address.[10] Senior Constable McNally agreed during the hearing that he had reflected repeatedly on the events of that day and had filled gaps in his memory. Such reflection would be natural. He said:

    I mean I played that many scenarios in my head and I have made up, filled in gaps and made more gaps...

39. I did not form such a favourable impression of Detective Roberts' candour. He tended to become aggressive and defensive when challenged in evidence. He was reluctant to make any concessions on any topic. In any event, Detective Roberts conceded that X may have said something to the effect that X could not rule out the Asian male having a gun.

40. It was submitted on behalf of Senior Constable McNally, that his evidence that he underlined the word "Gun" to signify that X had been asked whether X had seen "Miagi" with one should be accepted.

41. The note does not record the answer to that question and the court should therefore accept the evidence of the officers who were present when the conversation occurred that X answered the inquiry in the negative.

42. I am unable to accept the evidence of Senior Constable McNally and Detective Roberts on this point. The natural meaning of the contemporaneous note is that it records mention of a gun. The suggestion by Senior Constable McNally that an entry "Gun + cash" really means "no gun but an expectation of cash" is counter intuitive and belies common sense. The claim that "Gun" records a question that was asked is not consistent with the method in which the notes were taken. Senior Constable McNally conceded most if not all of the other entries on the page reflected information provided by the source, not questions he asked of the source. And, as noted above, he accepted that it would have been just as easy to write "no gun".

43. In my view, the weight of evidence suggests that X did say something to the officers to the effect that the Asian male could possibly have access to a gun or that he possibly had a gun in his unit. In other words, there was a possibility that the Asian male possessed a gun, just as there was a possibility that the officers would locate cash. These possibilities were recorded in Senior Constable McNally's note as "Gun + cash", and which both Detective Roberts and Senior Constable McNally conceded may have been mentioned in conversation by X.

44. This conclusion is supported by the repeated questioning of X about the presence of a gun at the Cairds Avenue premises whenever X was subsequently spoken to by Detective Roberts throughout the remainder of the afternoon and evening.

Decision to proceed with search

45. After the meeting with X, Detective Roberts and Senior Constable McNally returned to Hurstville Police Station to undertake further inquiries about the activities of the Asian male at Cairds Avenue. Sometime in the mid-afternoon, Detective Roberts had a telephone conversation with X who informed him that the Asian male was expected to receive 6 ounces of cocaine some time that afternoon or evening.

46. The cocaine was expected to be sold for approximately $40,000. Phone records suggest that this call occurred at 4:36pm. Detective Roberts spoke to his supervisor Detective Inspector Michael Ryan. They decided to "strike while the iron's hot" and apply for a search warrant to be executed that evening.

47. Detective Roberts and Detective Inspector Ryan explained their decision during the inquest. They both said they believed that executing the warrant provided a good opportunity to catch the Asian male in possession of the drugs before they were moved or on-sold. Detective Inspector Ryan said he was generally reluctant to execute warrants at night, but considered that a "source in play" - that is an informant who had direct access to the targets and the premises to be searched - presented a valuable opportunity and mitigated risks. Inspector Ryan said he understood that Middle Eastern purchasers would be involved in a transaction later that evening or in the early hours of the morning.

48. Even if the drugs had been sold by the time the warrant was executed, the officers expected that the Asian male would be in possession of a large amount of cash.

49. It does not appear that either officer gave any real consideration to the risk that the drug deal could be in process, with potentially violent and armed Middle Eastern criminals present when police approached the garage. Despite submissions to the contrary from various parties, I consider that based on the information provided by X this was a real possibility that should have been taken into account.

Intelligence gathering

50. During the afternoon and early evening of 8 September 2010, Detective Senior Constable Roberts and Senior Constable McNally oversaw further inquiries in preparation for the application for a search warrant. Detective Roberts began gathering officers to participate in the search. He asked Senior Constable McNally to prepare the operational orders.

51. Senior Constable McNally was aware that the Hamze and Kalache families were investigative targets because there was intelligence linking them to ongoing criminal conduct including activity involving drugs. He thought it likely that the intelligence included activities involving firearms. Senior Constable McNally said that MEOCS targets were listed at the Hurstville office and he would have looked at the list. It was submitted on behalf of Detective McNally that it was not the entirety of those families who were considered targets and not every member of those families was known to be prone to violence when confronted by police. I am of the view that such fine distinctions could play no part in the risk assessment of the planned operation when the accuracy of the information was unknown.

52. Plain Clothes Senior Constable Thomas Howes became involved in the preparation for the warrant at about 3:30pm. He conducted a general check on the unit complex on the police database without locating any information of significance. Senior Constable McNally confirmed that no firearms were registered to the location. He also conducted RTA checks (which were inconclusive) to see if he could identify the name of the owner of the car which may have belonged to the Asian male (as identified in the intelligence report described below).

Information from Constable Awaad

53. Detective Crews informed Senior Constable McNally and Detective Roberts that he knew a serving police officer who lived in the Cairds Avenue complex. That police officer, Constable Mohammad Awaad, was a friend of Detective Crews from their time together at the Campsie Local Area Command. Detective Crews rang Constable Awaad to gather more information about the Asian male and his activities.

54. He confirmed that an Asian male aged 50-60 years lived in unit 8 but he was not aware of the man's name and had very limited interactions with him. He was aware that the man lived with his wife and, he assumed, their children. He had observed that the Asian male had visitors to his garage.

55. Detective Crews later reported to his colleagues that Constable Awaad told him that many of the Asian male's garage visitors were of Middle Eastern appearance. Detective Crews also said that Constable Awaad suspected that the Asian male may have been involved in selling or dealing in pirated DVDs.

56. In his evidence at the inquest, Constable Awaad said that he had not noticed that the visitors were of any particular ethnicity. He also said he had not suspected the Asian male of any illicit activities involving DVDs. He thought the man might be engaging in legitimate computer work, such as computer repairs, in his garage. Constable Awaad conceded his recollection of the call was not perfect. There may have been a misunderstanding between the officers. It is unnecessary to resolve this minor conflict in the evidence.

57. Constable Awaad expressed surprise when Detective Crews informed him that the Asian male was believed to be involved in drug dealing. He was not aware of any incident involving the Asian male in the garage two weeks earlier so could not have conveyed this to Detective Crews (this prior incident is discussed below). He had no reason to say anything to Detective Crews which suggested that the Asian male was armed, threatening or likely to use violence against the police.

58. Constable Awaad did not recall being asked any questions about the layout of the unit block (although it was possible he was asked) or access to the unit block, aside from him mentioning to Detective Crews the garage roller door. He was willing and able to provide further information or assistance, if asked, in relation to the execution of the search warrant. At the time, he lived on the left side of the building so he could not provide access to the right tower, where unit 8 was located, but would have lent his access key to the officers. He was also prepared to lend his spare remote control for the garage roller door and to undertake any requested reconnaissance or surveillance.

59. The conversation ended with Detective Crews saying he would call Constable Awaad just before the warrant was executed so that he could leave the building. Constable Awaad waited at the house of a family member for Detective Crews to call after his work day ended.

Information from resident Q

60. Senior Constable McNally also tried to obtain more information about the Asian male. He conducted a search of the police database, COPS, and asked for the assistance of MEOCS intelligence staff. His inquiries led to an intelligence report dated 1 September 2010 relating to unit 8 of the building (the apartment where Philip Nguyen lived). The intelligence report was prepared by Constable Toni McNeice of Revesby Police Station.

61. It outlined information provided by a resident of the Cairds Avenue complex who contacted police about "suspicious activity at the location". The resident was known as Q in these proceedings.

62. Constable McNeice stated that Q informed her that an Asian male lived at the location with his wife and two children. He drove a white Toyota Camry, registration number QQY160, which he parked in front of a long garage.

63. Q reported that males of Middle Eastern appearance had been seen constantly at the garage. They would enter the garage before leaving after a short time. Q could not see the activities inside the garage because of the car parked in front, but said that the men would stop talking when Q walked past. The report recorded that Q suspected the resident male was dealing in drugs.

64. The report continued that Q had explained that remote access was needed to access the garage and offered to assist police to gain access if required. The report also recorded the name of the owner of the car and a previous alert for drug supply attached to the vehicle.

65. At about 3:00pm on 8 September 2010 Senior Constable McNally contacted Constable McNeice to obtain the telephone number of Q so that he could obtain more information about the Asian male.

66. Q resided on the left hand side of the complex when facing it from the street. Q was aware of a middle aged Asian male living in Unit 8 on the right side of the building. Q did not have many interactions with the Asian male but knew that he lived with his wife and her two children, a boy in his early twenties and a young girl of primary school age. On one occasion Q had asked the male to close the garage door in the basement and the Asian male had responded rudely.

67. Q became aware, from a neighbour in the complex, of an incident about two weeks prior to the search warrant.

68. Q was not informed precisely what had occurred but was aware the Asian male had been attacked by two men wearing balaclavas. Q had heard screaming and running in the garage/basement area at the time of the incident. When Q became aware from a neighbour that the Asian male had not reported the incident to the police, Q became suspicious of him and his activities. The incident prompted Q to contact Revesby police to make the report referred to above, that was recorded by Constable McNeice.

69. At the inquest, Q denied telling Constable McNeice that Q suspected that the Asian male was dealing drugs rather than just expressing general concern about suspicious activity. It is not necessary to resolve the conflict between the written record and Q's evidence on this point. It is possible that Q forgot expressing this concern or suspicion to Constable McNeice. It is also possible that Constable McNeice understood from Q's information that Q was expressing a suspicion about drugs even if it was not expressed in precisely those terms.

70. Q also insisted at the inquest that Q had relayed information to Constable McNeice about the incident with men in balaclavas. The officer did not recall this information being provided to her and there is no reference to it in her quite detailed intelligence report generated as a result of the conversation. I conclude Q is mistaken.

71. Senior Constable McNally spoke to Q some time after 6:30pm, when Q returned home from work and received a message from him on Q's answering machine. Senior Constable McNally asked Q about the layout of the building.

72. Q explained where the garage for unit 8 was located (downstairs, to the left attached to the same wall as the roller door entry) and offered Q's remote control access to the building. Q also explained that the building was divided into two secure entrance blocks and that Q could "buzz" Senior Constable McNally into the left side of the building. Q told Senior Constable McNally that he could then access the garage by going downstairs.

73. In his evidence, Senior Constable McNally referred to the separate sides of the unit block as "towers". He said Q had told him the only way he could access the right tower from the left tower and get to unit 8 was to walk through the car park of the complex and access another set of internal stairs to the right tower. In general, Q's evidence was of a very brief and general conversation, however Q's recollection of the details of the conversation was, understandably, limited. In contrast, Detective Roberts said he gained the impression from Senior Constable McNally that he had received detailed instructions about the layout of the building from Q and that Q had confirmed the content of the intelligence report.

74. I accept Senior Constable McNally's evidence that he was not told of the robbery attempt suffered by Mr. Nguyen a couple of weeks before Detective Crews' death. There is some contention as to whether Q told Senior Constable McNally the Asian male in unit 8 was a friendly man who sometimes walked his children to school as alleged by the officer. Q denied that when giving evidence. Q said Mr. Nguyen had not exhibited any warmth towards Q and the evidence indicates he was not an engaged step-father. It is submitted on behalf of Senior Constable McNally that his version should be preferred because he has repeated it a number of times and that it would be unfair to find he was mistaken because that was not put to him in evidence. I do not accept either submission. Q lived in the same unit block as Mr. Nguyen. Q had become concerned that he may have been involved in criminal activity. Q reported this to police. It is unlikely in those circumstances that Q would have painted him in a more amiable light than other evidence indicates was warranted. Procedural fairness to Senior Constable McNally does not require me to ignore the weight of the evidence as I find it.

75. The characterisation of Mr. Nguyen as a benign family guy was in my view mistaken and to some slight extent misinformed the risk analysis of the search of his garage.

The warrant application

76. The search warrant application was completed by Detective Crews. It was based on the information provided by X, together with other information obtained as a result of the further inquiries that had been made that afternoon. The first draft was prepared by Detective Roberts and emailed to Detective Crews at 5:05pm.

77. Detective Crews added further information to the draft including the information from Q, the outcome of the checks of COPS and the RTA, and other intelligence received from Senior Constable McNally and Constable Awaad. The final search warrant application was sent to Parramatta Local Court at 7.37pm and the warrant was granted at 7.58pm. It gave authority to officers of the MEOCS for the entry into unit 8, and the associated garage, to search for evidence in relation to the possession and sale of prohibited drugs.

78. The information contained in the warrant application is the most comprehensive record of the facts known to the search party as at 7.37pm, when it was faxed to the Local Court. Most relevantly, it included the following:

- X stated that an Asian male known as "Miagi" supplied "large quantities" of cocaine and heroin to customers, and specified that the cocaine and heroin was being sold to members of the Hamze and Kalache "Middle Eastern Crime families".
- X stated that, on 6 September 2010 at about 11pm, X had been present and witnessed "Miagi" sell half a pound of cocaine to a member of the Kalache family. Payment to "Miagi" was made with 3 ounces of heroin and cash.
- X said that this transaction took place in the garage belonging to "Miagi", in the basement of the block of units at 41-43 Cairds Avenue, Bankstown.
- This garage was "the 1st garage on the left upon entering the basement from the driveway accessed from Cairds Avenue".
- X stated that X knew "Miagi" through other criminal associates and described him as being an Asian male aged in his fifties, who drove a white Toyota Camry station wagon.
- X said that "Miagi" was "constantly dealing cocaine and heroin in amounts no smaller than 3.5 grams at a time", and that he "primarily deals prohibited drugs in large quantities such as several ounces at a time and mainly in the evening".
- "Miagi" had told X that he would have a further 6 ounces of cocaine on the evening of 8 September 2010. (Detective Roberts believed this information was provided by X at some stage after the initial meeting).

- Police intelligence records contained a previous report made on 1 September 2010 by Q a resident of the unit complex, complaining of suspicious activity by an Asian male in the basement garage.
- In that report, Q stated that the suspicious Asian male had numerous meetings in his garage with "Middle Eastern males". Q believed that the Asian male was dealing in drugs. Q also said that the Asian male drove a white Toyota Camry.
- Police contacted Q on 8 September 2010, and confirmed that the garage referred to by Q was the garage attached to unit 8 in the block of units. Q also confirmed that the Asian male, who Q believed was dealing in drugs, resided in unit 8.
- Further information had been obtained from a serving police officer who also lived in the same block of units.
- The police officer also confirmed that the user of the garage attached to unit 8 was an Asian male aged about 55-65 years, who he described as "short, chubby build, reading glasses and a receding hairline".
- In addition, the officer confirmed that the Asian male had numerous meetings in the garage with "Middle Eastern males".

79. After the warrant was issued, Detective Roberts supervised the preparation for the search of the garage and unit 8 to be conducted later that evening.

Relevantly, these arrangements included:

- Preparation of the operational orders for the proposed search which were drafted by officer McNally and submitted to Detective Roberts.
- Preparation of the State Crime Command Request to Conduct Operational Activities form (a form to authorise use of MEOCS resources for that activity) by Detective Roberts.
- Selection of officers to be involved in the search, and allocation of their respective roles was also undertaken by Detective Roberts.
- Review of the operational orders by senior supervising officers.
- Briefing in preparation for the execution of the search warrant.
- Arranging for the attendance of an independent police officer during the search.

Preparation of operational orders

80. The preparation of operational orders was required under the Standard Operating Procedures of the NSW Police Force, in relation to search warrants. Essentially, the purpose of them was to summarise the basis for the search, assess the risks associated with the search, and outline the plan for the entry and search of the premises.

81. The operational orders were prepared by Senior Constable McNally.

The risk assessment

82. The preparation of the operational orders included the completion of a risk assessment, designed to identify threats to the safety of police that may arise in the course of the proposed search. This involved consideration of the likelihood of potential risks, together with the potential consequences should those risks eventuate.

83. According to the operational orders he completed, Senior Constable McNally assessed all of the nominated risks to be of "low" likelihood. He also assessed the potential consequences of all of these risks to be "low".

84. Relevantly, the risks that Senior Constable McNally assessed to be of only "low" likelihood, with "low" consequences, included the following:

- Offender's access to firearms.
- Offender's intelligence for firearms.
- Offender's propensity to use violence towards police.
- Offender's propensity to use weapons towards police.

85. Senior Constable McNally assessed the risk of firearms on the basis of the information obtained from X and the absence of any other intelligence about the offender's access to firearms on the police computer systems. His evidence was that X had said there was no gun present (presumably at the premises) / "Miagi" did not have a gun and/or X had not seen him with a gun.

86. As the officers did not know the name of the Asian male, intelligence checks as to licensed or registered firearms could only be conducted in relation to the premises. Senior Constable McNally considered the reference to "weapons" as being weapons other than firearms. He said in evidence that he considered the likelihood of that risk to be low, with only moderate consequences, as the large number of police officers present were likely to be able to control a 55 year old man even if he was in possession of a weapon like a knife or a baseball bat. He made a similar assessment as to the risk of violence generally.

87. Senior Constable McNally did not consider the risk posed by the Middle Eastern investigative targets. He said he had never been told to address the risk posed by known associates or people who might be present at the premises when completing an assessment. However, Senior Constable McNally said he was not expecting the Middle Eastern investigative targets to be present when the warrant was conducted.

88. His understanding from Detective Roberts when completing the operational orders was that X was present at the location and only the Asian male (and possibly another Asian male) was expected to be present when the warrant was to be executed.

89. Senior Constable McNally accepted that any raid on a drug dealer raised the risk that customers would be present at the time. He said:

> *If there's drugs at any location we do a search warrant on there's a drug dealer, there could be a drug deal any time. Every time we do a search warrant potentially there's going to be someone coming to buy drugs.*

90. He also accepted that there was a risk that the customers may be those who had dealt with the dealer before. He agreed that in this case there was a risk that the Middle Eastern investigative targets could be present. He also agreed that the risk that they would be present, and could be in possession of firearms, was something that he should have considered, stating:

> *With hindsight now I totally understand and I will do that now but at that point I had never done that before and it was not a practice that I was acquainted with and I'd never done that before so hence I didn't do it that night.*

91. Each factor in the consequences section was also completed as "low". Senior Constable McNally's evidence was that, with the benefit of hindsight, his completion of the consequence column was mistaken. He said he assumed that consequences were to be assessed on the basis that if the likelihood of a risk was low then the likelihood of a consequence would also be low (because that consequence was unlikely to occur).

92. Senior Constable McNally said he now accepted that the consequence rating was to be completed on the assumption that the risk did in fact eventuate.

93. Senior Constable McNally believed he had received NSW Police Force training in risk assessments when he did an investigator's course in 2003 or 2004 and again in 2010 when he completed a detectives' education course. He has since reviewed the risk assessments he had performed prior to the Cairds Avenue search warrant and they contained a similarly flawed assessment of the consequences rating. He said that on occasions his superior officers or trainers had not identified this problem, although there would have been occasions where it was picked up. He added that on the morning of 8 September 2010 (the same day as the attempted search of Cairds Avenue) he had submitted a copy of a previous risk assessment he had completed to his detectives' education course as an assignment. It contained a flawed assessment of consequences.

94. The problem had not been identified by his MEOCS supervisor or by assessors of the detectives' course.

95. This misconception had the potential to completely negate the efficacy of the risk assessment. It is concerning that Senior Constable McNally's misunderstanding had not been detected and corrected.

Identification

96. The operational orders included the following instruction in relation to the dress to be worn by officers involved in the search:

> *All personal* [sic] *from State Crime Command – MEOCS will dress in appropriate clothing suitable for the execution of a search warrant. All arms and appointments to be carried at all times. Plain clothes officers will display police identification.*

Entry to the garage and the unit

97. The operational orders recorded the plan that once entry had been gained via the front security door, officers Brown, McNally and Baglin would "*go up to level one to unit number 8 and will knock on the door*". It stated that the remaining officers, including the video operator, would go to the garage area, gain entry and secure the premises. The occupants were to be contained in a common area of the house (unit block) and the warrant and occupier's notice were to be read and explained to them before any searching commenced.

98. Senior Constable McNally said in evidence that he knew at the time of preparing the operational orders that the officers going to unit 8 could not access the unit from the street level entrance on the right side. He said he knew from talking to Q that the officers would need to enter the left side of the building (assisted by Q) and go down to the basement to go up the internal stairs to reach unit 8. He said he did not include this detail in the orders because he intended to explain it at the briefing held before the execution of the warrant. For the reasons detailed below, I conclude this did not happen.

Surveillance and operational safety checks

99. The orders included a box which outlined "operational safety checks". The box was designed so that the safety check could be entered as "Y" or "N" and the person who conducted the check would be recorded alongside the check. The checks which were marked as completed included:

- *COPs checks conducted on premises*
- *ILS check* [firearms registry] *conducted on premises/persons listed*
- *Photographs of premises*

- *Surveillance conducted at premises*
- *Vests available and will be on site for use*
- *Independent officer, OIC, searcher/s, exhibits officer, video operator, arrest/interview team, scene preservation/security officers identified & aware of duties*
- *Entry implement (sledge hammer or similar) available for use*

100. The three safety checks which were marked as not completed were:

- *Dept of Housing/Lease checks conducted*
- *Other habitation checks conducted*
- *Plans obtained of premises*

101. Given the time available, this is not surprising. The question is did the search need to proceed in such a limited time frame? For reasons detailed later, I consider it did not.

102. The evidence indicates the entry "surveillance conducted" refers to when Detective Roberts and Senior Constable McNally had sat in a car parked outside the unit block with the source X and "*had a look at the premises*". The look involved stopping and then driving past the premises. It did not involve getting out of the car.

103. Senior Constable McNally ticked "vests available" (meaning ballistic vests) on the assumption that each police car would have two ballistic vests and that those vests would be sufficient for the officers attending the search warrant. He conceded that some officers attended the subject premises in cars containing three people and, as a result, there were not enough vests for each officer on site.

Selection of officers and allocation of their respective roles

104. According to the operational orders, the execution of the search warrant would involve the following officers in various roles. The roles were allocated by Detective Roberts and inserted into the orders on his instruction, as follows:

- Detective Inspector Michael Ryan – Operations Commander (although not to be present at the search)
- Detective Senior Constable Dave Roberts (acting at that time as a Detective Sergeant) – Field Supervisor
- Senior Constable Scott Brown – Entry/Searcher
- Constable Paul Baglin – Entry/Searcher
- Senior Constable Richard McNally – Entry/Exhibit Officer
- Constable William Crews – Case Officer (and holder of the warrant)

- Senior Constable Chris Gerogiannis – Video Operator
- Senior Constable Joshua Lavender – Surveillance/Arrest Team
- Senior Constable Thomas Howes – Entry/Arrest Team

105. All of these officers were members of the MEOCS. Apart from the uniformed officers, Constable Baglin and Senior Constable Gerogiannis, all of these officers were in plain clothes.

106. As it turned out, another uniformed officer, Senior Constable Fletcher Gentles, also took part in the search, although he is not mentioned in the operational orders.

107. Detective Crews was allocated the role of case officer. That role is outlined in detail in the Standard Operating Procedures in relation to search warrants. It is, however, clear from the evidence that Detective Roberts took the lead role in the preparation and execution of the warrant and from a practical perspective acted more in accordance with the role of operation commander/case officer as outlined in the Standard Operating Procedures. No criticism is made of the extra level of responsibility and oversight assumed by Detective Roberts. This was the first time Detective Crews had undertaken a search warrant at MEOCS. He was keen to gain experience and volunteered to undertake the role. Detective Roberts, as the more senior and experienced officer, assisted and supervised Detective Crews, and prepared the first draft of the search warrant application. Under the supervision of Detective Roberts, Detective Crews was expected to finalise all the relevant documents relating to the warrant and warrant application, announce the warrant to the occupier and provide and explain the occupier's notice. He was also expected to complete the forms required to be sent to the Local Court at the conclusion of the operation.

Review of operational orders by supervising officers

108. The Standard Operating Procedures of the NSW Police Force for search warrants (as at 8 September 2010) required the operational orders be reviewed by more senior, supervising officers. The review of the Cairds Avenue search warrant operation involved the supervising officers referred to below.

Detective Roberts

109. Senior Constable McNally stated that Detective Roberts reviewed the orders in his capacity as his supervisor and as the case officer/source handler who knew most about the operation. He thought Detective Roberts was likely to have made changes to the orders but could not recall any specific changes.

110. When he gave evidence Detective Roberts resisted the use of the words "review" or "checked" to describe his functions, but the level of his involvement was not really in dispute. He agreed that he had read the orders before they were submitted to more senior officers. He agreed with the risk assessment prepared by Senior Constable McNally, including the assessment of consequences. He could not recall if he made any changes to the orders.

Detective Inspector Mick Ryan

111. Detective Inspector Ryan was the most senior officer with direct responsibility for supervision of the Target Action Group of MEOCS. He approved the operation during a phone call with Detective Roberts without sighting the operational orders, or any other paperwork, because he had left the office at 3.06pm (before the documents were prepared).

112. Detective Inspector Ryan had previously been issued with a Blackberry device to review documents after hours but had been required to return it, apparently due to funding cuts. Detective Inspector Ryan felt he had enough information to approve the orders from a series of phone calls and updates from Detective Roberts throughout the afternoon.

113. Detective Inspector Ryan was aware that the warrant had been classified as a low risk operation and agreed with that assessment. He was aware that:

- the search warrant would target both a unit and garage and that the party was divided into two teams, both of which contained uniformed officers;
- the mode of entry was proposed to be a door knock, but forced entry was a possible contingency at the discretion of Detective Roberts;
- the target was a middle-aged Asian man believed to live with his wife and two children;
- the target dealt drugs to "Middle Eastern criminal identities" including Hamze and Kalache family members;
- some members of the Hamze and Kalache Middle Eastern families were known to have access to firearms;
- the target was expected to be in possession of $40,000 cash and/or 6 ounces of cocaine in the garage;
- the target was expected to engage in a drug deal during the evening of the execution of the warrant with Middle Eastern purchasers;
- a source was "in play" who was either present at the unit complex or had unrestricted access to the garage and was able to provide up to date intelligence about activities in the complex; and
- in discussions with Detective Roberts, the source had said that there were no firearms present.

114. Detective Inspector Ryan did not think it was likely that the search warrant party would disturb a drug deal in progress because of the source providing ongoing intelligence at the complex.

115. He was also under the mistaken impression that some physical surveillance was being conducted at the building, namely that officers were stationed in the street watching the premises. He was emphatic in his evidence that, in his last call with Detective Roberts, he had confirmed that the source had said there were no firearms present shortly prior to the search warrant being executed, or he had instructed Detective Roberts to confirm this (the latter is more likely as the phone records indicate that they spoke at 8:14pm, before the 8:39pm call from Detective Roberts to X, just prior to the execution of the search warrant).

Detective Superintendent Deborah Wallace

116. Detective Superintendent Wallace was the Commander of MEOCS. She was first informed of the search warrant operation by Detective Inspector Ryan in the mid to late afternoon of 8 September 2010, at around 3:30pm. It was customary for her to receive a pre-briefing from Detective Inspector Ryan prior to receiving any operational orders for a search warrant operation. Detective Inspector Ryan telephoned Detective Superintendent Wallace at Parramatta, where she was attending a series of meetings. Her mobile phone battery had started to run down throughout the afternoon which compromised her ability to communicate later in the day.

117. Detective Inspector Ryan told Detective Superintendent Wallace that his officers had received information from a "source in play" that a middle aged Asian man (otherwise unknown) was dealing drugs from a unit block in Cairds Avenue Bankstown.

118. The man was believed to act as a "middle man" (described by Detective Superintendent Wallace as a "broker") in drug supplies and to be in possession of 6 ounces of cocaine and/or $40,000 in cash. Detective Superintendent Wallace understood that it was expected that the drugs would be on-sold to an unknown Middle Eastern criminal group later that evening or in the early hours of the morning.[11] She was told that in addition to a "source in play" who was supplying information to the MEOCS officers, there was a "friendly" within the unit block who could give the officers access to the building.

119. Detective Superintendent Wallace was aware that the search warrant was to be executed at night and queried Detective Inspector Ryan, because she knew he preferred to execute warrants in the early morning. Both officers agreed that it was important to move quickly because of the risk that the drugs would be on-sold. Detective Superintendent Wallace was also eager to take advantage of what she described as a rare opportunity to have a source on the ground, providing regular updates to officers. She had little personal knowledge of the source, but proceeded on the understanding that Detective Roberts regarded the source as reliable.

120. Detective Superintendent Wallace received the operational orders on her Blackberry at about 8:20pm that evening. She routinely reviewed operational orders for search warrants conducted by MEOCS, and described her function as to:

> *Ensure that the orders contained sufficient information on which to, to conduct the operation. It was also to ensure that a risk assessment was conducted and it was to ensure that efficient appropriate execution strategies were in place as well as contingencies are considered and that resourcing was allocated.*

121. Detective Superintendent Wallace reviewed the operational orders, including the risk assessment matrix which she viewed, albeit with some difficulty, on her Blackberry screen. She was satisfied with the content of the orders and the overall risk rating assessment. She noted that the "consequence" section of the risk assessment matrix had been filled out incorrectly but agreed with the overall risk rating as "low". She said she substituted her own judgment as to the overall risk based on her belief that the presence of the source mitigated the risks. Detective Superintendent Wallace was critical of the risk matrix because there was no provision for mitigated risks.

122. In assessing the risk, Detective Superintendent Wallace saw that the Asian male was believed to deal with Middle Eastern investigative targets but said she did not know who they were. She did not know that the Asian male was believed to deal with the Hamze or Kalache families or about any recent deal between the target and Bilal Kalache. She was also unaware of Bilal Kalache's previous arrest during which he displayed aggression towards officers Howes and Roberts.

123. However, Detective Superintendent Wallace said that her agreement with the risk assessment would not have changed if she had been aware of this information. She was aware that some members of the Kalache and Hamze families had a propensity for violence and was aware that at least some members of the Hamze families had access to firearms. She believed that any risk could be mitigated by the presence of the source providing timely information to the search warrant party.

124. This, however, depended upon the source being reliable. Like Detective Inspector Ryan, she also shared the mistaken impression that some form of ongoing physical surveillance was in place around the perimeter of the unit complex.

125. While Detective Superintendent Wallace approved of both the orders and the operation, her approval was not communicated to Detective Inspector Ryan or any member of the search warrant team. She said that her phone battery was dead and her contact numbers were stored on her phone.

126. Detective Superintendent Wallace assumed that the officers would know that no contact from her meant that she had no concerns about the orders and that they were to proceed with the search warrant.

Detective Chief Superintendent Malcolm Lanyon

127. Detective Chief Superintendent (DCS) Lanyon was the Commander of the Gang Squad and was acting in the role of Director of the Organised Crime Directorate. He was the most senior officer of the authorising officers listed in the operational orders.

128. DCS Lanyon received the orders on his Blackberry at around 8:25pm on 8 September 2010 and spent about 10 minutes reviewing them. He was not aware of any proposed operation until he saw the orders.

129. While he was listed as an approving officer, he saw the purpose of receiving the orders as keeping him "fully informed" rather than seeking his formal approval.

130. He assumed, as it turned out incorrectly, that Detective Superintendent Wallace had already seen the orders and conveyed her approval. In fact, the orders were sent to Detective Superintendent Wallace and DCS Lanyon at the same time (8:18pm) and, as noted above, Detective Superintendent Wallace did not communicate her approval to Detective Inspector Ryan or any other officer before the warrant was executed.

131. DCS Lanyon did not consider it his role to scrutinize the "minutiae" of the operation partly because he assumed officers Ryan and Wallace had already done so and because of his senior role. DCS Lanyon considered that it was his role to examine the orders to confirm that the operation fell within the MEOCS charter and that the execution of the warrant was appropriate to the background as disclosed on the operational orders. DCS Lanyon read in the orders that it was proposed to search a unit and garage to locate drugs, that a door knock or "soft entry" was proposed, that a briefing had been (or was to be) conducted and that the operation was assessed as "low risk". He was satisfied (or "not dissatisfied") with the risk rating and the proposed operation.

132. DCS Lanyon was aware that the target of the warrant was known to deal with Middle Eastern investigative targets. He was not aware that the target was known to use multiple garages when dealing drugs with different people at the same time. Further, he was not aware of the target's dealings with members of the Hamze and Kalache families including the recent deal with Bilal Kalache two days earlier. He was aware that members of the Hamze family had a propensity for violence and may have access to firearms.

133. DCS Lanyon said this additional information, if known to him, would have prompted "a number of questions", which he said he would have put to Detective Superintendent Wallace. One question was what information the source held about who was present or likely to be present at the target premises. DCS Lanyon agreed that, in light of this additional information, the background, reliability and possible motivation of the source assumed greater significance.

134. His evidence was that if he had known of this further information (almost all of which was contained in the search warrant application) he would have ensured that he was satisfied that appropriate steps had been taken before allowing the operation to continue.

Briefing in preparation for the execution of the search warrant

135. At around 8:00pm on 8 September 2010, Detective Roberts, assisted by Senior Constable McNally, gave a briefing to explain the plan for the search to those officers selected to be involved. The briefing took place at the offices of MEOCS, at Hurstville Police Station. All of the involved officers, except the independent observer, attended the briefing.

136. Detective Roberts had a copy of the operational orders and the warrant at the briefing. Some additional copies of the operational orders were distributed at the briefing for the other officers.

137. During the briefing, Detective Roberts outlined at least the key parts of the operational orders to the assembled officers. The officers were informed of the roles they had been allocated. The officers were told that the search would target a middle-aged Asian male (name unknown) and that the target was involved in drug supply to Middle Eastern entities. The officers were aware that the object of the warrant was to locate drugs in a garage area. Some officers also recalled mention of a large amount of cash.

138. The officers were told that a source was in regular communication with Detective Roberts. Detective Roberts believed that there had been some discussion during the briefing about whether Constable Awaad should be used to gain more intelligence about the Asian male and activities in the unit block. He recalled suggesting that Constable Awaad or another officer could go into the garage to pretend to work on Constable Awaad's car so that the officer could observe activities in the garage. Detective Roberts believed other officers were reluctant to involve Constable Awaad because he lived in the building. No other officer gave an account of this discussion but, equally, no officer denied it occurred and there is no reason to doubt Detective Roberts on this topic.

139. It does not appear that there was any discussion during the briefing about how the warrant party would be identifiable as police to those who might not know that, although it is possible that the identification passage in the operational orders was read out loud or paraphrased. Detective Roberts and Senior Constable McNally both stated in their evidence that uniformed officers were included in the group (and in both the upstairs and downstairs teams) to identify the search warrant party as police officers. However, there does not appear to have been any communication of this plan to the uniformed officers, namely officers Baglin, Gentles and Gerogiannis. In particular, the weight of evidence indicates that the uniformed officers were not given any direct instruction to stay up the front or be visible so that their presence could identify the plain clothes officers as members of the NSW Police Force.

140. It also does not appear there was any discussion about the order in which the officers would enter the premises or if the officers would stop and "form up" outside the unit block to discuss the order of entry. The officers were presumably aware that forced entry was a possible contingency if knock entry was refused because entry tools were brought to the location. No officer recounted any discussion about other possible contingencies such as being met with violence or resistance.

141. The group was informed that Senior Constable McNally would obtain access to the unit complex through the resident Q. It does not appear that there was a detailed description of the layout of the building by Senior Constable McNally.

142. The officers were aware that a team would enter and go downstairs to secure the garage (the downstairs/garage team) while another team would go upstairs and secure the unit of the target (the upstairs/unit team).

143. Senior Constable McNally claimed in evidence that he told the group during the briefing that access could only be gained via the left tower and that unit 8 was in the right tower and accessible to them only by a stairway from the garage.

144. None of the officers who gave evidence could recall that being said. Those assigned to search the unit, Constable Baglin and Senior Constable Brown, acknowledged they had a poor recollection of the briefing and conceded it was possible the actual route was outlined during the briefing.

145. In terms of the risk posed by the warrant, the officers were informed that the warrant had been classified as low risk. The officers may have been informed that the intelligence did not suggest the presence of firearms. No officers questioned or queried that assessment. There was an opportunity for questions but it does not appear that any were asked.

146. The weight of evidence suggests that none of the following information was discussed during the briefing:

- that the Asian male dealt with the Hamze and Kalache families;
- that the Asian male had recently been involved in a drug deal with Bilal Kalache and 3 carloads of his associates;
- that there was a possibility or expectation that a drug deal could occur at the same time or close to the time of the warrant execution; or
- that the Asian male had a tendency to place buyers in different garages within the basement.

147. Towards the end of the briefing, Detective Roberts may have informed the officers that he was wearing a protective vest for the execution of the warrant. He may have told the officers something to the effect that they might choose to do the same.

148. Some of the officers who did not wear any protection did not recall this announcement when they gave evidence, but one of the officers who did wear soft body armour, Senior Constable Gentles, did recall something to this effect being said by Detective Roberts at the briefing.

149. Detective Roberts was firm in his evidence that he had revealed the identity of the Middle Eastern investigative targets referred to in the operational orders, namely the Hamze and Kalache families, during the briefing. He also believed that he would have conveyed the information that Bilal Kalache had been involved in a deal with the Asian male two nights before. There was little support for this in the evidence from any of the officers who were present.

150. However, it is difficult to resolve disputes and inconsistencies relating to the content of the briefing because the officers tended to have limited independent memory of the briefing and a number of the officers had trouble sifting their own recollection from their subsequent awareness of events arising from discussions with each other, committal and criminal proceedings and media reports.

Involvement of an independent officer

151. After the briefing at Hurstville Police Station, the search warrant party travelled in several cars to Bankstown Police Station to facilitate the involvement of an independent officer in accordance with the requirements of the Standard Operating Procedures in relation to search warrants.

152. The role of that officer was to provide an independent police presence during a search, as a safeguard in relation to the lawfulness of the search and the security of seized property.

153. On this occasion the role was allocated to Senior Constable Hussein Mousselamani (who was an acting Sergeant at the time). He had previously performed the role for MEOCS and knew Detective Roberts.

154. Senior Constable Mousselamani spoke for some time in his office with Detective Roberts, while the search party waited outside. Detective Roberts gave Senior Constable Mousselamani a copy of the operational orders and the search warrant. Senior Constable Mousselamani asked Detective Roberts to verbally summarise key features of the orders while he read through the orders and warrant in accordance with his usual practice.

155. He focused on ensuring the "legalities" were complied with, namely that the warrant was correctly signed and dated by the magistrate and that the location was in the appropriate local area command for him to act as the independent observer. Senior Constable Mousselamani also checked that the warrant was classified as low risk to ensure he was appropriately senior for the task and that there was no need for the assistance of a specialist group.

156. He did not consider it was his role to scrutinise or question the risk assessment ranking. His overall impression was that it was a "*low key, simple, run of the mill, a routine search warrant*".

157. Senior Constable Mousselamani expressed concern that two locations would be searched, namely the downstairs garage and the upstairs unit. He recalled that there was an expectation that drugs and cash would be located at the garage. He queried how he could be "at two places at once", observing both entry teams simultaneously. The officers agreed that the upstairs team would secure the unit, by waiting upstairs without knocking or engaging the occupiers, while Senior Constable Mousselamani observed the downstairs team secure the garage. Senior Constable Mousselamani would then go upstairs to observe the execution of the warrant with the occupiers of the unit. He was not told how he would reach the unit from the garage.

158. Senior Constable Mousselamani believed that, on arrival, the unit team would head upstairs rather than go down the stairs with the garage team to reach the unit via internal stairs.

Further contact with source

159. Phone records indicate that at 8:39pm, while the search party was at Bankstown Police Station, the confidential source X called Detective Roberts' mobile and they spoke for 219 seconds.

160. The inquest only received the officer's version of this call. He said X told him that X had left the garage about 10 minutes earlier. X said X was with another person (a known drug dealer referred to in the inquest as W).

161. X also said that another Asian man was present with the target in the garage but that he was not involved in the drug deal. Detective Roberts says he asked X if X had seen any firearms in the garage and X replied that X had not. X said X had seen a large amount of cash (around $40,000) but not drugs.

162. Despite the apparent absence of drugs, Detective Roberts determined to proceed with the search on the understanding that there was at least a possibility that both drugs and cash would be present, and that if the drugs were not present the cash could still be seized.

163. Detective Roberts said a number of times that he relied heavily on the last minute information provided by X about firearms. However, he did not completely trust X. He agreed that he had considered the possibility that X was personally involved in the drug deal. The possibility that X was misleading him or had hidden motivations did not appear to impact on his risk assessment or his determination to proceed.

164. Nor did he appear to given any real consideration to the possibility that a new and unknown Asian male was present in the garage or the possibility that the presence of cash could mean that buyers and/or sellers were still present in the garage.

165. Senior Constable Howes was present while Detective Roberts spoke to X. He heard Detective Roberts ask if any firearms were present at the location. He was particularly interested in the answer because he knew that there was a possibility that members of the Hamze or Kalache families might be present and he was aware that they may have had access to firearms. Detective Roberts told him that no firearms had been seen at the location. Senior Constable McNally recalled being told by Detective Roberts that he had spoken to X, who had left the building, and that there was an Asian guy and "another person in there" and no one else at the time X left the building (which, Senior Constable McNally estimated, was about half an hour prior to the officers entering the building). It does not appear that any of the remaining officers were told about the possible presence of at least one other person in the basement area or that the expected drugs had not been sighted, or that a large amount of cash had been sighted.

Constable Awaad attempts to warn Detective Crews

166. As described earlier, Constable Awaad, a police officer who lived in the unit block where the search was to occur, had been told of the search and provided some intelligence to Detective Crews.

167. He had asked Detective Crews to call him when the search was to occur so he could absent himself from the premises. When Constable Awaad had not heard from Detective Crews by about 8.15pm he decided to return home.

168. At around 8:30pm, he drove into the unit carpark and saw Mr. Nguyen and three other men in the garage area. One man moved a Toyota Camry sedan which was blocking entry to Constable Awaad's garage to allow the officer to park his car. The men were all standing in or in front of garage 8 at this stage. Constable Awaad tried to contact Detective Crews on his mobile phone to warn him about the presence of men in the garage. Constable Awaad could not reach Detective Crews (he could not recall if the phone went through to voicemail).

169. Constable Awaad was in partial uniform (his police pants were visible) and felt uncomfortable being present when he knew that the warrant execution could be imminent. He left the unit and drove to a nearby service station.

Approach to the search site

170. After Detective Roberts concluded the briefing with Senior Constable Mousselamani and his call with X, he explained to the assembled officers outside the station that the convoy of cars should travel to the block of units at 41-43 Cairds Avenue, Bankstown stopping briefly on Meredith St to allow Senior Constable McNally to get out and approach the unit on foot and gain access to the complex from the internal assister, Q.

171. The convoy proceeded in the following order:

- Senior Constable McNally travelled with officers Lavender, Brown and Baglin in an unmarked car;
- Detective Roberts travelled with officers Howes and Crews in another unmarked car;
- Officers Gentles and Gerogiannis (both in uniform) travelled in an unmarked car; and
- Senior Constable Mousselamani (in uniform) travelled alone in a marked car.

172. Either just before or just after the briefing at Bankstown Police Station, officers Lavender, McNally and Brown engaged in some last minute "surveillance" of the building complex which consisted of their driving in an unmarked car around the block in which the units were located and driving past the unit complex.

173. The officers did not see anything of interest during the drive-by.

Attempted execution of the search warrant

174. A little before 9:00pm Senior Constable McNally approached the unit block on foot and called Q on his mobile phone.

175. Unexpectedly, rather than buzzing him into the building remotely, Q walked from Q's unit and opened the front door to let Senior Constable McNally into the building. Senior Constable McNally was disconcerted when Q appeared in person. He did not want to risk Q's safety and was keen for Q to return to Q's unit. Q tried to give him directions but he cut Q short and urged Q to go inside. Senior Constable McNally did receive some directions to both the garage and the stairs to unit 8 from Q previously. He recalled that Q told him that garage 8 was next to the roller door entry: "*the first garage on the left as you're coming from the roller door, the last one on the right if you were to go out through the roller door*." He also recalled being told that the access stairs to unit 8 were around the wall to the right after he went downstairs. He was told that the access door was the last door along the wall if he followed it to the end and it was similar in appearance to the stairway access door for the left tower.

176. These directions were correct. However, as outlined below, they were not followed when the officers reached the basement. It is possible that Senior Constable McNally was distracted when he heard the directions because of his concerns for Q. His evidence was that he thought finding the garage and the right hand stairwell would be relatively straight forward once in the garage.

177. Once Senior Constable McNally had gained access to the building he notified the other officers. The officers drove from Meredith St and parked directly outside the unit block on Carmen St. Both officers Mousselamani and Gentles "double-parked" their vehicles in the street outside because there were insufficient parking spaces in front. Police presence outside the unit complex would have been obvious from this point.

178. There was inconsistency in the evidence about whether the officers were able to communicate through a secure radio channel dedicated to the search operation while they were in the unit block or if they relied on standard police radio and/or mobile phones. The issue is of some importance. The availability of a secure radio channel would have enabled easy communication between the officers after the shooting. In particular, it would have allowed the officers who were upstairs and/or outside the building to communicate with the officers downstairs in the garage. Prompt and effective communication between the officers after the shooting may have assisted them to locate Mr Nguyen, secure the unit and the garage area and allowed medical attention to reach Detective Crews more quickly

179. Some officers, including Senior Constable McNally, believed the only method of communication was through mobile phones or through the standard police radio channel. Senior Constable McNally believed that at one point during the warrant he had an "open" phone line to Detective Roberts.

180. Call records show a 96 second call between Detective Roberts and Senior Constable McNally at 8:58pm which suggests that there may have been such a connection, although it was not for a lengthy period.

181. Not all officers were aware of the mobile phone numbers of other officers and it is not clear if all officers carried phones or had their phones turned on.

182. Other officers, including Detective Roberts, believed that a radio channel had been allocated to the group for the evening. In particular, Senior Constable Gerogiannis recalled the number of the radio channel (which he recorded in his police notebook shortly after the events) and remembered hearing that Senior Constable McNally had gained access to the building on that channel while he waited in a car on Meredith St with Senior Constable Gentles. However, Senior Constable Gerogiannis was unable to say if the radio channel was only available in the cars or if it was also accessible on the portable radios carried by the officers.

183. As the call records confirm that Senior Constable McNally communicated with Detective Roberts by mobile phone, it appears unlikely that there was a dedicated radio channel available on the officers' portable radios.

184. It is apparent that there was no clear understanding as to how officers at different locations could effectively communicate with each other.

185. The search party exited their cars and quickly approached the unit complex. Senior Constable McNally stood at the door holding it open. The procession of all of the officers into the building became disorganised, because two of the officers, Lavender and Brown, left the search party to chase after a man they saw standing on the corner of Carmen Street and Cairds Avenue, whom they suspected might have been a lookout, or "cockatoo", for the persons involved in the drug deal in the garage.

186. Senior Constable Lavender stated that he yelled "*Police, just wait there a minute*" and caught up with the man at the corner of Carmen Street and Cairds Avenue. He was young, of Indian/sub-continental appearance and seemed surprised to be stopped by the police. Senior Constable Lavender decided that the man was unconnected to the search target and asked the man to leave the area.

187. Senior Constable Lavender returned quickly to join the search party. On the other hand, Senior Constable Brown appeared to believe that the man was a cockatoo associated with the search target and said he shouted "*the balloon is up*" to alert the other officers as he ran towards the door.

188. Many of the officers who gave evidence did not recall hearing any shouting and some said that they were unaware of the chase. On the other hand, Detective Roberts stated that he heard yelling, assumed it would have been heard in the garage area and determined it was necessary to enter the building quickly before any evidence was destroyed.

189. As a result of the chase, the upstairs team of officers Baglin and Brown lost contact with Senior Constable McNally, who was to lead them to unit 8 and each of the officers who was wearing a uniform ended up at the back of the group. Officers Roberts, Crews, Howes, Lavender, McNally, Gerogiannis, Gentles and Mousselamani went downstairs into the basement garage area. Senior Constable McNally held open the door until Senior Constable Gentles took over to allow him to join the officers at the front of the search party. When Senior Constable Brown returned from chasing the man at the intersection, he and Constable Baglin entered the building and went straight upstairs to try and secure unit 8 although, as previously explained, unit 8 was on the other side of the unit block.

Events in the basement

190. From this point in time, the tragic set of circumstances that led to the death of Detective Crews unfolded very quickly. All those involved have given detailed and multiple accounts of the relevant events. The accounts are not consistent, but that is not surprising, given the speed at which the events occurred and the extremely traumatic circumstances involved.

191. The officers allocated the task of securing the garage were led downstairs into the basement garage area by Detective Roberts. He was followed into the basement garage area by officers Crews, Howes, McNally and Lavender (although the order of entry into the garage is not entirely clear).

192. All of these officers at the front of the search party were in plain casual clothes. It appears from the video of the search warrant that none of these officers were displaying any visible identification as police officers.

193. Detective Roberts was carrying a cylindrical metal battering ram which he held in both hands. Detective Crews was carrying a red A4 sized notebook which contained the search warrant and occupier's notice.

194. Senior Constable Gerogiannis followed behind, operating the video camera. It appears that he was followed by the other uniformed officers, Senior Constable Gentles and Senior Constable Mousselamani.

195. The target location of the search was the garage associated with unit number 8. As described, correctly, in the search warrant application, this was directly adjacent to the main roller door driveway entry into the garage area.

196. The garage door was closed. After the search party went through the door into the basement area, they should have turned right, immediately out of the stairwell doorway, and then left, towards garage number 8. Unfortunately, Senior Constable McNally directed the search party to turn right, then right again.

197. Senior Constable McNally became disoriented when he entered the garage. He saw that the door to garage 8 was closed, with the lights off, and the door to garage 1 was open, with the lights on. At the time, he did not identify the numbers displayed on the respective garages. A car was parked outside garage 1. Senior Constable McNally recalled that X had told him that the target parked a car across his garage door.

198. He thought there might be another roller door adjacent to the open garage. He directed the officers towards the open garage.

199. By unlikely coincidence, the target of the search, Philip Nguyen, was in garage 1. Mr Nguyen had been involved in a drug deal that evening, in circumstances that appear to have been fairly consistent with the information initially provided to police by X.

200. That drug deal had involved a number of other persons, some of whom were still in the basement when the search party entered the basement. Tan Chung was inside garage 1 with Philip Nguyen when police advanced.

201. Three other persons who, it appears, were also involved in the drug deal, were inside garage 8, behind a closed internal roller door. It is likely that it was these men whom Constable Awaad had noticed when he drove into the garage area. It later transpired that one of those three persons had a firearm, which subsequent investigation confirmed had not been fired in the basement area that evening.

202. Philip Nguyen and Tan Chung had gone into garage 1 to use drugs. They had both consumed drugs earlier that evening, although it is not clear how affected they were by the drugs. As the officers approached garage 1, Tan Chung was preparing to smoke drugs on a table towards the back of the garage. He asked that Mr Nguyen get an implement to prepare the drugs (either a spoon or a smoking straw) from garage 8 and Mr Nguyen began to exit the garage to do that.

203. Mr Nguyen had a gun in the waist band of his trousers. He had obtained the gun shortly after the incident approximately two weeks earlier when he was attacked by two men wearing balaclavas.

204. As they approached the open door to garage number 1, officers Crews and Roberts were confronted by Philip Nguyen emerging from the garage.

205. Mr Nguyen drew his gun when he saw the two men. Detective Crews shouted something to the effect of "*gun*".

206. The sound and vision captured by Senior Constable Gerogiannis records garbled shouting immediately before and after the shooting. Some of the officers say they were announcing themselves as police officers and directing Mr Nguyen to drop his weapon. Five gunshots were fired in quick succession. There is inconsistency between the witnesses about the movements of Philip Nguyen immediately before and during the shooting. Detective Roberts recalled Mr Nguyen coming well outside the garage and crouching and moving forward until he was very close to Detective Crews near the Toyota Camry.

207. Mr Nguyen stated that he fired one shot outside the garage and immediately retreated back inside. Officers Lavender, McNally and Howes all gave different accounts about where Mr Nguyen was located but none recalled him coming as far out of the garage as described by Detective Roberts.

208. I accept that it is not possible to reconcile this evidence or choose one particular account. The situation was moving extremely quickly and dynamically and all of the witnesses were facing a tremendous amount of stress, and viewing events from different perspectives.

209. There is no clear or reliable account of the specific movements of Mr Nguyen shortly before, during and after the shooting. I am, however, satisfied that when Detective Roberts fired at him, Mr Nguyen was outside garage 1.

210. There was shouting from several persons immediately before the shots were fired, and directly after the shots were fired. The evidence as to what words were used and, in particular, whether "*search warrant*" or "*police/police don't move*" was shouted before or after the shots is not consistent. Mr Nguyen said he heard shouting but it was after he fired his shot and he could not understand what was said. It is certainly possible his evidence on this point is self-serving but there is no clear basis to reject it, particularly as Detective Roberts gained the impression that Mr Nguyen could not hear him. Yelling and shouting is audible on the search warrant video before and after shots were fired. However, the words cannot be clearly deciphered. A number of the officers believed that words to the effect of "*police search warrant*" were shouted prior to the shooting. None of the residents of the unit complex who were interviewed by police recounted hearing those words, nor did the men in garage 8, Mr Nguyen or Mr Chung (although all heard shouting).

211. It is not possible to determine with confidence whether these words were shouted and if so, at what point. Both officers Roberts and Howes, who did believe the words were shouted, fairly conceded that they could not be sure. In my view, it is more likely that nothing was said until the officers saw Mr Nguyen emerging from the garage holding a gun.

212. Whatever words were shouted at that time cannot be deciphered clearly on the video footage, and it is likely that they would have been difficult to understand and, therefore, of little effect.

213. The first shot was fired by Philip Nguyen. This bullet hit Detective Crews in the soft tissue of his upper left arm. Four shots were then fired from police firearms, being the .40 calibre Glock pistol issued to each of the officers involved in the search.

214. The order in which these four shots were fired is not entirely clear but it is likely that the first three of these four shots were fired by Detective Crews. These shots were generally directed towards Philip Nguyen and into garage 1. Ballistics evidence suggests that Detective Crews was facing towards the back of the garage as he fired the shots. No person was hit by any of the shots fired by Detective Crews.

215. The remaining shot was fired by Detective Roberts. He fired this shot while retreating, with the intention of defending himself and Detective Crews. Detective Roberts participated in a field interview on site at the garage shortly after the shooting. While there is no doubt he was still profoundly affected by the stress of the events, his account in the interview appears to be his most reliable account of the events in question:

> *He was walking out and he was ignoring our directions so it was like he almost couldn't hear us... And then I saw and heard a gunshot and I think I ducked down or hit the ground or something. I looked for cover, and there was more gunshots, I could see the flashes. Like, by this stage, I can't remember where I dropped the..., I'm sure by this stage I had a battering ram but I can't remember where I dropped it. But the next thing I had my gun out and when the firing started I heard a gunshot, I aimed at the, it was an Asian male who had come out. And I wasn't aware of what, I didn't stand in a well-aimed shot. I was trying to get cover and I think I just wanted to get low, I may have even hit the deck. I can't recall properly but he was shooting and I fired a shot in return. There were other shots, I can't remember the sequence. I'm pretty sure he fired his shot first. There were other shots fired and as I fired a shot, I could see other police behind me and I took cover behind this wall.*

216. Detective Roberts is adamant he was facing Mr Nguyen and aiming at him when he fired. However, he acknowledges he dropped the battering ram he had been carrying, drew his gun, took aim and fired while at the same time he dropped towards the ground, perhaps with one hand on the ground and turning towards his left.

217. Tragically, the shot fired by Detective Roberts was the shot that killed Detective Crews. The bullet first hit Detective Crews on the right shoulder, and then caused fatal injuries after entering into his neck. In evidence at the inquest, Detective Roberts confirmed that he fired the shot intentionally. Much later in the hearing, the defensive tactics specialist, Senior Sergeant Davis, gave evidence that he believed the shot fired by Detective Roberts may have been accidental. While that opinion is noted, the evidence of Detective Roberts in this regard was unchallenged, and there is no evidence before the court to directly contradict the account of Detective Roberts. Moreover, Detective Roberts has given evidence on this particular topic on several occasions and his evidence has consistently been to the effect that he fired the shot intentionally, in an attempt to defend Detective Crews and himself. I readily accept that he was entitled to fire in an attempt to protect himself and Detective Crews from Mr Nguyen.

218. However, in hindsight, it is apparent that he was not sufficiently steady when he fired and while he fired in the general direction of Mr Nguyen, that person was close to Detective Crews who, tragically, was hit by mistake.

219. Immediately after shots were fired, the involved police officers retreated to take cover behind the corner wall of the garage. At around this time, Philip Nguyen picked up the battering ram that had been carried by Detective Roberts, and placed it onto his shoulder.

220. Mr Nguyen then tried to fire the battering ram because he believed that it was some sort of bazooka or “big gun”.

221. Philip Nguyen threw the battering ram aside and called out to Tan Chung to follow him, stating that they were being robbed. He also told Mr Chung that his gun had jammed. Mr Chung had been hiding under a table towards the rear of the garage since the first shots were fired.

222. Mr Nguyen and Mr Chung ran through the access door that led upstairs to the right hand side of the complex where unit 8 was located. As they escaped, Mr Chung saw Detective Crews lying on the floor of the garage.

223. From his first interview Mr Nguyen has consistently said he believed the plain clothes officers were robbers, and not police officers. He said that two to three weeks before the shooting he had been the victim of a robbery, at garage number eight. In that context, he said that the men who suddenly confronted him when he emerged from the garage on the evening of 8 September 2010 were also robbers. He maintained that this was his belief even though, by his own admission, after the shooting Tan Chung had said *“No, it’s the police”*. In support of his belief that the men were robbers, Philip Nguyen referred to his previous experience, in 2005, when a search warrant was executed at his home by uniformed police accompanied by plain clothes officers.

224. He contrasted this previous experience of a search warrant with what he saw on the evening of 8 September 2010:

> *Yeah, because, you know, the police, you know, will come in with the, wearing with the police uniform, but this one only normal, you know normal jacket or…T shirt and short, you know, so I don't think so they are police.*

225. In several important respects, Mr Nguyen's evidence on this topic is independently corroborated:

- It has been established that Mr Nguyen was the victim of an attack around two weeks before the execution of the search warrant on 8 September 2010. This has been confirmed by admissions directly from one of those involved in the attack.
- The evidence of Tan Chung corroborates Mr Nguyen's account in that he confirms that Mr Nguyen said that he believed the approaching men were robbers. He gave evidence that after they had retreated to unit number 8, and heard the helicopter, Philip Nguyen said "Good, police come and save us".
- This is consistent with the transcript of the 000 call made by Philip Nguyen's stepson, Duy ('Jimmy') Nguyen, from inside unit number 8, seeking police protection from robbers who had broken into the garage. The transcript also refers to the robbers yelling, at the time of the call, from the garage, although what they were saying could not be understood. This was probably the shouting of police officers in the garage area whilst taking cover, before they considered that it was safe to render aid to Detective Crews.
- The transcript confirms that Mr Nguyen was present in the unit (from at least 9:10pm) when the 000 call was being made.
- Mr Nguyen's evidence that the men he saw approaching the garage were not identifiable as police officers is supported by the video of the execution of the search warrant which shows them wearing dark casual trousers and sweat shirts or jumpers quite different from the usual dress of even plain clothes officers. None of the officers who were seen by Mr Nguyen were wearing anything that would have made it apparent they were police officers.
- The recent robbery in similar circumstances explains his acquisition of a gun and his attempts to install a surveillance camera in his garage. These steps confirm that he was frightened by the previous robbery and feared another robbery in future. Such fear was rational and was based upon his understanding that his involvement in drug dealing provided a motive for robbers who wanted to steal drugs and/or cash.

- Mr Nguyen's evidence that he did not hear the officers identify themselves by shouting "police" is credible - whatever words were shouted would have been difficult to understand, especially by somebody whose English is as poor as Mr Nguyen's.

226. In all of the circumstances, I accept Mr Nguyen's evidence that he fired the first shot because he believed the approaching men were robbers, and not police officers. As he put it at the conclusion of his oral evidence:

Don't remember exactly but I am sure that I would not have fired the gun had I known they were police.

After the shooting

Events in the basement

227. The other officers quickly became aware that Detective Crews had been shot and was seriously injured. Officers McNally and Howes observed Detective Crews lying on the garage floor with a pool of blood forming around his head.

228. Almost immediately, Detective Roberts suspected that his bullet had injured Detective Crews and he became very distressed.

229. It is not clear why he formed that opinion. In his first statement, Detective Roberts recalled that he saw Detective Crews bleeding from the head on the ground after he fired a shot and was looking for cover.

230. This suggests that he saw Detective Crews on the ground very shortly after he fired. In evidence, however, Detective Roberts said that he did not see Detective Crews fall after he fired his shot and retreated for cover. He said that he began to believe he might have shot Detective Crews after he sought cover because he did not see Mr Nguyen on the ground or any blood to indicate that Mr Nguyen had been hit by the shot he had fired.

231. For approximately 19-21 minutes the police officers remained behind cover, under the mistaken belief that the person who had fired shots was still in garage 1, and was likely to shoot again if approached. Under that mistaken belief, the officers determined that they could not attend to Detective Crews, without placing themselves and their colleagues in further danger. Detective Roberts, as the field supervisor in relation to the execution of the search warrant, told the other officers, *"We can't go in, we can't risk another one of us getting shot"*.

232. Senior Sergeant Davis gave evidence during the later stages of the inquest that, in his opinion, the involved officers should nevertheless have advanced to retrieve Detective Crews after they became aware that he had been shot.

233. This opinion was not mentioned in either of his statements or his WorkCover interview and only emerged late in the oral evidence of Senior Sergeant Davis. As such, this opinion was not put to the involved officers, who had all given evidence earlier in the proceedings.

234. In the circumstances which prevailed I do not consider it would be fair to criticise the officers for not advancing when they reasonably believed that to do so would expose them to the shooter they believed to be still in the garage.

235. Ambulance officers first arrived outside the unit complex at about 9:09pm and were unable to treat Detective Crews until they were told the area had been cleared about 15 minutes later.

236. Some of the events were captured on video taken by Senior Constable Gerogiannis. The speed at which events unfolded, and shots were fired, is better understood on viewing that footage. The video does not show the shooting, but it does record the immediate aftermath. The extreme distress being experienced by all officers and, in particular, Detective Roberts, is also obvious.

237. Understandably, the versions of the various officers as to what happened after the shooting are inconsistent. However, the following approximate sequence of events seems most likely:

- The officers repeatedly called out from behind the corner wall for the offender to surrender and come out, shouting that their colleague was injured and they wished to go to his aid.
- Officers Mousselamani and Gentles both used their police radio to call for assistance almost immediately. Senior Constable Mousselamani made the first call, stating "*Bankstown one three, urgent, urgent, shots fired in Cairds Avenue, Bankstown, shots fired, shots fired*". He continued the call as he ran upstairs.
- Senior Constable Mousselamani ran to get a ballistic vest from his car, the plates on the vest fell out when he tried to put it on and he threw the vest aside. He made another call on his radio as he was returning to the scene.
- Senior Constable Lavender called out for more ballistic vests.
- Detective Roberts asked Senior Constable Gerogiannis "*did you catch that on film?*" and they discussed if he caught the shots being fired on the video camera.
- Senior Constable Howes also went upstairs to obtain ballistic vests from his car and returned, handing them to officers Roberts and Lavender.

- Senior Constable Gentles ran upstairs to his car and retrieved two ballistic vests and returned to the garage. As the officers continued to take cover and call for the offender to surrender, officers McNally and Roberts instructed the officers behind them to put their guns away.
- Detective Roberts told Senior Constable Gerogiannis to stop filming stating "*turn it off*" and "*don't, don't worry about that, don't worry about that, worry about yourself mate*". Senior Constable Gerogiannis redirected the camera but continued filming.
- Detective Roberts again told Senior Constable Gerogiannis to stop filming and the video was stopped. Senior Constable Gentles or Senior Constable Mousselamani instructed Senior Constable Gerogiannis to keep filming and the camera was turned back on.
- Detective Roberts called Detective Inspector Ryan at 9:08pm. The search warrant video records him saying "*…he was right next to Crewsy firing shots mate… I don't know who shot him mate, if it was me or him…I fired back, he was firing at me. He was firing at Crewsy, I fired back yep*".
- Shortly after the call to Detective Inspector Ryan, Detective Roberts again instructed Senior Constable Gerogiannis to stop filming and to go upstairs. Senior Constable Gerogiannis turned the camera off and went upstairs and was then told by another officer to commence a crime scene log. He began recording everyone who entered the area in his notebook.
- Detective Roberts made a call to X at 9.12pm. It is not clear what was said during this call.

Events upstairs

238. The unit team, officers Baglin and Brown, heard the shots while they were still upstairs in the left tower. The officers had deduced from the numbers on the apartments that unit 8 was not on the left side and were on their way downstairs when they heard shots and shouting from the basement. Instead of going down to the basement they ran outside and turned left towards the right tower. Constable Baglin threw away his battering ram and Senior Constable Brown discarded his police radio.

239. Somewhere outside the complex, Constable Baglin crossed paths with Senior Constable Mousselamani who was on the police radio stating "*shots fired, shots fired*".

240. He asked Constable Baglin for the exact location but Constable Baglin could not recall. It does not appear that the officers had any further exchange about what had occurred in the garage. Senior Constable Mousselamani may also have said something to the effect of "*an officer is down*".

241. Officers Baglin and Brown gained entry to the right side of the building by shouting until a resident let them in. They must have just missed crossing paths with Mr Chung and Mr Nguyen as they fled upstairs from the basement. Both officers could hear shouting from the garage below including words to the effect of "*come out*" and "*give yourself up*". They formed the view that the offender responsible for the shots must still be in the garage. They saw that the door to the basement was held open by a piece of rope. Constable Baglin descended the stairs and was able to see an officer lying on the ground and a battering ram. Constable Baglin did not identify himself in case the offender remained in the garage. He drew his firearm and assumed a position at the top of the stairs to cover the stairs.

242. Senior Constable Brown did not stay in the right hand tower, but moved to various locations. At one point he went back to the left side of the complex and down the stairs to the garage and saw the officers shouting frantically for the offender to surrender so they could assist their wounded colleague. Senior Constable Brown assumed that the offender must still be in the garage. It did not occur to him to mention to the officers in the basement that there were stairs from the basement on the right side going up to unit 8.

243. At some stage, Senior Constable Brown walked past the right side of the building and turned left into Cairds Avenue where a number of unit balconies faced onto the street. He shone his torch on one balcony and saw an Asian man, about 50 years of age, out on the balcony. Senior Constable Brown told the man to return inside and the man complied. A female police officer joined Senior Constable Brown and they observed the Asian male come out on the balcony again.

244. The Asian male said something that Senior Constable Brown could not understand. The officers shouted to him to return inside again and the man complied.

245. At some other time, Senior Constable Brown went up the stairs to the door outside unit 8. He heard a man's voice. He did not assume that the man was necessarily the offender but he knew that only Mr Nguyen's wife and children were expected to be in unit 8. He decided against entering.

The responding officers

246. Numerous police officers responded to the calls for assistance over the police radio network. The first responding officers arrived shortly after 9:00pm, some before Detective Roberts made his call to Detective Inspector Ryan at 9:08pm. The ambulance officers arrived outside the unit block at about 9:09pm. The early response was affected by some confusion and agitation, particularly in relation to how police and ambulance officers could approach Detective Crews to render assistance while the offender was still at large. Some police officers were determined to enter to rescue Detective Crews despite the danger.

247. Others wanted to wait for other officers or for a specialist group. Sergeant David Laird arrived and established a command post and perimeter. He told Senior Constable Mousselamani that it would take about 40 minutes for the Tactical Operations Unit to arrive.

248. Senior Constable David Wynne, a member of the Dog Squad, was one of the first officers to arrive. He was with his police dog, Able. He entered the basement and saw the officers at the corner wall calling out to the offender to surrender. Senior Constable Wynne assumed that the offender was still in the garage area. Senior Constable Lavender and another officer, Philip Taylor, asked about using the dog but officer Wynne decided against deploying Able to attempt to locate the offender. He explained in his evidence that he was concerned about the risk to a number of people inside and outside the garage (including Detective Crews on the floor) if he deployed Able. There was no effective way of ensuring Able could use scent to identify the offender rather than the others present.

249. There is no basis for criticism of Senior Constable Wynne for this decision. He was a candid witness with special expertise in the use of police dogs. His decision not to deploy Able was based on concern for the safety of those present, and the potential for the dog to get in the way, rather than any decision to put his dog's safety ahead of the critical need to assist Detective Crews.

250. At around the same time, a number of officers from the South West Metropolitan Area command entered the right side of the building, including officers Robinson, Alderman and Crematy.

251. These officers heard the yelling in the basement. They cautiously approached the downstairs area, passing Constable Baglin who was still covering the top of the basement exit stairs with his firearm. Senior Constable Robinson yelled out to identify himself as a police officer and extended his uniformed arm out the door and around the corner so that the police could see that he was a police officer. One officer Robinson emerged, it quickly became apparent to the police in the basement that the offender must have left the area.

252. Shortly afterwards, at about 9:22pm, the area was cleared and the officers were able to reach Detective Crews. Senior Constable Wynne handed Able to Senior Constable Lavender while Senior Constable Wynne and another officer, Senior Constable Wills, attempted to assist Detective Crews.

253. Ambulance officers took over within minutes, at about 9:24pm. Dr Joanna Irons arrived at the location of Detective Crews at about 9:27pm and took over patient care.

Unit 8

254. During this period, Philip Nguyen and Tan Chung were hiding in unit number 8, together with Mr Nguyen's wife, stepson and stepdaughter. The family had heard shooting and screaming. Mr Nguyen's stepson called 000 call for help in relation to what he believed was an attack downstairs. Mr Nguyen's stepson overheard Mr Nguyen tell his wife words to the effect that "*I shot someone who was breaking into garage, I think I killed him*". While Mr Nguyen was in the unit he unsuccessfully tried to flush his gun and ammunition down the toilet. The gun was later located concealed in a hot water unit on the outside balcony.

255. Later that evening, Philip Nguyen and Tan Chung came out of unit number 8, following dealings with a police negotiator, and were arrested. The three other persons involved in the drug deal, who had been inside garage 8, were also arrested. A pistol was later discovered partially concealed under the cushions of a chair in garage 8.

Treatment of Detective Crews

256. Detective Crews was taken to Liverpool Hospital suffering a transection of his internal jugular vein and severe damage to the common and external and internal carotid artery and to the vertebral artery. Despite aggressive medical intervention including emergency surgery, he was declared deceased at 12.13am on 9 September 2010.

257. An expert report by emergency physician Dr John Vinen was tendered in the inquest. Dr Vinen concluded that Detective Crews could not have survived his injuries. It is likely that Detective Crews lost consciousness immediately after the second time he was shot. I accept Dr Vinen's opinion that the delay in commencing treatment was highly unlikely to have made any difference to the prospects of Detective Crews' survival.

The critical incident investigation

258. The death of Detective Crews was investigated by a team led by Detective Inspector Mick Sheehy, in a manner consistent with NSW Police Force guidelines on the investigation of critical incidents. Pursuant to those protocols, the team was comprised of senior officers from the Homicide Squad of NSW State Crime Command.

259. The involved officers' weapons were taken for inspection and it was confirmed that only Detective Roberts had fired a shot. The other officers were tested for gunshot residue. Each underwent drug and alcohol testing. No illicit substances were detected.

260. The investigators took steps to separate the involved officers to prevent contamination of their evidence. The officers were offered counselling and appear to have been treated compassionately. Most of the involved officers gave statements on the night, with the exception of Senior Constable Mousselamani who was too distressed to participate. He provided a short account to investigators that night which was recorded in an investigator's note, which he later adopted.

Conclusions

261. There is no doubt William Crews was a much loved member of a close and supportive family. His sudden violent death was a terrible setback that they will continue to suffer indefinitely. I offer them my deep sympathy.

262. Detective Constable Crews was warmly regarded and admired by his colleagues as a hard worker and a team player - a good bloke and a good cop. He was committed to learning his new role as a detective in a challenging and complex setting. Clearly, he had a promising future as a police officer.

263. The police force and the public its members protect have therefore also suffered a significant loss with his passing.

264. The Middle Eastern Organised Crime Squad was dedicated to responding to an identified and growing threat to public safety. Its members bore that responsibility bravely: they proactively sought out and confronted dangerous criminals using traditional policing approaches such as cultivating criminal informants which they combined with more sophisticated strategies such as intelligence analysis to generate priority targets. The operation in which Detective Constable Crews was killed was an example of that methodology in practice.

265. The tactical operations MEOCS members engage in are intrinsically dangerous: they frequently involve engaging with violent criminals in volatile, unpredictable settings. There *are* other dangerous vocations: for example, too many truck drivers, miners and professional fisherman lose their lives at work. But police officers *intentionally* go into dangerous situations, putting themselves at risk to make the rest of us safer. It is essential therefore that whenever possible their activities are planned and controlled.

266. If mistakes are made their causes should be analysed so that they are not repeated.

267. Critiquing the planning and execution of the raid in which Detective Constable Crews died may to some seem harsh or even unfair on those involved. However, Bill Crews' family are entitled to know if his death could have been avoided. Further, the officers who will be required to be involved in similar tasks in future are entitled to expect that if mistakes were made, lessons have been learnt and improvements have been implemented. It is for those reasons this inquest has carefully scrutinised what happened in the hours and minutes before and after Detective Constable Crews was shot.

268. Based on the evidence put before the inquest, I can readily conclude the premises in Cairds Avenue warranted MEOCS' attention: the activities that were occurring there fell within the terms of reference of the task force. However, in my view there are bases for concern about aspects of the planning and execution of the operational response to the information received.

269. There is no suggestion that these mistakes were the result of callous indifference, or a wilful disregarding of police policy and procedures. However, there were errors in planning and execution that seem to have flowed from systemic problems with policies, inadequate training, ineffective supervision, insufficient attention to detail and regard to safety. Sadly, it seems likely that had these errors not occurred Bill Crews may not have died. It is incumbent on the NSWPF to ensure these mistakes are not repeated.

Pre-execution phase

Intelligence gathering and reconnaissance

270. In my view, the risk assessment of the operation was informed by inadequate intelligence gathering and reconnaissance. This process was marred by missed opportunities to gather significant information concerning the target of the search warrant and the layout of the premises.

271. To merely drive by the premises and stop briefly outside when two inhabitants of the unit block were willing and able to facilitate access to the basement was unwise and unnecessarily scant. Entry to the basement could have been effected in a manner that would not have alerted the persons of interest to the presence of police. This would have eliminated the confusion about the design of the basement that led to the search team attending the wrong garage and being confused about exit points from the area. The indication on the operational orders that "*surveillance conducted at premises*" also appears to have misled the supervising officers, who assumed that there had been or would be officers conducting physical surveillance of those premises.

272. For the reasons I have detailed in the summary of the evidence, I have concluded that when officers Roberts and McNally spoke to the registered informant X early in the afternoon on the day of the raid and Senior Constable McNally made a note "Gun + cash", he did so because X had told them there was or may be a gun at the premises. Both officers resisted the conclusion that they had been informed of the presence of the gun, in part by saying had that occurred they would not have undertaken the search without the assistance of specialists such as the Tactical Operations Unit. In my view they did not do that because they believed they could negate the risk by making continuing inquiries with X. I accept the submission made by various parties that if Detective Senior Constable Roberts had been told there may have been a gun at the premises he would not have ignored that. Indeed, he didn't. He sought to negate the risk by persistently quizzing X whenever he spoke to him throughout the rest of the day as to whether he had seen a gun, but this approach was flawed, based as it was on X necessarily knowing or seeing a gun if Mr. Nguyen had one.

273. In view of the initial advice about the possibility of firearms being present and, having regard to the activities thought to be occurring at the unit block, and the involvement of members of organised crime families, the likelihood of the MEOCS members meeting armed resistance should have been given greater weight.

274. The shortcomings in the pre-execution phase appear to have been driven, at least in part, by the perceived urgency to *"strike while the iron's hot"* after Detective Roberts was informed that the target was expected to receive 6 ounces of cocaine some time that afternoon or evening.

275. The independent policing expert who gave evidence, Dr Raymond Shuey, said that *"the imperative to undertake the search warrant at the time of the deal was not fully rationalised"* and the time imperative resulted in some issues not being addressed as carefully as they may otherwise have been. I accept that opinion.

Risk assessment

276. The risk assessment process that informed the operational order was critically compromised by Senior Constable McNally's lack of understanding of its basic concepts; the failure of he or Detective Roberts to identify some of the likely risks; and the inadequacy of the supervision by senior officers responsible for oversighting the process.

277. Officer McNally did not appreciate the difference between the likelihood of a risk eventuating and the gravity of the potential harm if it did. Because he concluded there was a low likelihood of any of the risks he identified as eventuating, he concluded the seriousness of their consequences was also low.

278. This mistake was obvious from the risk matrix he completed.

279. It is of concern that according to Senior Constable McNally he completed the risk assessment matrix in this case in the same way as he had done a number of others in the past and the same way he had done exercises at training programs and he had not been corrected.

280. I also accept the evidence of Dr Shuey that the circumstances of this case brought into play other risks that do not seem to have been considered. For example, the risk that a drug deal could be in progress, with potentially violent and armed Middle Eastern criminals present, when police approached the target garage. This was in circumstances where the officers had a paucity of information concerning the targeted Asian male. According to Dr Shuey conducting a search at or around the time of a drug deal is *"fraught with danger"* given the heightened level of awareness of those involved.

281. Conversely, I accept that through no fault of the search team members they did not know about an attempted robbery of Mr. Nguyen a couple of weeks before. As will become clear, that undoubtedly made the search more dangerous.

Supervision

282. It is concerning that neither Detective Roberts nor any of the more senior officers who reviewed the operational orders detected what was an obvious error in the way the consequences of the risks listed had been categorised.

283. The operational orders were approved by Detective Inspector Ryan and Detective Superintendent Wallace, although Detective Inspector Ryan did not view them. However, he said he agreed with the overall low risk assessment and approved the orders during a series of phone calls with Detective Roberts. His approval appears to have been given on the basis of an incorrect assumption as to the level of surveillance being conducted at the premises.

284. The approval by Detective Inspector Ryan also appears to have been given without proper scrutiny of the details of the proposed execution of the warrant and without proper consideration as to the potential risks involved. He sought to downplay the risks arising from the drug deal that was expected to occur at the subject premises that night involving Middle Eastern criminal identities by suggesting that the Asian male target was less likely to be a risk because Asians tend to be businessmen who are less likely to possess weapons or attack police. He also asserted that one of the other suspected criminal entities, the Kalache family was a "spent force", and noted that the Asian male lived with his family.

285. I am not persuaded that this was a reasonable assessment.

286. In submissions made on the former inspector's behalf it is correctly asserted that he was off duty when the orders were settled and he could not view them as his mobile device had been withdrawn. Further, he was led to believe that further surveillance was taking place and he was aware that X would be in the premises around the time the warrant was to be executed.

287. These factors led him to believe the risks could be adequately managed.

288. His submissions also take issue with the assertion of counsel assisting that senior officers imposed time pressures on the job. He may be right, but equally there is no evidence that the senior officers who overviewed the job sought to caution against rushing or insisted the search be postponed until all relevant intelligence could be gathered. They did nothing to rein in the unnecessary haste with which the job was being approached.

289. In submissions made on behalf of former Inspector Ryan and Superintendent Wallace it is suggested there was little likelihood of any Middle Eastern organised criminals being present when the warrant was to be executed because Mr. Nguyen was supposed to be buying not selling drugs that night. I am of the view little weight could be given to the particulars of the expected transactions. He was buying and selling drugs in sizable quantities to and from various other criminals. It was a volatile, unpredictable and potentially dangerous situation.

290. Detective Superintendent Wallace reviewed the operational orders and risk assessment on her Blackberry from home that evening. Her evidence was that she was satisfied with the content of the orders and the overall risk rating assessment. She said that she noted that the "consequence" section of the risk assessment matrix had been filled out incorrectly but that, in assessing the overall risk rating herself, she effectively by-passed the risk matrix and formed her own view as to overall risk based on her own experience and judgement.

291. Detective Superintendent Wallace was unaware of some relevant information but said that her assessment would not have changed if she had been, given the ability to mitigate the associated risks by the ongoing presence of the source providing timely information to the search warrant party. This, however, depended entirely upon the reliability of the source, and X's continued presence at the scene right up to the time that the search warrant was executed. It was an unwarranted assumption that diminished the protective effects scrutiny by a senior officer should afford.

292. Detective Superintendent Wallace did not convey her approval to the search warrant team because her work mobile phone's battery was discharged but she asserted it was understood by the search party that, in the absence of any order from her to the contrary, they were to proceed with the search. This seems somewhat lax in my view.

293. The operational orders were also sent to then Detective Chief Superintendent Lanyon, Acting Director of the Organised Crime Directorate. He explained that his role was not to examine the minutiae of the operation and that he was not required to approve the operational orders as such, but that he was provided the orders to confirm that the operation fell within the MEOCS charter and that the execution of the warrant was appropriate to the background as disclosed on the operational orders. As with Detective Superintendent Wallace, Mr. Lanyon was not aware of a number of areas of relevant information.

294. Unlike Ms Wallace, Detective Chief Superintendent Lanyon said that this additional information, if known to him, would have invoked *"a number of questions"* which he would have put to Detective Superintendent Wallace. He agreed that, in light of this additional information, the background, reliability and possible motivation of the source assumed greater significance and that he would have ensured that he was satisfied that appropriate steps had been taken to explore these before allowing the operation to continue.

295. The lack of rigorous scrutiny applied during the review and supervision process enabled the errors in the initial risk assessment process to pass without thorough critical assessment or correction. In my view these were shortcomings in the supervision and review of the operation by both former Detective Inspector Ryan and Detective Superintendent Wallace. They did not value add; they did not adequately fulfil their supervisory roles, in my view.

Briefing

296. It is apparent when the search party arrived at the Cairds Avenue premises, there was some confusion about the route the upstairs search team were to take to access unit 8. Senior Constable McNally knew they had to go down stairs into the basement garage from the left hand tower to access the internal stairway to unit 8 in the right hand tower, but none of the other officers recalled him telling them that during the briefing. The two tasked with searching that unit with Senior Constable McNally, officers Brown and Baglin, acknowledged they had a poor recollection of the briefing and conceded it was possible the route had been described during the briefing as claimed by Senior Constable McNally. Doubt is cast on his version by the actions of those other two upstairs searchers: they both ran upstairs in the left hand tower after they had lost contact with Senior Constable McNally outside the unit block. Senior Constable McNally was by this stage in the basement, no doubt expecting officers Brown and Baglin to follow him. It may be that because he was tasked to lead the search of the unit upstairs Senior Constable McNally did not feel the need to stress the somewhat convoluted route to it.

297. It is submitted on behalf of Senior Constable McNally that the failure of any of the officers to recall his detailing the access route to unit 8 and the mistaken approach taken by officers Brown and Baglin should not lead to a rejection of Senior Constable McNally's claim that he outlined the correct route in the briefing. However, in my view that submission overlooks the significance of the operational orders drafted by Senior Constable McNally which relevantly said: "*Once entry has been gained via the front security door, S/Cst Brown, S/Cnst McNally and Cst Baglin go up to level one to unit number 8 and will knock on the door.*" Copies of the order were circulated among the group and looked at during the briefing. It seems very likely that had Senior Constable McNally briefed the group on the route to be taken to unit 8, the conflict with his oral version and what was stated in the orders would have been noted and commented on with words to the effect: *"I know the operational order says just go through the door and straight upstairs but in fact... etc"*.

298. If that had occurred, it is highly unlikely no one would have remembered it or acted on it, in my view.

299. I conclude Senior Constable McNally failed to alert the group to the error in the operational orders and failed to alert the upstairs search team of the need to descend into the basement in order to access unit 8 in the right hand tower.

Attempted execution of search warrant

300. A number of mistakes were also made during the execution of the search warrant which compromised officer safety.

Confusion as to location

301. Senior Constable McNally admits he became confused about the location of the garage intended to be searched when he led the search party into the basement. When speaking to Q on the phone earlier in the day it was described as being adjacent to the roller door. He also received hurried directions when Q met him at the ground floor door to let him into the building. In his haste on entering the basement he made an error as to the location of the target garage. That was understandable: garage 8 was in darkness while another garage, number 1, was lit, open and had a car parked outside it. The search party were drawn to it. However, it's hard to avoid the conclusion that had the officers undertaking the operation made full use of all information available to them, including covert access to the basement, the mistake would not have been made.

Identification

302. At the relevant time, the NSWPF Police Handbook provisions relating to how officers should be identified when wearing plain clothes were unclear and potentially confusing. They seem to require that if arms or appointments had to be exposed during operational duty reflective vests and/or warrant cards or badges should be visible. I accept that there was no clear guidance given to officers about the issue in the circumstances that prevailed in this case. Nor was there any standard practice as to how they should conduct themselves to ensure they were appropriately recognised as on-duty police officers when executing search warrants.

303. The operational orders said "*Plain clothes officers will display police identification.*" That didn't occur and when Detective Crews and his colleagues confronted Mr. Nguyen they were not recognisable as police officers and there were no uniformed police officers in sight. I have found that the mistaken identity which resulted was a key factor in the drug dealer's decision to shoot. I accept Mr. Nguyen's evidence that he fired because he believed the men he suddenly confronted when he emerged from the garage were robbers, and not police officers. He was affected by drugs and had very poor English. They only saw each other for a couple of seconds before he fired. They didn't look like detectives – they looked more like robbers and he had been attacked by robbers in the same place a couple of weeks before.

304. Any instructions the police shouted were likely to be incomprehensible to a person in Mr. Nguyen's condition. I don't believe he would have been so foolish as to try and shoot his way out of the basement if he knew the group confronting him were police officers who he would expect to be armed. In my view, the failure to ensure that the officers confronting the offender were clearly identified as police officers was a dangerous error.

305. To be fair to Detective Senior Constable Roberts, it should be acknowledged that he had anticipated two uniformed officers being with the basement raiding party. However, he took no steps to ensure that happened and he took no steps to ensure any of the plain clothes officers were wearing police identification.

Discharge of firearm

306. It is clear that the fatal shot was fired by Detective Roberts while he was retreating and reasonably believed that he and Detective Crews were in imminent and extreme danger. The confrontation had come as a complete surprise and it is easy to accept that officer Roberts *"didn't stand in a well-aimed shot";* fired while he *"was trying to get cover";* when he *"wanted to get low";* and that he *"may have even hit the deck"*.

307. In his words he was “*half up, half down”* and “*as I fired a shot, I could see other police behind me*.” His evidence also suggests that he did not know exactly where Detective Crews was at the time - although he was clearly in the immediate vicinity of Mr. Nguyen. Further, such was Detective Roberts’ movement he was unable to control where his gun was pointing when he fired. I reject his evidence that he was looking and aiming at Mr. Nguyen when he discharged his weapon.

308. According to the evidence of Senior Sergeant Davis, the shot by Detective Roberts was fired contrary to the procedures and training given to officers in relation to the discharge of firearms, particularly the general safety principles that require an officer to be conscious of where the muzzle of the firearm is pointed and to be sure of the target.

309. It is easy to have some sympathy for Detective Roberts. There is no doubt he was caught unawares and may have panicked. That would be understandable – he had been suddenly thrust into a life threatening situation. His presentation at the inquest was defensive and seemed underpinned by a belief he had done nothing wrong.

310. It is difficult to know to what extent his truculent demeanour was fuelled by self-doubt and unremitting remorse. While he exhibited little insight in public, I am prepared to assume he knows he made a tragic mistake.

311. I am of the view that an officer of Detective Senior Constable Roberts’ experience should have realised that firing in the circumstances in which he suddenly found himself added to rather than negated the danger he and his colleagues were in, unless he was able to exert more control over his actions. Nothing can now be done about that, although

312. I anticipate the extensive firearms training all officers undergo that insists safety is paramount will be informed by the terribly sad outcome of this incident.

Onsite communication

313. The communication between the search warrant party members, particularly between the two groups who were tasked with searching the upstairs unit and the downstairs garage respectively, was inadequate. The evidence of the involved officers indicates they did not have a ready means of communicating to one another. There is no evidence this contributed to the shooting of Detective Crews, although it may have hindered the response. This was a flaw in the planning of the operation.

314. The operational order contained a heading "Command and Communications" but provided no indication how the officers were to communicate in the field.

Post shooting events

315. As a result of flaws in aspects of the planning of the operation already referred to – surveillance and communication in particular - after Detective Crews was shot his colleagues dared not go to his aid as they mistakenly feared they could not approach him without being exposed to the armed offender. It is now known that even immediate medical attention would not have saved his life. Still, Bill Crews lay alone on the cold concrete as his life ebbed away, while his colleagues unnecessarily held back. That must be as upsetting for them as it is for his family. The recording of their anguished screams for the offender to allow them to approach their wounded colleague witnesses their distress.

316. In retrospect, it might be puzzling that the officers who discovered the stairs to the garage from the right hand side of the building did not guess Mr. Nguyen had escaped. The hesitancy of those officers is also in contrast to the officers who subsequently arrived, entered the basement through those stairs and cleared the area. However, in view of the very traumatic events the raiding party had just experienced, I believe that to be critical of them would be unfair. None had advanced weapons and tactics training: they were mostly relatively junior detectives or general duties officers who had thought they were attending a routine search. As a result of the flawed risk assessment and the failure of the supervising officers to intervene, none of the search party was expecting or prepared for what unfolded. Their indecision when things went so badly awry was understandable and did not, in any event, contribute to the death.

317. In summary, as is so often the case, this death occurred because of cascading, compounding errors, none of which in isolation directly caused the death. On occasions, police officers are forced by exigent circumstances to rush into dangerous situations to prevent harm to others. This was not such a case: there was no pressing urgency that demanded an immediate response or that should have prevented more careful preparation prior to searching the Cairds Avenue premises.

318. Lack of rigor in the supervision or oversight allowed inadequate planning and preparation to go undetected. No one undertook sufficiently careful and considered analysis as to what needed to be done and how it could most safely be done. Those shortcomings contributed to an emergency arising in which a mistake was more likely to happen. Tragically, in this case, that mistake was fatal.

319. These criticisms must be tempered by acknowledging that they occurred because the officers involved were so committed to their mission they allowed a degree of indiscipline and hastiness to override circumspection. There was however no deliberate disregard for safety, and no promotion of private interest above public purpose. They were doing what they had sworn to do – protect the public – and sadly, one of them died doing it.

Findings required by s81 (1)

320. Having considered all of the documentary evidence and the oral evidence heard at inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased
The deceased person was William Arthur George Crews.

Date of death
Mr. Crews died on 9 September 2010.

Place of death
He died in the Liverpool Hospital in New South Wales.

Cause of death
The cause of the death was gunshot wound to the neck.

Manner of death

While executing a search warrant on residential premises in Bankstown with a number of other officers, Detective Constable William Crews was fatally wounded when he was unintentionally shot by another police officer who returned fire from a drug dealer who had mistaken the police officers for criminals come to rob him.

Recommendations

321. The Coroners Act in s82 authorises coroners presiding over inquests to make recommendations concerning matters connected with the death that are designed to contribute to public health and safety and/or to prevent deaths occurring in similar circumstances in future. The circumstances of this case raise the following issues for consideration from that perspective:-

- Risk assessment for search warrant executions;
- Oversight of search warrant planning;
- Identification of officers during operations;
- Communication during operations;
- Building approach and entry procedures;
- The wearing of body armour;
- “Man down” response; and

- The extent of defensive skills training.

322. Pleasingly, those issues have since been reviewed and reformed by the NSWPF. However, of concern is the delay in that response, even after serious shortcoming had been identified by the police force's preeminent expert in weapons and defensive tactics training, Senior Sergeant Davis. That officer was involved in reviewing the sad incident in which Detective Crews lost his life from the outset. He attended the scene the next day and was present when the officers involved did their "walk through" interviews. In a report presented in February 2011, Senior Sergeant Davis made 11 recommendations. For reasons which were not adequately explained during the inquest there was no official response to them until a Search Warrant Working Party (SWWP) produced a report in May 2014, over three years later. That working party was only set up after WorkCover initiated a prosecution against the NSWPF alleging it had failed in its obligation to ensure the health, safety and welfare at work of all of its employees. The SWWP conducted a comprehensive review of all existing search warrant procedures, documentation and training to achieve a single, unified approach to the execution of search warrants, and remove inconsistency in search warrant documentation.

323. The SWWP produced a draft report in June 2013 and, following consultation across the NSW Police Force, produced a final report in September 2013 containing 33 recommendations. On 24 September 2013 these were endorsed by the CET, and a Project Implementation Team ("PIT") was established in order to bring the recommendations into effect and, in particular, to develop and implement a Search Warrant Tool Kit. The PIT also sought external advice from a risk management consultant, who provided a report in March 2014. The Tool Kit was then developed and training was commenced. The new procedures were implemented from 1 November 2014.

Risk assessment

324. As is detailed earlier in this report there is a body of evidence indicating the risk assessment process in use in 2010 was not understood or correctly applied by the officers involved in the fatal incident. This has been addressed by the Search Warrant Tool Kit. The risk assessment tool was demonstrated during the inquest. Dr Shuey described it as a very good model to ensure that the risks are all dealt with. It includes a risk appreciation checklist, which acts as a prompt to remind the Case Officer to consider various aspects of the operation and whether they present a risk. Where information is unknown, this is highlighted in red, which acts as a visual aid for the Case Officer and the authorising officers to remind them that unknown factors may increase the risk rating. The presence of unknown factors does not automatically result in a higher risk rating. Dr Shuey considered this method for the treatment of unknowns to be appropriate.

325. The assessment of risk is performed manually, with the Case Officer arriving at his or her own assessment of risk according to the appropriate descriptions of the likelihood and consequence of the relevant events. Some rating choices are restricted, for example a risk of "death or serious injury from the use of firearms" can initially only be rated with major or severe consequences (C4 or C5). The effect of this is that where such risks exist this will automatically result in a higher risk rating.

326. Another significant improvement is in relation to how the overall risk of a search warrant is determined. The old risk matrix applicable at the time of the incident assessed overall risk on the basis of the majority of risk rankings applicable to nine different topics. Under the new system, a single high risk rating in relation to officer or public safety automatically results in an overall risk rating of high, requiring an application for assistance from the Tactical Operations Unit.

327. If the approving officer considers that the initial risk rating for the operation is not acceptable, the Case Officer is required to "treat" the risk that is to consider how the risk might be mitigated by different strategies. There is a library of suggested strategies, which will be enhanced over time, and these act as a prompt for appropriate action. For example, one way to mitigate the risk of firearms is to ensure that officers wear ballistic vests. Following this process, the risk is re-assessed and submitted for approval.

328. This electronic risk assessment tool as a whole is a far more sophisticated system than the one used in 2010, and this may itself be an issue. The SWWP concluded that it was not an overly onerous undue administrative burden as case officers were likely to be making the same enquiries in any event. However, anecdotal evidence suggests the administrative burden of complying with the new procedures might deter some officers from seeking search warrants. The inquest heard no evidence about this and accordingly no findings can be made. However, I trust the NSWPF will keep this under review: it is unnecessary in my view for safer policing to lead to less effective policing.

Oversight of search warrants

329. The procedures in place in 2010 required a number of senior officers to review the operational orders before a search warrant was executed. Surprisingly, none of those officers in this case detected what should have been obvious defects with a potential to impact upon safety.

330. The new procedures require three senior officers, including in most cases the Local Area Commander, to check, recommend and authorise the risk assessment. This usually involves physically signing the document, although there is provision for electronic approval. The approving officers are also required to approve the Operational Orders.

331. This approval process involves those senior officers confirming both that the risk assessment has been completed appropriately and that the risk rating for the operation is acceptable or, alternatively, requires treatment.

332. This process is, in my view, a substantial improvement over the previous system.

The Safety Check Officer

333. In a further effort to ensure officer safety is of paramount importance, every search warrant operation will now have an allocated Safety Check Officer, whose role is to ensure that safety is discussed during briefings, safety procedures are observed during the execution of the warrant, and safety issues are raised and reported after the operation has completed. The Safety Check Officer is required to consider various aspects of the operation including, in particular, communication between officers and access to and egress from premises.

334. This role will normally be undertaken in conjunction with another role, for example by a Searching Officer. An officer must be trained in order to undertake the role, which is included in the standard training for the new search warrant procedures.

335. Where the Safety Check Officer has a concern about an aspect of the operation, it is anticipated that this concern would be communicated to the Case Officer, and if not acted upon then onwards up the chain of command. The Safety Check Officer does not have any right of "veto" due to safety concerns. However, the creation of this role, with its focus on safety, is clearly a substantial improvement over the previous procedures.

Identification

336. As detailed earlier in this report, it seems likely that the person who started the shooting that ended with Detectives Crews' death did so because he was unaware the group of men confronting him were on-duty police officers. In an effort to address this, a new Operational Orders template provides a "default" position for the clothing police should wear in executing a search warrant. In normal situations, all officers in the Entry Team should wear one of four dress options (uniform, fluorescent vest, overt body armour with the flaps out or load bearing vest). Any departure from this must be justified. In addition, the default position for police identification is that it should be displayed before approaching the premises. Any operation that involves a deviation from the default position in relation to identification must be the subject of a review by the Search Warrants Review Committee.

337. I conclude these reforms address the weaknesses of the previous arrangements that were highlighted in this case.

Communications

338. The Operational Orders template requires the Case Officer to record the communication methods that will be used during the operation, including radio channels, call signs and (where relevant) other methods of communication such as mobile phones. Communications is also one of the areas to be considered by the Safety Check Officer.

339. If these requirements had been applied at the time of this incident, the deficiencies referred to earlier in relation to communications would not have arisen.

Forced entries

340. In recognition of the risk the execution of search warrants can pose if the subjects of the search are likely to resist, forced entry into a building will be performed by appropriately trained tactical officers in all but "low risk" situations.

341. In regional areas, where there is some scarcity of specialist resources, the Public Order and Riot Squad has provided training in building entry to ensure that appropriately trained officers are available to effect forced entry in medium and low risk operations. So far, 12 facilitators and 306 officers have received this training.

Training and review of search procedures

342. Police officers are required to undertake training in the new procedures before participating in any search warrant. The method for training is that senior officers (Detectives and Senior Sergeants) receive one full day's training on the Risk Assessment tool and the Operational Orders. These officers then become facilitators who provide training to other officers. The training for the other officers takes 4 hours. So far a total of 5,395 officers have received this training.

343. There is an ongoing review process for the new procedures, overseen by the Search Warrant Review Committee (SWRC). At the conclusion of an operation, the Case Officer must identify whether certain defined issues have arisen during the execution of the warrant, including where forced entry was used, injuries were sustained, firearms were discovered unexpectedly and the operation did not proceed.

344. He or she then completes a situation report and sends it to the SWRC. These case reports are reviewed, together with supporting information and appropriate remedial action is taken. In addition, the SWRC conducts random sampling to check for any issues.

345. This process provides a useful mechanism for monitoring and improving the new procedures. Superintendent Crandell stated that the SWRC was likely to continue this function indefinitely. Eight Search Warrant Practice Notes have already been issued to clarify instructions.

346. The review process may also identify whether the procedures are being correctly followed, or whether officers are avoiding the processes or deciding not to obtain search warrants due to the procedures.

347. In my view, these mechanisms should provide for adequate engagement with the new procedures and continuous improvement.

Ballistic vests

348. On the evidence before this inquest, none of the available types of body armour would have provided sufficient ballistic protection to save the life of Detective Crews. This is due to the position of the wound to Detective Crews' shoulder and the fact that no ballistic armour in use at the time would have offered sufficient protection in that area.

349. Nevertheless, it is pertinent to consider whether the use of body armour should be mandated during the execution of forced entry search warrants. Senior Sergeant Davis recommended that all officers engaged in search warrants should wear at least soft body armour.

350. The present policy is that it is worn at the officer's discretion, subject only to the commander considering that it is required following a risk assessment. The evidence shows that for various understandable reasons soft body armour is not widely used.

351. Consideration was given to changing the current policy on when to wear soft body armour. In light of the new search warrant procedures, which require the involvement of tactical police in medium and high risk search warrants and where forced entry is required there is no basis to further review this issue.

352. It is also pertinent that the NSW Police Force is planning to introduce integrated lightweight armour-bearing vests (ILAVs) that will hold weapons, appointments, and soft body armour panels. The ILAVs will also clearly identify the wearer as a police officer. An ILAV is relatively easy to put on and remove, and is therefore more likely to be worn than the existing soft body armour.

353. It is also intended the ILAVs will be available to all officers. This reinforces the adequacy of the current policies.

Availability of overt ballistic armour

354. There were insufficient overt ballistic vests for all officers present during the execution of the search warrant at Cairds Ave in September 2010.

355. According to evidence given during the inquest, at that time, there were 4524 overt ballistic vests on issue, which is approximately one for every three officers, although not all officers would be expected to be on duty at the same time. Overt ballistic vests are distributed so that generally most police vehicles ought to have two vests available. However, this policy is not mandated.

356. I have considered recommending all marked police cars should, when in use, be equipped with two overt ballistic vests. However I accept that in view of the new procedures that require medium and high risk search warrants to be executed or overviewed by tactical units who will always have access to appropriate equipment, the additional cost of putting vests in all cars, many of which would never be used, cannot be justified.

Defensive tactics training

357. Evidence indicating that officers Crews and Roberts failed to effectively respond to being confronted by an armed offender led to a recommendation from an expert who gave evidence at the inquest that the training for all officers in how to react to such threats should be increased.

358. Two days of mandatory defensive tactics training is presently undertaken by all NSW Police Force officers every financial year. The content of the course varies from year to year, to take account of issues arising in the field and, as a result, some fundamental aspects of training are only dealt with on a cyclical basis.

359. Currently, one day is spent on general defensive tactics and the other is for "live fire" training. However, the total time spent using a firearm is approximately only 2 hours. Officers who fail to achieve a sufficient score during the training, and who fail to correct this on the day, are given remedial training and an opportunity to take the test again, prior to being approved for operational duty.

360. Senior Sergeant Davis recommended that the amount of mandatory defensive tactics training be increased to 3 days for all police officers. This recommendation derives from his analysis of the circumstances leading to the death of Detective Crews. He observed that mandatory training already includes skills relevant to the situation the officers found themselves in on 8 September 2010.

361. These skills include facing an armed suspect, shooting whilst on the move, shooting using one hand and using cover whilst conducting fire. Both Detective Crews and Detective Senior Constable Roberts had undertaken such training, as they were required to, prior to 8 September 2010.

362. However, Senior Sergeant Davis noted that such training cannot completely replicate the levels of physical and mental stress acting on officers when they confronted with a real life situation. In his opinion, if an officer receives more training then, when he or she is placed in a stressful situation, the appropriate response is more likely to be instinctive. As a result, he recommended that the present 2 days of mandatory training should be increased to 3 days, for all police officers, *"to ensure complete operational preparedness for all NSW Police Force officers who may be faced with a similar situation"*.

363. Superintendent Hiron conceded that this was a common sense approach and that NSW Police Force could not argue against it.

364. The SWWP considered the proposal to increase Mandatory Training in its Supplementary Report in May 2014. It resolved to prepare a cost and needs analysis, noting that *"until this was done, it could not be established if an additional day was required, or if, in fact, an additional day would be sufficient"*.Superintendent Hiron prepared a report to the CET regarding this proposal. As at 3 February 2015, no decision had been made by the CET. However, it appears from his evidence that the resourcing implications are of concern.

365. It has been estimated that up to 20,000 operational shifts would be lost were Senior Sergeant Davis' recommendation implemented. Further, it is already difficult to find sufficient trainers and venues.

366. Dr Shuey criticised this approach and suggested that the NSWPF should instead identify the training need first, and then work out how this could be achieved. He suggested that there may be other ways to deliver aspects of mandatory training, which may free more time for defensive tactics. Some training is now delivered online and virtual simulation also has potential, although a number of witnesses were of the view that the most important and beneficial training was that involving scenario role play, where officers are required to interact with real people in different scenarios.

367. It appeared from the evidence of Superintendent Hiron that the NSWPF has not given any consideration to a more limited roll-out of increased mandatory training for officers who may particularly need it. Presently, the only officers who might receive more training on defensive tactics appear to be those who require remedial live fire training and those in specialist groups such as the Tactical Operations Unit.

368. It was suggested that extra defensive tactics training could be given on a limited trial basis to officers in geographical areas who statistically face more firearms; officers in squads that are more likely to face firearms; officers in the first four years of training; officers who request more training; or a sample of officers. Participants in a limited trial could then be assessed to determine whether the training had measurably improved their defensive tactics skills.

369. In light of the circumstances giving rise to this incident, and Senior Sergeant Davis's initial recommendations shortly after his review of the incident in February 2011, it is of concern that the NSW Police Force had apparently not given any consideration to some form of limited trial of a third day of defensive tactics training. In principle, such a trial could provide a means to quantitatively assess the benefits of additional training and make a properly informed assessment of the value of such training. It could also assist in identifying which officers would most benefit from additional defensive tactics training. However, I accept that the content of mandatory firearms and defensive tactics training has been significantly revised since this incident. The training now includes a focus on high risk incident management and the activation of the TOU.

370. It also includes "man down" drills and the live fire component includes moving and shooting, shooting from cover and the use of body armour. I am confident the adequacy of that training will continue to be reviewed.

In summary, while it is obvious that aspects of policing are inherently dangerous and cannot be rendered risk free, it is equally clear that systematic analysis of the risks can lead to them being reduced and safety increased as a result. I have summarised above the relevant changes that have been introduced recently. I am satisfied that the NSWPF has rigorously engaged with each of the inadequacies highlighted by the circumstances in which Detective Bill Crews died. It seems to have accepted that continuous review and improvement is essential to maintain an optimal level of operational safety. I don't consider any recommendations from this court would contribute further to that process at this stage.

3. 389486 of 2011

Inquest into the death of AA finding handed down by Deputy State Coroner Freund at Glebe on the 11th November 2015.

Introduction

This is an inquest into the death of AA, who was 23 years old when he passed away in the late evening of 15 May 2011, after he was found hanging whilst in custody in his cell at the Ebenezer unit of the John Morony Correctional Centre, Berkshire Park, in outer Sydney.

As AA's death occurred whilst he was in custody, this is a mandatory inquest pursuant to section 23 and 27(1)(b) of the *Coroners Act 2009*.

AA is survived by his parent's AA senior and AA mother and 2 older sisters. His unexpected death has left a massive hole in their lives and it is clear from the five days of this inquest that his parents loved him dearly. He was on all accounts an exceptional young man, who had a promising future and who at the time of his death was trying to turn his life around.

The function of the Coroner and the purpose of this inquest

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

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

A coroner, pursuant to s.82 of the Act, also has the power to make recommendations, including concerning any public health or safety issues arising out of the death in question.

It is convenient to note at this juncture the comments of the then State Coroner, Derek Hand, in the *Inquest into the Thredbo Landslide* at p.10.

"The inquest plays an important function as a fact finding exercise, essential to investigate and answer the relatives' and public's need to know the cause of death free from the constraints of inter parties litigation.

It does not apportion guilt. Although not expressly prohibited by the Act, it is not the function of the inquest to determine any question of civil, let alone, criminal liability."

Similar observations were made by his Honour Justice Hedigan in *Chief Commissioner of Police v Hallenstein.*

In relation to AA's death his identity, place, date and direct cause of his death are not in issue. This inquest has principally focused on the manner and the surrounding circumstances of his death in particular examining the events which occurred in the weeks and days leading up to 15 May 2011. These issues evolved and had to be expanded upon, as the inquest proceeded and included:

- Was AA presenting with acute symptoms of a mental illness as at 20 April 2011?
- Should AA have been placed in a "one out" cell on 27 April 2011, after he clearly expressed suicidal ideation at the RIT review on 20 April 2011?
- Was AA appropriately supervised once he was placed in protection in a one-out cell?
- Should more have been done once AA had been waitlisted for the Mental Health Screening Unit ("**MHSU**") on 2 May 2011?
- Should AA have been prescribed an anti-psychotic drug such as Olanzapine on 2 May 2011?
- Was there a proper clinical handover between clinical staff in April-May 2011 (and in particular on 9 May 2011)?
- Was AA advised of the fact that he had been refused parole?
- Were there any deficiencies in the investigation of AA's death?
- Are there any recommendations arising from AA's death?

I shall deal with each of these issues in turn.

Background

AA Junior was born 22 October 1987. He was the youngest child and an only son.

The evidence indicates that AA, an average student, completed fifth form at Papaakura High School in New Zealand, however he excelled at the arts, including singing and was an extremely talented sportsman, having played at a junior representative level in both Rugby League and Rugby Union.

AA was over 6 foot 7 inches tall and as a result of his size and physical stature was the target of local gangs who sought his support. From about the age of 18 he was regularly using cannabis and amphetamines. Accordingly in September 2008, when he was 21 years old, his parents moved AA to Sydney to stay with family, in an attempt to get him away from these bad influences. AA's childhood sweetheart remained in New Zealand to finish her university studies but intended to move to Australia to be with him once her studies were completed.

On Friday 26 September 2008, AA and his cousin attended the Greystanes Inn in Merrylands. During the course of that night they were involved in an altercation with another patron whom they assaulted and then stole $300 from him. They were both charged with aggravated robbery and related offences and made full admissions.

Initially AA was denied bail by police however, on 26 November 2008, AA was granted conditional bail.

Thereafter AA committed a number of offences while on bail including: shoplifting; special category driver drive with special range PCA; and malicious damage; all the above offences were committed on different days but notably occurred when AA was intoxicated.

On 13 May 2010, AA appeared in the District Court in Campbelltown and was sentenced to a term of imprisonment of 3 years and 6 months commencing on 5 November 2009 and concluding on 4 May 2013, with a non-parole period of 18 months. Accordingly, his earliest possible release date was 4 May 2011.

On 19 November 2010, as a result of his conviction for the aggravated robbery offence, the Department of Immigration and Citizenship advised AA that he was liable for visa cancellation.

On 21 February 2011, AA's visa was cancelled. As a result of the cancellation of his visa, AA was advised that upon his release from custody, he would be taken to immigration detention and deported. AA appealed this decision with the support of his parents.

The evidence indicates that up until April 2011, AA did not exhibit any signs of self-harm or mental illness. These records included a psychological assessment conducted in November 2009 and further similar assessments in May 2010 and February 2011.

In March 2011, AA was transferred from the Oberon Correctional Centre to John Morony Correctional Centre. Three weeks later, on 23 March 2011, his interstate transfer request (to be closer to his family in Victoria) was refused due to uncertainty over his immigration status.

On 3 May 2011, AA successfully argued his appeal regarding the cancellation of his Visa. His father attended this appeal hearing in support.

On 14 April 2011, the State Parole Authority refused AA's parole due to issues with post-release accommodation. A review was scheduled for 12 May 2011.

On 20 April 2011, AA told drug and alcohol counsellor Rita Vella that: "I need a phone call to my mother. I need to talk to her about something personal and if I get sent back to the yard or my cell I'm going to hang myself"[12]

As a result of his expression of self-harm, staff placed him in a safe cell and arranged for the Risk Intervention Team ("**RIT Team**") to assess him. The RIT team comprised of Senior Assistant Superintendent, Cheryl Waters, acting Nurse Unit Manager Robyn Lloyd and psychologist Farrah Houshmand. It was the evidence of Ms Houshmand that:

"AA during interview presented as tearful and emotional and initially was uncooperative and occasionally was reluctant to respond to some of the questions regarding his mental status at the time, however, as the RIT proceeded he become more honest and open regarding his self-harm/ suicidal thought. For example he repeatedly stated: "I am stressed out because I don't know how to handle and deal with my father upon release".
He also stated that "my father had an affair with my ex-girlfriend, my father has a very negative attitude and he is very difficult man to deal with, I cannot trust my father anymore and I feel hopeless and helpless about his uncaring attitude".

The RIT team on 20 April 2011 recommended that AA:

- remain on RIT for review on 21 April 2011;
- be accommodated in a safe cell for 24 hours; and
- be referred to the Clinic NUM and to the psychologists on Wednesday.

On 21 April 2011, the following day, AA again met with the RIT Team for review. On this occasion the RIT was constituted by Welfare Officer Chris Luckman, Mental Health Registered Nurse Chris Piipari and Case Manager Ferdinand Ricotta. The evidence was that AA advised them that:

- "he had got caught up in a lot of emotions - family stressors. Parents live in Melbourne- had phone contact yesterday";
- he denied any further thoughts of self-harm; and
- he agreed to share a cell stating that "he does not like to be by himself."

The conclusion of the RIT team was that he be taken off the RIT alert but he was to remain “two-out” in a cell. He was also to be further reviewed by a Corrective Services psychologist.

As a result of the RIT assessment on 21 April 2011, AA was placed ”two out” in a cell. To affect this, in accordance with policy, a Health Problem Notification Form ("**HPNF**") was completed by Chris Piipari, the Justice Health mental health nurse, and placed on AA’s Case Management File, as required.

I note that the RIT assessment of 20 April 2011 and the review of 21 April 2011 were noted on AA's electronic record, called the Inmate Profile Document, in the Justice Health file and in Corrective Services case notes (or what are sometimes called ‘E notes’).

On 25 April 2011, Anzac Day, AA was found to have two black eyes and bruises to his body and neck.

He was interviewed by a Justice Health registered nurse, Julie Omoronke Edagbami, and advised that he had "fallen in the shower" but said that he wished to remain in the Main block as he was going home soon. However, on 26 April 2011 he complained of stomach pains, and was taken to the clinic where he confided in staff that he wished to stay away from the cell block where he was housed and that he had no intention of harming himself. He was placed in a safe cell for observation overnight, with a note to the supervising Corrective Services officer to the effect that he was on a two out cell placement from the recent RIT.

On 27 April 2011, AA was interviewed by a Corrective Services officer, Senior Assistant Superintendent Mark Peteru. It was the evidence of Mr. Peteru that:

- he summoned AA from the safe cell to his office for the purpose of interviewing him in regard to his request for protection.;

AA indicated during the course of the interview that he feared for his safety from other inmates and that fear stemmed from "inmates having knowledge that he has inherited a considerable amount of money from New Zealand, and they would try to extort money from him”; that at the time he carried out the interview he was unaware that AA was on a "red card" or "two out placement" or that he had recently been the subject of a RIT assessment; and he did not check AA's Case File or OIMS file.

Following the interview Mr. Peteru recommended and approved AA's placement in Special Management Area Placement ("**SMAP**") until 4 May 2011. Accordingly, AA was placed in a one out cell (namely a cell on his own) in the Ebenezer Wing ("**E unit**").

That same day, Alan Curtin a Justice Health registered nurse, received a phone call from a Corrective Services officer who said that he had placed AA in segregation on protection. Mr. Curtin prepared a Health Problem Notification form for AA’s single cell placement on protection.

AA also consulted with Ms Houshmand, psychologist on 27 April 2011.

On 1 May 2011, Corrective Services Officer Joern Goetze spoke with AA and he denied thoughts of self-harm. By now AA was on protection, in a single cell and had been so for at least 4 days.
On 2 May 2011, AA was seen by the Justice Health Mental Health Nurse Christine Muller for the first time and Ms Muller conducted an extensive mental health assessment taking an hour. Ms Muller's evidence can be summarised as follows: AA had been escorted to the clinic by Senior Assistant Superintendent Cheryl Waters who had advised her that: "she had been involved in the recent RIT reviews....that AA's family had told her that the things AA was saying were not true and she thought he was making up stories for attention"; AA told Ms Muller that: "he had come into a significant inheritance from the mother of an ex-girlfriend, that his current girlfriend was having an affair with his father and that his ex-girlfriend had arranged for a gang in New Zealand to kill him"; she noted that AA Had lost 6.6kgs in weight in one week; that his presentation was consistent with systematised delusions and he offered no insight; she noted that the things AA was saying about his family members appeared unusual, and with AA's permission she spoke to his mother via telephone who advised her that there was a family history or schizophrenia and that AA "was always talking in riddles"*;* she noted that this was AA's "first presentation of psychosis"; by telephone, she spoke with her clinical supervisor Dr Adam Martin, a senior psychiatrist and then Clinical Director, Community Correction Mental Health at Justice Health.

She discussed her assessment of AA and Dr Martin advised her "not to commence psychotropic medication due to the potential side effects and risks associated with prescribing medication for a patient that has never had this type of drug and where there is not capacity to have him medically reviewed";

She completed a referral to the wait list for the MHSU at the MRRC, Silverwater, and forwarded it to the Nurse Unit Manager; she also spoke to Cathryn Gibson, the manager of Offender Services and Programmes, about need for urgent mental health intervention in custody or in community and need for Justice Health staff to be advised if AA was returned to custody.

I note that is common ground that at that time a psychiatrist was not available to visit John Morony to conduct reviews of patients with mental health issues.

On 3 May 2011, AA attended the AAT for his immigration hearing. He represented himself. His parents travelled from Melbourne to attend to provide support. The result was deferred.

The following day, namely 4 May 2011, a number of things occurred: a report to the Parole Authority was prepared recommending that parole not be granted due to his uncertain immigration status; AA spoke to his mother my telephone. That conversation was recorded and transcribed. In essence, AA indicates he thinks his parole decision will be made by 14 May 2011 and that he was confident he would get parole; a MHSU bed meeting was convened and assigned AA a B rating, with a priority of four. As a consequence he remained on the waiting list for transfer to the MHSU and remained in protective custody in E wing.

On 5 May 2011, Malcolm Clark, a Senior Community Corrections officer made a file notation noting a parole review date on 12 May 2011. AA's protection status was upgraded to limited association that day due to his fears of other inmates. Although the General Manager of John Morony at the time, Mr. Aboud, believes that a Protected Custody Direction would have been prepared as required for this change (and the change is noted on the system electronically), no such direction was found on AA's Case Management File.

On 6 May 2011, AA saw Ms Houshmand, the Corrective Services psychologist again. Her evidence was that he presented as "emotionally stable" and denied any current self-harm/suicidal ideation and he "expressed future orientation". On 7 May 2011, AA spoke to his mother by telephone and told her his parole review was on 12 May 2011.

On 9 May 2011, Nurse Muller returned to the John Morony Correctional Centre and was surprised to see that AA was still there. It was her evidence that she spoke to Lisa Hogan, the Nurse Unit Manager to remind her that AA was on the MHSU wait list and that he needed to be reviewed (as part of a follow up plan she had devised when reviewing him on 2 May 2011 and which is documented in the clinical notes in his Justice Health file). I note that Ms Hogan has no recollection of this conversation having taken place.

On 11 May 2011, AA's visa was reinstated by the AAT and he was informed of this on 12 May 2011. On 12 May 2011, the State Parole Authority affirmed its decision of 14 April 2011 to deny AA parole.

15 May 2011 - Date of death

On 15 May 2011, the day of his death, AA went into the yard around 8.40am. At 8.57am AA rang his mother. The phone call was recorded and the transcript records him as saying "they are fucking me around with my parole". His mother asked if he got told about his parole and he said "no' but that he "want" his immigration, which is probably a mistranscription of he "won" his immigration. He told his mum the call was going to cut out and that he was alright.

After he was returned to his cell, AA used his medical call system in his cell and made a request to speak to Corrective Officer Rourke, privately. Mr. Rourke attended AA's cell together with Assistant Superintendent Danny Loloa. AA stated that "he was scared and feared for his life from other inmates who were after him". Mr. Rourke advised AA that he was safe in "E Unit" as he was in separate accommodation and these words seemed to reassure AA.

Mr. Rourke was concerned about AA's presentation and ordered a psychologist's review.

At 12.30pm, Mr. Rourke undertook a physical head check and asked AA if he wanted his yard open to which AA replied "no chief".

At just before 3pm on 15 May 2011, AA was locked in his cell for the evening. On the evidence, that was the last time he was seen alive.

At 9.10pm AA was found deceased hanging by his bed sheets attached to the fire sprinkler in his cell, after water flooding from a broken sprinkler head was seen to be flooding the corridor of the cell complex.

Was AA presenting with acute symptoms of a mental illness from 20 April 2011?

The first real indication that clinicians had observed that AA's mental health may be declining was when he expressed suicidal thinking to Corrective Services welfare officer, Ms Vella, on 20 April 2011. Ms Vella immediately arranged for a RIT team to review him. Ms Houshmand, psychologist was a member of that team, along with the then acting NUM, Robin Lloyd and Cheryl Waters from Corrective Services. Ms Waters acted as scribe.

After deciding that AA was a risk to himself based on his suicidal ideation, the obvious decision was made to house him in a safe cell and recommend further RIT review, referral to the Clinic Nurse Unit Manager and to see a psychologist.

AA was reviewed the following day by a different RIT assessment team who decided, after interviewing AA, to accept his assurances that he was no longer suicidal and had had an opportunity to speak to his mother. They took him off the safe cell placement but recommended a "two out" placement to ensure some degree of company and oversight for him.

Ms Houshmand gave evidence on 19 August 2015 and on 29 October 2015. She initially told this inquest in August this year that she thought AA may be displaying signs of a first time psychosis, but she wasn't sure and he seemed genuine, if tearful. It was surprising that she had made no note of her tentative thoughts or provisional diagnosis.
When Ms Houshmand was recalled on 29 October 2015, she clarified that whilst she thought what AA was saying *might* possibly be delusional, ultimately she concluded that she could not be certain as she had no evidence to test the hypothesis against or support it and what he was saying was not obviously delusional and could well have a basis in fact. Accordingly, she decided there was no real evidence that he was delusional and chose not to record either on the RIT form or make an entry on the E case notes about her provisional diagnosis.

It was the evidence of Christine Muller that when assessing AA on 2 May 2011, "His thoughts were to some extent disjointed and there was evidence of paranoid delusions."

She also states, "I noted that this was AA's first presentation of psychosis". Indeed in Ms Muller's email that day to refer AA to the MHSU wait list, she wrote, "This patient presents as having a paranoid delusional disorder and was recently on a RIT after expressing thoughts of suicide by hanging in response to some delusional ideas…".

Expert Evidence was obtained from Dr Michael Guiffrida, Forensic Psychiatrist who stated:

"In my opinion there can be no reasonable doubt that AA was suffering from a serious mental illness namely an onset of a first episode psychotic illness with paranoid persecutory delusions...and... revealed some evidence of thought disorder or at least disjointed thoughts.

The diagnosis was probably of an emerging paranoid schizophrenic illness first episode. It was in the context of the development of those paranoid persecutory beliefs and the fear that he was going to be killed that AA contemplated suicide which was likely to have been a continuing feature of his illness and given his paranoid psychosis remained untreated and that he was left in a single cell protection area he deteriorated to the point where he was overwhelmed by his delusion and his fear and chose to suicide as a relief from his torment".

I note that Dr Yvonne Skinner, Psychiatrist agreed. Accordingly, I am satisfied on the balance of probabilities that AA was suffering acute symptoms of a mental illness from 20 April 2011.

Should AA have been placed in a "one out" cell on 27 April 2011, after he clearly expressed suicidal ideation at the RIT review on 20 April 2011?

There is no doubt that AA requested a SMAP placement on 27 April 2011 and it is likely that his real fears about his physical safety, from the incident of 25 April 2011, coupled with his delusions drove this request.

His SMAP placement was approved by Justice Health Nurse, Mr. Alan Curtin, whose evidence was that "it is my usual practice to review the patient's medical record before completing a HPNF form".

Mr. Curtin gave evidence on the penultimate day of the inquest.

He was called primarily so he could offer an explanation as to the inherent contradiction in his statement evidence namely his evidence that he checked AA's medical file before he completed the HPNF form and his later evidence that he was not aware that AA had previously been placed two out due to suicidal ideation. Mr. Curtin gave the following oral evidence in relation to the discrepancy inter-alia that: he was not aware until he read the file that AA was "two out" as a result of suicidal ideation; and the fact that AA had previously expressed suicidal ideation was not an impediment to the change, as ideation can change daily and on his assessment it wasn't currently present.

It is also important to note that being placed "one out" is the inevitable result of being placed in SMAP. There were no "two out" cells in John Morony's E unit.

Moreover on 2 May 2011, Nurse Muller made a clinical determination that AA should be "one out" for his own protection and the protection of others, which in my view superseded the events of 27 April 2011.

This determination was not criticised by either Dr Guiffrida, Dr Skinner or Dr Chew, who added that in his view instability from psychosis was not something he thought the RIT would recognise as requiring a safe cell.

Accordingly, I am satisfied on the balance of probabilities that it was NOT inappropriate that AA was accommodated in a "one out" cell from 27 April 2011 when he requested protection and segregation.

Was AA appropriately supervised once he was placed in isolation?

As indicated, on 27 April 2011 AA was transferred into SMAP and on 5 May 2011 he was transferred into protective custody. The evidence from Mr. Patrick Aboud, the then General Manager of John Morony, was to the effect that there is no material physical difference between these arrangements and a segregation order, as an inmate is kept isolated in a "one out cell" .

I note that there are legislative safeguards relating to segregation and protective custody directions, which are set out in sections 8-22 of the Crimes (Administration of Sentences) Act 1999 (as at May 2011), which states:

8 Release from custody

Unless sooner released on parole, an inmate who is serving a sentence by way of full-time detention (the ***current sentence***) is to be released from custody on the day the sentence expires (the ***release date***), as determined in accordance with Division 1 of Part 4 of the *Crimes (Sentencing Procedure) Act 1999* but subject to any variation of the term of that sentence under this or any other Act.

- An inmate may be released from custody:
- at any time on the release date for the current sentence, or
- if the release date for the current sentence is a Saturday, Sunday or public holiday and the inmate so requests, at any time during the next day that is not a Saturday, Sunday or public holiday.

This section does not apply to an inmate who, as at the release date for the current sentence, is subject to another sentence that is being served by way of full-time detention:

- where the other sentence commenced before, but will not end until after, the release date for the current sentence, or
- where the other sentence commences immediately after the release date for the current sentence.

9 Definitions

In this Division:

protective custody direction means a direction referred to in section 11.

segregated custody direction means a direction referred to in section 10.

suspension direction means a direction referred to in section 20 (1) (a).

10 Segregated custody of inmates

The Commissioner may direct that an inmate be held in segregated custody if of the opinion that the association of the inmate with other inmates constitutes or is likely to constitute a threat to:

- the personal safety of any other person, or
- the security of a correctional centre, or
- good order and discipline within a correctional centre.

The general manager of a correctional centre may exercise the Commissioner's functions under this section in relation to the correctional centre and, on each occasion he or she does so,

Must notify the Commissioner of that fact and of the grounds on which the segregated custody direction was given.

A segregated custody direction given by the general manager of a correctional centre does not apply in relation to any other correctional centre.

Subsection (3) is subject to section 15.

11 Protective custody of inmates

The Commissioner may direct that an inmate be held in protective custody if of the opinion that the association of the inmate with other inmates constitutes or is likely to constitute a threat to the personal safety of the inmate.

The Commissioner may also direct that an inmate be held in protective custody if the inmate requests the Commissioner in writing to do so.

The general manager of a correctional centre may exercise the Commissioner's functions under this section in relation to the correctional centre and, on each occasion he or she does so, must notify the Commissioner of that fact and of the grounds on which the protective custody direction was given.

A protective custody direction given by the general manager of a correctional centre does not apply in relation to any other correctional centre.

Subsection (4) is subject to section 15.

12 Effect of segregated or protective custody direction

An inmate subject to a segregated or protective custody direction is to be detained:

- in isolation from all other inmates, or
- in association only with such other inmates as the Commissioner (or the general manager of the correctional centre in the exercise of the Commissioner's functions under section 10 or 11) may determine.

An inmate who is held in segregated or protective custody:

- is not to suffer any reduction of diet, and
- is not to be deprived of any rights or privileges other than those determined by the Commissioner (or the general manager in the exercise of the Commissioner's functions under section 10 or 11), either generally or in a particular case, and other than those the deprivation of which is necessarily incidental to the holding of the inmate in segregated or protective custody.

13 Form of direction

A segregated or protective custody direction must be in writing and must include the grounds on which it is given.

Information concerning review of segregated or protective custody direction

As soon as practicable after an inmate is directed:

- to be held in segregated custody under section 10, or to be held in protective custody under section 11 (other than at the inmate's request),
- the general manager of the correctional centre is to provide the inmate with information concerning the inmate's rights to a review of the segregated or protective custody direction.

Transfer of inmate held in segregated or protective custody

If an inmate held in segregated or protective custody under a segregated or protective custody direction given by the general manager of a correctional centre is transferred to another correctional centre, the segregated or protective custody direction applies:

in relation to the correctional centre to which the inmate is transferred (***the receiving correctional centre***), and

in relation to the conveyance of the inmate to the receiving correctional centre, including custody of the inmate in any correctional centre in which the inmate is held during the course of being conveyed to the receiving correctional centre.

Within 72 hours after the arrival of the inmate at the receiving correctional centre, the general manager of the receiving correctional centre must review the segregated or protective custody direction, having regard to the grounds referred to in section 10 or 11, and give one of the following directions:

- a direction revoking the segregated or protective custody direction,
- a direction confirming the segregated or protective custody direction,
- a direction confirming the segregated or protective custody direction but amending its terms.
- A direction given under subsection (2) has effect according to its terms.
- A segregated or protective custody direction that is subject to a direction under subsection (2) (b) or (c) is, on and after the giving of that direction, taken to be a segregated or protective custody direction given by the general manager of the receiving correctional centre.
- A direction by the general manager of a receiving correctional centre revoking, confirming or amending a segregated or protective custody direction has effect even though it is given outside the period during which it is required to be given under this section.

16 Review of segregated or protective custody direction by Commissioner

The general manager of a correctional centre where an inmate is held in segregated or protective custody must submit a report about the segregated or protective custody direction to the Commissioner within 14 days after the date on which the direction is given (***the relevant date***), regardless of whether the segregated or protective custody direction was given by the Commissioner or by the general manager of a correctional centre.

Within 7 days after receiving the report, the Commissioner must review the segregated or protective custody direction and give one of the following directions:

- a direction revoking the segregated or protective custody direction,
- a direction confirming the segregated or protective custody direction,
- a direction confirming the segregated or protective custody direction but amending its terms.

If the direction is confirmed, the general manager of the correctional centre where the inmate is held in segregated or protective custody must submit a further report about the direction to the Commissioner within 3 months after the relevant date, and within each subsequent period of 3 months after that period.

Within 7 days after each occasion on which the Commissioner receives any such further report, the Commissioner must review the segregated or protective custody direction and give one of the directions referred to in subsection (2) (a)–(c).

The confirmation of a segregated or protective custody direction by the general manager of a correctional centre under section 15, or by the Review Council under section 22, does not affect the requirements for reporting about and reviewing a segregated or protective custody direction under this section.

A direction by the Commissioner revoking, confirming or amending a segregated or protective custody direction has effect even though it is given outside the period during which it is required to be given under this section.

In this section: ***report***, in relation to a segregated or protective custody direction, means a report recommending whether or not the segregated or protective custody direction should be revoked, confirmed or amended.

17 Revocation of segregated or protective custody direction

A segregated or protective custody direction remains in force until it is revoked.

The Commissioner may, at any time, revoke a segregated or protective custody direction or amend its terms.

The Commissioner must revoke a protective custody direction given at the request of an inmate if the inmate requests the Commissioner in writing to revoke it.

The general manager of a correctional centre may exercise the Commissioner's functions under this section in relation to the correctional centre.

18 Report to Minister on segregated or protective custody direction

As soon as practicable after confirming a segregated or protective custody direction, the Commissioner must give written notice of that fact to the Minister, giving reasons for the confirmation direction, if:

- the confirmation direction will result in the inmate being subject to a total continuous period of segregated or protective custody exceeding 6 months, or
- the inmate has already been subject to a total continuous period of segregated or protective custody exceeding 6 months.

This section does not apply to a direction confirming a protective custody direction that was given at the request of an inmate.

19 Review of segregated or protective custody direction by Review Council

An inmate whose total continuous period of segregated or protective custody exceeds 14 days may apply to the Review Council for a review of the segregated or protective custody direction under which the inmate is held in segregated or protective custody.

The application is to be in writing and is to include the inmate's reasons for making the application.

The Review Council must review the direction unless subsection (4) applies.

The Review Council may refuse to review the direction if:

- the application does not, in the opinion of the Review Council, disclose substantial grounds for a review, or
- the Review Council has previously determined a review of the same direction under this Division and the application does not, in the opinion of the Review Council, disclose substantially different grounds for review.

The Review Council may not refuse to review a direction under subsection (4) if a period of more than 3 months has elapsed since the Review Council determined a review of the segregated or protective custody direction.

This section applies regardless of whether the relevant segregated or protective custody direction was given by the Commissioner or by the general manager of a correctional centre.

20 Suspension directions by Review Council

The Chairperson of the Review Council may give a direction for:

- the suspension of an inmate's segregated or protective custody direction, or
- the transfer of an inmate to a different correctional centre.

A suspension direction may be given at any time after an application for a review is made and before it is determined.

While a suspension direction is in force, the inmate is not to be held in segregated or protective custody unless a new segregated or protective custody direction is given.

The Chairperson may at any time vary or revoke a suspension direction.

- A suspension direction does not revoke a segregated or protective custody direction.
- A direction for the transfer of an inmate to a different correctional centre may be given:

- if the Chairperson considers that the inmate's removal would facilitate the review of the segregated or protective custody direction, or

- for any other reason that the Chairperson thinks fit.

The determination of a review of a segregated or protective custody direction by the Review Council under section 22 revokes any suspension direction applying to the segregated or protective custody direction.

21 Procedure for review of segregated or protective custody direction by Review Council

In determining any matter relating to the segregated or protective custody of an inmate, the Review Council is not bound by the rules of evidence but may inform itself of any matter in such manner as it thinks appropriate.

The Review Council must cause notice of any hearing in relation to a review to be given to the inmate who applied for the review.

If the inmate so wishes, the Review Council must allow the inmate to be present, and to be heard, at the hearing.

The inmate may be represented by an Australian legal practitioner chosen by the inmate or, if the Review Council so approves, by some other person chosen by the inmate.

The Commissioner or the general manager of a correctional centre (or both) may be represented by an Australian legal practitioner or by some other person.

Division 2 of Part 9 applies to the conduct of a review by the Review Council under this Division.

22 Determination of review by Review Council

In reviewing a segregated or protective custody direction, the Review Council must take the following matters into account:

- whether the direction was given or reviewed in accordance with this Division,

- whether the direction was reasonable in the circumstances,

- whether the direction was necessary to secure the personal safety of the inmate or any other person,

- the security of, and the preservation of good order and discipline within, the relevant correctional centre,

- the interests of the public.

In determining an application for review, the Review Council may revoke, confirm or amend the segregated or protective custody direction to which the application relates." These laws recognise the extreme nature of such orders and the potential harm to individual inmates."

Moreover regulation 289 of the *Crimes (Administration of Sentences) Regulation 2014* states:

"An inmate who is confined to cell for the purposes of punishment, or under a segregated or protective custody direction, must be kept under daily observation by a prescribed Justice Health officer and have access to essential medical care." (formerly clause 298 of the Crimes (Administration of Sentences) Regulation 2008 (repealed)).

AA was in a one out cell from 27 April 2011 and in protective custody from 5 May 2011. It was the evidence of Trevor Perry, the Service Director of Custodial Mental Health for Justice Health that:

"The then Justice Health policy 1.360 Segregated Custody set out directions to staff for the mandatory observation of inmates in segregated or protective custody or confined to a cell for punishment.

The version of the policy that was in force in May 2011 was published in May 2009. Specifically, the duties of nurses in relation to inmates in segregated custody in correctional centres other than Long Bay Hospital are set out in section 5.1 of policy 1.360 which states:

'All inmates/patients subject to a Segregated Custody Direction must be seen at least daily by nursing staff and at least weekly in the Clinic. A notation related to the review must be made in the patient medical file.

The patient should be offered an appointment once a week with the Medical Officer (MO). If the nurse has any concern the MO must see the patient with the next 24 hours.'"

In regard to the nature of the observations of an inmate that a nurse must make, the policy states in the same section:

"While a physical examination will not usually be necessary, the minimum contact should include a discussion with the patient, which should be aimed at assessing his or her current physical and mental health state and any potential risks."

The policy required the nurse to make a record of the patient's "wellbeing" in the patient's clinical notes".

No record could be found of any other visits by a Justice Health employee to AA recorded between 2 May and 15 May 2011. It was submitted by Mr. Brock, for AA Snr that the only reasonable inference is Justice Health was in breach of its obligations from 5 May 2011 when AA was placed under a protective custody direction in that: Justice Health did not comply with clause 298 of the *Crimes (Administration of Sentences) Regulation* 2008; none of the objectives under 1.360.2 were met; and the daily assessments and clinical notes were not completed as required by 1.360.51.

I agree. AA should have been subject to daily checks by a nurse. Those checks should have been a discussion about how he was doing so if in the event he was to further decompensate there would be a greater chance of this vulnerability or risk being picked up and managed prior to a catastrophic end.

The safeguards put in place to manage and protect a vulnerable inmate such as AA were not adhered to and it is only reasonable to conclude that if they had been applied AA's chance of surviving his mental illness would have increased enormously.

Should more or could more have been done once AA had been waitlisted for the Mental Health Screening Unit ("MHSU") to manage his risk of self-harm?

The evidence indicates that AA was referred to the MHSU on 2 May 2011 by Mental Health Nurse Christine Muller. The following day, namely 3 May 2011 a MHSU bed meeting was convened and assigned AA a B rating, with a priority of four. As a consequence he remained on the waiting list for transfer to the MHSU and remained in protective custody in E wing until he died on 15 May 2011.

As previously indicated I am satisfied that AA was suffering from an acute mental illness as of 27 April 2011 which was diagnosed by Nurse Muller on 2 May 2011. The issues that flow from this are whether his risk of self-harm was firstly higher and secondly if so, was his risk so high that steps should have been taken to mitigate that risk other than placing him on the MHSU waitlist.

The best person to assess AA's risk of self-harm was in my view Nurse Muller. As an experienced mental health nurse practitioner, she conducted a detailed assessment of AA on 2 May 2011 and took contemporaneous notes of that meeting. She gave oral evidence on 20 August 2015 and presented as both honest and forthright. Her evidence was that she initially assessed AA's risk of self-harm as "moderate" and explained in evidence that:

"*my concern was more that he may kill someone else"; he did not express suicidal ideation; however he had increased suicide risk factors as he had been diagnosed with "a first presentation psychosis".*

As a consequence, Nurse Muller discarded the idea of having AA put on a RIT and placed in a safe cell while on the waitlist, on the basis that a safe cell was a punitive environment and he would be less likely to tell her if he was feeling like he wanted to harm himself if he was in that environment.

Nurse Muller was also firmly of the view that AA was safer by himself in a "one out" cell because that meant he was less able to harm others, and it meant that his paranoid delusions about his own safety would not be fuelled and he would feel safer.

It was also the evidence of Nurse Muller that her concern about AA and his risk factors was such that she raised it with more senior people in Justice Health, namely Dr Martin, Catherine Hancock and Mr. Perry, after her initial assessment of him on 2 May 2011, and produced a number of emails and diary entries to support this assertion.

The documents produced by Nurse Muller however do not specifically refer to AA or his specific circumstances. Accordingly, they can be better described as her advocating for better clinical pathways for mentally ill inmates to obtain better clinical assistance.

Nurse Muller clearly did have meetings and discussions with Dr Martin, Catherine Hancock and Lisa Hogan after 2 May 2015. Moreover, both Catherine Hancock and Dr Martin (in referring to his meeting with Ms Muller on 5 May) conceded that AA was raised as an example of the lack of pathways whilst Lisa Hogan said that it was possible he could have been mentioned as an example, but she didn't specifically recall the conversation.

It is important to note however, that all these witnesses deny that Nurse Muller raised AA as a patient who was at high risk.

Nurse Muller was and is clearly an experienced, caring and competent mental health nurse practitioner. At the relevant time she was clearly frustrated at the lack of resourcing and pathways available to mentally ill inmates to get better care within the Custodial System. She advocated for her patients. AA was one of those patients. No doubt looking back through the prism of hindsight Nurse Muller has overrated the risk she evaluated as moderate when she initially assessed AA on 2 May 2011.

In relation to what clinical pathways were available to the critically mentally ill patient as at 2011, the evidence was as follows:

Refer, then transfer the patient to the MHSU at Silverwater Correctional Centre: the evidence from Dr Martin and Mr. Perry was that this was and is the only practical pathway available;

Transfer the patient to the Metropolitan Remand and Reception Centre ("**MRRC**"): this could possibly be carried out by filling out the appropriate HPNF form however the evidence from Dr Martin, Mr. Perry and Mr. Aboud was that, because of the numbers of inmates coming through the MRRC daily,

This pathway would only be used in extremely urgent cases and used very rarely; and Involuntary transfer to Long Bay Hospital under section 55 of the *Mental Health (Forensic Provisions) Act 1990*: this pathway was not available in 2011 at John Morony Correctional Centre as it required both a doctor and a psychiatrist to sign the schedule and there was no psychiatrist attending John Morony Correctional Centre at this time.

Accordingly, the only pathway available to a patient such as AA who had been assessed as a "moderate" risk of self-harm was the referral and transfer to the MHSU.

I note that since AA's tragic death, further resources have been provided to the John Morony Correctional Centre. These include:

- A psychiatrist attends John Morony Correctional Centre one day per fortnight and is available weekly if urgent matters arise; and
- A Mental Health Clinical Nurse Consultant attends John Morony Correctional Centre one day each week.

I note that Dr Guiffrida also encouraged the use of teleconferencing (or telehealth as it was referred to) for psychiatric review as an emergency measure, although noting the obvious advantages of face to face review. Dr Chew noted that telehealth is used for outlying centres such as Broken Hill. In my opinion, Justice Health should consider the use of telehealth for psychiatric review in appropriate situations where review is urgently required and a patient cannot be seen face to face, or where staff envisage a prolonged period on the MHSU waitlist before the patient is transferred and admitted.

Should AA have been prescribed an anti-psychotic drug such as Olanzapine?

It was the evidence of Dr Guiffrida that:"I could see no reason why AA could not have been commenced on one of the safer antipsychotic medications initially in a low dose with a gradual increase during with time he could be reviewed by Ms Muller, being a very senior nurse practitioner who would be I think perfectly capable of managing by commencing a delusional patient on an antipsychotic medication..."

Dr Skinner did not agree. Her evidence was: "AA had not previously taken anti-psychotic medications. In considering the prescription of anti-psychotic medication, a number of factors must be taken into account. Individuals react differently to medications, particularly with respect to side effects. Common side effects of anti-psychotic medications include:

stiffness (dystonia) and shakiness
Feeling drowsy and sluggish
Uncomfortable restlessness, agitation
Dizziness(due to reduced blood pressure)

Some side effects of medication are serious and potentially lethal....

Occasionally persons who have suicidal thoughts are more inclined to act on those thoughts in the early stages of treatment with medication, and should be closely monitored during the early stages of treatment".

It is clear that the supervision proffered to AA who was being housed in a "one out" cell in protective custody was less than adequate (despite legislative requirements that he be checked daily).

There were obvious risks to commencing AA on anti-psychotic medication without adequate supervision and accordingly I am not critical of either Dr Martin or Nurse Muller for taking the more conservative approach and deferring the option of medication until he was in an environment like the MHSU where he would be better supervised.

Was there a proper clinical handover between clinical staff?
NSW Health defines a clinical handover as "the transfer of information, accountability and responsibility for a patient or a group of patients".

It was the evidence of Nurse Muller that on 9 May 2011, when she was unable to gain access to AA as he was already locked in for the afternoon, and prior to leaving for the day, she spoke to the Nurse Unit Manager Lisa Hogan and "handed over the information regarding my immediate patient who was due to attend court that week. I also informed the NUM Ms Hogan that AA had remained in custody after his AAT hearing and was on the wait list for the MHSU and needed to be seen".

It was the evidence of Nurse Hogan, the NUM, that firstly, she did not recall this conversation or handover occurring but "it could have happened" and secondly she did not have the clinical expertise to make a mental health assessment of someone who was acutely ill.

It appears that AA fell through the cracks at this point in time. From the evidence there may have been an expectation on the part of Nurse Muller that another mental health nurse would see him after 9 May 2011.

Without both a note in the progress notes to record the handover and/or an alert on Patient Administration System (“**PAS**”) in the incoming nurse’s diary that AA should be seen, there was every risk that the follow-up would not occur, particularly in circumstances where there was a gap of some days in between one nurse finishing their mental health duties at John Morony and another one starting theirs. Clearly this occurred.

Communication and standardising the recording of that communication is the key to any busy health management system. No one person can be expected to remember the details of one or more patient from one day to the next. I note that since AA's death, improvements have been made by Justice Health in relation to standardising handover procedures.

However in my view they do not go far enough, particularly in cases where direct handover (that is a handover from practitioner to practitioner) is not possible and delay of a day or more is possible. In such cases not only should a note of the handover be made firstly in the case file but an actual appointment should also be made for the patient/inmate in the incoming practitioner’s PAS appointment diary. Furthermore, education is the key to ensure those procedures are followed and adhered to by all staff.

Was AA advised of the fact that he had been refused parole?

On 12 May 2011, the State Parole Authority met and issued a "Notification of Determination by the State Parole Authority in respect of review of decision not to make a parole order" ("**the Parole Refusal**") in relation to AA, copies of which were forwarded to: the Manager, Offender Records, John Morony Correctional Centre; Benjamin Gillies/Joanne Stapleton, Bathurst District Office, Probation and Parole Service; and the Officer in Charge of Windsor District Office/ Parole Unit, Probation and Parole.

The Parole Refusal stated:

"TAKE NOTICE that the State Parole Authority, at its meeting on 12 May 2011 considered the case of the abovenamed offender and determined that the decision of 14 April 2011 is to stand and that the offender not be released from a correctional centre at this time.

The Parole Authority is not satisfied, on the balance of probabilities, that the release of the offender is appropriate in the public interest, the Parole Authority has regard to the following matters:-

Needs for post release accommodation [unconfirmed post release accommodation].

The offender can apply to be reconsidered for possible release on the anniversary of the parole eligibility date 4 May 2012. If the offender applies to be considered for parole the Authority will require a probation and parole officer's report and correctional centre report not later than ......

PLEASE ENSURE THAT A COPY OF THIS NOTIFICATION IS HANDED TO THE INMATE, READ TO THEM, ITS EFFECT EXPLAINED TO THEM, AND THEIR RIGHTS IN RESPECT OF THE AUTHORITY'S DETERMINATION EXPLAINED TO THEM".

There is no evidence that AA was ever informed of the Parole Refusal.

I note however that in his conversation with his mother on 15 May 2011 he indicates that he is still not aware of the parole decision.

I accept Mr. Brock's submission that whether AA was informed or ignorant of the outcome of the Parole Authority, the situation was deplorable.

He was acutely mentally unwell and in isolation. There is evidence that his release date was prominent in his mind and it is reasonable to infer the unsatisfactory management of this information contributed to his ill health.

It was the evidence of Christine Moellmer, Community Corrections Officer for Corrective Services that there is, "no specific written policy or procedures relating to the communication of parole refusal to inmates". This is surprising considering that the consequences of receiving such information may be potentially devastating. The dissemination of such information in my view should be regulated.

Were there any deficiencies in the investigation of AA's death?

There were clearly a number of deficiencies that came to light in relation to the investigation into AA's death that was carried out by Corrective Services.

These include: one of the time logs from the scene was not kept; and the CCTV footage from the cell corridor area was not downloaded as requested by Mr. Aboud.

As indicated at the outset of this inquest, as AA died in Custody this is a mandatory inquest pursuant to section 23 of the Act. AA died in a single cell.

There were no witnesses to his death. The CCTV footage would have no doubt provided the best evidence and valuable comfort to his family yet it was not available as it was not downloaded. This should never have occurred.

Accordingly, I recommend that training be conducted at the John Morony Correctional Centre on the specific issue of maintaining and preserving a crime scene and crime scene management generally.

Conclusion

AA's death is a tragedy. He was a young man who had the love and support of his family, and enormous potential for a positive future once he was released from custody. However the demons of his mental illness got the better of him, and he took his own life, while alone in his cell on 15 May 2011.

I have identified a number of deficiencies in the care and treatment AA received for his mental illness.

I understand that resourcing within the NSW prison system is stretched and that no doubt will be under a greater burden with the reported growth in the prison population. However, an inflexible under-resourced mental health system will have long term ramifications on both the individual and society as a whole when the poorly or inadequately treated inmate is ultimately released.

Coronial Recommendations

To: **The Chief Executive Officer**
Justice Health & Forensic Mental Health Network:

I recommend that:

1. When there is a handover of patient care, a note of that handover should be recorded in the patient's case file.

2. In the event that there is no opportunity for direct handover from clinician to clinician (e.g. a gap of a day or more), the patient should be recorded on the incoming clinician's Patient Administration System (PAS) waiting list as an appointment, as part of the handover.

3. The current Policy 1.360, Continuum of Care, Segregated Custody, be amended to make it clear and unambiguous that it also applies to directions for protective custody.

4. There be education of nurses in their obligations under the Justice Health segregated custody policy (applying the current Crimes (Administration of Sentencing) Regulation 2014 clause 289) as to the scope of the duty required, including making a record of the observations, when seeing protective custody inmates.

5. That consideration be given to the use of telehealth as an emergency measure for psychiatric review in situations where a psychiatric review is urgently required and a patient cannot be seen face to face, or where staff envisage a prolonged period on the MHSU waitlist before the patient is transferred and admitted

To: **The Commissioner**
Corrective Services NSW, Department of Justice:

I recommend that based on the fact that the regulations require Justice Health to monitor inmates subject to protected custody and segregated custody directions, a revision be made of current Corrective Services NSW, Section 14, Segregated and Protective Custody policy (Exhibit 1, Volume 6 Tab 73, attachment 7) at clauses 14.7.4 and 14.7.7 to ensure that the requirement to notify Justice Health of a direction is included.

To: **The Commissioner of Corrective Services NSW, Department of Justice and The Chief Executive of Justice Health and Forensic Medicine Health Service:**

I recommend consideration be given to whether a revision should be made to the OIMS system to include notification to Justice Health in the form of an alert (via the Justice Health PAS system) of a protective custody or segregated custody or confinement direction, when it is made.

Formal Finding:

I find that AA died on 15 May 2011 in Cell 247 in the Ebenezer Unit of the John Morony Correctional Centre by hanging whilst suffering an acute mental illness most likely a first episode delusionary psychosis, after taking steps to take his own life.

4. 58625 of 2012

Inquest into the death of Ismail Housman finding handed down by Deputy State Coroner Truscott at Glebe on the 18th November 2015.

This inquest concerns the death of a young man, Housam Ismail, who died of injuries sustained as a passenger in a vehicle, which failed to obey a stop sign, and collided with a vehicle at the intersection of Cumberland Road and Albert Street Auburn. The driver of the vehicle in which Housam was travelling was charged offences criminal offences in relation to his death. Those criminal proceedings have been concluded and this inquest is resumed pursuant to section 79 Coroners Act 2009.

Housam, who was known as “Sam”, was born on 18 April 1990 and was 21 years old when he died on 22 February 2012. At the time of his death he lived with his parents on Rickard Road at Auburn. He was the youngest of six children. Sam’s father Abdul Ismail describes him as a good son, honest, family-oriented and generous, with a wide circle of friends. Sam had been working with his father as a cabinetmaker since he left school.

On the evening of Wednesday 21 February 2012 Sam was at home with his family. In the late evening he went out telling his father that he was going out to buy cigarettes. He visited his friend Ayman Lakkis, and at about 11.30pm the pair left Mr Lakkis’s house. They met up Adam Allam and Rabeh Dannawe. All four were travelling in a blue Mitsubishi 380 Magna (593-RVZ). The driver was Adam Allam; Rabeh Dannawe was in the front passenger seat; Ayman Lakkis was in the rear right hand side; and Sam was in the rear left hand seat.

At about 12.21am on 22 February 2012 Sergeant Blackburn was travelling in a marked police vehicle on Park Road, Auburn. He was driving in a northerly direction. He saw the Mitsubishi exit a roundabout at an intersection he thought was Park and Beatrice Streets. The Mitsubishi was travelling south towards him.

Sgt Blackburn says the Mitsubishi was travelling at excessive speed and it went over onto the incorrect side of the road, which caused him to move his vehicle to the left.

Sgt Blackburn turned his vehicle around in the driveway of a service station, which he thought was on Percival Street and commenced to follow the Mitsubishi, which had turned right.

A couple of days before the inquest Sgt Blackburn had returned to the area and identified that street as Union Road. He said that when he made his statement, he had made a mistake about the name of the roundabout street - it was Helena Street.

As Allam's vehicle passed Sergeant Blackburn on Park Road, Sergeant Blackburn did not see who the occupants of the car were but glimpsed that the registration plate was interstate. When he entered Union Street he saw Allam's vehicle about 50 m at a roundabout still travelling at speed. Sergeant Blackburn activated his warning lights and siren in order to stop the vehicle. However, it did not stop and continued along Union Road until it turned left into Cumberland road.

At this point Sgt Blackburn decided to commence a pursuit. He notified police radio and provided some information regarding his location and speed. He said that he was in pursuit, the car had a Queensland Registration Plate and he was on Cumberland.

Cumberland Road is a main road that has a number of dips and rises. As a result there were periods when the Mitsubishi was briefly out of sight as it passed over a crest. After passing through the intersection of Wellington Street (which is controlled by traffic lights) the road rises and Sergeant Blackburn lost sight of it. He was aware that the next intersection went left and right and thought that if he couldn't see the Mitsubishi he would terminate the pursuit. His vehicle passed over the crest, he couldn't see the Mitsubishi and after about 50m he saw the collision debris and saw the very damaged vehicles in the intersection of Albert Road.

Vehicles travelling along Cumberland Road are required to stop at the Albert Road intersection. The tendered evidence demonstrates that Mr Allam entered the Albert Road intersection at speed and failing to stop at the stop sign collided with a Mazda driven by Mr Michael Patten who was travelling eastbound along Albert Road.

The Mitsubishi struck the near side front of the Mazda then collided with a power pole, a stop sign, a post box and a low brick wall before coming to a stop. Sgt Blackburn stopped his vehicle, declared the accident and need for emergency services over the police radio. Numerous ambulances, the fire service and other police units arrived within minutes. Sam was the first to be conveyed to hospital but he died shortly after his arrival.

A police vehicle pursuit is timed from the moment the pursuing officer declares over VKG he is in pursuit until when it was terminated. The records indicate the accident occurred within about a minute of the pursuit being called. The distance between Union Road and Albert Street is a little over a kilometre. A kilometre a minute is 60kph; a distance of 1 ½ kilometres over that time is 90 kph. So the average speed must have been about 75 kph. It was a 50 kph speed zone. When Sergeant called the pursuit he told VKG he was travelling at 70 kmh. In his evidence he said after that point he could not say what he speed was but he did not gain on the Mitsubishi, he thought that there was about a 100 m difference between them which is consistent with his vision from the crest of the hill to the site of the accident.

Sgt Blackburn approached the scene and began to assess the injuries. Constables Napier and Silva arrived about 2 minutes after Sergeant Blackburn. Constable Napier gave evidence and he said that they had been under light and siren due to the pursuit being called. 12.25am .The first Ambulance arrived at 12.30am within 8 minutes of Sgt Blackburn radio call reporting the accident and calling for ambulances.

Almost immediately after the accident a large number of young men emerged from the houses in the area and some also began to arrive in cars. These men made efforts to free the occupants from the vehicles, including using a crow bar, but the cars were badly damaged and the doors of the Mitsubishi were jammed shut. These efforts made the car move causing the injured passengers to be jolted in the car. He directed the crowd to desist and they became hostile thinking that the police were not helping.

In fact, Constable Napier was completely helpful, he arranged for one of the people to hold Sam's head so he didn't move and Constable Napier held the head of Ayam Lakkis, which was covered in blood. Constable Napier was reaching through the broken glass of rear window to do this and maintained that position until Ayam could be removed from the vehicle.

The driver Adam Allam was not seriously injured in the accident. Sam was critically injured and Ayam was seriously injured, neither had been wearing seat belts. In the other vehicle, Mr Patten severely injured. He endured multiple operations and spent 10 months in hospital. He lost permanent use of his right arm.

Sam was taken from the vehicle after the fire service removed the car door and was taken to Westmead Hospital.

The hospital notes show he was treated aggressively, with 8mg adrenaline and CPR was continued for 42 minutes. However, despite the efforts of treating staff he was declared deceased at 1.32am.

An external post mortem examination was performed with reference to the Hospital records. The Post Mortem Report identifies the cause of death to be head and neck injuries; in particular a skull fracture and probable fractures to the upper cervical spine were noted.

Drug testing of the driver Allam, showed that he had taken cannabis and diazepam prior to driving. Dr Perl, a pharmacologist was of the opinion that the level of diazepam would have been a contributory factor to the manner of his driving, although she was unable to assess or determine what the degree of impairment actually could have been.

Mr Allam was charged with offences and he pleaded guilty to charges of Aggravated Dangerous Driving occasioning the death of Sam Ismail. He also pleaded guilty to other charges in relation to Mr Patten and other passengers in Mr Allam's vehicle. He was sentenced to 4 years imprisonment. He will be eligible for parole until 15 April 2016.

The Inquest is required to be held under s27 (1) (b) of the Act as Mr Ismail has died as a result of or in the course of a police operation (s23 (1)(c)).

I have received a brief of evidence and heard evidence from Detective Sergeant Wakeham, Sergeant Blackburn and Constable Napier. Detective Sergeant Wakeham was the Senior Critical Incident Investigator and he interviewed Sergeant Blackburn within 5 hours of the incident.

Detective Sergeant Wakeham said he was satisfied that Sergeant Blackburn complied with his obligations under the NSW Police Service Safe Driver Policy in relation to conducting the police pursuit. He said that he was satisfied that Sergeant Blackburn had considered risk factors such "as traffic conditions and the manner of the driving displayed by the driver, there were low risk factors in that it was past midnight on a week night with limited traffic, they were travelling on back streets so the risk to oncoming traffic was limited, the road was a straight line so there was nothing which represented risk to the public, the weather was fine and dry.

Detective Wakeham commented that Sergeant Blackburn had said in his interview that he had decided that if he would terminate the pursuit if he lost sight of the vehicle as he crested a rise. Detective Wakeham said that Sergeant Blackburn said was compliant with policy 6 (I think he meant 5).

Detective Sergeant Wakeham attempted to obtain statements from Dannawe and Lakkis but they each refused to tell him about the circumstances of their being in the vehicle and what had occurred that night. Some claimed to have no memory but Detective Sergeant Wakeham believed that they were uncooperative rather than failing to recall the events.

Detective Wakeham explained that police searched Allam's vehicle. Behind the radio facia they found a clear resealable bag contained 18 smaller bags each containing cannabis with a usual street price of about $50 each. On the back seat was a bag, which contained 11 diazepam tablets and $350 cash. He was of the view that the drugs and cash were consistent with drug supply activity. He suggested that Allam failed to stop when Sgt Blackburn directed him to do so in Union Street because he was evading police searching and locating the drugs in his motor vehicle. That is a reasonable opinion particularly taking into account the criminal of some of the occupants in the vehicle (Sam excluded).

Sergeant Blackburn participated in a directed interview and later signed a statement adopting that interview. In his interview he set out where he first saw allam's vehicle, which he has now corrected in his evidence as referred to above.

Detective Wakeham did not ask him in the interview why he decided to stop and then pursue Allam.

He gave his reasons in his evidence. He said that Allam had committed a traffic offence by speeding at the Park Road and Helena Street roundabout and crossing his 2 wheels just over the double white lines before immediately correcting onto the left side of road. Sergeant Blackburn performed his turn to follow Allam because he decided that he would breath-test the driver.

Sergeant Blackburn said that when he entered Union Road, Allam's vehicle was at the roundabout of Gordon and Union Roads and he activated his alerts and Allam accelerated. Sgt Blackburn said he decided to call the pursuit within seconds because it was evident Allam was accelerating and evading police.

Sgt Blackburn estimating that by the time Allam's vehicle was turning left into Cumberland St, the police vehicle was at the Union and Gordon Rd roundabout. This was the point at which he commenced the pursuit. Using the scale on the street map tendered in evidence, this is a distance of about 1.5 km.

That evidence is consistent with the time of the VKG records and the speed of 70 kph, as reported by Sergeant Blackburn at the time was travelling on Cumberland Road. Sergeant Blackburn's evidence that he did not gain on the vehicle and would terminate the pursuit if he could not see the vehicle once he came over the crest after the Wellington Street intersection was a reasonable decision. It shows that he was aware of and assessing the risk factors required under the Safe Driver Policy.

Sergeant Blackburn told Detective Wakeham that he had only lost sight of the vehicle for a second, but I think it is a little longer - though the pursuit was only about a minute, Sergeant Blackburn said in his interview to him it felt like just seconds which indicates that the pursuit was indeed one which Sergeant Blackburn was prepared to abandon within a short period of time with reasonable regard to the Safe Driver Policy.

Sergeant Blackburn was honest and frank about his decision to pursue Allam's vehicle. He conceded that though the traffic offence was minor, the fact that the vehicle accelerated quickly turning right into Union Road was sufficient to be concerned about the manner of driving to stop the vehicle to subject the driver to a breath test. Sergeant Blackburn saw the vehicle's registration plates were interstate but had no opportunity to obtain sufficient details to call for an inquiry about the vehicle.

Sergeant Blackburn said that prior to seeing Allam's vehicle he had been conducting general patrol duties in relation to "traffic, crime, people misbehaving, and domestics". He said it was not his normal practice to pursue "fail-to-stops". He would usually require something more but there had been a spate of drive-by shooting in the area and which caused him to be concerned about the vehicle. Sergeant Blackburn said that most people stop when a police officer activates the siren and lights but this vehicle accelerated away, which caused him to think that they were up to no good. During the extremely short pursuit Sergeant Blackburn did not attempt to gain on Allam's vehicle because he considered that it would be dangerous to do so.

The scene of the collision was extremely traumatic but Sergeant Blackburn appropriately positioned his vehicle, provided directions through VKG and dealt with the crowd and only went to his car to write notes when he was relieved by fellow officers and emergency services were taking control of the scene.

The issues in the inquest are few- to identify any contributing factors to the accident and to consider whether Sergeant Blackburn's conduct was appropriate. In regards to the latter, there are no criticisms about Sergeant Blackburn's conduct calling the pursuit, and the decision to stay a safe distance back from the vehicle and determining to terminate if he did not regain sight of it once he had a clear view from the crest of the rise. He dealt with the accident scene appropriately. In regards to the contributing factors, it is likely that Allam was attempting to evade Sergeant Blackburn, at a time that he was probably impaired by cannabis and diazepam and motivated by a fear that the drugs in his vehicle would be discovered.

It is difficult to assess with accuracy the speed at which Allam was travelling at the time he entered the Albert St intersection, it could have been as much as near double the posted zone speed of 50 kph.

At that time Sergeant Blackburn's vehicle was probably still on the approaching side of the crest given that he did not see the collision occur as he came over the crest. This is consistent with his evidence that he kept a very generous distance behind Allam's vehicle so not to press him to drive faster.

There are no recommendations I need to make in relation to this Inquest but note that the Safe Driving Policy remains unchanged though there have been many coronial recommendations suggesting their improvement to minimise deaths in police operations.

Formal Finding:

That Housam Ismail died on 22 February 2012 at Westmead Hospital of neck and head injuries suffered when he was a passenger in a motor vehicle in a police operation.

5. 247660 of 2012

Inquest into the death of AB finding handed down by Deputy State Coroner MacMahon at Newcastle on the 20th July 2015.

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

Non-publication orders have been made in accordance with Section 74(1) (b) Coroners Act 2009 in respect of the following evidence:

Exhibit 1, Tab 21, Tab 53, Tab 63, Tab 79, Tab 78 Annexure A-G, and Tab 80

Order made in accordance with Section 75(5) Coroners Act 2009:

In accordance with Section 75 (5) Coroners Act 2009 I make an order permitting the publication of a report of the proceedings subject to the restriction that in any such report the identity of the deceased and any relative of the deceased is not to be publishes and the deceased is to be referred to by the pseudonym 'AB'.

Findings made in accordance with Section 81(1) Coroners Act 2009:

'AB' [redacted] died between 7 August 2012 and 8 August 2012 at the Cessnock Correctional Centre, Lindsay Street, Cessnock in the State of New South Wales. The cause of his death was the combined effects of plastic bag asphyxia and neck compression due to hanging. The manner of his death was self-inflicted with the intention of ending life.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

Nil

6. 83234 of 2012

Inquest into the death of Jean Govinden finding handed down by Deputy State Coroner MacMahon at Glebe on the 25th February 2015.

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

The publication of the names, current residential address and any information (including photographs, video footage or voice recordings) identifying, or tending to facilitate the identification of, the children of Anthony and Veronica Ghalloub is prohibited.

Orders made in accordance with Section 75 Coroners Act 2009:

Orders made in accordance with Section 75(2) that continue following the delivery of these Findings:

The publication of the names, current residential address and any information (including photographs, video footage or voice recordings) identifying RF, RF2, LG, MG, MH, BH and JG and other relatives of the deceased Jean Vincent Didier Govinden is prohibited.

Orders Made in accordance with section 75(5) allowing the publication of a report of the proceedings:

Subject to the non-publication orders made in accordance with Section 74 and 75 Coroners Act 2009 a report of the Findings and the Reasons in these proceedings may be published.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

To: The Minister of the Commonwealth of Australia responsible for the administration of the Telecommunications Act 1997 (Commonwealth) or other relevant legislation:

That the Government give consideration to requiring that, before a person is able to purchase a SIM card for use in a mobile telephone or other similar device, that person establish their identity by the provision to an appropriate authority of evidence in a similar manner to that required when opening an account with a bank or other financial institution.

Introduction:

Jean Vincent Didier Govinden (who I will refer to in these Reasons as 'Govinden') was born in Mauritius on 4 September 1979. When he was about eight years of age he moved with his family to Melbourne and two years later to Sydney.

In 1998, during his final year at school, Govinden came to the attention of police following the commission of two offences for which he was dealt with by the District Court. He was not charged with any criminal offences thereafter.

In about 2005 Govinden commenced a relationship. This relationship developed and in 2010 he became engaged to be married. He and his fiancée commenced residing together in Dundas Valley. It was proposed that they would be married in mid-2012.

Govinden had an interest in hunting and archery. In March 2012 both he, and his fiancé, had NSW firearm licences. He owned a registered A Remington 308 Rifle and his fiancé owned a registered .22 calibre rifle. In March 2012 both firearms were stored at the St Mary's Pistol Club. Govinden was also involved with the Northern Archers Club of Sydney. Govinden also enjoyed gambling and attended the Star Casino on a regular basis.

A little after 7pm on 14 March 2012 Govinden attended a property in West Ryde. That property was, at the time, the home of Anthony and Veronica Ghalloub and their children. There were CCTV security facilities at the property that recorded what happened thereafter on the front porch.

Govinden knocked on the door which was answered by Veronica Ghalloub. Govinden held himself out to be a police officer investigating an incident that had recently occurred in the area. About 7.10pm Anthony Ghalloub returned home. There was a conversation between the Ghalloub's and Govinden on the front porch of the property. During the course of the conversation Anthony Ghalloub recognised Govinden as a person who was engaged to his second cousin.

At 7.26pm Anthony Ghalloub and Govinden were the only persons on the front porch. The CCTV footage shows Govinden put the notebook in which he had been making notes into his backpack and then withdraw a gun out of the backpack and stood over Anthony Ghalloub. He then quickly ushered Anthony Ghalloub to the front door and forced him inside at gunpoint.

On the evening of 14 March 2012 Anthony and Veronica Ghalloub were to attend Mrs Ghalloub's parent's home to celebrate her father's birthday. At 8.11pm Veronica Ghalloub phoned her sister Julianne Boyagi and explained that she would not be able to attend the function. The call was ended abruptly. Ms Boyagi thought the call was unusual and discussed her concerns with her sister Claudia Shashati. They decided to go and visit their sister and check on her.

On arriving at 63 Winbourne Street, Ermington Ms Boyagi and Ms Shashati knocked on the front door and got no response. They then went around the property. The property was closed up. Ms Shashati then had a phone conversation with her brother after which Ms Shashati called triple zero to report her concerns.

That call was made at 8.45pm and during the course of the call Ms Shashati stated to the operator that her sister's family had been:

'…having some threats, some life threats and …threats and my sister hasn't been answering the phone at all, they're in the house…I think there is a man inside the house holding them hostage because I have a picture of a man that's been there…'

A police attended 63 Winbourne Street in response to the call to triple zero with initial vehicles arriving at 8.53pm and 8.55pm. Following police being deployed at the front and rear of the property Sergeant Gary Lawler approached the front door. As he did so the front sensor light was activated. He could hear voices coming from inside the house.

He heard an attempt to open the front door. The door then opened and Veronica Ghalloub and her children came running out of the house. They began to cry hysterically. The CCTV recording shows them running onto the front porch at 8.59pm.

Sergeant Lawler followed by Senior Constable Tanti and Constable Thomas entered the property. Sergeant Lawler saw Anthony Ghalloub standing in the hallway adjacent to stairs that led down to a lower level in this house. Mr Ghalloub identified himself as the owner of the house. When asked if anyone else was in the house Anthony Ghalloub denied that there was.

At about this time Veronica Ghalloub told Claudia Shashati that there was a gunman in the house. Ms Shashati told police who were at the front of the house. The CCTV shows Ms Shashati running up to a police officer who was standing at the front of the house and point inside. The information was given to Sergeant Lawler and Senior Constable Tanti. When challenged with this information Anthony Ghalloub confirmed the existence of the gunman in the house. He was then told to sit on a couch in the lounge room. Sergeant Lawler and Senior Constable Tanti then began searching the house.

On entering the ensuite bathroom Sergeant Lawler found Govinden lying on his back on the tiled floor. Govinden had blood on his face and on the floor under his head. To Govinden's left was a sawn off .22 calibre Long Rifle Stirling Model 22 self-loading rifle. Sergeant Lawler checked for a pulse and found none.

Sergeant Lawler then contacted police radio and requested that an ambulance be called. The NSW Ambulance Service records show that call was received at 9.03pm. Ambulance officers arrived at the property at 9.14pm.

When he arrived Paramedic Van Katwy observed a large pool of blood beneath Govinden's head. He found Govinden to be without pulse and asystolic. Govinden's death was reported to the Office of the NSW State Coroner on 14 March 2012 by Detective Senior Constable Ram.

Jurisdiction of Coroner:

The relevant coronial legislation is the Coroners Act 2009. All legislative references will be to that legislation unless otherwise indicated.

Section 6 defines a *"reportable death"* as including one where a person died a *"violent or unnatural death."*

Section 35 requires that all *reportable deaths* be reported to a coroner.

Section 18 gives a coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or the person who has died or is suspected to have died was ordinarily a resident of New South Wales.

Section 23 (c) provides that a senior coroner has exclusive jurisdiction to conduct an inquest where the person has died *'as a result of or in the course of a police operation.'*

Section 22 defines a senior coroner as being the State Coroner or a Deputy State Coroner.

Section 27(b) provides that where a death occurs in circumstances to which Section 23 applies an inquest is mandatory.

Section 74(1) (b) provides a coroner with the discretion to prohibit the publication of any evidence given in the proceedings if he or she is of the opinion that it is in the public interest to do so. Section 74(3) provides that it is an offence to breach such an order.

Section 75 deals with proceedings concerning self-inflicted deaths. Section 75(1) authorises a coroner, during the course of an inquest where it appears to him or her that the death may be self-inflicted, to make certain specified non-publication orders. Where, at the conclusion of an inquest, a finding is made that the death was self-inflicted Section 75(5) prohibits the publication of a report of the proceedings unless the coroner makes an order permitting the publication of such report. Section 75(6) permits a coroner to make such an order where he or she considers that it is desirable in the public interest for such a report to be published.

The primary function of a coroner at an inquest is set out in Section 81(1). That section requires that at the conclusion of the inquest the coroner is to establish, should sufficient evidence be available, the fact that a person has died, the identity of the deceased, the date and place of their death and the cause and manner thereof.

Section 82 (1) of the Act provides that a coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths.

Section 81(1) matters:

Govinden's identity as well as the date, place and cause of his death were not matters of contention at inquest.

Identity:

The deceased person found by Sergeant Lawler on 14 March 2012 was identified by Leading Senior Constable Simon Searles as being that of Jean Govinden. Leading Senior Constable Searles is a fingerprint expert attached to the Police Fingerprint Operations Branch. The identification was made by comparing the fingerprints of the deceased person found by Sergeant Lawler with the fingerprint records held in respect of Govinden by NSW Police. I accept the evidence of Leading Senior Constable Searle. I am satisfied that the deceased person found by Sergeant Lawler on 14 March 2012 was Jean Vincent Didier Govinden who was born on 4 September 1979.

Date and Place of Death:

The evidence of Sergeant Lawler was that when he found Govinden's body at West Ryde about 9pm on 14 March 2012 he had no pulse. This was confirmed some fifteen minutes later by Paramedic Van Katwyk. I accept the evidence of both Sergeant Lawler and Paramedic Van Katwyk and am satisfied that Govinden died on 14 March 2012 at West Ryde in the State of New South Wales.

Cause of Death:

Following Govinden's death his body was taken to the Department of Forensic Medicine at Glebe where an autopsy was conducted by a forensic pathologist Dr Istvan Szentmariay.
Dr Szentmariay commenced his examination at West Ryde prior to Govinden's body being removed to Glebe. At the scene Dr Szentmariay noticed a single gunshot wound to the head. On further examination during autopsy Dr Szentmariay found:

'A contact gunshot wound (with soot deposition and partial muzzle imprint) to the right side of the head (temple).'

On the basis of his examination, and taking into account the information he had been given by police, Dr Szentmariay recommended that the cause of Govinden's death be recorded as being:

'Gunshot wound to the head (contact range of fire)'.

I accept the evidence of Dr Szentmariay and having regard to the evidence available to me I am satisfied that the cause of Govinden's death was a gunshot wound to the head.

Issues for Inquest:

The evidence at Inquest focused on the manner of, or the circumstances that led to, Govinden's death, the involvement of police in those circumstances and whether it was necessary or desirable to make any recommendations in accordance with Section 82 in relation to any matter connected with Govinden's death.

Police Involvement:

Where a death occurs and there is a police involvement in the circumstances of that death it is important that such involvement be independently and publically examined so as to ensure that the actions of police officers in the course of their duties are fully accountable to the public. This is why the NSW Parliament has enacted in the Coroners Act 2009, and previous Coronial legislation, a requirement that all deaths arising *out of or in the course of a police operation* are to be the subject of a mandatory inquest. The rational for this being that, as described by former State Coroner Waller, it provides a positive inventive to (police to act appropriately) and satisfies the community that deaths in such (circumstances) are properly investigated. It also has the effect of protecting the police involved in such circumstances from false or malicious allegations.

The first issue to be determined is whether or not Govinden died as a result of the actions of a member(s) of the NSW Police Force.

The evidence is that Claudia Shashati phoned triple zero at about 8.40pm on 14 March 2012 seeking police assistance. Constable's Collis and Armstrong arrived at West Ryde at about 6.53pm in vehicle EW35. This was followed by Sergeant Lawler in vehicle EW38 who arrived at about 8.55pm.

Veronica Ghalloub and her children are seen to be running from the home on a CCTV recording timed at 8.59pm.

Sergeant Lawler, and other police, can be seen on that CCTV footage to enter the house about 10 seconds after Veronica Ghalloub and her children left the house.

On entering the house to undertake the search Sergeant Lawler firstly finds Anthony Ghalloub and then, having told him to sit in the lounge room, continues his search with Senior Constable Tanti. He subsequently found Govinden on the floor of the ensuite and, at about 9.03pm, calls police radio seeking ambulance assistance.

The evidence is that in the period from the arrival of the police to the discovery of Govinden no gunshots were heard by any of the persons present.

I am satisfied that there is no evidence whatsoever to suggest that Govinden's death was the result of any action by an officer of the NSW Police Force. Although on the evidence available the precise time that Govinden received the injury that led to his death cannot be determined it is likely that it occurred prior to Sergeant Lawler, and other police, entering the property at West Ryde on 14 March 2012. I am, however, satisfied that Govinden died *'in the course of a police operation.'*

I am satisfied that the response of NSW Police to these traumatic events both at the time of the events and since has been both timely and professional.

Manner of Death:

I have found that Govinden died as a result of a gunshot wound to the head. In the circumstances the manner of his death can be the result of either a homicide, misadventure or self-inflicted. I am satisfied that the evidence establishes Govinden's death was self-inflicted.

I have reached this conclusion having regard to the circumstances in which his body was found with the firearm nearby, the location of the gunshot wound to the head, the soot deposition and muzzle imprint found on his head showing that the muzzle was close to his head when the firearm was discharged. The existence of no evidence to suggest that any other person at the time had contact with the firearm before it was discharged, and the general circumstances of the events of that evening. On the evidence available it would be unlikely that his death resulted from an accidental discharge of the firearm and, on the balance of probabilities, I am therefore satisfied it was deliberate.

Why did Govinden's commit suicide?

The coronial investigation and the bulk of the evidence led at inquest sought to identify the circumstances that led to Govinden acting to end his life.

This involved an investigation of his background and financial circumstances together with the financial circumstances and events surrounding Anthony Ghalloub at the time.

The Evidence:

Govinden's financial circumstances:

It was apparent that during 2010 Govinden's employment circumstances became unstable. He was also gambling on a regular basis. Between April and August 2010 he was unemployed and had no regular source of income. The evidence showed that he received a series of gifts or loans totalling about $20,000. He continued however to spend heavily.

In August 2010 Govinden resumed employment. About this time he drew down a loan of $20,000 from GE Finance.

At the end of July 2011 Govinden was again unemployed. From then until his death in March 2012 he had no apparent income. During this time however he received $50,000 from his friend David Ng, $5,000 from his fiancée and $29,000 from his brother. The police investigation suggests that the bulk of this money was spent on gambling and discretionary lifestyle expenses. In February 2012 Govinden withdrew about $14,600 from his bank account $6,200 of which was from ATM's at or near The Stare Casino in Sydney.

In 2011 and 2012 Govinden and his fiancée were residing in a townhouse that was owned by her parents. Neither was paying rent for the property. His ordinary living expensed were apparently not great. On the day of his death however the evidence showed that he had $950 in the bank and debts of at least $117,000.

The .22 Long Rifle Calibre Stirling Model 20 self-loading rifle:

The police investigation determined that the sawn off .22 rifle found with Govinden on 14 March 2012 was not one of the firearms registered to either himself or his fiancée. On 16 March 2012 police retrieved the firearms that were registered to Govinden and his fiancée from the St Mary's Gun Club.

The investigation was not able to determine where, when or how Govinden was able to acquire the firearm he was found with. It was established that the rifle was manufactured in the Philippines however it did not appear that it had ever been registered. A ballistics investigation found the firearm to be in good working order. It was not known how the rifle barrel came to be sawn off.

Govinden's car:

At the time of his death Govinden owned a Ford XR6. On 16 March 2012 the brother of Govinden's fiancée advised police that he had he had seen it parked in a shopping centre car-park on the corner of Marsden Road and Victoria Road, Ermington. This was about 650 metres form the Ghalloub residence and 2.5kilometres from his home.

Govinden's car was searched by police. In the boot were located a number of items including a knife set; a set of men's black gloves, a camouflage balaclava; a copy of the Daily Telegraph dated 18 August 2011 (on the front page of which were items relating to the Mosman collar bomber); a reflective vest; a blue rope and Govinden's passport. In addition inside the car were found testamurs of Bachelor of Commerce, Bachelor of Laws and Master of Technology awarded to Govinden by the University of New South Wales. The investigation subsequently established that each of the testamurs were forgeries.

Govinden's Laptop Computer:

On 1 May 2013 Police obtained the computer that Govinden used prior to his death. With the assistance of the State Electronic Evidence Branch the electronic data stored on the computer was examined by Detective Senior Constable Ram. The examination of the computer contents did not contain any evidence linking Govinden, or his known associates, to Anthony Galloub nor did it contain any evidence suggesting that Govinden was engaging in any criminal activity.

The evening of 14 March 2012:

Govinden arrived at the Ghalloub family residence at about 7.07pm on 14 March 2012. He had left his home in Dundas a little after 6pm and had informed his fiancée he was 'going to Star City'. Govinden engaged in conversation with Veronica and or Anthony Ghalloub on the balcony until 7.26pm when he withdrew the firearm from his bag and forced Anthony Ghalloub to go inside the home at gunpoint.

The Ghalloub family were then held at gunpoint until 8.59pm when Veronica Ghalloub and her children ran from the home. After this police entered the house and found Govinden's body in the ensuite a little before 9.03pm. The Ghalloub family were thus held at gunpoint for just over an hour and a half.

That hour and a half was no doubt a terrifying experience for the Ghalloub family in particular the children. The memory of the event given by Anthony and Veronica Ghalloub has been recorded in the evidence tendered during the course of the inquest and it is not necessary for me to repeat it here other than to highlight certain aspects of the conversation that occurred during that time.

Veronica Ghalloub recalled that at one stage Govinden asked Anthony Ghalloub questions about his business and when he was told that it was in finance Govinden responded saying words to the effect of:

'How could it possibly go so wrong?'

Govinden then said:

'You obviously know why I am here.'

When the Ghalloub's said that they did not know why he was there he responded:

'*My head's on a bounty. If I don't go back and do what I was meant to do, they'll come after me, so you've got one of two options. Get some money.'*

After this there was further conversation about how much the Ghalloub's might be able to have access to and when the amount of *'about'* a hundred thousand dollars was mentioned Govinden responded:
Well that's not going to be enough!'

Anthony Ghalloub also recalled that about this time Govinden said words to the effect of:

'If I don't get out of here with money I'm as good as dead.'

Anthony Ghalloub Financial situation on 14 March 2012:

The evidence assembled during the course of the police investigation established that on 14 March 2012 Anthony Ghalloub was in serious financial difficulties. He was late with the payment of his home mortgage. He was also being pursued by persons who had loaned money to him to invest and who had not received interest and loan repayments on time. The evidence is that the amounts that had been invested with Anthony Ghalloub were substantial amounting to millions of dollars.

In March 2012 the evidence shows that Anthony Ghalloub was trying to give the impression to his investors that the investments were secure but that there were delays in repayment due to various reasons that he was endeavouring to resolve however, in about September 2012, he announced to investors that their money had, in fact, been lost.

Threats towards the Ghalloub family:

Claudia Shashati's evidence was that in about February 2012 Veronica Ghalloub told her sister that Anthony Ghalloub was receiving threats about money. It was said that those threats were being directed towards Anthony Ghalloub, Veronica Ghalloub and their children. In her evidence at the inquest Veronica Ghalloub identified various persons who had spoken to her in a threatening way. The evidence is that each of the persons identified by Veronica Ghalloub as persons who had spoken to her in a threatening way were persons who had invested money with Anthony Ghalloub.

On 14 March 2012 prior to Govinden arriving at the property a person drove onto and stopped in the driveway. Veronica Ghalloub approached the driver and recognised him as being a John Khalil. Her evidence was that she had a conversation with John Khalil and that the conversation was in the following terms:

I said, 'Hi John, can I get you to move your car. Why did you park like this' and he frantically turned around and said, 'Where is he? I want to talk to him. Where is he? I said, 'He's not here', 'I need to talk to him', and I said 'You need to leave. My kids are coming home. You need to leave. He's not here. His words were, 'If you don't get him to call me I can't stop them from coming.'

Veronica Ghalloub then said that her mother arrived to drop something off at her home and Mr Khalil drove away.

John Khalil also gave evidence at the inquest. He said that he was a person who had lost money that had been invested with Anthony Ghalloub. He said that the amount in his case was $42,000 which he had given to Anthony Ghalloub in cash. He said that the money was his children's money.

John Khalil agreed that he had sent SMS messages to Anthony Ghalloub demanding that his money be returned and saying that he owed other people money who were *'giving him a hard time.'*

He asserted, however, that he made this up and he was just telling a story to get his money back. He said that he was trying to scare Anthony Ghalloub into giving him his money back.

Whilst giving evidence John Khalil was shown various SMS messages that had been sent to Anthony Ghalloub from his phone. One such message was sent on 27 February 2012 that said:

Tony, please make sure you're home tonight. It's out of my hand, the boys need to know where the money is. I can't stop them anymore, thanks.'

John Khalil agreed that the message had been sent from his mobile on his behalf however he said that it had been typed by someone who he could not now remember. After intense examination by Counsel Assisting John Khalil eventually asserted that it was written by a cousin however as he has '*so many cousins'* he could not remember which one it was.

It was put to John Khalil that on 8 March 2012 a SMS was sent from his mobile to Anthony Ghalloub in the following terms:

'Tony, people want their money, there's going to be big problems I'm telling you now. They're demanding your address and I'm still defending. I tried calling you. They were right next to me. No more chances. You've got til the end of the day to let me know, otherwise they will come and get twice the payment from you. Ring me, you've got til 5'

Mr Khalil agreed that the message was sent from his mobile on his behalf by a person who had typed it for him but once again he could not remember who that person was. He said that he simply wanted to scare Anthony Ghalloub into giving him back his money and that he had made up the involvement of other people.

Mr Khalil agreed that he had also subsequently caused an SMS to be sent to Anthony Ghalloub in the following terms;

'Tony, call me and stop bullshitting to me, so call me now or I'm coming with the boys to your parents' place, so stop trying to hide. I'm sick of your bullshit so call me no'

He also agreed that on 14 March 2012 he sent an SMS to Anthony Ghalloub saying:

Tony, please ring me, stop trying to hide, I need to talk to you. I've been good so far so call me back.'

When it was put to John Khalil that on 14 March 2012 he also went to the Ghalloub home and spoke to Veronica Ghalloub he said that he couldn't remember. He agreed that he had been to the Ghalloub home on a number of occasions. He subsequently agreed that on an occasion he had spoken to Veronica Ghalloub at the front of her home and she had said that Anthony Ghalloub was not home.

John Khalil denied that he had ever said to Veronica Ghalloub words to the effect of:

'If you don't get him to call me I can't stop them from coming.'

On 12 September 2012 an SMS message was sent to Patrick Sahyoun, Veronica Ghalloub's brother, from an unidentified person concerning Anthony Ghalloub in the following terms:

You are on a list of people investing in or personally involved with Anthony Ghalloub. We are a popular media group preparing action on behalf of all people that have invested with him. Apparently, he has until a Friday deadline to show proof, after that we commence action. You need to join the fast growing group so SMS your name back to this number by Friday to be put on the list. I think you are all living in desperation. I have the resources to expose him. SMS with your purport (sic) it's the fastest way.

On 14 December 2012 two males (wearing hooded jumpers) attended the home of Anthony Ghalloub's parents in Carlingford and set fire to his father's Mercedes Benz motor vehicle. The police investigation of this matter was not been able to identify the persons responsible for that fire. The Inquiry into the cause origin of the fire was conducted concurrently with this Inquest. In my findings in that matter I was satisfied, for the reasons set out therein, that the occurrence of the fire was an attempt to threaten Anthony Ghalloub, or his family, following the failure of his business. (See my Findings and Reasons in *Matter number 13/48300 – Fire 1 Bankshill Street, Carlingford* dated 25 February 2015).

On 26 January 2013 there was a series of SMS messages between Patrick Sahyoun and an unknown person. This was the same unknown person who had sent him an SMS on 12 September 2012. The communication between them (S for sender and PS for Patrick Sahyoun) went as follows:

(S) 5.47pm: *'Patrick. We have been watching you. We are taking over. You have until 8pm tonight to tell us exactly where anthony ghalloub is. Your and your families safety is in your hands. If you open your mouth to the police or family it will be game over. We know more about you than you think. If we do not hear from you, you and your family will be hearing from us.'*

(S) 6.18pm: *'Still waiting on your sms.'*

(PS) '*I don't know who you are but obviously you have been watching the wrong person. I haven't seen Anthony since 26th dec at north shore hospital.'*

(S) *'You have 97 mins to find out. Unless your family is not worth protecting.'*

(PS) '*Like I told you I DON'T know where he is. Leave me and my family alone as we have been burnt just like you have'.*

(S) *'Not good enough 90 mins'.*

(PS) *'Oh we'll call me to discuss and stop hiding behind the messages.'*

(S) 6.31pm: *'You will see me. You have 88 mins you fucking smart arse. Fuck you and your family you fucking cunt. Ill eat you for breakfast.'*

This communication was well after the events of 14 March 2012 however it gives a flavour to the extent of the anger directed towards Anthony Ghalloub and his family.

The police investigation was unable to identify who it was that sent the SMS's to Patrick Sahyoun. The reason was that the person who had obtained the SIM card for the number from which they were sent had given a false name and address when purchasing it.

Govinden / Ghalloub Connection:

Notwithstanding an extensive investigation police have not been able to identify a financial connection between Govinden and Anthony Ghalloub or his business. There is no evidence available to suggest that Govinden had invested money in Anthony Ghalloub's business and there was also no evidence found that identified a connection between Govinden and any other person who had done so.

Discussion and conclusions:

There is no doubt that as at 14 March 2012 many people were very angry at Anthony Ghalloub as a result the apparent loss of their money following the failure of his business. For my purposes, as coroner examining the manner and cause of Govinden's death, it is not necessary for me to go into the details of that business and the reason for its collapse other than to know that millions of dollars were involved and the resultant anger was considerable.

There is also no doubt that some person or persons resorted to threats in order to try and obtain the return of their money. For the most part those persons have not been able to be identified by the police investigation.

John Khalil was a person who had made threats to Anthony Ghalloub saying that he was being pressured by other persons. He agreed that he had tried to scare Anthony Ghalloub into returning the money he had invested in the business but denied that any other persons were involved saying that he had made it up.

He denied that he had ever said to Veronica Ghalloub: *'If you don't get him to call me I can't stop them from coming.'*

John Khalil was a most unimpressive and evasive witness. I do not believe that I could rely on anything he said in evidence unless it was supported by other evidence.

I do not believe that he was trying to assist the investigation and I do not believe that he was telling all that he knew. Veronica Ghalloub however was more credible on this point. I am satisfied that on 14 March 2012 John Khalil attended the Ghalloub residence and said the words as described by Veronica Ghalloub and that later in the day Govinden also attended the residence. There is, however, no evidence available that would allow me to find that Govinden attended the Ghalloub residence at the behest of John Khalil. It may well be, however, that John Khalil knows a lot more about this matter than he was prepared to admit.

It would, however, seem to be reasonable to conclude that Govinden attending the Ghalloub residence on 14 March 2012 was, in some way connected, with Anthony Ghalloub's failed business. Govinden said as much to Anthony and Veronica Ghalloub during the time that they were held at gunpoint.

There is no evidence available to suggest that Govinden had a direct personal involvement in Anthony Ghalloub's failed business. On the evidence available it would also seem unlikely that Govinden would have acted on his own behalf in holding up the Ghalloub family. It is therefore probable that he did so at the behest of a third party.

It was well established that Govinden was a gambler and in March 2012 was in considerable debt. It is also possible he had debts that have not been able to be identified by police and that those debts have been used as a lever to get him to do what he did. The evidence available has not, however, been able to identify the person or persons at whose behest Govinden acted on 14 March 2012.

It can never be known why, when police arrived at the Ghalloub residence on 14 March 2012, Govinden chose to end his life? Perhaps the realisation that he was likely to be arrested and then spend some time in prison was too much for him or perhaps his comment to Anthony Ghalloub during the time he held up the Ghalloub family that:

'If I don't get out of here with money I'm as good as dead' had a significance that we will never understand. Either way the situation he found himself in at the time appears to have led him to take that action that he did to end his life.

Section 82, Coroners Act 2009 Recommendations:

Section 82 gives a coroner conducting an inquest the discretion to make recommendations he or she considers necessary or desirable that is connected with the death the subject of the inquest that is being conducted. In this case the evidence discloses that threatening SMS's were sent to Patrick Sahyoun, the brother-in-law of Anthony Ghalloub, and his family. Doing so could, if the sender was able to be identified, result in the sender being prosecuted for an offence that carries, in the case of a threat to cause serious harm, a maximum penalty of imprisonment for seven years. (See Commonwealth Criminal Code Act 1995, Section 474.15).

Because, as in this case, the SIM card and number could be purchased using a false name and address such threats were able to be sent with impunity.

This situation would seem to me to be contrary to the public interest. In the circumstances I propose to make a recommendation to the relevant Minister in accordance with Section 82 of the Act that when a SIM card for a mobile telephone or other communication device is purchased the purchaser be required to provide proof of identity similar to that required when opening an account at a bank or other financial institution.

Section 75 Consideration:

The Coroners Act 2009 recognises that where a person's death is self- inflicted there can be considerable pain and distress to the deceased's loved ones. The Parliament seeks to address this by providing that when a finding of self-inflicted death is made a report of the proceedings not be published without the specific orders of the coroner conducting the Inquest.

The coroner does, however, have the power to allow such a report where he or she is of the opinion that it is desirable to do so.

In this case there are two competing public interests. The first is that of Govinden's family for privacy whilst the second is the public interest in the examination of the actions of the police in this case and the circumstances that led Govinden to take the action that he did.

The evidence is that the circumstances of Govinden's death received considerable publicity in the media at the time. In the circumstances I have formed the opinion that in this case the interest of the public of being informed of the outcome of the Inquest outweighs that of the privacy issues for the family. In this regard I am satisfied that, to some extent, the non-publication orders that I made during the course of the Inquest, and will continue following the delivery of my Findings, are sufficient to protect the public interest in protecting the privacy of the family of the deceased.

Formal Finding:

That Jean Francis Didier Govinden (born 4 September 1979) died on 14 March 2012 at West Ryde in the State of New South Wales. The cause of his death was a gunshot wound to the head. His death was self-inflicted.

To: The Minister of the Commonwealth of Australia responsible for the administration of the Telecommunications Act 1997 (Commonwealth) or other relevant legislation:

That the Government give consideration to requiring that, before a person is able to purchase a SIM card for use in a mobile telephone or other similar device, that person establish their identity by the provision to an appropriate authority of evidence in a similar manner to that required when opening an account with a bank or other financial institution.

7. 59259 of 2013

Inquest into the death of Tracy Brannigan, finding handed down by Deputy State Coroner MacMahon at Downing Centre on the 16th June 2015.

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

1. The names of the children of the deceased.
2. The photographs of the deceased at Tab 2 of Exhibit 2, and
3. Exhibit 13.

Reasons for Findings:

Tracylee Brannigan (who I will refer to as 'Tracylee') was born on 3 March 1971. Her parents separated when she was a baby. Her mother worked very hard to provide her with loving care and a good education. Unfortunately as a teenager she became involved in the illicit drug culture. This resulted in her becoming drug addicted and involved in criminal activities.

Notwithstanding her problems Tracylee's mother continued to provide her support and encouragement as did her partner and other friends. Tracylee had two children.

Tracylee was convicted of various drug related offences on 27 May 2009 and was sentenced to imprisonment for a period of six years with a non- parole period of four years. She was eligible for parole 26 May 2013.

In December 2012 Tracylee was transferred to the Dillwynia Correctional Centre at Berkshire Park in western Sydney. On 25 February 2013 at about 5:00am Tracylee's cellmate raised the alarm and correctional officers on entering her cell found Tracylee to be deceased. Her death was reported to the Office of the State Coroner that day.

Jurisdiction of the Coroner:

Section 18, Coroners Act 2009 (the Act) gives a coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or the person who has died or is suspected to have died was ordinarily a resident of New South Wales.

Section 27 of the Act sets out the circumstances in which the holding of an inquest is mandatory.

One such circumstance is where a death occurs in circumstances covered by Section 23 of the Act. Section 23(d) refers to a person who dies in a correctional centre. As Tracylee's death occurred in a correctional centre an inquest into her death is mandatory. Section 23 of the Act also requires that such an inquest be conducted by either the State Coroner or a Deputy State Coroner.

The primary function of a coroner at an inquest is to be found in Section 81(1) of the Act. That section provides that at the conclusion of the inquest the coroner is to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

Section 82 (1) of the Act provides that a coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths.

Identity, Date and Place of Death:

Tracylee' body was identified by Ms Leanne O'Toole on 25 February 2013. Ms O'Toole was, at the time, the Acting General Manager of the Dillwynia Correctional Centre and had known Tracylee since her arrival at that Centre.

The date of her death was also not a matter of contention. Tracylee was observed to be alive when placed in her cell at Dillwynia Correctional Centre at about 3:30pm on 24 February 2013 and was subsequently found deceased at about 5:00am on 25 February 2013. She therefore died in her cell at Dillwynia Correctional Centre at some time between those two events.

Cause of death:

The cause of Tracylee's death was also not contentious. Following her death an autopsy was performed by Dr Kendal Bailey a forensic pathologist.

Based on her findings at autopsy, and taking into account the toxicology and serology reports she received, Dr Bailey concluded that the cause of death was due to Heroin Toxicity.

It was found that in Tracylee's blood there was a potentially fatal level of morphine and metabolites specific to heroin. I accept Dr Bailey's conclusion as to the cause of Tracylee's death.

Issues of Inquest:

The primary issue for inquest was to inquire into the manner, or circumstances, of Tracylee's death.

There was also a need to investigate the circumstance of Tracylee's incarceration in order to ensure that there were no systemic failures that led to, or contributed to, her death. This examination arose from the fact that Tracylee had been deprived of her freedom. The former State Coroner Kevin Waller described the reasons why such examination is mandatory in the following terms:

> *The answer must be that society, having affected 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 is not exacerbated by ill-treatment or privation while waiting trial or serving 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 prisoners in a humane fashion, and satisfies the community that deaths in such places are properly investigated.*

In the case of Tracylee's death there was a serious allegation made that Tracylee was not properly cared for by corrective services officers prior to her being placed in her cell at 3:30pm on 24 February 2013 and, by implication, this contributed to her death. That allegation needed to be examined in detail.

Kat Armstrong was a friend of Tracylee's. She is also the director of an organisation known as WIPAN. That organisation was established in 2008 and was designed to advance the wellbeing and prospects of women in the criminal justice system. Ms Armstrong visited Tracylee on 24 February 2013. She arrived at about 2:00pm. There was some delay in getting Tracylee to the visitors section however after she arrived they spent about 20 minutes together.

Ms Armstrong made a statement to police on 4 March 2013. In that statement she asserted that at the time of her visit she formed the opinion that Tracylee was under the influence of some form of opiate or some pill of some sort. She said that she asked her what she had taken however Tracylee denied that she had taken any drugs.

She said that because of her state Tracylee was not in a position to contribute very much to their conversation.

Ms Armstrong said that she did not specifically tell any corrective services staff of her concern because she believed that Tracylee's condition was obvious to them.

She said that she engaged in some loud conversation with Tracylee that she expected would draw attention to Tracylee's condition. She did not see it as being her role to 'dob' on her friend so did not specifically tell any corrective services staff of her concerns. Ms Armstrong subsequently repeated her assertion on national television.

Ms Armstrong gave evidence at inquest. In her evidence she said that there was no doubt in her mind that at the time of her visit Tracylee was seriously affected by drugs specifically some form of opiate. In addition to the matters she referred to in her statement in her evidence she said that she had also indirectly raised her concerns with a male corrections officer on her way out after the visit. Once again she did not directly say that she thought Tracylee was under the influence of drugs but believed her comments to the officer would have implied that was the case.

When she was asked why she had not mentioned this in her statement in March 2013 she said that she had told the police officer who had take her statement however he had not recorded that fact.

Lauren Ironside was Tracylee's cellmate at the time of her death. Ms Ironside found her deceased and called for assistance on the morning of 25 February 2013. An electronic interview of some 666 questions was conducted with Ms Ironside on 25 February 2013.

Ms Ironside also gave evidence at the inquest. In her evidence at the inquest Ms Ironside said that at the time of Tracylee's return to the cell following her visit with Ms Armstrong she formed the opinion that Tracylee was under the influence of drugs. This suggestion was new evidence and contradicted the statement that she made in her interview on 25 March 2013 at answer 291 when she said that Tracylee, on her return from the visit, was not 'stoned.'

The allegations made by Ms Armstrong and Ms Ironside are very serious. If, at the time of her return from her visit with Ms Armstrong she was under the influence of drugs it would not have been appropriate for her to be locked in the cell for the night.

It would have been necessary, in accordance with corrective services procedure, for her to be taken to the clinic and examined by a Justice Health nurse and, if it was found that she was so affected, placed in an observation cell until the effects of the drug had dissipated.

If it was the case that Tracylee was so affected, and corrections officers knowingly failed to take her for assessment an observation, it would be necessary for me to consider making recommendations that disciplinary action be commenced against such corrections officers.

To determine what occurred on 24 February 2013 evidence was received at inquest from corrections officers Kerri Pedley and Dimity Geddes, who were officers supervising Tracylee during the course of the visit, and corrections officers Westleigh Giles, Steven Vella and Robert Eastwood who undertook muster prior to Tracylee being locked in her cell for the night. Each of these officers said that their training and experience allowed them to identify when an inmate was affected by drugs. Each of the officers said that at the time they observed Tracylee on 24 February 2013 she was not affected by drugs.

In questioning the corrections officers the representative of the family implied that the various officers may not have been able to identify subtle changes that might have been present if Tracylee was in fact affected by drugs but was trying to hide that fact. Because of this Dr Judith Perl a forensic pharmacologist was asked to examine the CCTV recording of Tracylee during the course of the visit and provide an expert opinion as to whether or not Tracylee was affected by drugs. Dr Perl, as a consequence of her training and experience, is an expert in the effects of various drugs on the person and is, as such, able to identify the more subtle changes that such drugs have on individuals. Having examined the CCTV of the visit Dr Perl was strongly of the opinion that Tracylee was not drug affected at the time of the visit.

I accept the evidence of Dr Perl and the five corrections officers. I reject the evidence of Ms Armstrong on this point. In addition I am satisfied that as a friend of Tracylee had Ms Armstrong really thought she was under the influence of a drug at the time of the visit she would have mentioned that fact to a corrections officer out of concern for her friend.

The fact that she did not do so supports the contention that that was not a concern that she held at the time but a reconstruction of events that was developed following Tracylee's death.

Why she made the assertions that she made in her statement, during the course of the inquest and when commenting on the matter on national television can only be a matter for speculation however it may be that she was acting out of some misguided agenda of trying to improve the lot of females in custody.

In the case of Ms Ironside I found her to be a most unsatisfactory witness. Why she stated at the inquest that Tracylee was under the influence of drugs at the time of her return from the visit would also be the matter of speculation. She was, however, clearly wrong.

What happened after 3:30pm?

The only direct evidence available as to what happened after Tracylee and Ms Ironside were locked in at 3:30pm was what Ms Ironside told the police in her interview on 25 February 2013.

In summary she said that Tracylee gave her a Rivotril tablet and after that Ms Ironside went to sleep. Ms Ironside also said that before she fell asleep she also saw Tracylee take some tablets as well. In her statement Ms Ironside said that this occurred after lockdown however in her evidence she said that the tablets were consumed prior to lockdown and not afterwards.

I have already found Ms Ironside's evidence to be questionable. I found that her evidence on this matter is also unsatisfactory. I do not accept that Tracylee consumed Rivotril tablets as asserted when Ms Ironside said she did. In this regard I had the benefit of the evidence of Dr Judith Perl.

Dr Perl gave evidence that Rivotril is a commercial name of a drug known as Clonazepam. That drug was found in Tracylee's blood at autopsy however Dr Perl's evidence was that it was in such low quantities that it must have been consumed at a time well before that suggested by Ms Ironside. I accept this evidence and conclude that I cannot place any reliability on Ms Ironside's evidence as to what happened in the cell after she and Tracylee were locked in at 3:30pm on 24 February 2013 unless such evidence were supported by other credible evidence.

Dr Perl confirmed in her evidence that the level metabolites of the heroin found in Tracylee's blood at autopsy was potentially fatal. Dr Bailey's examination of her body at autopsy did not find any evidence to suggest that the administration was other than voluntary. At autopsy fresh injection marks on her body found.

There was a great deal of evidence available to suggest that Tracylee continued to use illicit substances whilst in custody and was known for her drug seeking behaviour. Heroin was her drug of choice. I am satisfied that it is more likely than not that sometime after she and Ms Ironside were locked in their cell on 24 February 2013 Tracylee administered heroin to herself and that administration resulted in her death.

Tracylee's family have suggested that her death was preventable and that 'the system' let her down. They have asserted, in general terms, that had she been given better educational and rehabilitation opportunities and had, as a known drug user, her cell been searched prior to her being locked up at 3:30pm, and her cell been monitored during the course of the night she may not have overdosed.

They have suggested that I make various recommendations in accordance with Section 82 in order to remedy these perceived deficiencies.

Dealing with the issue of searches first the evidence was that about 75% of women inmates in NSW correctional facilities had drug addiction issues. The availability of illicit substances in correctional facilities is an endemic problem. Some inmates will go to considerable lengths to obtain drugs. The evidence available to me was that the problem was recognised and various actions were taken to try and mitigate the problem. I had available to me an outline of such action. For my purposes I do not need to set such action out in detail.

Part of that action however includes searching cells. The evidence was that 5 or 6 cells a day are searched on a random basis and if information becomes available to suggest that an inmate might have contraband then targeted searches are also undertaken. Tracylee's cell was in fact the subject of a random search on the morning of 24 February 2013.

The family was critical of the policy of not searching cells prior to lockdown. Their hypothesis was that as Tracylee was a known user her cell should have been searched before she was locked in and if this had been done the drugs she used would have possibly been found and she would not have died.

Similarly the family suggest that drug users were more likely to use drugs in their cell after lock down and as Tracylee was a known drug user her cell should have been monitored in some way to ensure that she did not use drugs or, if she did, identify when she had overdosed and be able to provide assistance at a time when she might have been able to be revived.

Finally the family had concerns that because Tracylee arrived at Dillwynia in December 2012 and was on sanctions because of breached of prison rules she was precluded from engaging in educational and rehabilitative programs that might have encouraged her to not use the illicit substances that resulted in her death. Dealing with the last matter first it is trite to say that before a drug addict can begin the journey to overcoming the addiction they have to want to do so.

The evidence was overwhelming that Tracylee did not want to abandon her addiction. The records of Tracylee's interaction with Justice Health staff on 21 September 2010, 29 June 2011, 23 August 2011, 25 May 2012, 25 August 2012, 22 October 2012, 21 October 2012, 16 January 2013 and 21 February 2013 was consistent in her refusal to accept any assistance that was offered to help her with her addiction.

She simply did not want to, or was unable to, deal with her drug problem at the time. I do not accept that the absence of any available programs during her time at Dillwynia contributed in any way to Tracylee's death. I do not consider that the circumstance of Tracylee's death give rise to my needing to make recommendations as to the timing, or availability, of educational or rehabilitative programs for inmates.

The monitoring of inmate cells is a difficult issue. Certainly there are cells available for short term occupancy of inmates that are suicidal and have other problems that require close observation. Inmates who are found to be drug affected are monitored to ensure their safety until that crisis passes. Random monitoring of inmates in ordinary cells would however raise significant privacy issues for the occupants. Inmates are entitled to be treated with dignity and respect. Observing them in their cells would counter that obligation particularly in an environment where inmates are being prepared for release into the community. I am not prepared to recommend that such monitoring occur.

The regime of searching cells is part of a considered approach to preventing contraband being available to inmates.

The evidence was that such searches have been successful in identifying the existence of contraband. This is to be commended. The evidence of corrective service officer Giles that most drug taking will occur after inmates are locked in does, however, suggest that the searching of cells on a random basis at, or shortly after, lockdown would possibly identify additional contraband that had been secreted outside the cell during the day.

I propose to recommend to the Commissioner of Corrective Services that consideration be given to the conduct of searches of cells on a random basis at that time in addition to the current searching regime.

The representatives of the family have also suggested that I should make recommendations as to the training of corrective service officers concerning the identification of inmates affected by drugs and alcohol. There is nothing in the evidence available to me in this inquest to suggest that there is a need for such training. I do not therefore propose to adopt that suggestion.

It has also been suggested that Corrective Services assess the viability of the implementation of a full body scanner at Dillwynia as a pilot project. The purpose of such a scanner would be to identify contraband on the person of inmates that cannot be located by currently approved searching techniques.

This suggestion may be a good one however there was no evidence before me as to the costs of the implementation of such equipment and the suitability of use of such equipment in a correctional centre such as Dillwynia that is preparing inmates for release into the community. Indeed comments during the course of giving her evidence by Leanne O'Toole, the acting general manager of Dillwynia at the time of Tracylee's death, suggest that it may not be appropriate. I do not therefore believe it is appropriate for me to make such a recommendation.

Media attention:

The nature of coronial proceedings is such that it inevitably attracts media attention. The inquest into Tracylee's death was no different. On Monday 9 June 2014, the evening before the inquest commenced, Tracylee's death was the subject of extensive coverage on the ABC's program '7:30'. No criticism of the producers is made for them bringing these issues to the attention of the public. It is important that it occur and coroners welcome it occurring.

During the ‘7:30’ coverage Ms Armstrong was interviewed. She repeated the allegations that she made in her statement and again during the course of the inquest. As mentioned above those allegations were found to be not credible. The rejection of the evidence of a witness in an inquest or other legal proceedings is not unusual. That is what occurred in this case. One of the reasons why it is mandatory for an inquest to be conducted in the case of a death in custody is to ensure that persons responsible for the care and treatment of persons who have been deprived of their liberty have been appropriate. Coroners have quite rightly been quick to point out when such care has been less than appropriate.

Equally coroners should not be restrained in acknowledging when, as in this case, the officers responsible for the care of inmates have acted appropriately. Indeed where, as in this case, such officers are the subject of serious allegations of dereliction of duty that are not supported by the evidence this fact should be acknowledged. The difficulty that arose in this case appears to have occurred as a result of the ‘7:30’ program being shown prior to the commencement of the inquest. This meant that the producers did not having access to all the evidence surrounding Tracylee’s death. This resulted in them broadcasting to the public allegations that were subsequently found not to be credible. This could have had a negative effect on the perception of the public as to the competency and commitment of the various corrective service officers involved in the care of inmates. This is a most unfortunate outcome.

Formal Finding:

Tracylee Brannigan (born 3 March 1971) died between 24 February 2013 and 25 February 2013 at the Dillwynia Correctional Centre, Berkshire Park in the State of New South Wales. The cause of her death was Heroin Toxicity which was self administered. There was no evidence to suggest that in administering the drug the deceased intended to end her life. The manner of her death is therefore misadventure.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

To: The Commissioner of Corrective Services:

That consideration should be given to the implementation of random searches of cells at, or shortly after, the afternoon lockdown with particular attention being given to cells occupied by inmates that are known, or reasonably suspected, to be users of illicit substances whilst in custody.

8 & 9. 2013/98426 & 2013/98427

Inquests into the death of Nicholas Karayiannis and AA findings handed down by Deputy State Coroner Dillon at Glebe on the 13th October 2015.

Note: Non-publication orders have been made in relation to photographs taken at the scene after the deaths.

Introduction

This is a joint inquest into the deaths of Nick Karayiannis and AA, both of whom were on remand at the Metropolitan Reception and Remand Centre at Silverwater at the time of their deaths. When a person dies in custody in NSW the Coroners Act requires that an inquest be held into the cause and circumstances of that death.

On 1 April 2013, both Mr Karayiannis and Mr AA were found dead in the cell they had shared. The police investigation that followed found evidence that Mr Karayiannis had been killed by Mr AA who then took his own life.

The coroner's functions and the nature of the inquest

An inquest is an independent judicial inquiry by a coroner. When a person to whom the state owes a particular duty of care dies in the custody of the state, questions can and should be asked. Loss of liberty is the greatest punishment that our society can impose on a member of this community or visitors to it.

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

The corollary of this extraordinary state power to detain people in custody is the responsibility to care for and protect prisoners.

If, for whatever reasons, the system intended to protect prisoners fails to do so, s 23 of the Coroners Act 2009 requires that an inquest be held.

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

The background

AA

AA had been arrested by Australian Federal Police on 1 March 2013 and charged with attempting to possess a commercial quantity of imported drugs.

He was received at the MRRC on 5 March and was assessed by a mental health nurse on 10 March 2013 as being fit for normal cell placement.

AA had previous periods of incarceration dating back to August 1999. The assessment of Mr AA on intake in 1999 was that he was suicidal and unwell as a result of withdrawal from a heroin addiction. During a subsequent period of incarceration it was noted on 21 September 2000 that ripped sheets were located in a cell hosing Mr AA. It appears Mr AA was appropriately managed by Corrective Services and Justice Health post these events.

Other than these notations, there is no other mental health history for Mr AA during further periods of custody in 2000 and 2007 until 2011. Mr AA received medical treatment for heroin use and Hepatitis C as well as other minor medical matters during these times. Corrective Services Case Management files covering all Mr AA's periods in custody do not indicate a history of violence or any incidents of violence toward other inmates.

Shortly before the fatal incident, however, Mr AA received bad news. His mother had died and he also had learned that another member of his immediate family, his sister in Vietnam, had died. It appears that these events may have been the trigger for his decision to take his own life.

What he does not appear to have reckoned on was Mr Karayiannis thwarting his original attempt. How that happened we do not know but clearly it played on Mr AA's mind because there was no previous indication of bad blood between the two men.

Nick Karayiannis

Mr Karayiannis was 42 at the time of his death. Many members of his family attended the inquest. He was obviously much loved by his family. He had two daughters, Maria and Nicoletta, and a son Michael, all of whom lived with him after he and their mother separated. Maria described him as "a very strong and confident man" who was healthy, socially active and "a good provider" with a passion for jet-skiing. He was in business selling boats and had previously been in cementing and had driven trucks.

He was arrested on 7 March by NSW Police and charged with manufacturing a commercial quantity of a prohibited drug. This was his first time in custody. He was also screened and found not to have any significant mental health conditions. Justice Health records indicate Mr Karayiannis did not present with any history of or current symptoms of ill health. He denied any mental health issues or drug misuse.

AA's previous suicide attempts

The police investigation found that Mr Karayiannis had intervened in a previous suicide attempt (or perhaps two attempts) by Mr AA. Mr Karayiannis spoke of this to his daughters Maria and Nicoletta, fellow inmate Melih Basturk, his lawyer and a friend Bellal El Saadi. The ripped sheets found in 2000 indicate that Mr AA had probably made serious plans to take his own life at that time.

Mr Karayiannis told his lawyer Mr Van Houten that he intended to notify the pod manager of Mr AA's attempt. He also told others that he had notified a correctional officer. Corrective Services has a very clear and strong protocol that is intended to deal with all indications of possible self-harm. Officers are required to treat such notifications as emergencies.

It is possible that an officer was given some information by Mr Karayiannis but 'laughed it off'. If so, that would be a clear breach of the policy.

But whether Mr Karayiannis in fact told a correctional officer we do not really know. If Mr Karayiannis did say something to an officer, we do not know exactly what was said or how what was said was interpreted by the officer. It is also possible that Mr Karayiannis intended to inform an officer but changed his mind. It is unlikely that he was afraid of Mr AA but perhaps he was in fact trying to be respectful of Mr AA's privacy.

It is also possible that Mr AA had asked Mr Karayiannis not to report the incident or had threatened to harm Mr Karayiannis if he did so. In any event, no record of such a notification was found during the investigation. Neither inmate is reported to have given any indication to correctional staff that they had concerns for their safety or the safety of their cell mate.

At reception, it appears that inmates are offered a handbook that explains various aspects of gaol routine to them. Mr Karayiannis's property did not include such a handbook. While there is some evidence that many prisoners do not receive a handbook, the better evidence seems to be that they are available to prisoners but are not forced on prisoners. As there is a widespread culture of refusing to 'dob' or 'give up' other people in gaol, whether Mr Karayiannis would have followed the instruction in the handbook to report risk or incidents of self-harm can only be a matter of speculation.

The night of 31 March – 1 April 2013

On 31 March 2013 Mr AA and Mr Karayiannis participated in the afternoon muster without incident. Both were secured in cell 353 by Correctional Officers. At the time the deaths occurred both Mr Karayiannis and Mr AA were classed as 'Normal Cell Placements' and had no current alerts on the Offender Management System.

During the night, probably between 10.30 and 11.00pm, a remand prisoner in a cell beside cell 353 heard what he thought were the sounds of a fight coming from the cell in which Mr AA and Mr Karayiannis were locked up.

He and his cellmate heard screaming and banging. The prisoner who gave evidence said that he thought the noise was from Mr Karayiannis. He estimated that the fight had taken about one or two minutes.

Although fighting and shouting was quite common in the wing, that prisoner said that he had not heard fighting in Mr Karayiannis's cell before that night and that both he and Mr AA were "quiet".

As it now appears, the sounds that emanated from the cell were of Mr Karayiannis fighting for his life as he was being strangled by his cell-mate Mr AA. Despite the desperate sounds that they heard, neither of the prisoners next to cell 353 pressed the 'knock-up' button to call for help.

Nor, did anyone else in the wing, although the noise must have been heard by others. At about 6.15am on 1 April 2013 during morning head check both Mr Karayiannis and Mr AA were located deceased in cell 353.

The response by correctives staff upon locating Mr Karayiannis and Mr AA was generally in accordance with the Deaths in Custody Protocol.

The issues

The circumstances of these two deaths raised the following issues that have been considered at this inquest:

- What was involved in assessing AA as suitable for normal cell placement?
- Was there a systemic failure to recognise the potential risks of placing Nick Karayiannis in a cell with AA?
- During the night, what was heard and should that noise have raised the alarm?
- Did MRRC staff who discovered the deceased respond in accordance with the Deaths in Custody Protocol?

Assessment of AA for normal cell placement

Mr AA was seen by Registered Nurse Tolentino on his reception at the MRRC. RN Tolentino had no access to his previous files or history. This initial assessment process operates in much the same way as a triage system. All RN Tolentino had to go on was what he was told by Mr AA and his own impressions and experience.

Although Mr AA denied any previous history of mental illness and denied being on any medication, Mr Tolentino formed the impression that he was slightly depressed and referred him for a further mental health assessment to RN Barbara Sullivan, an experienced mental health nurse. He also allocated Mr AA to a group cell in case he was at risk of self- harm.

RN Sullivan saw Mr AA five days after his initial assessment. He told her that he was in a good mood. She found no signs of major mood disorder, psychosis or thought disorder and he appeared to her to be at most slightly depressed about coming back into custody, a very normal reaction. He denied any suicidal ideation or planning. In her view, he was fit for normal cell placement.

Assessment of suicide risk is much more difficult than is generally recognised within the community.

Many studies of psychiatric patients who have committed suicide have shown that it is virtually impossible to predict whether a person will commit suicide, even if that person is assessed as being at high risk. In many cases, the most significant risk factor is a previous suicide attempt.

In this case, Ms Sullivan did not know the history of Mr AA's previous plans in 2000. She was not told about that episode by Mr AA and she did not search through all his files. Her evidence was that she had examined the most recent Justice Health files only and found nothing that would have raised a question concerning suicidal thinking.

Systemic failure in risk assessment?

In my view, an assessment of mental health status should take into account the whole history of a patient, as far as it can reasonably ascertained. This is standard medical and psychiatric practice. RN Sullivan did not explore Mr AA's entire history. Whether it would have been reasonably practicable to do so is somewhat unclear. Certainly the records were not easily accessible in computerised form, an issue about which I will comment below.

In any case, while it may have caused her to probe a bit more deeply, it seems unlikely that her assessment of Mr AA's mental health in 2013 would have been significantly different if she had discovered the 2000 episode in the files.

One of the systemic problems that both RN Tolentino and RN Sullivan had to deal with was that the information and IT systems that they had to use did not efficiently bring together all the relevant information they needed to make the most accurate mental health assessments they were capable of making. To a very large degree, because of the inefficiencies of the information systems they were using, both nurses had to rely on their own experience and clinical judgments.

RN Tolentino had virtually no information, other than that supplied by Mr AA, about the patient's history. We know that this history was inaccurate and incomplete in at least one significant respect and this raises the question whether it was inaccurate and incomplete in other significant respects. While in this case, RN Tolentino's judgment seems to have been appropriately conservative, in that he decided that Mr AA should be assessed by a specialist mental health nurse, a less cautious and experienced nurse may not have taken that approach.

Similarly, RN Sullivan had an incomplete history both because Mr AA did not supply her with all the relevant information himself and because she searched only the most recent file.

It is notorious that a large proportion of the gaol population of NSW suffers to, varying degrees, from mental illness. Presumably, of those, a significant number are suffering depression and adjustment problems due to being locked up. But significant numbers are also people with lengthy histories of mental illness of different types.

Assessing prisoners at the reception stage and also during their periods of incarceration is a core function of the correctional system, involving both the Department of Correctional Services and NSW Health. That task is difficult enough for those whose responsibility it is to carry out without the additional burden of the inefficiencies of the patient / inmate information systems complicating the process.

To meet that responsibility adequately, it seems to me that a better patient information system than was available to RNs Tolentino and Sullivan is needed.

I understand that the patient record system is now being upgraded to a fully electronic system. Evidence was also given that warnings and notifications received by the Department of Corrective Services concerning risk of self-harm are routinely notified to Justice Health. When implemented, this system will significantly reduce the current inefficiencies and should enable Justice Health staff to access a more complete patient history than is currently available.

Noise during the night?

Mr Karayiannis died resisting his attacker. His struggles were heard by prisoners but not by those whose job it was to protect him. After 9.30pm or so, the correctional officers who would ordinarily be monitoring the pod for disturbances or requests for help, were at the other end of the gaol.

Nobody in the pod alerted the correctional staff to Mr Karayiannis's fatal struggle. No one pressed a 'knock-up' button to call for help.

According to Mr Basturk, who heard a disturbance and assumed that it was a fight, prisoners are reluctant to use the 'knock up' button to 'dob' on people fighting because of their fear of retribution. Prisoners are subject to disciplinary proceedings within the gaol system if they breach prison rules and regulations. The possibility of retribution for 'dobbing' is real. Mr Basturk also gave evidence that fighting and shouting in cells is common. Most prisoners ignore it.

It is one thing for the Department of Correctional Services to install 'knock-up' buttons. It is another thing to create a culture of using them in the kinds of circumstances that occurred in this case. It is true that 'knock-up' buttons are frequently used by prisoners.

Sometimes this is for legitimate reasons, such as people becoming ill in their cells; but it is also common for prisoners to use them to play pranks on correctional staff. Evidence was given by Mr Basturk that knock-up calls are sometimes ignored by staff.

I do not accept this evidence. Obviously if no one is in the wing at the time to respond, it may be some period before the call is responded to as it has to be transferred to other locations. But the weight of evidence is to the effect that every call is responded to, notwithstanding the considerable number of nuisance calls.

The real protection for prisoners, however, is the capacity of experienced staff to monitor the sounds coming from cells. Senior Correctional Officer Scott Perkins told the court that from the pod office, located in the middle of the pod, officers can hear any shouting or loud noises and are able to distinguish between serious problems which require their immediate attention and more sociable noises, such as barracking for football teams.

Mr AA was an experienced prisoner. It is reasonable to assume that he knew that, once the security check had been completed at 9.30pm, there were no correctional staff in the pod and that therefore there would be no one to intervene if he attacked Mr Karayiannis after that time and Mr Karayiannis made loud noises in a struggle. He also probably knew that it was unlikely that anyone in the wing would 'knock-up' the staff if his attack on Mr Karayiannis was noisy.

SCO Perkins told the court the reason there were no officers in the pod after the security check was that there had been staff cuts so all the available officers on the watch were gathered together in one location at the other end of the gaol. Whether there actually have been staff cuts is not clear. Assistant Superintendent Murray Stewart gave evidence that staffing levels on B Watch had been more or less constant for many years.

The end result of this combination of a culture of silence and absence of correctional staff is that Mr Karayiannis was left unprotected against Mr AA.

The response to the incident

First Class Correctional Officer Lachlan Hilton and his colleague First Class Correctional Officer Damian Cooke made the dreadful discovery that Mr Karayiannis had been killed and Mr AA had taken his own life only in the morning at about 6.15 am when they were conducting head checks.

Mr Karayiannis was found tied to his bed and Mr AA was hanging from a homemade ligature. Both men were beyond resuscitation. It is evident that they had probably been dead for several hours. The scene was understandably very distressing for the correctional officers. They called other staff to bring a tool to cut down Mr AA and Mr Hilton cut the bonds restraining Mr Karayiannis. Nurses were called as was an ambulance.

According to the protocol governing response to such incidents, correctional staff should also have immediately commenced CPR pending the arrival of the medical team. In the circumstances, while the protocol was not carried out in its entirety, this oversight did not make any difference.

Should more be done?

The deprivation of a person's liberty by the state brings with it the heavy responsibility of protecting that person while he or she is in the custody and care of the state. Although cells are fitted with 'knock-up' alarms, correctional staff know that this is not a complete answer to problems that the death of Mr Karayiannis (and, indeed, other killings in cells) raise.

Evidence was given by Assistant Superintendent Murray that if sufficient staff were to be placed in the pods to be available to hear and respond to loud incidents occurring during the night more than double the current staffing levels would be required. His evidence was that to spread the available staff (usually 14) across the pods at night would be inefficient and risky.

That may well be so. Perhaps other less expensive, technological solutions to the problem of protecting prisoners at night are available. The problem, however, cannot be ignored and it will not go away. The state owes its prisoners a duty of care. It also owes a duty of care to correctional staff and cannot place them at risk.

Conflicting evidence about the availability of the handbook was given. I accept that the handbook is readily available but that some prisoners either do not receive it or do not take an offered copy.

In my view, a copy should be handed to every prisoner on reception and he should be made to sign for it or a record should be kept in some other way that it has been given to the prisoner.

One problem that arose during the police investigation of the incident was that there was no efficient way of identifying correctional officers who had entered the pod during the night of the incident. While careful records are kept of prisoners being brought in and leaving the pod, it seems surprising that the same stringency of record-keeping is not applied to staff coming and going. This appears to be a gap in the security of the system and, in my view, should be rectified.

Conclusion

This case is tragic and very unusual. Unfortunately, homicides in gaols happen from time to time. What is unusual, perhaps unique about this case, is that Mr Karayiannis seems to have died because he had previously successfully prevented another prisoner, his cellmate, from taking his own life.

It is a paradox that mentally ill prisoners are often placed with others in cells so that they can be watched and their deaths prevented yet, in this case, it was the carer who first lost his life.

Mr AA's suicide, much less his violence towards Mr Karayiannis, was not predictable. It is virtually impossible even for highly experienced psychiatrists to predict a suicide even in high risk individuals. He had not displayed signs to Justice Health staff or Corrective Services. While some prisoners knew of his attempted suicide that Mr Karayiannis had prevented, it is very unclear what, if anything, was known by correctional staff about this. Mr AA had no significant history of violence either in gaol or in the community. That he would take such extreme measures against Mr Karayiannis could not have been foreseen.

What I think was foreseeable, although perhaps remotely, was that without a monitoring system in the pods during B Watch, someone could be attacked and hurt and that, given the culture against 'giving up', someone could be very badly harmed without protection.

Mr Karayannis was obviously much loved by his family and his friends. I hope that they will accept my sincere condolences and those of the coronial team.

Formal Finding:

I find that Nick Karayiannis died on the night of 31 March – 1 April 2013 in cell 353 of Pod 11 in G Block, Metropolitan Reception and Remand Centre, Silverwater, New South Wales due to ligature strangulation inflicted on him by his cellmate AA while in the custody of the Department of Corrective Services.

I find that AA died on the night of 31 March – 1 April 2013 in cell 353 of Pod 11 in G Block, Metropolitan Reception and Remand Centre, Silverwater, New South Wales by hanging with the intention of taking his own life while in the custody of the Department of Corrective Services.

Recommendations

That the Department of Justice (Corrective Services) investigate and implement a system for ensuring the greater safety during B Watch of inmates being held in the Metropolitan Reception and Remand Centre, Silverwater by improving the capacity of correctional staff to monitor unsafe activity within the pods during that watch.

That the Department of Justice (Corrective Services) give a Male Inmates Handbook to all male inmates received at the Metropolitan Reception and Remand Centre, Silverwater and that it implement a system of recording that each inmate has received the handbook.

That the Department of Justice (Corrective Services) implement a system of recording entries to and exits from pods by correctional staff during B Watch.

10. 123760 of 2013

Inquest into the death of AB finding handed down by Deputy State Coroner Forbes at Glebe on the 13th July 2015.

This inquest concerns the sad death of AB on 20 April 2013. He was a 33 year old man who had been released from Parklea Correctional Centre on 9 April 2013 into the custody of Villawood Immigration Detention Centre (VIDC). His permanent residency in Australia had been revoked and he was facing being deported to Papua New Guinea.

On 19 April 2013, at VIDC, he inflicted deep cuts into his arms and neck and was taken by ambulance to Liverpool Hospital. He underwent surgery at the hospital. Upon his recovery he broke the window of his fifth floor hospital room and went out onto a ledge. Police were called and after 12.5 hours of negotiations he caused himself to roll off the ledge and fell to his death.

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

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

This inquest is a mandatory inquest by reason of the fact that AB died during the course of police negotiations. The combined operation of ss. 27 and 23 of the Act require a Coroner to conduct an inquest where the death appears to have occurred *"in the course of police operations".*

"The purposes of a s.23 Inquest are to fully examine the circumstances of any death in which Police ... ... have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances.

In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82." [1]

It should always be borne in mind that inquests are not criminal investigations, nor are they civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. This Inquest has been a close examination of the circumstances surrounding AB's death and pursuant to s.37 of the Coroner's Act a summary of the details of this case will be reported to Parliament.

AB

AB's mother has requested this Court to refer to her son as AB in this Inquest, and I accede to that request. AB is a much loved son of his parents. He was born in Papua New Guinea in 1979.

AB and his mother lived in Papua New Guinea until he was about 6 years old, at which time he came to Australia with his mother and commenced living with his father.

In 1987 AB's mother and father married. Later in 1987, AB's mother gave birth to a second son. After AB's mother's marriage, she and AB applied for and were granted permanent residency in Australia, although AB never became an Australian citizen.

AB attended Dapto Public School and then Kanahooka High School near Dapto where he completed Year 11. After leaving school, AB had a number of labouring and other jobs, and attended some courses at TAFE. His Mother described him as an outstanding sportsman, who was at some stage selected to play rugby league for NSW.

When he was about 25 years old, he commenced a relationship and had 2 children.

On 25 March 2009 AB committed a serious assault on his partner, and was sentenced to imprisonment for a total period 3 years 5 months. On 7 June 2011, while AB was serving his term of imprisonment, the Minister for Immigration cancelled his permanent residency visa, on "character" grounds.

This decision was based on his criminal convictions. As AB was not an Australian Citizen, he became liable to be deported to Papua New Guinea.

On 26 September 2011, having served his term of imprisonment, AB was transferred to VIDC to await his deportation to Papua New Guinea. AB challenged the decision to cancel his visa. The Administrative Appeals Tribunal affirmed the Minister's decision to cancel the visa. Appeals by AB to a single judge of the Federal Court, and then to the Full Federal Court, were unsuccessful.

Facts in outline

AB's first transfer to VIDC

On 26 September 2011 AB was first transferred from prison to the VIDC. He was there for about 2 weeks. I find his conduct between 26 September and *9* October 2011 made it plain that he would rather remain in gaol in Australia than be sent to Papua New Guinea. This is not altogether surprising, given that since the age of 6, AB had lived in Australia.

While in the VIDC, AB undertook conduct aimed at ensuring that he stay in Australia. He:-

1. Damaged property inside the Detention Centre
2. Contacted NSW Police wishing to confess to various crimes
3. Made threats to "take a hostage" inside the Detention Centre

On 9 October 2011, AB committed a serious and unprovoked assault on a Serco Australia Pty Ltd (Serco) security officer employed at the VIDC. Serco is the company responsible for security at the VIDC. I accept that this assault was committed by AB for the sole purpose of attempting to remain in Australia rather than being deported to Papua New Guinea.

AB was taken into Police custody and charged with assault occasioning actual bodily harm. The next day he pleaded guilty at the Local Court to the offence charged and was sentenced to 18 months imprisonment, with a non-parole period of 12 months. AB was detained in various NSW Correctional Centres, until 9 April 2013.

Second transfer to VIDC

On 9 April 2013, AB was released from Parklea Correctional Centre into the custody of Serco and taken to the VIDC.

Prior to AB's arrival at the VIDC, there was concern as to whether he could safely be managed at that facility (or whether a request should be made for him to stay in a NSW prison until ready to be deported). Ultimately, a decision was taken by the Department of Immigration and Border Protection (DIBP), in consultation with Serco that AB would be accepted into the VIDC -but would be housed initially in the highest security Murray Unit.

Arrival into Murray Unit at the VIDC

On Tuesday, 9 April2013, AB arrived at the VIDC and was placed in the Murray Unit. He remained in the Murray Unit until12 April 2013. In the Murray Unit, AB was subject to very tight security, and was either locked in a cell- like room or was accompanied by at least three Serco escorts wearing a body armour (referred to as Personal Protective Equipment or PPE).

At about 1.50pm on the day that AB arrived he was interviewed by Serco Intelligence Manager, Ms M Lawlor. Ms Lawlor asked AB a number of questions, aimed at assessing the risk he might pose to staff and other detainees. The conclusion she reached was that there was a-*"High probability AB will assault an officer so that he can be placed back in a correctional environment...it will be unprovoked and opportunistic – will wait until security measures are not as rigid"*

A "Full Client Placement Assessment" apparently carried out that same day concluded that AB's risk to others was "extreme"[3]

On the morning of Wednesday 10 April2013, AB was interviewed by DIBP case worker Mr G Campbell. The purpose of that interview was to provide AB with documents which informed him of the procedures connected with his removal from Australia, and of his rights to consent to that process or to seek some form of review. Mr Campbell explained that the interview was conducted (for the most part) with three armoured guards standing behind him.

Although AB said little at the beginning of the interview, Mr Campbell said that AB seemed to relax a little as the interview went on. AB indicated that he intended to apply for a Protection Visa, and that he would resist his deportation. At about 2pm that day, IHMS Mental Health Nurse R Flack interviewed AB through a "slot" in the door of his cell with three armoured Serco guards in the room.

The purpose of this assessment was to determine how AB's placement in the Murray Unit was impacting his mental health. Nurse Flack recorded – *"Denies suicidal thoughts; denies thoughts of self-harm; denies thoughts of harm to others; guarantees safety of self and others. Client mental state at this time is not being affected by his current placement in Murray cells, client will require daily review by mental health team. Email sent to relevant stakeholders".*

At about 9.11am the next morning (Thursday 11 April 2013) AB was visited in the Murray Unit by Mental Health Nurse T Fagaloa. This assessment also occurred through a "slot" in the cell door, and in the company of armoured Serco guards. Nurse Fagaloa completed a PSP (Psychological Support Program) Care Plan, in which she noted that – *"Client reviewed for review of care plan ...denies suicidal ideation/TOSH/thoughts of harm to others...Client willing to engage with Mental Health and agreeable to review.*

Mental Health Nurse Fagaloa also noted – *"Client stated he was OK. Cooperative in interview. Client able to explain context of previous assault on Serco officer ...legal representation at the time had given him the impression that he had no other avenues to stay in Australia and so assaulted officer in attempt to remain here ...has been told that there is another avenue available for appeal ...Client was open about drug use while in prison stating that he used daily ...last used Morphine 100mg on 09/04/13 ...Stated that Morphine was the drug he used most ...Nil abnormal perceptions or psychosis evident ...Risk low- Denies TOSHISI/harm to others ... PLAN- Review as COC* (Client Of Concern) *12/04/13 – Writer has discussed with Primary Health re assessment of withdrawal symptoms. Client aware of pathway to access MH if required"*

While AB was being "assessed" by Mental Health Nurse Fagaloa, a "VIDF Daily Briefing meeting" commenced (at 9.20am) in which AB was discussed.

Ms Lawlor reported her concerns that AB had not interacted with the officers, remained quiet and reserved, and was clever and calculating- *"the danger signs are present".* The meeting was informed that IHMS had advised that AB was not on any prescribed medications, and that while a 24 hour extension of his placement in the Murray Unit was likely, this would not extend to the weekend, given that AB had presented with "nil issues" since his arrival.

At about 12.30pm that same day, Registered Nurse K Origlasso (to whom Nurse Fagaloa had spoken) conducted an "Induction Health Assessment" on AB.

While AB told her that he had *"smoked heroin in jail every day for 6 months",* Nurse Origlasso (who has significant experience in the management of patients with drug histories) concluded that AB did not appear to be in acute withdrawal. A urine drug screen carried out that day showed no trace of opiates.

Nurse Fagaloa had noted after her basic assessment that AB should be reviewed as a Client of Concern on 12 April 2013 but this did not occur.

It has been suggested that this was because, in the "VIDF Daily Briefing" at 9.15am that morning, the meeting was told by Ms M Mailei (head of the Mental Health team) that AB was not a Client of Concern in terms of mental health issues. The reason might also be linked to the fact that a decision appears to have been taken the previous night to integrate AB into "the mainstream". On the morning of Friday 12 April 2013 AB was transferred from the Murray Unit to the less restrictive Blaxland Unit.

Transfer to Blaxland Unit

AB was transferred to "Dorm 2" of the Blaxland Unit, where he was housed with other detainees. AB was not assessed or seen by any Mental Health nurse or other mental health professional while he was in the Blaxland Unit.

On Sunday, 14 April 2013, AB was visited by his mother. According to his mother, AB was "good" that day. They cracked jokes and had some food together. She said he did not speak of harming himself, and noted in her statement that he had never harmed himself previously.

There are limited records of AB's behaviour and conduct between his arrival in the Blaxland Unit on 12 April 2013 and Friday 19 April 2013, when he was taken to Liverpool Hospital. That is probably because in the Daily Briefing meeting of 12 April 2013, the action plan was for Serco to monitor AB, especially re "drug control". The meeting seems to have agreed that AB would be *"discussed weekly at the stakeholders meeting".* It seems clear that at this stage the focus on AB was his risk to others and not his risk to himself, or his mental health generally.

This seems to be confirmed by the minutes of the Daily Briefing meetings held on Monday 15 April and Tuesday 16 April, in which the only mention of AB relates to security issues. On Monday 15 April 2013 he was placed on "Security Watch" requiring 30 minute observations. This was because of concerns that he may attack someone, or incite others to violence, not because of any mental health concerns.

In an entry of Monday 15 Apr 2013, a Serco Officer noted:

"Client seems to be in good health. Eatswell. Sleeps well. No issues. Client has settled in dorm 2, made few friends [AB] *has been good, he has made few friends and has been polite to officers ...* ".

On the same day, the DIBP case worker Mr G Campbell attended the Blaxland Unit to speak again to AB. AB refused to speak with him.

The Serco Security Watch Occurrence Log noted that (at 2.30pm) AB had *"seen JP to sort out his paperwork"* and (at 6.30pm) it was noted that he was *"exercising in gym with friend".*

The next day, Tuesday 16 April 2013 the Security Occurrence Log entries indicate nothing out of the ordinary.

They note that at various times during the day, AB was – *working on paperwork with fellow client; playing pool; watching TV; and outside having a cigarette, talking with other clients*. The Security Occurrence Log entries continue into the next day – Wednesday 17 April 2013, noting that AB was (at 9am) *very quiet- did not respond to greeting.* However, he apparently (at 10.30am) said *"thank you"* after receiving some mail, and it was noted (at 3.26pm) that *"Client interacting with myself and 2 other clients in the outside courtyard, appears to have a positive attitude so far being in detention".*

The thirty minute Security Watch observations continued into the next day- Thursday 18 April 2013. Although no security concerns were noted, the log entries record that AB was very quiet, stand-offish, distracted and not sleeping well – *"Will respond bluntly when spoken to".*

Friday 19 April 2013

The Security Watch Occurrence Log records two observations early that morning:- (8.03am) *Client appears to be asleep. No interaction* (09.02) *Client outside talking with CSO Pucher + CSO Pedrosa- Remains distant, not wanting to talk much* At about 10.30am a "code black" was called, after it was discovered that AB had obtained a razor blade, and inflicted deep cuts to his arms and neck. Although the blade does not appear to have been retained and photographed, various witnesses described it as the type of small blade that would usually be found inside a disposable razor.

The "Reception Assessment Process Checklist" completed by Serco on 9 April 2013, when AB arrived at the VIDC, notes that he was issued with "razor" as detainees were provided with shaving equipment at the VIDC.

AB refused to put down the razor blade, and continued to cut himself. Upon her arrival, Serco Intelligence Manager Ms M Lawlor took charge of the situation and was successful in engaging with AB, and to some degree distracting him from inflicting further injury to himself.. Shortly after this, Serco security officers (wearing Personal Protection Equipment) took hold of AB, and detained him on the ground, where he was handcuffed. He was treated for his injuries by ambulance officers before being taken (under guard) to Liverpool Hospital, where he arrived shortly after 12.30pm.

He was scheduled under the *Mental Health Act (NSW) 2007.* This meant that he was detained at the Hospital as an involuntary patient. While in the Hospital, AB's custody was in the hands of the six Serco officers who were given the task of preventing him from escaping.

AB was taken into surgery to treat his wounds in the late afternoon and was taken to recovery just before 7.30pm. At about 9.10pm that night he was transferred to the surgical ward 5E, on the fifth floor.

He remained under guard that night by 6 Serco officers while in the ward, and there were no adverse incidents.

Saturday 20 April 2013 at Liverpool Hospital

On Saturday 20 April 2013, AB woke up around 6.40 am and made a number of requests, including a request that his family be informed that he was in hospital. It seems that this request was passed up the chain of command at Serco and was being considered when the events took place.

At 7am, a nurse gave AB a dose of Endone (Oxycodone), and shortly after this he was taken downstairs by the Serco guards for a cigarette.

At about 8am there was a change of shift of the Serco guards, with six new staff taking over. Shortly after this, AB ate some breakfast.

Just after 9am, both nursing staff and a Serco officer noted that AB appeared to be calm and acting appropriately. The Serco escort notes at 9.05am recorded that – *"Hospital Nurse visits the client ...calm and communicating positively ...Escort team maintain line of sight at all times ...all exit points covered ..."*

However, at about 9.30am or shortly after, AB suddenly picked up a metal stool and then a metal-framed chair, and commenced smashing them against the window glass. Although Serco staff tried to intervene, AB swung the chair at them and threatened to "kill them". He soon created a hole in the window large enough for him to jump through.

Two of the Serco guards (apparently believing that there was no structure outside the window to prevent AB falling to his death) managed to grab hold of his legs. It seems that they very valiantly held on to AB's legs for as long as they could, despite the fact that AB was struggling, and throwing glass at them.

He also told them that he had Hepatitis C (which an autopsy later confirmed) and that he would infect them with his blood. Three of the Serco guards received cuts from glass thrown by AB. After a struggle that took perhaps some minutes, AB managed to struggle free, and ended up on an area outside the window, which was the roof of a room on the floor below.

At this point, AB was 5 storeys from the ground, and the ledge and roof on which he had placed himself provided no means of safe escape. Police arrived within minutes and took over the management of the situation in ward 5E. Police Negotiators, Police Rescue, Tactical Response and General Duties police were involved. Paramedics and Fire Officers also attended.

The police carefully considered whether there was any safe way in which AB could be subdued physically and brought inside the room to safety. However, none of the physical interventions that were debated were considered realistic, given the position (an exposed roof with a 5 storey drop) in which AB had placed himself.

The task of trying to convince AB to come inside was, therefore, left to the police negotiators. Between about llam that morning, and just after 11.30pm that night, a team of police negotiators, working in pairs, attempted to engage with AB and convince him to come inside the room.

Significantly perhaps, AB's conversations with police negotiators were not focussed on threats of suicide. According to the police negotiators, AB did not say he was going to jump" if his demands were not met. At one stage, he said he would stay on the roof “for a week", and at other times said that police would have to shoot him, because he was "not jumping".

The negotiators used a variety of strategies (over many hours) in trying to convince AB to return to safety. Regrettably however, none were successful in getting him to re-enter the building. By about llpm, it was obvious that AB was very tired and was "shaky".

Police were very concerned that in this state, he may fall from the roof. It seems likely that at this stage, AB was not only extremely fatigued, but also was probably suffering from hypothermia (police noticed that he had been shivering for several hours).

However, by late in the evening, there were signs that the negotiations might be getting somewhere.

AB had been given two cigarettes, and had become quiet and (seemingly) more cooperative. This led to the negotiation team leader, Detective Senior Sergeant Abeyasekera, removing the pieces of broken glass from the window, and actually opening the window on its hinge, so as to make it easier for AB to re-enter. He was also able, without protest from AB, to reach out his hand through the window to AB, in an attempt to get him to come in.

However, just after 11.30pm that night, AB, without any explanation, moved away from the window towards the edge of the roof. He was apparently very weak and tired at this point. Once at the edge of the roof, AB lay down, then lifted his head towards police and said something like *"Tell my mother I love her"* or *"Say goodbye to my mother"* and then rolled his body off the roof. A paramedic, Mr Green noted that these actions occurred *"all of a sudden- there was no indication of it".*

The issues

The important issue for this Inquest is the examination of the continuum of care and treatment provided to AB by Corrective Services, Justice Health, Serco, IHMS, DIBP, NSW Police and Liverpool Hospital prior to his death.

Counsel Assisting, Mr Bourke SC, in his opening statement outlined a number of questions that go to this issue that were explored during the course of this Inquest. They were as follows:

a. Did the risk assessment conducted by the Department of Immigration and Border Protection and Serco in respect of AB in April 2013 correctly identify the risk posed by *I* to AB?

b. Was the risk AB posed to himself and others managed appropriately during his detention in VIDC in April2013? In particular:

- Should AB have been accommodated other than in VIDC?
- Should AB have had access to a cutting implement? How did he gain access to that cutting implement?
- Was the response to the incident of self-harm on 19 April 2013 appropriate in the circumstances?

- Did the mental health screening and treatment of AB in April 2013 during his detention in VIDC appropriately identify and manage any mental health concerns?

- Was the escort conducted by officers of Serco on 19 and 20 April 2013 appropriate and executed in accordance with the developed escort plans?

- Was the risk AB posed to himself and others managed appropriately during his admission to Liverpool Hospital on 19 – 20 April 2013? In particular, was the mental health treatment and assessment AB received after his arrival at Liverpool Hospital appropriate and conducted in accordance with policies of Liverpool Hospital?

- Was the Police operation conducted on 20 April 2013 appropriate m the circumstances?

- Was the communication between various agencies involved with AB (including Serco, IHMS, DIBP, Police and Liverpool Hospital) effective in managing the risk posed by AB to himself and others?

- Whether the Coroner should, pursuant to s.82 of the *Coroners Act 2009,* make any recommendation/sin relation to any matter connected with AB's death.

- Having heard all the relevant evidence in relation to those issues and considered the submissions made by all of the parties I will now deal with the matters that I consider to be relevant to my function as a Coroner. I group them into the following three categories

- Were the circumstances surrounding ABs transfer from Corrective Services custody to VIDC appropriate?

- Were the circumstances surrounding his self-inflicted injury at VIDC and subsequent transfer to Liverpool Hospital appropriate?

- Was the police operation appropriate?

Were the circumstances surrounding AB's transfer from Corrective Services to VIDC appropriate?

In October 2012, while AB was still in Parklea, he was assessed for inclusion to the Justice Health & Forensic Mental Health Network Self- Medication Program. He was dispensed 30 days' supply of Quetiapine 400mg, to be taken each night, on a monthly basis. This continued up to the date of his release and transfer to VIDC in April2013.

When AB arrived at VIDC no one was aware that he had been on any medication. The Inquest was informed that detainees do not arrive with their medical records. It is necessary to obtain the detainee's consent before medical records from Justice Health can be obtained. IHMS Health Services Manager, David Ferry explained that in the past when consent has been obtained and a request sent, it may take between 2 days and 2 weeks to receive the information from Justice Health. IHMS informed the Inquest that in recent months Justice Health have responded more quickly and that on some occasions IHMS have received the requested medical records on the same day that the request was made.

Clearly it is desirable for the IHMS medical staff to be aware of any medical history of a detainee upon their arrival.

Since the completion of oral evidence in this Inquest a statement from the Manager, Health Information and Record Service, of NSW Justice Health, Ms J Dyer, has been received. Ms Dyer states that there is no reason why a document similar to a "discharge summary" cannot be prepared for an inmate who is to be released in cases of "ongoing patient care". Ms Dyer notes that the recent introduction of an electronic system for accessing Justice Health records has made it easier for Justice Health staff to more readily obtain medical information, and will assist in the preparation of a document similar to a "discharge summary".

These represent positive changes and I propose to recommend that a "discharge summary" accompany a prisoner when they are being transferred from Corrective Services to immigration detention.

I note that the DIBP is in the process of negotiating a Memorandum of Understanding with NSW Corrective Services which includes the issue of the provision of health information at the time or prior to transfer from Corrections to administrative detention. I also note that the DIBP have stated in submissions that consent for provision of medical records will be requested from a detainee at the first point of contact between a DIBP officer and a detainee.

This normally occurs at the point of transfer. I propose to make a recommendation that such a procedure be implemented.

The DIBP has also undertaken, in collaboration with IHMS to write to each of the State Correctional Authorities within Australia, to establish a formal commitment to and clearer way of obtaining health records. I commend the steps that are being taken to provide for "on going medical care" and propose to make a recommendation that will facilitate the provision of all relevant medical records in cases involving transfers from Correctional Centres in NSW.

VIDC reception and health screening

Given the history of AB's assault on the Serco guard during his first detention at VIDC it is not surprising that the primary concern by Serco on receiving AB on behalf of DIBP was on the risk that AB might harm others.

A decision was made that he was to be detained in the high security Murray Unit for assessment. If his conduct had warranted it, there was an option of last resort for him to be returned to corrective services custody pending his deportation. This was never required. The evidence suggests his risk to others was monitored closely, carefully and appropriately during his time at VIDC.

AB did not receive any "treatment" for mental health issues while in the VIDC, and was not diagnosed as suffering any mental health condition.

AB was seen on Wednesday 10 April by Mental Health Nurse Richard Flack, and also on Thursday 11 April by Mental Health Nurse Fagaloa.

These were both short interviews, conducted through a "slot" in his locked cell door, and in the company of three Serco officers. Nurse Flack stated that he *"couldn't do the full mental health assessment because the guards were present"* and carried out a *"basic risk assessment".* When AB was reviewed the next day by Nurse Fagaloa three guards were again present, which made it difficult to do a proper assessment. There can be little doubt that this process compromised the quality of the mental health assessments and that in any event those assessments were primarily for the purpose of assessing the appropriateness of AB remaining in the Murray until Dr Diamond, an expert Psychiatrist, provided an independent review of the circumstances surrounding AB's death. Dr Diamond's conclusion is that the events prior to 19 April 2013 did not suggest that AB was at risk of self-harm or suicide.

In that regard, the quality of the mental health assessments may have had limited significance to the tragic outcome. However, Dr Diamond did state that the two mental health assessments that were done were cursory and would not have been adequate to fully assess AB's mental/psychiatric state. While I do not find that a comprehensive mental health assessment would have prevented the events of 19 April 2013 I agree with Dr Diamond that the situation "left an angry violent, uncertain and distressed individual largely to his own devices…without any expert health management."

A lesson to be learned in hindsight may be that a person with AB's history could well have benefitted from more comprehensive psychological/psychiatric assessment and support while he was in the detention centre environment.

I note that IHMS have a Mental Health Screening and Assessment procedure and that the current policy states that a Comprehensive Mental Health Assessment is to be conducted between 10 to 30 days after a person arrives in immigration detention, unless triggered earlier by a clinical concern. This time frame has been set to accommodate the fact that many detainees who come into detention are transferred on to other facilities within a 7 to 10 day period. I do not propose to make any recommendation about changes to that policy. I do however note that Serco and the DIBP could reflect on Dr Diamond's following comments:

"In my opinion the clear identification of[AB] as somebody who posed a security threat described as extreme, could well have been assisted by providing him with some assessment of his psychological state to begin with and possibly ongoing assistance to deal with his psychological vulnerability and disturbance."

In the future it may be appropriate that in cases where there is a real and established concern that someone may harm others that the concern be considered as a "clinical concern" that would trigger a Comprehensive Mental Health assessment earlier than the standard 10 -30 days.

Were the circumstances surrounding self-inflicted injury at VIDC and subsequent transfer to Liverpool Hospital appropriate?

Self-harm incident

AB inflicted the deep cuts in his arms and neck while he was in the Blaxland Unit. The implement that he used was the very small blade from a disposable razor. AB had no significant history of self-harm and there is no criticism of detainees being given access to appropriate and reasonable personal grooming equipment such as a small disposable razor.

The events surrounding his self-harm are described by a number of Serco officers. The Client Services Manager Ms Aiono-Laga described a "brief scuffle" which occurred when Officer Tang tried to "throw a blanket over [AB]" and that action was taken to remove other detainees from the area.

Then Serco Regional Intelligence Manager, Ms M Lawlor arrived and engaged AB in conversation and distracted him from inflicting further cuts until Serco officers could don their protective gear and bring AB under physical control. This process was captured on a video recording. The events shown on the video are described by Dr Diamond in his report and he notes that there was no evidence of excessive violence, and that AB did not offer significant resistance. Dr Diamond notes that shortly after this, AB was attended to by Ambulance officers, and then transferred to hospital. Dr Diamond notes that *"All transfers are done in a relaxed, leisurely manner".* It was managed appropriately.

Surprisingly, however, AB's mother was not informed about the self-harm incident and that he was taken to Liverpool Hospital for surgery. AB's mother had been at VIDC visiting her son on 14 April 2013 and after his surgery he made a specific request that his family be told that he is in Liverpool Hospital. The Department explained that without a detainees consent they were not in a position to contact the next of kin. I am informed that DIBP have made changes to their procedure so that in the future next of kin can be in accordance with S.75*(S) Coroners Act 2009* I permit a publication of the report of this notified of incidents of this nature. A revised "Detention Client Interview – Part C" form used by DIBP now includes a specific question asking whether the person gives their consent to the Department contacting next of kin in the case of an emergency. This is a positive step, and avoids the need for any recommendation about the matter.

Transfer to Liverpool Hospital

The physical management of AB once he left VIDC in the ambulance was with a team of six Serco officers who were tasked with guarding him. There was no effective communication between Serco and Liverpool Hospital. No protocol existed between the Hospital and Serco in relation to these types of matters. The Hospital's security personnel were not aware that Serco officers were on the premises. Since the events of AB's death there have been changes to the relevant procedures and communication between the hospital and VIDC has improved. In April 2015, a Policy Directive entitled "Patient in custody of the Department of Immigration and Citizenship" was issued by the South Western Sydney Local Health District.

That document now sets out directions, to be followed by hospital staff in cases where an Immigration detainee is brought into the hospital. That document represents a positive and welcome step in addressing the lack of communication that took place in AB's case.

In addition to this Policy Directive, there has commenced a process of communication between the DIBP and the Liverpool Hospital, which has led to a draft "Letter of Understanding" with a view to preparing a "Memorandum of Understanding" between the two agencies concerning the timely provision of information on patient transfer. Annexures "A" and "B" are documents setting out the details of the changes that have been made by Liverpool Hospital and IHMS since AB's death. I commend the response to this issue and I am satisfied that it has been addressed and that no recommendations are required in that regard.

IHMS have also implemented changes to improve communication with hospitals to which a detainee from VIDC is transferred. IHMS now send a referral form to the relevant hospital when a person leaves VIDC, which includes information regarding the detainee's medical history, previous investigations, current medications, assessment and plan. IHMS have also implemented procedures to ensure a registered nurse (during business hours) or a staff member from a telephone centre with access to IHMS' records (after-hours) provides relevant medical information to an emergency department, where it is known to which hospital the detainee is being transferred.

Was the Police operation appropriate in the circumstances?

The police operation involved a large number of officers, and brought together a wide range of highly skilled operatives. This included general duties police, tactical operations police, police rescue, police negotiators, ambulance and paramedics, and fire fighters. Police arrived on the scene very promptly, and the evidence demonstrates that careful attention was given to all reasonably available options, with the intention of bringing AB to safety.

In the circumstances, the only available option was the option that was adopted- namely, for police negotiators to attempt to convince AB to come inside of his own accord.

Although this was ultimately unsuccessful, this failure was not through want of police efforts.

The only comment of a critical nature by Dr Diamond was the comment that, with the benefit of hindsight, further attention should have perhaps been given to the likelihood of hypothermia, and its effects of muscle-weakening, loss of resolve and possible "acceptance of death". In this regard, Dr Diamond said that consideration perhaps should have been given, later in the night, to consulting with a psychiatrist or other doctor about AB's apparent physical distress (shivering, weak and unsteady). If this had been conveyed to a relevant medical practitioner, it might have resulted in a suggestion to provide AB with some form of physical "comfort" such as a blanket, or a hot drink. Dr Diamond noted however, that his comment was made only with the benefit of hindsight, and observed that police negotiations of this kind routinely are successfully completed without involving external consultants.

In all the circumstances I accept that the negotiation process was carried out (as Dr Diamond said) expertly and in accordance with known and acceptable adherence to proper procedure. However, I direct that a copy of these findings be provided to the Commander, Police Negotiation Unit, so that consideration can be given to the comments of Dr Diamond on the possible effects of hypothermia, and the implications this might have in police negotiations generally.

Formal Finding:

That AB died on 20 April 2013 as a result of multiple injuries he suffered when he caused himself to fall from height at Liverpool Hospital.

RECOMMENDATIONS

- I recommend that the NSW Justice Health & Forensic Mental Health Network implement a procedure whereby a document in the nature of a "discharge summary" is prepared for patients being transferred from a NSW Corrections Centre to an Immigration Detention Centre, which summarises any current or recent medical conditions including mental health history and past attempts at self-harm and any current or recent medications of the patient.

- I recommend that the Department of Immigration and Border Protection implement a procedure whereby, prior to the transfer of any person from a NSW Corrections Centre to an Immigration Detention Centre, the person is requested to provide a signed consent to the release of medical records, and whereby any signed consent is promptly forwarded to the relevant health service agency within the Immigration Detention Centre.

- I recommend that International Health and Medical Services revise its policies to require that consideration be given, in cases of persons transferred from a NSW Correctional Centre, to obtaining any relevant medical records especially where any health discharge summary provided by Justice Health includes information believed to be clinically significant.

11. 153360 of 2013

Inquest into the death of AA finding handed down by Deputy State Coroner Forbes at Glebe on the 11th August 2015.

NOTE: PURSUANT TO S 75 OF THE CORONERS ACT 2009 I DIRECT THAT THERE BE NO PUBLICATION OF ANY MATERIAL THAT IDENTIFIES THE DECEASED PERSON OR HIS FAMILY

INTRODUCTION

This inquest concerns the sad death of AA. He was a 19 year old man who was an inmate at Long Bay Correctional Centre. He is a much loved son and brother and his family have asked for him to be referred to by his first name, AA. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* is to make findings as to:

(a) the identity of the deceased;

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

(c) the physical or medical cause of death; and

(d) the manner of death, in other words, the circumstances surrounding the death.

Section 82 of the *Act* also permits a Coroner to make recommendations that are considered necessary or desirable in relation to any matter connected with a death that relates to issues of public health and safety. AA's death was reported because it occurred while he was in custody. In these circumstances an inquest is mandatory pursuant to the combined operation of ss. 27 and 23 of the *Coroners Act 2009.*

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

Pursuant to s.37 of the *Coroner's Act 2009* a summary of the details of this case will be reported to Parliament.

AA

AA was born in 1993 and had an older sister, and step siblings. His natural father passed away in April 2014.

As a child AA grew up in Currabubla. According to his sister, the children pretty much looked after themselves.

In 2002 an application was filed by the Department of Community Services for parental responsibility for AA and his siblings to be transferred to the Minister. This application was based on a number of reports to the Department surrounding mental health issues associated AA's mother who had been diagnosed with schizophrenia, manic depression and anxiety.

The children were placed in foster care in Queensland. After approximately 2-3 years they returned to live with their father in Boronia Heights with weekly supervision from Life Without Barriers and the children remained under the parental responsibility of the Minister.

In 2008 the Department became aware that AA had begun to exhibit out of control behaviours, acting out, fighting at school and had disclosed verbal and emotional abuse occurring at the home by his father. This information was also confirmed by one of his siblings who stated that after returning home, AA began to miss school. Eventually he was expelled from the local school for assaulting another student and attended three different High Schools before completing year 10.

In 2007 AA and M left their father's and moved to Port Macquarie to live with their mother.

In February 2013 he was sentenced for a number of offences and on 13 Feb 2013 when he arrived at the Mid North Coast Correctional Centre he was assessed by Justice Health Nurse Anthony McMahon.

During his reception screening he informed Mr McMahon that he had been diagnosed with schizophrenia requiring Seroquel medication, 100mg in the morning and 200mg at night.

AA completed a "Kessler 10". This tool is used to measure the current level (last four weeks) of stress, anxiety and depression.

AA received a score of 10 / 50 which indicated that he may not be experiencing any significant levels of distress at the time he completed the test. AA also denied any previous attempts of suicide or self-harm.

Mr McMahon said that at the end of the screening he completed a summary of his findings and found that AA was a young offender with previous gaol experience that he presented as calm and relaxed that he had a possible diagnosis of schizophrenia treated with Seroquel and he contacted Justice Health Medical Records to obtain scripts. He also said he created a referral on Patient Alert System to the Mental Health Nurse for follow up and management.

AA was placed on an appointment list at the Mid North Coast Correctional Complex for review for 9 March, 26 March, 29 March and 1 April 2013 however he did not attend those appointments as he was moved to the Grafton Correctional Centre on 18 Feb 2013. He was not placed on the waiting list for the Mental Health Team at Grafton after he was transferred.

On 4th April 2013 AA was transferred to Long Bay Correctional Centre. Once again he was not placed on the waiting list for a Mental Health follow up.

On 7th April AA was assigned Bakery duties. AA's duties included 6.30am weekday starts working in the flour mixing area.

On the 8th May 2013 AA was interviewed by Senior Correctional Officer Craig Creighton and Correctional Officer Clarke in relation to a proposed DNA test to be obtained from him. This procedure was planned in accordance with the Crimes Forensic Procedure Act NSW 2000 Part 7. During this meeting AA was reported to be calm and happy. According to Mr Creighton, AA did not raise any problems or issues associated with the taking of his DNA. He signed the pre interview form willingly and was provided with an information pamphlet.

CIRCUMSTANCES OF DEATH

About 4.30am on 15 May 2013 AA's cellmate was released from his cell by the night watch officer so he could attend for Bakery duties.

About 6.00am Mr Mark Yates and Correctional Officer Pravat Dash attended AA's Wing to collect a number of inmates, including AA, for bakery duties. AA informed Correctional Officer Dash that he was sick that morning and couldn't attend. Correctional Officer Dash informed AA he would pass the information on and advised AA that if he required any medical attention to let him know.

AA replied that he would attend the morning clinic. (Corrective Services notes record that at around this time AA had been showing a lack of interest in his bakery duties and on the 2 May 2013 he was counselled and warned. On the 13th May 2013 he was given one more lifeline.)

At about 7.10am muster was called by Correctional Officer's Izard, Warren, Kaur and Assistant Superintendent Michael Frawley. All inmates were accounted for and checked against the muster book and the cell card.

AA was due to have his DNA obtained. At about 8.20am, Correctional Officer Debra Po'oi asked for AA who was the first name on the list to have his DNA obtained.

One of the inmates, Mr Butler, approached AA's cell and noticed the door was closed but not locked. Mr Butler opened the door and observed the cell was dark. He looked in and saw someone who appeared to be standing on a chair near the window. It took a few seconds for his eyes to adjust before he could see. He then yelled out to AA but when he did not respond he took three steps into the cell and noticed a ligature of green cell sheeting around AA's neck which was tied to the metal grill on the outer window cavity. He could see AA's skin and his lips were blue. He immediately exited the cell and told another inmate to not let anyone into the cell as it was now a crime scene. That inmate tried to undo the knots that were around AA's neck.

Correctional officer Izzard entered the cell and cut the bed sheet with a 911 tool. AA was moved to a clear area where CPR was commenced. Shortly after Correctional Officer Po'oi attended and radioed for urgent assistance. Officer Po'oi lent down and checked for AA's radial pulse and for a femoral pulse but was not able to locate one. Senior Assistant Superintendent Dino Krizman attended the scene and took charge of the CPR duties and the management of the scene. A time log was commenced at about 8.35am by Correctional Officer Warren. At this time Correctional Officer Po'oi was instructed to search the cell for any form of suicide note which she did but none was found.

Justice Health personnel attended and took over resuscitation duties. The medical team was led by Dr Mica Apasojeviv until the arrival of paramedics at 8.46am.

At 9.08am AA was removed from the cell was taken by Ambulance to Prince of Wales Hospital in a critical condition.

He was admitted into the Intensive Care Unit where he was continually monitored. A CT examination revealed that he sustained global ischemic brain injury. AA deteriorated and with family consultation the medical team made a decision to cease further medical treatment. AA passed away at about 2.30am on 17th May 2013.

CAUSE OF DEATH

On that same date a limited Post Mortem was conducted by Dr Brouwer who determined that the ligature mark present on his neck was in keeping with that caused by the torn strips of material. Dr Brouwer recorded the cause of AA's death as "in keeping with the consequences of hanging."

MANNER OF DEATH

There were seven occasions from the beginning of April 2013 up to an including 14 May 2013 when AA did not attend the clinic to pick up his medication.

AA last attended to receive his medication on the 12 May 2013.

Paragraph 6.6.1 of the Justice Health and Forensic Mental Health Network Medication Guidelines states

"Any patient who has been prescribed antipsychotic or antidepressant medication and who does not attend must be followed up immediately. If the patient refuses to take the medication once contact is made, the patient must be seen by the treating psychiatrist at the earliest opportunity. There should be daily contact with the patient until the psychiatrist sees them. This should be used as an opportunity to educate the patient regarding the need for medication and to gain an understanding of why the patient does not wish to continue the medication. This is particularly important for patients prescribed antidepressant and antipsychotic medication."

This guideline was not complied with in relation to AA's non attendances for his medication. He was not followed up after any of his non attendances, he was not educated regarding the need for his medication, there was no attempt made to understand why he did not wish to continue his medication and not only was he not seen by his "treating psychiatrist" but no arrangements were made for that to occur. In fact he didn't even have a "treating psychiatrist" as he had never been seen by the Mental Health Team since he arrived in custody three months earlier.

The evidence suggests that this guideline is not complied with in the normal procedure at the clinic. Evidence showed that the normal procedure for when a patient does not attend to pick up their medications would be to page them over the loud speaker to attend the clinic to collect their medication. If they did not attend, a referral was made on the Patient Administration System (PAS) to refer them to Mental Health Nurse waiting list. In AA's case this was not done supposedly because he was already on the PAS waiting list system from February 2013 when he first entered custody.

It is striking that not only is the guideline ignored but that attempts are not made to locate the patient with the assistance of Corrective Services and furthermore that Corrective Services are not notified that an inmate is not taking his antipsychotic medication.

In AA's case there is no evidence that his non-attendance to collect his medication caused or contributed to his decision to take his own life. There is no evidence his mood, behaviour or demeanour had changed.

There were no signs that AA was contemplating intentional self-harm.

AA's cell mate was interviewed in relation to AA's death. He stated that he got along well with AA who was generally in a happy mood and seemed to get along with everyone. He said AA did not mention any issues and talked about an extradition to Queensland when his sentence had expired in NSW but was not worried about it. He said he saw AA when he was woken to go to Bakery duties the morning of the 15th May 2013 and he was still sleeping on the bottom bunk. A second inmate was also spoken to and confirmed that AA had not mentioned any concerns or worries to him when he last spoke to him on the 14th May 2013.

AA's father provided an audio statement to Investigators. He advised that AA had never spoken to him of any issues he was having in jail and he believed AA was looking forward to getting out in the near future. He did not believe that AA was worried about returning to Queensland to face any other outstanding matters or provide his DNA. According to his father, AA had never previously discussed killing himself or committing self-harm.

An investigation was also conducted by Mr Farrell from Corrective Services. He noted that:

- On 8 May 2013 AA was interviewed regarding his post release plans by the Community Offenders Services and Programs Section who recorded that 'The offender appeared positive and was more than happy to discuss his post release accommodation plans and goals'.
- On 9 May 2013 AA was seen by Case Officer Widge who stated that AA appeared calm and not depressed and expressed interest in being referred to a Psychologist for an appropriate course to address *'his offending behaviour'.*
- On 10 May 2013 AA was also interviewed by a Welfare Officer who stated that inmate A presented as *'future orientated, made good eye contact and nil other issues were raised'.*
- On that same date AA had been seen by a Services and Programs Officer who discussed his participation in an upcoming program called Getting SMART.
- The file note states that he completed a pre-program interview and stated he is willing to participate in all 12 sessions of the program.

The evidence does not allow me to make a finding as to why AA took his own life but it is clear that there were no suspicious circumstances and that his death was intentionally self-inflicted.

I accept Counsel Assisting's submissions that Corrective Services responded appropriately on the day AA was found hanging and that the subsequent investigation was appropriate.

CONCLUSION

AA's death highlighted shortcomings in relation to compliance with Justice Health's own guidelines and policies. Firstly, despite being referred by Justice Health Nurse McMahon in February 2013, when AA entered custody, to be reviewed by a mental health clinician this never occurred during the whole time he was in custody. Although he was initially given appointments and on a waiting list in February 2013 at the Mid North Coast Correctional Centre, once he was transferred he did not have any appointments scheduled and he was never seen by the Mental Health Team. The medication and dosage he was receiving was as a result of his own request and he was never assessed as to its appropriateness.

Secondly, the only people that knew he had not attended for his medication on the seven occasions in April and May 2013 at Long Bay Correctional Centre were the nurses that were dispensing the medication. This was not only in breach of the concerns set out in the guidelines but also highlights the lack of communication with Corrective Services who would have been able to assist in locating AA and also could have been on high alert for any change in his demeanour. I note that Justice Health and Forensic Mental Health Network and Corrective Services acknowledge the importance of these shortcomings and are willing to implement changes that will ensure this situation is not repeated. I propose to make recommendations that address these issues.

FORMAL FINDINGS

I find that AA died on 17 May 2013 at Prince of Wales Hospital, NSW. I am satisfied the cause of his death was hanging. The manner of his death was intentionally self-inflicted.

RECOMMENDATIONS

To the Minister for Health:

1. **I recommend that Justice Health review practices and procedures in relation to the transfer of inmates between correctional centres for the purpose of ensuring that any outstanding mental health reviews or existing appointments to see the Justice Health Mental Health Team be rescheduled at the new Correctional Centre.**

2. **I recommend that the Drugs and Therapeutic Committee of Justice Health and Forensic Mental Health Network be provided with a copy of these findings and consider:**

   (a) reviewing the current procedures as set out in 6.6.1of the Medication Guidelines.
   (b) training Justice Health staff in relation to the requirements of 6.6.1 and 7.7.3 of the Medication Guidelines.
   (c) reviewing communication between Justice Health and Corrective Services on issues relating to an inmate's non-attendance for antipsychotic medication.

12. 159048 of 2013

Inquest into the death of Dean Krasser finding handed down by Deputy State Coroner Freund at Glebe on the 28th April 2015.

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

These are the findings of an inquest into the death of Dean KRASSER.

Introduction

Dean Krasser was 42 years old when he passed away. At the time of his death he was an inmate at Long Bay Correctional Facility. He is survived by his mother Mrs Carol Krasser, father Gerhard KRASSER and brother Paul KRASSER.

The Inquest

As Mr Krasser was in custody at the time of his death, this is a mandatory inquest pursuant to section 23 of the Coroners Act 2009 as his death occurred whilst in Custody.

The role of a Coroner as set out in s. 81 of the *Coroners Act 2009* is to make findings as to:

1. the identity of the deceased;
2. the date and place of a person's death;
3. the physical or medical cause of death; and
4. the manner of death; in other words, the circumstances surrounding the death.

A Coroner, pursuant to s. 82 of the *Coroners Act 2009*, also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

Background

Mr Krasser was born on 29 January 1971. The records indicate that when Mr Krasser was about 6 years old he suffered a knock on the head whilst playing Rugby Union.

Examination and scans at Prince of Wales Hospital revealed a cyst sitting on a nerve at the rear of his eyes.

During an operation to remove the cyst, complications ensued as the cyst burst and his pituitary gland was destroyed. He ultimately required treatment with human growth hormone due to the damaged pituitary gland.

Mr Krasser was diagnosed with type II diabetes in his early thirties which was managed with medication. A couple of years later he was also diagnosed with Epilepsy which was also managed with medication. His medical records indicate that this did not interfere greatly with his everyday life. In 2010 he was being treated by a Psychiatrist who diagnosed him with a mild case of OCD. Again this did not cause him any major issues or disruption in his life. He never smoked or drank alcohol and was not known to take illicit substances.

Mr Krasser was known to police and had been since he was a juvenile. His first involvement being 1982 with the ensuing years resulting in convictions for a number of offences including stealing, break and enter, enter enclosed lands, goods in custody, possess prohibited weapon, common assault and driving offences. Since July 1989 he was incarcerated on a number of occasions with a substantial amount of time spent in custody. On 23 March 2012, Mr Krasser was sentenced at Sydney District Court for break and enter offences. He received a total sentence of 4 years and 7 months with the earliest possible release date being 18 June 2013.

In December 2011, Mr Krasser entered custody at MRRC and during the screening process it was noted that he had a history of epilepsy, previous surgery to remove a brain tumour as a child, type II diabetes and sleep apnoea requiring the use of a CPAP machine. It was noted that he had a previous cerebrovascular accident (CVA) in June 2010. Documented suicide and self-harm attempts also occurred in 2006, 2007 and 2010. He was diagnosed with depression in August 2011 and was currently being treated with antidepressant medication.

On 15 March 2012, the Mental Health Nurse reviewed Mr Krasser following concerns by Correctional Officers that he was not moving and was non-responsive in the mornings. A health problem notification form was completed recommending two out cell placement due to health concerns and a history of epilepsy. He was upset with this placement and the use of safety restraints and risk intervention team placement was necessary.

On 19 March 2012, a Justice Health review was conducted where Mr Krasser was cleared from the risk intervention team and it was noted that he was strictly two out cell placement throughout the centre due to complex medical issues.

During the course of his incarceration Mr Krasser was often upset with the two out placements and on 04 June 2012 it was noted that due to his frustration at not receiving a one out placement that he banged his head on the wall resulting in a head laceration.

On 23 July 2012, nursing staff attended to Mr Krasser as Corrective Services staff were unable to wake him. He was unresponsive and required stimulation through sterna rub. A similar incident was noted on 10 December 2012 with physical stimulation applied to his shoulder. Mr Krasser woke with no problems and stated that this occurred every morning.

On 28 November 2012, Mr Krasser's his testosterone levels were reviewed and quarterly Sustanton injections were increased to monthly. On 10 February 2013, he reported a fall in the wing resulting in a sore back. There were no further complaints following this incident. On 23 March 2013, he refused his monthly Sustanton injection and was placed on the GP waiting list for review.

On 1 May 2013, Mr Krasser was reviewed by the GP and treated for upper respiratory tract infection. No other issues were noted. He was reviewed by psychologist, Fatima A-Sibai on 2 May 2013 in relation to his OCD. She noted he was on a number of medications including Metforman for diabetes, Tegratol for epilepsy, Sustanton for hormone control and Serenance for OCD.

In the weeks leading up to his death Mr Krasser shared a two out cell with Stuart McGinn. Mr McGinn stated that they got on quite well and that Mr Krasser was a *"pretty mellow sort of bloke who was never loud or in your face".* Mr McGinn told Police that during the afternoon/evening of 14 May 2013, Mr Krasser returned to the cell and mentioned that he may have just lost his job. He did not elaborate but seemed upset. About 10:00pm, Mr Krasser was at the sink within the cell washing something when he hit the right side of his head on the shelf to the right of the sink. He indicated that it hurt but that he was alright. There was no blood sighted and Mr Krasser's behaviour was no different to any other night.

The Fatal Incident

On the morning of 15 May 2013, Mr McGinn woke up around 7:00am and noticed that Mr Krasser was still sleeping with his CPAP machine turned off. As he was no longer working he was left to sleep in. They were advised around 7:30-8:00am that they were in lock in and not allowed out until further notice. Mr McGinn returned to his top bunk and went back to sleep. He got up about 10:30-11:00am and spoke with Mr Krasser.

He picked something dark coloured off Mr Krasser's pillow and threw it out before asking if he was alright. Mr Krasser indicated he was alright and so Mr McGinn left him alone to sleep.

At about 2:30pm on 15 May 2013, Mr Krasser was observed by nursing staff on a medication round to be drowsy, incontinent of urine, small amount of vomit on his pillow and with left side paralysis to his arm and leg. He was treated by nursing staff and complained of headache. He was transferred by ambulance to Prince of Wales Hospital Emergency for possible CVA around 3:00pm. En-route to Hospital he was communicating with Ambulance Officers and advised that he had woken with a headache about 4:30am that morning. He took two panadol with no effect. He was unable to move his left hand side but did not tell anyone and did not get out of bed all day. This information was recorded by Ambulance Officers in the Electronic Medical Record.

Mr Krasser was admitted to Prince of Wales Hospital on 15 May 2013 after suffering a suspected stroke. After admission he underwent decompressive craniectomy which involved a piece of his skull being removed and remaining out to allow the brain some space in the case of swelling.

About 3:24am on Wednesday 22 May 2013, whilst being treated by a nurse, Mr Krasser spontaneously went into cardiac arrest. CPR was commenced. For the next two hours ICU staff performed CPR as required, administering adrenalin and other drugs as necessary to stabilise Mr Krasser and support heart and lung function. Life was pronounced extinct at 6:17am on Wednesday 22 May 2013 by Dr George Lukas.

The investigation

Following Mr Krasser's death, a review of his management in particular his health issues was conducted by Corrective Services.

I note that Mrs Krasser, Mr Krasser's mothers raised concerns during the course of the inquest regarding two specific issues namely:

1. Why Mr Krasser's condition had not been detected earlier by Corrective Services so that he could have been transported to hospital earlier; and
2. Why had she not been notified of his condition by Corrective Services and only by the hospital.

I will deal with each of these issues in turn.

It is clear that on the morning of 15 May 2013 the facility was in lockdown. As a result Mr Krasser and his cell mate Mr McGinn remained in their cell. All evidence indicates that Mr Krasser responded to all attempts by Mr McGinn to check on his well being. Moreover, Mr Krasser was responsive in the ambulance and advised the attending ambulance officers that he did not advise anyone of his condition.

Mr Krasser was placed into a "two out" cell as a result of his medical condition. He chose for whatever reason not to advise Mr McGinn of the seriousness of his health on the morning of 15 May 2013 and unfortunately at the various "head checks" he also chose not to advise the attending officer that there was a problem.

Accordingly, after reviewing the Corrective Services Case Management File I am satisfied that Mr Krasser's health issues were managed appropriately while he was in custody and any issues raised were addressed and managed accordingly. All protocols were followed by Corrective Services with regard to deaths in custody. In relation to Justice Health it appears he received satisfactory treatment.

The second issue raised by Mrs Krasser causes concern. The evidence indicates that Mr Krassser was transported and arrived at Prince of Wales Hospital at about 3:00pm on 15 May 2015 and Mrs KRASSER was not contacted until about 5:30pm by the Hospital for consent to perform brain surgery.

There is NO evidence that she was ever contacted by the General Manager in relation to the transfer of her son to hospital this is clearly in breach of the Corrective Services NSW Inmate Health and Welfare Policy Section 7.3.6.3 which states:

When an inmate is admitted as an "in-patient", with no advance warning (e.g. Heart attack, appendicitis, serious assault), the General Manager is to ensure that the inmate's emergency contact person is notified of the situation, on the same day it is confirmed that the inmate will be admitted as an "in-patient". The lack of communication from the General Manager of MRRC to Mrs Krasser in relation to the condition of Mr Krasser has obviously caused unnecessary distress to his family at what was a very stressful time bearing in mind that the condition of Mr Krasser was critical at the time.

Autopsy Report

The post mortem examination was conducted by Dr Liliana SCHWARTZ. The cause of death was Massive Pulmonary Thromboemboli complicating with an antecedent cause of Deep Vein Thrombosis of the left leg.

Identity of deceased:

The deceased person was *Dean Krasser*

Date of death:

Died on *22 May 2013*

Place of death:

Died at *Prince of Wales Hospital*

Manner of death:

Natural Causes

Cause of death:

Massive Pulmonary Thromboemboli complicating with an antecedent cause of Deep Vein Thrombosis of the left leg.

13. 200605 of 2013

Inquest into the death of Jake Innes finding handed down by Deputy State Coroner Dillon at Glebe on the 27th February 2015.

Introduction

This is an inquest into the death of Jake Robert Innes. Jake was a 21 year old man who died in a car crash following an attempt by police in a marked police vehicle to intercept the vehicle in which he was travelling at high speed.

Jake's death has devastated his family and friends, many of whom were present in court throughout the inquest. He was much loved and those who knew him described him as a young man who loved life, was affectionate, courteous, generous, thoughtful of others and great company. He was liked and respected and the large number of people who gathered in court demonstrated the high regard in which Jake's family is held in their community.

His father Robert, quite correctly and insightfully, described him as still being a "boy" who was growing up. That is correct. Neuroscientists tell us that the human brain does not fully mature until a person is about 25 years old. The last part of the brain to mature is the section which governs our ability to make judgments. At 21, young people, especially young men, are prone to overindulge in risky activity because they do not have the experience and maturity to fully assess the risks they are taking. Learning from experience is part of that process of maturing. Sadly, in Jake's case, not only has his family lost a much-loved son but our wider society has lost a young man of great potential. His sudden and unexpected death is indeed tragic.

Because Jake died in the course of a police operation – the attempt to intercept his vehicle the Coroners Act requires that an inquest be held. In a society in which the rule of law prevails, a police force is not a law unto itself. In civil society, a police force is a guardian of the lives and welfare of the members of that society. Police officers are members of the society they serve to protect. The police force has a virtual monopoly on the use of deadly force and law enforcement powers. For all these reasons, a police force in a democracy is accountable to the society from which it springs.

An inquest is a public, independent judicial inquiry. It is one of the main ways in which our society holds its police force to account when lives are lost in the course of a police operation.

It has been observed that:

The purposes of a s.23 Inquest are to fully examine the circumstances of any death in which Police …… have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82." (Waller's Coronial Law & Practice in New South Wales 4th Edition at para [23.7] (page 106))

That said, this inquest is not a quasi-criminal trial of Jake, his friend Luke Barrett or the police officers involved in the incident. But if NSW Police Force policies, procedures and training are designed to minimise the risk of harm during police operations, it is appropriate to examine the officers involved in the incident and the policies they were applying.

The issues

A coroner is obliged to make findings, if possible, as to the identity of the person who has died, the date and place of death, the cause of death and the manner or circumstances of death. In this case, it is the manner and circumstances of Jake's death that raises the difficult questions. They are:

- Who was driving?
- How did the crash occur?
- Why did the crash occur?
- Why was Jake killed and Luke Barrett severely injured?
- Could Jake's death have been prevented?
- Did the police comply with relevant police procedures and policies?
- Did the police cause or contribute to causing the death?

In summary, my answers to these questions are that:

Jake was driving the car.

The car hit a guard rail on an off-ramp from the Hume Highway near Denham Court. Jake lost control of the car due to a combination of factors including excessive speed, worn tyres, wet road surface, road configuration and his own physical impairment, probably while attempting to evade police interception;

Jake's death probably could have been prevented, and Luke Barrett's injuries minimised, had they been wearing seatbelts at the time of the crash and, self- evidently, regardless of the seatbelts, had the car stopped when directed to do so by police. The involved police officers complied with relevant police policy and procedures;

Although there is an obvious causal link between the police signalling a direction to the driver to stop and the accident, the police action itself did not cause or contribute in any significant way to Jake's death

I will now explain my conclusions.

Because Luke Barrett's licence had been suspended but Jake had a full licence, whenever he and Jake were together, which was a frequent occurrence, Jake would almost always drive. This was a sensible arrangement. Luke Barrett owned the red Toyota Seca sedan in which Jake was later killed and Luke Barrett injured. At the time of the accident, they were working together and sharing a house. Although Jake owned a car himself, it was cleaner and in better condition than Luke Barrett's Seca. So this was the car in which they drove to work and used to run around together.

On the evening of Saturday 29 June 2013, Jake and Luke Barrett, who were close friends and workmates, visited the Bradbury Hotel where they socialised with friends, had a number of drinks and played gaming machines and pool.

At about 9.30pm, Jake, Luke Barrett and two other friends, Matthew White and Shane Gveric, travelled the short distance to Shane Gveric's house in the Seca. Shane Gveric was then on a break from his shift working at the hotel.

The car was driven by Jake to Shane Gveric's house and later back to the hotel. Luke Barrett occupied the front passenger seat on both trips. Some time about 11.30, Jake and Luke left the hotel and travelled north. There are no witnesses available to see who was driving when the pair left the hotel.

Exactly where they went is also not clear, although there is some evidence to suggest they travelled via Campbelltown Road and onto the Hume Highway where they continued to travel north. At about midnight, a marked police vehicle in which four officers had been conducting "high-visibility" policing in south-west Sydney, was returning from duty to the Bass Hill police station, also heading north on the Hume Highway.

They observed the Toyota pass them in the outside lane at excessive speed. Each officer estimated the speed differently but all agreed that it was excessive and that an attempt should be made to stop the car. The driver Constable Flores activated the warning lights, but not the siren. He and the officer in the front seat apparently had some difficulty finding the correct button to press to activate both lights and sirens. Within a very short period, the officers observed the Toyota cross to the left hand lane and then leave the highway at the Campbelltown Road or Denham Court exit. They followed the vehicle, although no contact was made with police radio.

Three of the four officers lost sight of the car once it crossed the lanes. It was quite some distance ahead of them and, due to rain on the road, was throwing up a large plume of water behind it. Visibility was further diminished by darkness and rain falling on the police vehicle's windscreen. At about the same time as the police lights were activated, Jake was on a phone call to Ebony McPherson. That he noticed the police car is clear from his conversation with her. Just before he terminated the call, he said to her: "I'll call you back. The cops are coming." Very shortly afterwards the crash occurred.

What the police had seen was the Toyota cross four lanes from right to left (from lane 4 to lane 1 then onto an off-ramp. The exit at Denham Court comprises a relatively tight left hand bend, which is restricted to 60 kph, with an advisory 55 kph speed limit. When the Toyota entered this bend it was almost certainly still travelling at high speed. At this point the conditions were dark, the road was wet and it may have been raining lightly. The Toyota collided with the guardrail on the right and suffered extensive damage, spinning 180 degrees and coming to a stop in a position facing back towards the highway.

One of the police officers had noticed the car take the exit. The police car which had been travelling in lane 2 when the Toyota passed it, then followed the path of the Toyota. As they approached they saw that it had crashed and that the guard rail was badly damaged.

They did not know how many people had occupied the car but they rightly suspected that the occupant or occupants were injured. The police car stopped near the crashed vehicle. One of the officers contacted police radio at 12.09am to report the accident. All four officers approached the car to give assistance. Jake was found lying inside the car, with his head against the driver's door.

Initially, the police were unaware that Luke Barrett had been ejected from the car in the crash. As he had been thrown several metres away from the car, and the police were concentrating on helping Jake, he was only noticed several minutes later. A later physical examination of the car found that neither seatbelt had the characteristic damage generally found when a seatbelt has been strained under pressure in a high- speed collision. This evidence plus the pattern of injuries to both men and the positions in which they were found by police, indicates that neither Jake nor Luke Barrett was wearing a seatbelt.

A number of other police vehicles and ambulances attended, and the Fire service helped to remove Jake from the car. He and Luke Barrett were taken to Liverpool Hospital.

Jake suffered serious injuries, including a depressed skull fracture and an unstable fracture to the neck. Despite the efforts of treating staff, his injuries were assessed and believed to be non-survivable. On 1 July 2013 life support was withdrawn, and at 1.39am Jake died. Luke Barrett also received very serious injuries during the accident. He remained in hospital for about 10 weeks.

Who was driving the Toyota?

Luke Barrett was unable to recall the accident afterwards. Given the severity of his injuries, including brain trauma, this is not surprising. In my view, he made a genuine effort to give honest evidence but he simply has no recollection of the details of the night. He was unable to say whether he or Jake had been driving.

The accident was thoroughly investigated by a Critical Incident team led by Det Sen Sgt David Tucker. A number of pieces of evidence were gathered that, taken together, prove that Jake was almost certainly the driver:

Jake had often, perhaps even usually, driven Luke Barrett's car if he and Luke were going somewhere in the car together.

He had been driving the car earlier in the evening. Luke had lost his licence, whereas Jake had a full licence. It therefore made sense for Jake to drive rather than Luke if they were together.

Luke Barrett is shown on CCTV footage at the Bradbury Hotel wearing a white cap. Although evidence was given that he often wore a cap, in the CCTV footage from the hotel that night, Jake is seen to be hatless. An independent eyewitness who saw the Toyota shortly before the crash told police that the passenger was wearing a white cap.

The front offside area of the Toyota received the worst damage and Jake received worse injuries than Luke Barrett. Jake was found with his head jammed between the driver's side door and the steering wheel.

The driver's side window was shattered. It is theoretically possible that a large man (about 192cm tall and reasonably strongly built) could be thrown through the window in a crash if he was driving but common sense suggests that this is an unlikely route for Luke Barrett to have taken as he was ejected from the car. If he was ejected from the passenger side door, as seems more likely, and he had been driving, he would have had to cross from the driver's seat to the passenger door past Jake who remained in the vehicle. This seems implausible.

Jake's blood was found on the steering wheel and driver's seat.

A driver is generally more likely to become aware of the presence of police behind the car because he or she can see to the rear using mirrors. Jake's conversation with Ebony McPherson shows that he had been alerted to the presence of a police car behind him.

How did the crash occur?

Although the crash was not witnessed, it was relatively easy to reconstruct from the pattern of damage found by the crash investigators. In essence, rather than take the sharp left-hand bend, the car continued along a more or less straight line until hitting the right-hand guard rail with its offside front. It may have become airborne after doing so and was certainly spun 180 degrees before coming to a halt.

Why did the crash occur?

The crash happened because a number of physical and human factors combined within a very short space of time:

The car Jake was driving was travelling at excessive speed.

This brought it to the attention of the police in the police car it passed. The police made a decision to attempt to stop the car. The police alerted the driver to their presence by putting on their lights, indicating that they wanted him to pull over and stop.

Rather than doing so, Jake made a spur-of-the-moment decision not to stop but to leave the freeway via the Denham Court exit. He was probably motivated to do so because he knew he was affected by alcohol and possibly drugs and did not wish to be caught and breath-tested by police with the consequences, including loss of licence, that would almost inevitably follow.

His judgment and driving ability were probably impaired to some extent by intoxication. He entered the off-ramp at a speed too high for the car to handle given its condition and the condition and design of the road.

The car’s front tyres, the main braking tyres, were worn and in poor condition, providing insufficient grip in the circumstances. The surface of the road was wet and the sharp left-hand bend was difficult to manoeuvre through at excessive speed even in good weather.

In most cases, this minor error of judgment – which every driver has probably made at some time -- would result in no damage being done.

Or if damage was done, it would only be to the cars. It is terribly tragic that such a small mistake has had such consequences. Why was Jake killed and Luke Barrett severely injured?

Was Jake's death preventable?

Evidence was given by an expert crash investigator and biomechanics expert, Mr Michael Griffiths, that in his opinion this crash would have been survivable had Jake been wearing a seatbelt. He drew this conclusion from the fact that the cabin of the car had survived reasonably well, the principal damage being to the car in its crumple zones.

Leaving aside the circumstances leading up to the crash, Jake was killed and Luke Barrett badly injured because they suffered a catastrophic car crash without taking the elementary precaution of fastening their seatbelts.

To his great credit, Luke Barrett has participated in road safety education since the accident. Jake and Luke, and their families and friends, have, however, paid an enormous price for this simple, youthful indiscretion.

Did the police comply with relevant police procedures and policies?

As I noted in the introduction to these remarks, an important part of an inquest into a death in a police operation is the inquiry into whether the involved officers had complied with their training and with the standard operating procedures of the NSW Police Force while conducting the operation. Such training and procedures are designed in part to ensure public safety insofar as that is reasonably compatible with carrying out their lawful operations. Police do not have a licence to use excessive force in maintaining peace and good order in our society.

The NSW Police Force has implemented a "Safe Driving Policy" that governs all police operations and duties conducted in police vehicles. Among other things, the SDP covers "urgent duty" driving and "pursuits".

The SDP declares that a pursuit commences when a police officer decides to pursue [i.e., follow or keep in contact with] a vehicle that has ignored a direction to stop.

The question was raised whether Constable Flores, the driver of the police vehicle, was engaged in a pursuit or was still in the "catch-up" phase of the operation. In my opinion, so short was the time available to Constable Flores in making the decision to pull the Toyota over, turning on the lights, then losing sight of the Toyota then coming across the crashed vehicle that the question is theoretical only.

Constable Flores gave evidence that appeared to me to be plausible and honest that, although he had seen no indication that Toyota was in fact complying with the direction to stop indicated by the flashing lights, he did not know where the Toyota had gone because he had lost sight of it in the cloud of spray. So he had not decided what to do about pursuing it. If that is correct, he had not commenced a pursuit.

In any event, even if a pursuit had technically commenced there was no time available to follow the usual procedure of radioing VKG before they came across the crashed car.

It seems to me that Constable Flores and other officers in the vehicle followed their training and, whether they were conscious of it at the time or not, complied with the Safe Driving Policy in all material respects.

On their arrival at the scene, the police immediately rushed to Jake's aid. This was both commendable from a humanitarian point of view and brave because the engine bay of the crashed car was smoking and the officers had a reasonable fear that the car might catch fire or even explode while they were trying to help Jake. It was also obviously compliant with their duties as emergency service personnel.

Did the police cause or contribute to causing the death?

Jake's father Robert, in a statement to the court, made the wise and honourable observation that it seems that Jake made a young man's immature mistake in the way he drove the car that night. It was the manner of driving that was the primary cause of the accident.

Although it could probably be said that, but for the police decision to attempt to stop the Toyota, the accident would not have occurred, for the reasons I have outlined above, the police officers involved in this incident do not bear responsibility for Jake's death. To their great credit, Jake's family did not claim that the police officers were responsible.

Conclusions

This most unfortunate event teaches some very old lessons: That dangers can arise very quickly on the roads. That these events can happen to anybody – good people can die on the roads due to mistakes they make or others make. That small mistakes can have catastrophically disproportionate consequences.

The Innes family have suffered terribly and their suffering continues. Sadly, there is no "closure". But all who have participated in this inquest will have noted their dignity and sadness, and their care for each other. I hope that their memories of the lively young man they loved so much will in time soften the blow they have suffered. I also hope that they will accept my sincere and respectful condolences and those of the staff of the Coroners Court.

I would also note that Constable Flores, himself only a young man, spoke kindly and compassionately to Mr and Mrs Innes after he had given his evidence. This was a fine gesture on his part and one I wish we saw more often in the Coroners Court.

Formal Finding:

I find that Jake Robert Innes died on 1 July 2013 at the Liverpool Hospital as a result of blunt force injuries he suffered to his head and neck when the car he was driving on 30 June 2013 onto the exit ramp to Campbelltown Rd, Denham Court from the Hume Highway ran out of control and crashed into a guard rail at excessive speed in the course of a police operation intended to get his vehicle to stop.

14. 222036 of 2013

Inquest into the death of Trent Lenthall finding handed down by Deputy State Coroner Forbes at Glebe on the 3rd June 2015.

Trent Lenthall died on 20 July 2013 when the car he was driving hit a tree. Shortly before the collision he was being pursued by police.

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

- ***the identity of the deceased;***
- ***the date and place of the person's death;***
- ***the physical or medical cause of death; and***
- ***the manner of death, in other words, the circumstances surrounding the death.***

The Act also requires a Senior Coroner to conduct an inquest where the death appears to have occurred "*in the course of police operations".* (s.23, s.27).

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

This inquest is not a criminal investigation, nor is it civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. This Inquest has been a close examination of the police actions on the evening of Mr Lenthall's death and pursuant to s.37 of the Act a summary of the details of this case will be reported to Parliament.

Section 82 of the Act also permits a Coroner to make recommendations that are necessary or desirable in relation to any matter connected with a death that relates to issues of public health and safety.

Trent Lenthall

Mr Lenthall was only 36 at the time of his death. He was a man that had a troubled past including being the victim of sexual abuse while being in State Care during his childhood. Unsurprisingly, he suffered from mental health problems including depression and post-traumatic stress disorder. He also had substance abuse problems and involvement in the criminal justice system.

Shortly before his death life was looking up for Mr Lenthall. He was living with his partner, who was pregnant with his child. His partner stated that since he had found out about the pregnancy to her knowledge he had not used illegal drugs and was obtaining his methadone daily. This is supported by the pathology report[2] which shows no illicit drugs in his system when he died.

According to psychologist Ms Munro[3] who had been treating Mr Lenthall as recently as the day before he died, Mr Lenthall was excited about the prospect of becoming a father. He told her he wanted to do everything right so that he could be a good father to his child.

Facts in outline

At approximately 11.30pm on Saturday 20 July 2013, Constable Bale, Constable Dimovski and Detective Sergeant Guthrie from the Newtown Local Area Command were travelling in Newtown 140, an unmarked grey Holden Commodore Wagon. Constable Bale, who holds a silver licence, was driving. Constable Dimovski was the front passenger. Detective Sergeant Guthrie was the rear passenger. Detective Sergeant Guthrie was at the time the head of the Pro-active Crime Team and the officers' duties on the evening were to patrol crime hot spots and target property and drug related crime.

The officers were travelling north along Liberty Street, Stanmore when they observed a vehicle travelling at high speed south on Liberty Street then abruptly turn right into Trafalgar Street without indicating. Constable Bale accelerated and turned left into Trafalgar Street and began to follow the vehicle, to observe it further.

There is CCTV footage of the vehicle travelling along Trafalgar Street as it passed Stanmore Railway Station. Senior Constable Fenton of the Metropolitan Crash Investigation Unit analysed that CCTV footage and estimated that at the time Mr Lenthall passed Stanmore Railway Station his vehicle was traveling at approximately 108km/h. and that the police were approximately 10 seconds behind traveling at approximately 65km/h.

Detective Sergeant Guthrie described the vehicle as it travelled along Trafalgar Street, as travelling at high speeds and moving in and out of the middle of the road to avoid speed bumps.

A decision was made to stop the vehicle for the purpose of a random breath test.

Constable Bale stated that he followed the vehicle left into Merton Street and saw it accelerate away from him. The vehicle then turned left into Stanmore Road, and then immediately right into Middleton Street. Constable Bale activated the lights and sirens on Middleton Street to get the vehicle to stop. Constable Bale said the vehicle did not stop but accelerated away. Constable Dimovksi then notified VKG that a pursuit had been initiated.

The vehicle continued to accelerate away from Police, making several turns, right onto Newington Road then left onto Bright Street, before turning left onto Addison Road, Marrickville. Constable Bale indicated that the vehicle was travelling at approximately 110km per hour on Addison Road and continued to pull away. . Detective Sergeant Guthrie considered the pursuit should be terminated and instructed Constable Bale to terminate the pursuit. Constable Bale said he was already decelerating, the siren and lights were turned off and Constable Dimovski notified VKG: “Yeah, we’re going to terminate the pursuit VKG,

The light at the intersection of Addison Road and Enmore Road, Marrickville turned green as police arrived at it. A number of people were standing on the corner at a hotel and pointed in the direction the vehicle travelled. CCTV was captured by the hotel, which depicts the vehicle turning right at high speed and appearing to drift onto the wrong side of the road, just prior to turning right.

Approximately twelve seconds later, the police vehicle turned right onto Enmore Road, which turns into Victoria Road, Marrickville. After approximately 500 metres the officers observed a plume of smoke and dust near the intersection of Victoria Road and Chapel Street, Marrickville and saw that the vehicle had crashed into a tree.

Police immediately attended to give aid to the driver, but Mr Lenthall had sustained fatal injuries. An Ambulance and other police arrived within minutes.

Mr Ahmed witnessed Mr Lenthall's vehicle crash. He was driving along Victoria Road when he heard a screeching noise. He looked in his rear vision mirror and saw a car three lengths behind him swing back and forth four times before crossing the road and colliding with a tree. He recalled that police arrived approximately thirty seconds later. Another civilian witness, Samuel Gerber, was at a bus stop a short distance away on Victoria Road when he heard the crash occur, he started walking towards the crash scene and recalled police arrived 30 seconds to one minute later.

The Post Mortem recorded the cause of death as combined effects of blunt trauma injuries to the head and chest, with significant alcohol and methadone intoxication as major contributing factors. At the time of the incident Mr Lenthall had a blood alcohol concentration of 0.110/100ml and a methadone level of 0.71 mg/L.[5]

At the time of his death Mr Lenthall was a disqualified driver. He had been disqualified from driving for five years from 1 May 2009. The vehicle Mr Lenthall was driving was owned by his defacto partner and was unregistered.

Issues

The principal issue in this Inquest is whether the pursuit of Mr Lenthall was appropriate in all of the circumstances. Counsel Assisting, Mr Edwards, in his opening statement outlined a number of questions that go to this issue that were explored during the course of this Inquest. They were as follows

- Was the pursuit of Trent Lenthall commenced and conducted in accordance with the NSW Police Force Safe Driving Policy? In particular:
- Was it reasonable to commence the pursuit?
- When was the pursuit terminated?
- Is the NSW Police Force Safe Driving Policy sufficiently clear on the circumstances in which a pursuit should and should not be commenced?

- Have any changes in NSW Police Force practice or policy been instituted as a result of this incident?

- What steps have been taken, or changes made to NSW Police Force practice or policy, in response to the recommendations made in the inquests into the death of Hamish Raj and Jason Mark Thomson?

- Ought any recommendations be made pursuant to s 82 of the Coroners Act 2009?

I will now consider those issues.

- Was the pursuit of Trent Lenthall commenced and conducted in accordance with the NSW Police
- Force Safe Driving Policy?

- Was it reasonable to commence the pursuit?

The NSW Police Force Safe Driving Policy, Pursuit Guidelines provide that:

"*1. The decision to initiate and/or continue a pursuit requires weighing the need to immediately apprehend the offender, against the degree of risk to the community and police as a result of the pursuit.*
You are under no legal obligation to initiate a pursuit and in many circumstances the safety of the community and police will dictate that no pursuit be initiated…"

On the evening of 20 July 2013 Detective Sergeant Guthrie was the most senior officer in Newtown 140. He stated that he made the decision to initiate the pursuit of Mr Lenthall. He said that when he saw that the vehicle was the type of vehicle that is easily stolen and often used in robberies in the local area, and when he observed the vehicle manoeuvre quickly around the corner, that they decided to follow the vehicle to see what it was doing at that time of night. He said that when the police began to follow the vehicle and it took further evasive action to get away that he became more suspicious. He said a decision was made to pull the car over for a random breath test and that the police indicated to the vehicle to stop. He said that when the vehicle did not obey that direction and sped off his suspicions were further heightened.

He said that he considered that it was safe to initiate a pursuit as there was almost no traffic at that time in that area and there were no pedestrians. He stated that the risks were minimal.

Constable Bale described the decision to commence the pursuit as a “collective decision”, but he did not recall whether anything was specifically discussed. With respect to the NSW Police Force Safe Driving Policy, Constable Bale indicated that he considered the danger to potential road uses, to the person in the vehicle and to himself and that the vehicle had not obeyed a direction to stop. Constable Dimovski agreed that the decision to commence the pursuit was a collective decision.

But he was not aware that the vehicle was a Subaru and that played no part in his decision to pursue the vehicle. He gave evidence that at the time of calling in the pursuit he gave consideration to the NSW Police Force Safe Driving Policy, in that he was aware Constable Bale had the appropriate level of licence to engage in the pursuit, that the police vehicle was an appropriate category, that there was low traffic and that the vehicle had refused a direction to stop.

I am satisfied that on the evening the police weighed the need to immediately apprehend the offender against the risk to the community and that the police complied with the Pursuit Guideline 1. I am not sure whether the decision to initiate the pursuit needed to be by the senior officer present or a collective decision, the Pursuit Guidelines are silent on that point. I also note that pg. 25 of the NSW Police Force Safe Driving Policy provides that a pursuit must be considered *“as a last resort”* that *“will only be engaged in when the gravity and seriousness of the circumstances require such action and there are no other means of responding.”* As will be referred to below, I consider that the NSW Police Force Safe Driving Policy could be clarified to provide further guidance to officers as to the circumstances in which a pursuit should be initiated.

When was the pursuit terminated?

The NSW Police Force Safe Driving Policy, Pursuit Guideline 2 states that:

You are under no legal obligation to initiate a pursuit and in many circumstances the safety of the community and police will dictate that no pursuit be initiated. Similarly when a pursuit is considered to be too dangerous it must be terminated”

No criticism will be levelled at any officer who decides to terminate a pursuit."

Each of the officers involved in the pursuit estimated that it lasted for less than one minute. The VKG recording confirms this. The distance from the location the pursuit is first reported to VKG, in the vicinity of Bright Street, to the end of the pursuit is 1.1 kilometres.

I accept the evidence that the officers quite correctly and appropriately decided to terminate the pursuit once it became dangerous. [redacted] . [redacted] .

I commend the officers on this decision to terminate the pursuit and am satisfied that they complied with Pursuit guideline 2.

Is the New South Wales Police Force Safe Driving Policy sufficiently clear on the circumstances in which a pursuit should and should not be commenced?

The NSW Police Force Safe Driving Policy, Pursuit Guideline 5 states that:

*"5. When engaging in a pursuit, you should ensure that there is reasonable cause to believe that the person being pursued has committed, or has attempted to commit, an offence **and** the offender is attempting to evade apprehension".*

At no point did any of the officers say that they were "engaged" in the pursuit because they had reasonable cause to believe the driver had committed or attempted to commit an offence, other than the failure to stop. It is not clear whether "engaging" in a pursuit is the same as "initiating" a pursuit. This should be clarified. Furthermore, the officers spoke about their "suspicion" that an offence had been committed, but that falls short of having a "reasonable cause to believe" that Mr Lenthall had committed an offence. For example, Detective Sergeant Guthrie indicated that due to the manner of driving, time of night and type of vehicle, he thought the driver may have been involved in a robbery, aggravated break and enter or that the vehicle contained prohibited drugs.

Constable Bale gave evidence that the offence he was investigating when he chose to pursue the vehicle was “failure to stop RBT”. Constable Bale said he was also aware they had had a high number of Subarus being stolen in used in break and enters in the local area.

There was no doubt that Mr Lenthall was attempting to avoid apprehension or “evade police”, but that element alone does not seem to satisfy Guideline 5. It is my view that the word "and" in Guideline 5 clearly connotes that the police should have "reasonable cause" to believe the commission of an offence other than those derived from the attempt to evade apprehension.

The New South Wales Police Force Safe Driving Policy also states at p 25 that:

“You must consider a pursuit as a last resort. It will only be engaged when the gravity and seriousness of the circumstances require such action and there are no other immediate means of responding”.

The “circumstances” is a term that is not defined but would presumably include the gravity and seriousness of the nature of the offence and the consequences to the community if that offender is not apprehended at that point in time. It would be preferable if police were given clear guidance as to the categories of offences where it is appropriate, and not appropriate, to conduct pursuits.

The task of frontline policing is a difficult and dangerous one. As most police pursuits occur on public roads they pose serious risks to the safety of members of the public.

Analysis of data from the Australian Institute of Criminology’s National Deaths in Custody Program, the NCIS and from police agencies has showed that the number of police pursuit related fatalities over the last eleven years has been an annual average of 20 deaths of all of the policing activities few situations pose a greater risk to the community.

Police pursuits that end in fatality not only impact upon the community but on the deceased and their family and friends and the police officers involved in the incident. Deciding whether to pursue a motor vehicle is among the most critical decisions made by a police officer. For the guidelines to assist the police they must be clear and concise.

In the Inquest into the death of Hamish Raj, my colleague Deputy State Coroner Dillon, identified and recommended that the New South Wales Police Force Safe Driving Policy be amended to eliminate the ambiguities in relation to when to initiate a pursuit.

I endorse his recommendation.

Have any changes in NSW Police Force practice or policy been instituted as a result of this incident?

I note that in a letter dated 18 May 2015, the NSW Police Force informed this Inquest that, pursuant to the Critical Incident Guidelines, in pursuits where a death has occurred that there is no Critical Incident Review Report prepared review of the incident until the Inquest is completed.

As a result of this practice no changes have been instituted to police policy as
a result of this incident.

What steps have been taken, or changes made to NSW Police Force practice or policy, in response to the recommendations made in the inquests into the death of Hamish Raj and Jason Mark Thomson?

I have been informed that the recommendations made in the inquests into the death of Hamish Raj and Jason Mark Thomson are still being considered by the Minister.

Ought any recommendations be made pursuant to s 82 of the Coroners Act 2009?

I direct that a copy of these findings be forward to the Minister for Justice and Police for consideration together with the recommendations in the matter of Hamish Raj and Jason Mark Thomson.

Formal Finding:

I find that Trent Lenthall died on 20 July 2013 at Victoria Road, Marrickville, and NSW as a result of blunt trauma injuries to his head and chest he received when the car he was driving collided with a tree shortly after a police pursuit of his vehicle. Alcohol and methadone intoxication were significant conditions that contributed to but did not cause his death.

15. 246399 of 2013

Inquest into the death of AA finding handed down by Deputy State Coroner Dillon at Glebe on the 2nd April 2015.

On 13 August AA's father had planned to work with AA doing some painting, AA however was not feeling well or so he told his grandmother and father. When Mr AA spoke to AA at about 11.30 he thought that AA sounded upset, one of the main reasons that AA was upset was that he was still trying to keep in touch with his ex girlfriend and could not adjust to the break up she had initiated. He had a very emotional conversation with his mother about this and other matters troubling him before walking out of the house sometime after 1pm.

At about 1.50pm AA called E from the railway bridge at Kogarah. He was crying as he spoke to her and told her that he was going to jump. At about 2pm a train approached the bridge from Rockdale Station. It was travelling at about 80 kilometres per hour. About 200 to 300 metres from Kogarah Station the driver Mr Mark McLoughlin who was about to start braking anyway, saw AA standing on a safety platform attached to the bridge. He believed that AA was going to jump, so he immediately applied the emergency brakes.

E was still on the phone to AA at this time. Over the phone she heard the train approaching and called out to AA not to jump. He did not answer her, then she heard a loud bang.

AA had mistimed his jump so that instead of landing in front of the train he hit the destination board and was thrown onto the roof, receiving significant internal injuries as he did so.

The train pulled into Kogarah Station with AA lying on the roof. He was in great pain and asking for help and for someone to call his mother. The station duty manager, Ms Mannal Papacostas and plain clothes Senior Constable Benjamin Short who was on the platform waiting for a train tried to reassure AA and keep him reasonably calm and on top of the train while emergency services came to rescue him and Sydney Trains worked to isolate the overhead power lines to enable emergency services personnel to climb onto the roof and rescue AA.

Senior Constable Short called triple-0 to ask for emergency services to attend urgency. At least one other person a school student who had witnessed AA's fall into the path of the train also called triple-0.

These calls resulted in a number of police officers rushing to the station from the Kogarah Police Station and the local area. The ambulance and fire rescue services were also dispatched. This was being done the police officers on the platform tried to find ways of improvising some protection for AA. Unsuccessful attempts were made to find something to cushion his fall and to improvise a way of reaching him to keep him steady on top of the train.

There were no ladders of sufficient link and no other things immediately available at the station that would have enabled police or anyone else to climb to the roof. Police cars are not equipped for complex rescue operations involving high voltage electricity. This may have been fortunate because Senior Constable Short told the inquest he would have liked to have climbed up and held AA where he was until rescue teams arrived, but this may have placed both of them at risk from the overhead lines. One of the lesser known hazards of high voltage electricity lines is that it is not always necessary to touch the line to be electrocuted, because electricity will always seek the quickest way to earth. It can arc from a high voltage line towards a person who approaches too close. If a person is in the course of being electrocuted a second person touching that person will also be electrocuted.

It was necessary both to de-energise the overhead lines and to await the arrival of rescue specialists before AA could be lifted from the roof of the train.

The procedure for isolating of the power lines for Sydney Trains is complex and requires strict safety guidelines to be followed. I will deal with the question of how the power line at Kogarah was isolated and why it took 17 minutes for emergency services personnel were cleared to climb onto the roof in more detail below.

The critical fact however is that for that period due to the dangers of the high voltage lines, emergency services were unable to secure and rescue AA.

At about 2.18pm AA sat up on the train roof, shifted his legs over the side of the train then slipped and fell onto the platform.

Senior Constable Short was unable to catch him as he fell, and he struck his head on the platform in front of Leading Senior Constable Mark Butler who had been talking to AA. Leading Senior Constable Butler immediately cradled AA's head. In one of the most moving moments of the whole inquest, he described making eye contact with AA who appeared to understand that another person was trying to look after him and AA's eyes went blank.

Leading Senior Constable Butler was in tears as he described this moment. Dr Chris Georgiou and Nurse Karla Kolarosso who were passengers at the station immediately attended AA and assisted Senior Constable Short and Leading Senior Constable Butler to stabilise him until paramedics arrived about four minutes after AA had fallen. AA was transported to St George Hospital but he had sustained fatal injuries and could not be resuscitated. He was diagnosed at the hospital as suffering a catastrophic head injury. Later autopsy found however that AA had suffered multiple broken ribs and severe internal injuries.

The forensic pathologist Dr Kendall Bailey who examined AA gave evidence at the inquest that the internal injuries alone would probably have been fatal but thought that a possible closed head injury AA suffered when he fell to the platform could not be excluded as a contributing factor.

Dr Peter Grant the emergency physician who had carriage of AA's case at St George Hospital reviewed the x-rays taken during the limited autopsy and agreed stating "I would concur with Dr Bailey's finding of blunt force injury as the cause of death. It would also be my opinion that the witness closed head injury was likely to have been a contributing factor.

<u>HOW WELL DID SYDNEY TRAINS RESPOND?</u>

Apart from applying emergency brakes the driver of the train Mr Mark McLoughlin notified the rail operation centre by hitting the emergency button on the train's radio and then spoke to the relevant signaller.

Two guards, one of whom was off duty realised that something had happened when the train came to a sudden stop, both guards spoke to the Rail Management Centre to explain the situation. This set in motion the process of isolating and de-energising the section of powerlines supplying electricity to the train.

While that was being done the duty manager of Kogarah Railway Station, Ms Papacostas, assisted police especially Senior Constable Short in attempting to reassure AA that help was on the way and to comfort him. In recounting what had happened that day she broke down in tears. She behaved with great compassion and exemplary professionalism in very difficult and frustrating circumstances. Both AA's family and myself as Coroner, a live question is why the process took 14 or 15 minutes.

In an emergency such as this one it is self evident that the power lines ought to be de-energised and isolated as quickly as is consistent with the safety of emergency personnel, railway staff and of course members of the public involved.

I was told during the inquest that the current process had been developed following the Waterfall railway disaster in 2003 and the subsequent special commission of enquiry by the Honourable Peter McInerney QC.

During the Waterfall incident due to fears that they may be electrocuted it had taken about an hour and a half before ambulance officers, police and others would undertake rescue operation safely. The Waterfall Commissioner, not surprisingly found this to be unacceptably long.

The current process was explained by Mr Paul Cassar, the control and co- ordination manager, at the infrastructure control or ICON, at Central Station and Mr Christopher Huntley, an electricity system operator with Sydney Trains. According to Mr Cassar a highly experienced railway engineer, Sydney Trains is one of the few railway networks in the world that uses a rescue power outage process even in life threatening situations.

Rescue Power outage process does not physically disconnect high voltage overhead wires from the electricity supply. From the ICON Centre using a computer system, electrical systems operators can de-energise sections of line by remotely operating circuit breakers.

Evidence was given by Mr Cassar and to electrical systems operators, Mr Huntley and Mr Vladimir Blagus that this process does not necessarily result in a complete loss of power for various reasons. For example insulators may not work properly due to rain water or dust interfering with them.

Only a complete physical isolation of the section, including earthing the overhead wire to the train line absolutely guarantees that the overhead wire is safe to approach.

For this reason only expert rescue teams which have been trained to work in high voltage areas and which are equipped with appropriate protective equipment and clothing are permitted to work close to de-energise overhead wiring during a rescue outage.

Mr Huntley was on duty at the ICON Centre on the afternoon of August 2013. At 2.03pm the electrical system operators were telephoned by a train controller at the Railway Management Centre who told him there was a person on top of a train at Kogarah Station and that they needed to drop the power.

A group of four electrical systems operators work each shift at ICON, control the electrical supply for the whole Sydney Trains Network. The system runs on 1500 volts DC. An electrical cable carrying enough energy to drive trains will instantaneously deliver a fatal electrical shock to any human being who touches it.

Before anyone could approach AA on top of the train therefore the section of overhead wiring above him had to be isolated and de- energised by the use of circuit breakers that are located at various points along the network. Shutting down a busy section of the Sydney Trains Network has ramifications for the whole network. Train controllers, signallers and electrical system operators must work together as quickly as possible, both to remove the life threatening hazard, but also to ensure that trains do not continue into the area that is being isolated.

The train that crosses from an energised section of overhead wire, into a de-energised section may bridge the two sections and re-energise the isolated section. For safety reasons therefore it is critical that buffer zones be created around the section of overhead lines that is being isolated. Train controllers must communicate with trains and signallers to manage the movement of trains in and approaching the critical zone and they must also of course manage the flow on effects, but they come later once the emergency has been dealt with, within the isolated section of line.

Once the call was received in the ICON all four of the electrical systems operators on duty worked together to identify the section of line to be isolated.

Each electrical system operator has a set of A3 diagrams for the whole of the network, the team in ICON was a very experienced group and knew exactly which diagrams were needed. The diagrams show among other things the locations of all circuit breakers and their identifying numbers. In an emergency all the electrical systems operators work together to check diagrams, cross checking and communicating with the train controllers.

The isolation of the overhead line above the train on which AA there was in total 19 circuit breakers that had been open. Mr Huntly called operations at 2.06pm and notified them that the power supply between Wolli Creek and Rockdale on the down, Illawarra line, the line to Wollongong and all tracks between Rockdale and Carlton a buffer zone was down.

In his statement Mr Huntley then explained the checking process that is carried out before rescue teams are permitted to work under the overhead lines. He said "After dropping the power urgently we have to go back through the diagrams in a careful manner to check that we de-energised everything that we needed to and that it had been done correctly. At the same time we continued to perform our other duties as electrical system operators which include dealing with telephone and alarms which are raised in the computer system that controls the electrical system. When an incident occurs it is a dynamic situation and is dealt with differently each time, depending on the circumstances at the time, including the complexity of the lines required to be de-energised and the workload. I digress to say I have not written this, but the area of line they were dealing with is a very complex section, series of sections including a junction.

The general process for reviewing the area that had been de-energised involves identifying the location of the incident, identifying the required sections to be energised, checking the diagrams for the correct sections to de-energise and checking that the correct circuit breakers had been opened on the computer system.

Once this is verified the information is written onto the rescue power outage, or RPO form, completing the form you are usually undertaking a further check that the correct circuits have been de-energised and that no circuit should be de-energised and that no additional circuit should be de-energised. These checking processes are important because we need to ensure the circuits which are de-energised are correctly identified and effective for allowing rescue workers to access the area.

The usual process is that another person would check the RPO form and sign it as checked.

Mr Huntley stated that the usual process had been followed on the afternoon of 13 August 2013 and "the RPO was issued as quickly as possible. Until the RPO is issued and notified to operations, rescue crews are not permitted into the effected zone. In retrospect although it made no difference to the outcome for AA, the process would probably have been accelerated if Mr Huntley had not also started to arrange for field staff to attend the relevant substations while simultaneously taking responsibility for completing the RPO document.

Perhaps a couple of minutes or so could have been shaved off the time taken and this was conceded by Sydney Trains to be a lesson learned. That said, because we do not know what else was going on at the time Mr Huntley made those arrangements with field staff or whether someone else was available to do that task it would be unfair to criticise Mr Huntley on this point.

COULD THE ORIGINAL CHECK BY MR HUNTLEY HAVE BEEN CONDUCTED MORE QUICKLY?

This was a question only raised by Mr Sheppard in final submissions. She pointed out that according to the documentary evidence presented to the Court Mr Glen Royals who had not given oral evidence or been questioned had apparently completed the cross check within a couple of minutes of Mr Huntley filling out the RPO form. The question was a reasonable one that came after the conclusion of the evidence. Adjourning the inquest to obtain further evidence would have delayed concluding the inquest for several months and so I have decided not to do that.

Nevertheless it appears to me that the answer to the question is reasonably straight forward. Mr Royals was working on the same problems as Mr Huntley, he would have been able to cross check Mr Huntley's RPO form because he had access to all the diagrams and computer pages as well as Mr Huntley.

In his statement Mr Royals indicates that he may have assisted Mr Huntley with the process as he prepared the form but he now cannot recall. He may have taken his own notes of the various circuit breakers he had opened and other operations he had performed.

By the time he cross checked the RPO form he was obviously familiar with that section of the network because he had been working on it himself. Anyone familiar with an environment can move through it much more quickly and efficiently than a person exploring it for the first time.

Further, in practical terms some of Mr Huntley's work had already been cross checked by Mr Royals, as Mr Royals had been working on those sections himself and checked them previously. We do not have it directly from Mr Royals or Mr Huntley or Mr Cassar therefore it does not appear to me to be surprising that the final RPO cross check could be completed within a much shorter time than the original emergency removal of tar or the original RPO check completed by Mr Huntley.

Unfortunately just before notification could be issued of the RPO AA fell to the platform. The New South Wales Fire Brigade Rescue Team arrived a few minutes later.

HOW WAS THE POLICE OPERATION CONDUCTED?

A significant number of police officers were involved in the incident. Only a few had direct involvement with AA. Plain Clothes Senior Constable Short was off duty, waiting on the platform when he heard a loud bang as the train approached the platform, he saw a person on the roof. He called the triple-0 emergency line and spoke to AA who was in pain telling him to stay where he was because help was on the way. A short time later a number of other officers arrived, but were unable to mount the roof of the train because they were warned that the overhead wires should be regarded as live until verified by Sydney Trains.

All the officers on the platform were concerned for AA's safety and several times officers encouraged him to stay where he was and to try to relax while help was coming. Inspector Rafiq Azarkar tried to find a mattress or cushion to place on the platform underneath AA in case he fell but was unable to.

Evidence was given by Ms Papacostas that railway stations do not generally have ladders or mattresses or such items because they might be used for inappropriate and indeed dangerous purposes by unauthorised people.

A crew from Fire and Rescue New South Wales was also dispatched but like the police they would have been unable to ascend to rescue AA until given clearance to work underneath the overhead electricity lines. As it happened the clearance was given at a very short time before they arrived on the scene.

A question that occurred to AA's family was whether the police officers who were on the platform when AA fell could have done more to catch him or break his fall. Senior Constable Short in fact tried to do that but found it impossible to hold AA. Unfortunately the laws of physics are very rigid and unforgiving.

The force that struck Senior Constable Short as he tried to catch AA was very great. A A weighed about 92 kilograms, he fell from a height of about three metres. In this situation force is measured is newtons by the formula mass by acceleration. A newton is the force needed to accelerate one kilogram of mass at the rate of one measure per second squared. Gravity causes objects to accelerate at a rate of 9.8 metres per square.

Even with some friction being applied as he slid off the train it would have taken AA less than a second to hit the platform once he fell. Due to the variables involved without conducting a scientific test, it is impossible to measure or even estimate the force that struck Senior Constable Short but it must have been very substantial. It took considerable courage even to attempt to catch AA. Catching him was physically impossible and breaking his fall was not much easier even if everything had gone well. In both his witness statement and his oral evidence at the inquest Leading Senior Constable Butler describes stepping back when AA fell as he was concerned about being injured. In my view Leading Senior Constable Butler, not a very large man and 57 years of age probably acted instinctively when he did so, he had only a split second in which to react. If he flinched, this is not surprising, falling towards him was a large young man weighing over 90 kilos from a height of approximately three metres.

If at that moment Leading Senior Constable had attempted to help Plain Clothes Senior Constable Short, this may have helped marginally, but he also may have impeded Short's attempt to help AA. There was almost no time for Leading Senior Constable Butler to prepare or brace himself as AA fell. He had a split second only in which to react to AA falling and Short lunging forward to try to catch AA.

In such circumstances, although he appears to be highly self critical, I do not believe that he is deserving of criticism. In my view Leading Senior Constable Butler demonstrated considerable moral courage in frankly stating that he had been frightened by AA's fall. His caring attitude towards AA both before and after AA's fall deserves commendation and respect.

He behaved as did other police officers and railway staff like good Samaritans, caring for and showing compassion to a badly hurt stranger.

Unfortunately neither he nor Senior Constable Short were blessed with super human strength as well.

In my view the involved officers behaved as well as anyone in such a situation could be expected to. They had the agonising experience of watching and speaking to AA trying to sooth him as they waited for a rescue team to arrive and for notification that the live wires powering the train had been isolated and de-energised. It was obvious to all who saw the police witnesses who gave evidence that the officers were deeply affected by AA's death and their experience of being unable to save him at the station. They were all experienced officers who had previously attended scenes at which people had committed suicide on railway tracks, but this was an entirely novel situation for them and the railway staff. Very few people survive being hit by a train. None of them had faced the situation of such a person lying injured on top of a train.

IN SUMMARY.

The police operation was conducted as well as the circumstances allowed. The officers immediately on the scene reacted quickly and efficiently to arrange for a rescue team to attend urgently, they identified the danger to AA as he lay on the roof of the train and they sought to reassure him that help was on the way and to keep him as calm as possible. They also sought to no avail to find things with which they could improvise a soft landing for AA if he fell. Each of the officers who gave evidence deserves commendation for their humanity towards AA. His death was not their fault.

IN CONCLUSION.

AA is no statistic, but it is worth noting that last year the Australian Bureau of Statistics reported that suicide is now the single most common cause of death among people in the 15 to 24 years of age group. It is more common than deaths in motor accidents. More than 200 young men and 100 young women take their own lives in Australia per annum, about one every day. The Australian Institute of Health and Welfare has reported that intentional self harm including attempted suicide is a substantial cause of hospitalisation in young people.

In 2010/2011 26,000 people in Australia were hospitalised for intentional self harm and of these 29% were aged 15 to 24. Young woman aged 15 to 19 had hospitalisation rates for self injury almost three times those of young men. In 2013 Kids Helpline, Australia's National Telephone Crisis and Counselling Services for those aged five to 25 facilitated nearly 10,000 counselling sessions with children and young people who were assessed by the counsellor as having current thoughts of suicide. Kids Helpline also responded to nearly 16,000 contacts with children and young people aged five to 25 who were assessed to have self injury and self harming behaviour.

The objective fact is that Australian young people are at greater risk of death or physical harm from a major depressive illness than from war or terrorism. Governments recognise this problem and large resources have been and continue to be committed to it, but it remains unfortunately an almost intractable problem.

The death of a troubled 18 year old in the circumstances of this case is a tragedy, not only for AA and his family and friends, but for the wider community. Despite the efforts of police and other emergency service personnel, of railway staff and others who were more intimately involved in his life he died very prematurely. We cannot know where AA's life may have led had he survived this incident, but given his good character, his generosity of spirit, his capacity for friendship and the obvious intelligence of his parents, which he no doubt inherited, we can assume that he would have grown into a young man with a real contribution to make to our society.

AA was much loved by his family and others who knew him. Their grief and pain due to his death has been increased by the manner of his death.

Few experiences are more agonising for parents and families than the loss of a child and a death by suicide of a young person is even more troubling.

I hope and I speak to you directly now, I hope your happy memories of AA will help you with the heartbreak you are feeling now and have been feeling, Mrs AA I know you have some criticism or you have some unresolved questions. I am sorry I disagree with you. If I could provide you the answers that you like I would but I obviously have a different view about how Senior Constable Butler performed and I also think that the railway did its best to get the powerlines down as quickly as possible. I know that for people in your situation one of the things that - one of the things that many, many families hope is that something positive will come out of an inquest that will save other people's lives.

Although I am not making any recommendations I do believe that Sydney Trains have looked at this case and have learnt at least one lesson, which is that the RPO form should be filled out by one person if possible without being distracted by getting other staff out to substations and so forth, and when one compares this case to what happened in the Waterfall case, which I did, I think they worked pretty well to get the power lines down, given the horrific affects of high voltage on people, and I have gone down to the morgue and seen someone who got electrocuted on top of a train, I can see why they have to be so careful.

It is a most unpleasant sight. So the greatest care has to be taken but most of all that is really not what I have to say. I think that I have - well I cannot remember being more deeply affected in an inquest than by seeing the CCTV footage of AA on top of the train in pain.

It really affected me, it affected everybody who was there on the day. I am quite sure it has affected all of you much more terribly than it affected me or anybody else. I am so sorry that you have lost a beautiful young man, he looked to me like a beautiful boy and I cannot imagine what you are going through.

You have all sat there with great dignity and thoughtfulness, you are obviously very intelligent. You have been through a dreadful, dreadful experience. I hope in due course that your memories of AA will help you through what you are going through now. I am so sorry I can't do more. Thank you for listening and thank you for being so good, and most of all thank you for telling me about AA I really appreciate it.

Formal Finding:

I find that AA died on the 13th August 2013 at St George Hospital as a result of a combination of blunt force injuries to his chest and head, occasioned when, with the intention of taking his own life, he deliberately jumped from a railway bridge into the path of a train approaching Kogarah Railway station, he subsequently fell from the roof of the train onto the station platform during the course of a police operation, striking his head.

16. 265085 of 2013

Inquest into the death of AB finding handed down by Deputy State Coroner Forbes at Glebe on the 16 June 2015.

NOTE: PURSUANT TO S 75 (5) OF THE CORONERS ACT 2009 I PERMIT A PUBLICATION OF THE REPORT OF THIS MATTER HOWEVER EVIDENCE IDENTIFYING THE DECEASED OR ANY MEMBERS OF HIS FAMILY SHALL NOT BE PUBLISHED IN ANY REPORT AND THE DECEASED SHALL BE REFERRED TO BY THE PSEUDONYM AB

REASONS FOR DECISION

This inquest concerns the sad death of AB. He was only 34 years of age when he took his own life while he was an inmate at Goulburn Correctional Centre.

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

(e) the identity of the deceased;

(f) the date and place of the person's death;

(g) the physical or medical cause of death; and

(h) the manner of death, in other words, the circumstances surrounding the death.

The Act also requires a Coroner to conduct an inquest where the death appears to have occurred "*while in lawful custody*". (s.23, s.27)

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

AB was born on 23 April 1979. He is a much loved son and brother. He had a limited criminal history relating to supply and possession of drugs.

On 28 May 2013 he entered the custody of Corrective Services NSW for the first time. He was on remand for supply of a commercial quantity of Methamphetamine (7.3kg). The next mention date was 08 October 2013.

On 29 May 2013 in a screening interview he informed Corrective Services NSW that he was affiliated with the Hells Angels Outlaw Motorcycle Group. Accordingly, he was not placed in the same wing as rival motorcycle groups.

On 31 May 2013 Justice Health completed a 'Reception Screening Tool' document and concluded that there were *'nil medical issues identified'*. No Risk Intervention Team (RIT) plan or alerts were identified as being required for his medical management in custody.

On 04 June 2013 a CSNSW 'Initial Classification' was completed. During this process AB advised that his father had committed suicide 12 years earlier and that he'd been seeing a counsellor about the incident. He was not identified as a risk of self-harm and was secured in remand at Parklea Correctional Centre.

On 06 June 2013 AB advised that other inmates at Parklea Correctional Centre believed he was a Police Officer and had threatened his life. As a result he was provided with Special Management Area Placement (SMAP) at Parklea. He was subsequently relocated to Goulburn Correctional Centre on 30 July 2013.

On 23 August 2013 he appeared in Court on a bail application. His mother provided an affidavit to the Court which set out that she was concerned about the deterioration of his wellbeing in Goulburn Correctional Centre[13]. She has informed this Inquest that she thought her concerns contained in that affidavit would be passed on to Correctional Services. Despite this misunderstanding, having read the affidavit, I am of the view that Correctional Services would not have necessarily formed the view that AB was at risk of self harm.

At 11:41am on 24 August 2013 AB made an Offender Telephone System (OTS) telephone call. During the call he indicated he had nothing left and that he was struggling with the fact he may be sentenced to life. He said if he got life he would last a week and there was no way he was doing life. At 10:14am on 28 August 2013 he made a further OTS telephone call to the same friend. He left a voice message saying that he loved the recipient of the call and said goodbye.

At 10:49am on 28 August 2013 AB made an OTS telephone call to a different friend. During the call he indicated that he was bail refused at Court and they told him he was getting life or 25 years which had shattered and devastated him. When asked about seeing his mother on the weekend he said it was hard to say goodbye.

At 10:06am on 29 August 2013 AB made an OTS telephone call to another friend. During the conversation he indicated he was doing it tough and really struggling. He said he wanted to go home badly.

On 29 August 2013 he was secured in Cell 44 in Unit 2 with inmate Christopher Hibbard. Mr Hibbard described AB as seeming down and out, depressed and miserable. He said AB had spoken to him several days before his death about a family member taking their life and that he felt he should do the same.

At 6:40am on 30 August 2013 Correctional Officers unlocked the door to Cell 44 in Unit 2 to take Mr Hibbard for transfer for Court. Whilst leaving the cell Mr Hibbard saw that AB had a blanket over his face but said that he was awake at the time. AB wished Mr Hibbard good luck. There were no indications for concerns of welfare of HAZZARD at this time.

At 8:30am on 30 August 2013 during the inmate 'let go' procedure in Unit 2 AB was located suspended by his neck from the window at the rear of Cell 44. He was cut down and the ligature removed from his neck. CPR was commenced without success. Life was pronounced extinct at 9:10am.

A forensic crime scene examination was conducted. A handwritten 'suicide note' addressed to his mother was located.

A post mortem examination was conducted by Dr Rebecca Irvine and I accept her opinion that the cause of death was a result of hanging.

Whilst in CSNSW custody AB was able to contact twelve nominated persons via telephone and he did so on a daily basis. He also had 38 physical visits from friends and associates whilst in custody.

AB planned his death. This is supported by the suicide letter written to his mother telling her that he was sorry for taking his own life. It appears he deliberately suspended himself from the window in Cell 44 in desperation of the prospect of a lengthy custodial sentence. There is no evidence available to suggest that CSNSW or Justice Health were aware that he was contemplating these actions.

I accept the Officer-in-Charge's opinion that AB was screened sufficiently and that his cell placement was appropriate. All protocols were followed by Corrective Services with regard to deaths in custody. The Crime Scene was managed by Corrective Services staff in an efficient and competent manner.

In relation to Justice Health, it appears he received satisfactory treatment

AB's mother says that she did not realise she could speak to someone at Corrective Services about her concerns of AB's welfare. Corrective Services and Justice Health have provided copies of the material and information that is available for support of inmates and their families. A copy of this material is Exhibit 2 and Exhibit 3. This material shows that there were a number of avenues that she could have pursued. While AB's mother accepts this material may well have been available she says that she was never made aware of it. Corrective Services would do well to be aware of her experience and ensure all possible steps are made to ensure the material is appropriately displayed and available.

Formal Finding:

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was AB

Date of death

He died on 30 August 2013

Place of death

He died at Goulburn Correctional Centre

Cause of death

The death was caused by hanging

Manner of death

Suicide

17. 286184 of 2013

Inquest into the death of Adam Southwick, finding handed down by Deputy State Coroner Forbes at Glebe on the 3rd December 2015

Introduction

This inquest concerns the sad death of Adam Southwick who died on 20 September 2013 while he was in custody at Coffs Harbour Police Station.

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

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

The Act also requires a Senior Coroner to conduct an inquest where the death appears to have occurred while a person is in lawful custody. (s.23, s.27).

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

An inquest is an independent judicial inquiry into how a death came about. It is also a way of unearthing situations that may jeopardise lives and finding better ways of reducing those risks.

This Inquest has been a close examination of the police actions on the morning of the death and pursuant to s.37 of the Coroner's Act a summary of the details of this case will be reported to Parliament.

Adam Southwick

Adam was 37 years of age at the time of his death. He had two children, Jayden born in 2007 and Jye James born in 2009. His family have asked for him to be referred to by his first name in these findings.

At the time of his death Adam was living in Gymea with his mother Dianne Veitch. He was also very close to his brother, Joshua. They have both been left bereft.

On 13 September 2013 Adam travelled to Coffs Harbour to visit his former de facto and his children. He travelled from Sydney by train and hired a car in Coffs Harbour.

On the evening of Thursday, 19 September he spoke on the phone to his brother and mother in Sydney. They said that he appeared fine and was talking about returning to Sydney the following day.

Later that evening he had an argument with his former de facto. He became violent toward her and threatened her with a knife

She said that his behaviour had changed after he had taken pills.

Following the argument Adam attempted to drive his hire car. At about 3.40am, Mr Jarrard Towner, a resident of Vincent St, Coffs Harbour, awoke to hear a loud thud. He went out to his backyard and saw the orange flashing lights of Adam's hire car. It appeared to have crashed nose first down an embankment. When police subsequently located the vehicle, they observed that it had extensive front damage, including a cracked windscreen.

Prince Street

At about 4 am, just around the corner from where his car was found, he was observed by a number of local residents. He was said to be moaning and groaning. He attempted to open a front screen door. He attempted to climb a fence but fell off it backwards and then staggered into a car, hitting his head. One of the residents, Mr Ball described him as appearing drunk or on drugs. He observed him stagger and fall over a number of times.

Ultimately he was seen falling over between two parked cars and then pull himself up onto the nature strip where he lay until police arrived.

Another resident, Ms Menrath described him as just lying there and every now and then she could hear him like he was gasping for a bit of air and then sort of yelling at someone and then just going quiet and laying there.

Ms Menrath called 000 to request police and ambulance assistance at about 4.45am.

Senior Constable Osborne and Constable Herbert arrived at Prince St, Coffs Harbour at around 4:48am. They had previously been in Vincent St where Adam's car had been left. The police saw Adam lying on the ground. He was naked from the waste up. His clothing was on the ground nearby and there were $50 and $20 notes on the ground. He was making loud noises.

They helped him get up and assisted him to walk to the police van. One of the residents said he was barely able to walk, half walking and being dragged. Another described Adam as looking like a rag doll. He was not described or observed by any of the neighbours as resisting police in any way.

Ms Menrath and Mr Ball gave evidence that they heard the following conversation.

'What's your name?'

'Adam'

'Come on you can't stay here; we're going to help you'.

Ms Menrath gave evidence that the police were very nice to Adam.

It was evident that Adam was severely intoxicated. Police were not able to further identify him at this point and he could not walk without assistance.

Constable Osborne said that they decided to take him back to the police station for further assessment and for a decision to be made as to whether he needed medical attention. He was being detained as an intoxicated person pursuant to s.206 of the Law Enforcement Powers and Responsibility Act 2002 ("LEPRA").

Constable Osborne gave evidence that as they were placing Adam into the police van that Adam grabbed Constable Osborne's vest and pulled it down.

In evidence, Constable Osborne said that while it may have been consistent with Adam having trouble walking that at the time he formed the view that it was aggressive and an attempt to prevent himself being put in the van. Constable Osborne formed the view it warranted handcuffs being placed on Adam.

The local residents that gave evidence did not see this incident or Adam being handcuffed. They were not close enough and the light was not bright enough for them to be in a position to give reliable evidence in detail as to what occurred as Adam was being placed in the police truck.

There is no dispute between the witnesses including the police that up to the point of being placed in the van Adam did not resist police.

Whether he was resisting getting into the van or was falling over when he pulled Constable Osborne's vest is not clear, certainly by all accounts once he was in the van he began to kick and yell. The residents heard that. Ms Menrath said she could hear him yell and kick once he was inside the police van. Mr Ball said that once Adam was in the van that he said "let me fucking out of here" and that he was banging and crashing in the back of the van. His reaction once in the van may be consistent with him having been reluctant to get into the van.

Once he was in the van the police collected Adam's personal affects, clothing and money from the street. They then commenced to drive back to the station.

According to police Adam continued to yell out and kick while on route to the police station. Constable Herbert and Senior Constable Osborne radioed police VKG and asked for the ambulance to be called off at approximately 4.59am while on their way back to the station and in fact passed the ambulance which was heading to Prince Street. Ambulance records indicate that the Ambulance had been called off by about 5.04am.

Coffs Harbour Police Station

The police vehicle arrived at Coffs Harbour police station at 5:06am. There is a CTTV camera in the garage at the police station. The footage from the camera shows the police van being reversed into the garage and parked. Both Senior Constable Osborne and Constable Herbert then go into the station leaving Adam in the back of the police van.

Constable Walsh was the custody manager at the station that evening.

He gave evidence that there were two intoxicated persons in the cells for whom he was making arrangements to release when the van arrived. Adam was left in the van in the van dock while that was completed.

At 5:09am the footage shows Constable Herbert and Senior Constable Mackney going to the parked van, Senior Constable Mackney checks the inside of the van by looking through the observation window. They both then leave and head back inside the station.

At 5:13am, some 7 minutes after the van had arrived at the station; Senior Constable Osborne and Constable Herbert return to the van, open the door and drag Adam out on the ground. He is handcuffed and unable to walk. He appears on the footage to offer no resistance and is unable to stand or walk. They drag him along the corridors to the charge room and he is placed on the floor outside the charge dock. There is CCTV footage of the prisoner corridor and the charge room. Constable Osborne removes Adam's shoes and trousers.

Adam is then dragged into the charge dock at 5:15.

He cannot sit up. He is dragged into the dock and placed on the floor. The door is closed. He has insufficient room to lie down straight. It is not in dispute that the length of the dock is shorter than he is. At autopsy, Adam was measured to be 1.74m tall with a BMI of 30.72 and the dock was 1.488m. He is cramped and cannot stretch his legs out. A still photograph of him in the dock can be seen at Exhibit 3.

After the dock door was closed, at 5:15am, he can be seen moving his legs. At this point there are 5 police officers in the charge room observing him in the dock.

At 5:18am he appears to completely stop moving.

At 5:19am Senior Constable Osborne knocks on the glass door of the dock and then opens the door and together with Constable Herbert attempts to reposition Adam. Senior Constable Osborne, Constable Herbert, Sergeant Maria and Constable Prado stand near to the dock and watch Adam.

At 5:22 Sergeant Maria crouches down and watches Adam closely for a number of seconds.

At 5:23 Constable Predo claps her hands at the door as she is checking Adam. Senior Constable Walsh opens the dock door and nudges Adam's leg with his foot.

About 30 seconds later Constable Herbert and Senior Constable Osborne start dragging Adam out of the charge dock and Senior Constable Osborne removes Adam's handcuffs and prepares Adam for CPR. Senior Constable Osborne gave evidence that Adam's jaw was clenched tightly closed.

At about 5:27 CPR is commenced. Senior Constable Osborne administered mouth to mouth resuscitation while Senior Constable Walsh did chest compressions.

At 5:32am ambulance officers arrive. Sadly, Adam was unable to be resuscitated and was taken to Coffs Harbour Health Campus and confirmed life extinct at 6:10am.

Cause of Death

On 26 September 2013 an autopsy was conducted by Dr I Brouwer. She determined that the cause of Adam's death was

"*as a consequence of methyl amphetamine intoxication while being restrained in a confined space. Positional asphyxia as major contributory factor in the cause of death cannot be excluded".*

Dr John Vinen, Emergency Physician, provided an independent expert review of this matter. He had a similar view to Dr Brouwer, though placed a greater emphasis on positional asphyxia as the primary cause of death. He was of the opinion that all of the information including the post mortem report and CCTV footage at the police station point towards positional asphyxia in association with drug related sedation as the cause of death.

He explained that positional asphyxia occurs when body position interferes with respiration, resulting in asphyxia and that intoxication due to drugs and or alcohol are usually sufficient to prevent the person from moving to a position that protects their airway and or respiration.

He said that positional asphyxial deaths tend to occur in a similar manner, with subjects initially struggling with respiratory difficulty, which may go unnoticed, then become quiet and inactive after several minutes at which stage they are noticed not to be breathing.

He said that people with an obstructed airway develop paradoxical breathing due to the obstruction in an attempt to breathe where the chest rises and the stomach withdraws followed by the opposite movements for a period of time which to a lay person can look like the person is breathing when in fact no air is flowing in or out, this is followed by cessation of breathing [respiratory arrest] and unless immediately corrected cardiac arrest.

What should have happened? What are the relevant police policy and procedures?

Sergeant Piet, Principal Tutor, Safe Custody, has the responsibility for the development, content and delivery of NSW Police Safe Custody Course. He gave evidence that the legislation and policies that apply to a person in a similar situation to Adam are:

Part 9 LEPRA

Part 16 LEPRA

The Law Enforcement (Powers and Responsibilities) Regulation 2005

NSW Code of Practice for Custody, Rights, Investigation, Management of Evidence (Code of Practice for CRIME).

Sergeant Piet gave evidence that having reviewed the available material in relation to this case that the police failed to follow that legislation and policy. The primary and continued failure was failing to identify risk. He gave evidence that the Code of Practice for CRIME states at page 52

“Immediately call for medical assistance, (in urgent cases send the person to hospital) if someone is in custody:

Appears to be ill

Does not show signs of sensibility and awareness; is unconscious

Fails to respond normally to questions or conversation

Is severely affected by alcohol or other drugs (eg:incapable of standing from a sitting position unassisted, seen to be lapsing in and out of consciousness)

…otherwise appears to be in need of medical attention”

He said that when the police arrived at Prince Street they had already received a report that Adam was falling over, falling off a fence and falling into vehicles. He noted that when police observed Adam, he was unable to walk and unable to state who he was. At that point, in his view, the risk to Adam’s well-being should have been assessed and it should have been clear Adam was a person in need of medical assistance and an ambulance should have been called to attend upon him at the scene.

He also said that the failure to identify risk continued back at the police station. He said that the custody manager at the station failed to assess Adam while he was in the back of the van for 7 minutes in the garage at the police station.

He said that if an assessment had been correctly done an ambulance should have been called to attend upon Adam at the time he was in the garage. He said Adam should have been placed in the recovery position in the garage pending the ambulance arrival.

The police evidence demonstrated confusion as to whether the custody manager had assumed responsibility of Adam's care before he was brought from the garage to the station. Clearly there needs to be clarification in the policy of this point. Either way his risk should have been assessed in the garage when the van arrived at the station. He should not have been left in the van for 7 minutes unaccompanied and unassessed.

Sergeant Piet stated that in his opinion a detainee's inability to walk indicates high risk and requires immediate inspection as to level of consciousness. A person in such a state should not be dragged anywhere by police. He says an ambulance should be summonsed to where the person is. Clearly, Adam should not have been dragged from the garage at the police station into the charge room.

Once Adam arrived in the charge room Sergeant Piet stated that an immediate assessment should have been undertaken. He should have been left on floor in the recovery position and an ambulance called.

An assessment of Adam was not done appropriately.

The custody manager, Senior Constable Walsh, gave evidence that in his assessment Adam was fully conscious when he was brought into the charge room. Senior Constable Walsh can be seen on the CCTV footage primarily continuing to be concerned with paper work. My assessment of the objective evidence contained in the CCTV is that there was clearly an insufficient assessment of risk to Adam by Senior Constable Walsh.

Sergeant Piet said the cuffs could have been left on if there was reasonable concern that Adam was feigning and concern that he may suddenly become violent and threaten police. He said that it would have been preferable for Adam to be handcuffed in the recovery position so he could be monitored until an ambulance arrived.

Sergeant Piet said that while the custody manager is primarily responsible for the prisoner that every police officer in the station has authority to call for medical assistance.

Sergeant Piet said that all police should be aware that it is NSW Police Policy that unconscious people are not to be kept in custody and that all police, regardless of rank, are authorised to call for medical assistance.

Sergeant Piet was also critical of the decision to place Adam in the charge dock.

When Adam was placed in the dock the risk to him was not appropriately assessed or evaluated. The evidence given by the five police officers standing around the dock at the time demonstrates this;

Senior Constable Walsh, the custody manager, confirmed that Adam was placed lying on the floor of the dock in a position that restricted his ability to move.

He didn't believe he was in a cramped position, he didn't notice that his neck was twisted in an awkward position up against the end wall of the glass and he wasn't worried about positional asphyxia. He believed he was in the recovery position. This observation was clearly incorrect.

Sergeant Maria stated that at the time he thought Adam was in a safe position in the dock and it was the most appropriate place for him to be. He said that he didn't consider Adam was at risk for asphyxia. This observation was clearly incorrect.

Constable Osborne stated that that he didn't understand at the time the issues of blocking airways and didn't think Adam might not be able to breathe.

Constable Herbert said that he wasn't concerned about the position Adam was placed in the dock. He said that the position Adam ended up in was virtually the recovery position but obviously tight for space.

Constable Predo said that when Adam was in the dock, he was lying very cramped up and his head and shoulders were pressed up against the wall of the dock. His head was in a position that was pressed up against his chest. She believed he was too big for the dock lying on the ground. She was questioned on the risk of positional asphyxia and she stated she wasn't concerned about his breathing.

Clearly these observations and assessments were all poor. Several of the involved officers had recently completed the NSW Police Safe Custody Course. This indicates that the police training as to how to assess consciousness and the risk of positional asphyxia has not been adequate or is not being followed.

After observing the CCTV footage of Adam in the charge dock, Dr Vinen stated that the space on the floor into which Adam was placed was too short to allow him to lay down without compromising his airway. He said Adam was clearly unconscious when placed on the floor of the dock with the observed leg movements attributable to involuntary movements made in an attempt to breathe while his airway was obstructed due to his position in the charge dock.

He said that what is apparent is that Adam arrested some time prior to the police pulling him out of the dock. He said

"His head was pressed against the front corner of the dock with his neck flexed and he can (stet) moving his legs then ceasing to move at 0515 hours prior to the agonal event at 0518 hours followed by police officers repositioning him at 0519 hours then observing him for a short period then walking away then returning to observe him again followed by dragging Adam out of the charge dock commencing cardiac massage at 0527h hours.

At no stage following the cessation of leg movement followed by the agonal event did he show signs of life."

Dr Vinen said that not only did police not appreciate that Adams airways might have been compromised and not only was there was a delay in them recognising that Adam was not breathing but this was followed by a delay of three minutes commencing CPR after Adam was dragged out of the dock and the handcuffs removed. He said this was significant because the longer the delay in commencing cardiac massage after cardiac arrest, the less likely a successful outcome.

There were many days of evidence and cross examination on the issue as to when and how the ambulance that attended upon Adam at the station was arranged. The five officers in the charge room on the evening cannot all agree.

The objective evidence shows that the first call to NSW Ambulance was by Constable Predo via VKG at 5.19.56. (which is equivalent to 5.21.53 on CCTV Camera 19).

The Second call was by Constable Mackney at 5:22:43. (which is equivalent to 5.24.40 on CCTV Camera 19.)

If there was any discussion about calling an ambulance prior to 5:19 it is unlikely from watching the CCTV footage that officers perceived that urgent medical attention was required. Sergeant Maria gave evidence that he said that an ambulance should be called shortly after Adam was placed in the dock. Even if I accept the evidence that this conversation took place it was not acted upon in an urgent manner. The first call to the ambulance was not made until 5:19:56. It was only when the calls were actually made to the ambulance that the officers can be seen to be obviously concerned about Adam's need for urgent medical attention. At this point, in Dr Vinen's opinion, Adam had already suffered "the agonal event".

Both Dr Vinen and Sergeant Piet have expressed the opinion that it should have been evident to the police from the point of time of their arrival at Prince Street that Adam required medical attention. Dr Vinen gave evidence that the majority of patients with methamphetamine intoxication survive with medical treatment.

Report of Death to the Coroner

The police Report of Death to the Coroner (P79A) in relation to this incident was substandard. It includes the following inaccurate and apparently self-serving statements:

Paragraph 2 states that the police requested NSW Ambulance to attend the police station while they were on route back to the station. This was inaccurate and misleading. The NSW ambulance was in fact cancelled by the police on their way back to the station.

Paragraph 3 states that the deceased arrived at the station at 5:13. This was also inaccurate. The deceased arrived in the garage at the station seven minutes before that.

Paragraph 4 states that it was due to his aggressive behaviour that the deceased remained handcuffed whilst in the dock and that during this time the deceased continued to be agitated and aggressive. This description of Adam while he was in the dock is also inaccurate and misleading. By the time Adam was placed in the dock he was handcuffed, unable to walk and was dragged into the dock. Adam was unresponsive for the time he was in the dock. The P79A gives an inaccurate impression that the officers were dealing with an aggressive individual that needed to be forcibly restrained.

These apparent inaccuracies came to my attention towards the end of the inquest. Accordingly it was not possible for evidence to be called in relation to all of them. There is not sufficient evidence before me to enable me to determine how all of these inaccuracies came to be.

I have been handed up a copy of an amended P79A dated 25 September 2013. That document never made its way to the Coroner's file. In any event I note it still had Adam arriving at the police station at 5:13 and it too described Adam in the charge dock as continuing to yell at police. On any viewing of the CCTV footage this is clearly incorrect.

A report of death to a Coroner is an important document particularly in matters which involve deaths in police custody where there is a need for a transparent and independent investigation from the outset. It is of concern that in this matter the report to the Coroner was so manifestly incorrect.

Formal Finding:
I find that Adam Douglas Southwick died on 20 September 2013 at Coffs Harbour Health Campus, NSW. I am satisfied the cause of his death was as a consequence of methyl amphetamine intoxication while being restrained in a confined space. Positional asphyxia as major contributory factor in the cause of death cannot be excluded. The manner of his death was misadventure.

RECOMMENDATIONS

To the NSW Minister for Police

That this matter be investigated and reviewed by the New South Wales Police Professional Standards Command.

That the NSW Police Force reviews the implementation of policies and training (including continuing professional development programs) dealing with ill or intoxicated detainees.

That the Code of Practice for Crime be revised so as to include:

A clear demarcation of responsibility for persons in custody, including when and in what circumstances a custody manager assumes responsibility for a detainee from arresting police;
The importance of promptly removing persons from police vehicles upon arrival at a station so that they can be appropriately monitored and assessed;

In the event of delay in removing persons from police vehicles, the need for face to face monitoring whether by the custody manager or a delegate;

The circumstances in which it is inappropriate to place an ill or intoxicated person in a dock;
The inappropriateness of dragging detainees who are unable to walk by reason of illness or intoxication;

The appropriate procedure for the transport of ill or intoxicated detainees from public places to either a police station or hospital in circumstances where medical attention is required.

That the review give consideration to providing further training and/or undertaking further steps to improve the implementation of Police policies in relation to the following:

That if a detainee is incapable of sitting upright without assistance and communicating verbally by reason of illness or intoxication, medical assistance should be sought (including by calling an ambulance);

That detainees should not be placed in the dock where, by reason of illness or intoxication, they are unable to sit upright without assistance;
That detainees with a diminished level of consciousness should not be placed in a dock with their hands handcuffed behind their back;

That no detainee should be placed on the floor of the dock or in a confined space that may restrict their movement and ability to breathe;

The need to closely monitor ill or intoxicated detainees for fluctuations in consciousness levels.

That consideration be given to introducing a requirement that all custody managers and shift supervisors likely to be involved in the supervision of custody arrangements complete the safe custody course;

That all NSW Police Stations with custody facilities should clearly display a poster or other document that provides guidance to officers in relation to:

- the care and assessment of detainees including in relation to levels of consciousness of detainees

- risk factors arising in relation to detainees suffering from intoxication or medical conditions;

- a reminder that all police officers, regardless of rank, are able to call an ambulance whenever they consider appropriate.

That NSW Police seek to develop and implement a policy or memorandum of understanding with NSW Health and NSW Ambulance regarding the transportation and care of intoxicated detainees

18. 304282 0f 2013

Inquest into the death of James Ciappara finding handed down by Deputy State Coroner MacMahon at Glebe on the 16th January 2015.

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

Other than as outlined in the Reasons for these Findings the publication of Exhibit 1, (the NSW Police Force – Safe Driver Policy), is prohibited.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

To: The Minister of the Commonwealth of Australian responsible for the administration of Part 3-3 of Schedule 2 to the Competition and Consumer Act 2010.

> *That having regard to the inherent dangers associated with the use of petrol powered motorised bicycles consideration be given to the banning, under Australian Consumer Protection Law, such equipment and products designed to enable the conversion of pedal powered bicycles into petrol powered motorised bicycles.*

Findings:

James Ciaparra (who I will refer to as James in these Findings) was born on the 3rd December 1998. At the time of his death he was 14 years old. James was the son of Joanne Mauceri and Jeffrey Ciappara. In 2013 he resided with his mother at Green Valley in south western Sydney and was enrolled at the James Busby High School. He owned a black and purple coloured BMX pushbike

In 2013 Hayden Davis was a 15 year old young man who lived in the same area as James. As a 12 year old Davis was taught how to assemble what is known as a 'Gasman'. A Gasman is an adult mountain bike with a motor attached to it. The motorised bike engine kit can be purchased on eBay or from motorbike shops. These can be purchased for less than $200. The kits include a 66CC engine. Davis owned a Gasman.

In about August 2013 James met Davis and they began to 'hang out' together. From time to time they would go riding together. James would ride his BMX and Davis his Gasman. James said to Davis that he would like to have a Gasman.

On 7 October 2013 James and Davis agreed to swap their bikes. Davis had been trying sell his Gasman but had not been offered an acceptable price. James wanted to own a Gasman, but did not have any money. The swap satisfied their respective needs.

Davis showed James how to start the Gasman. James understood the instructions and started the Gasman in front of Davis. James then took the Gasman for a ride before returning to Davis's house to collect some oil and a bike chain about 9pm. James then rode the Gasman away.

About 9.15pm on 8 October 2013 a police patrol car, Green Valley 37 (GV37), was travelling in Cartwright Avenue, Miller. Cartwright Avenue was the street in which James home was situated. The officers in GV37 observed a motorised bike without lights and other safety devices swerving harshly before turning into Miller Road.

GV37 followed the bike into Miller Road. Warning devices were activated in an attempt to get the rider to stop. They were subsequently deactivated. The rider continued along Miller Road and then turned right into Southdown Street. The police vehicle followed. The rider then rode into Banks Road where the bike collided with a vehicle travelling south in Banks Road. The rider was thrown from the bike and subsequently run over by a vehicle travelling north in Banks Road. The rider was James.

The police who had been following attended the collision and rendered assistance. An ambulance was called. James was taken to Liverpool Hospital where he underwent emergency surgery. Unfortunately, shortly after midnight on 9 October 2013, James died whilst undergoing surgery. James's death was reported to the Office of the NSW State Coroner on 9 October 2013.

Jurisdiction of Coroner:

The relevant coronial legislation is the Coroners Act 2009. All legislative references will be to that legislation unless otherwise indicated.

Section 6 defines a *"reportable death"* as including one where a person died a *"violent or unnatural death."*

Section 35 requires that all *reportable deaths* be reported to a coroner.

Section 18 gives a coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or the person who has died or is suspected to have died was ordinarily a resident of New South Wales.

Section 23 (c) provides that a senior coroner has exclusive jurisdiction to conduct an inquest where the person has died *„as a result of or in the course of a police operation."*

Section 22 defines a senior coroner as being the State Coroner or a Deputy State Coroner.

Section 27(b) provides that where a death occurs in circumstances to which Section 23 applies an inquest is mandatory.

Section 74(1) (b) provides a coroner with the discretion to prohibit the publication of any evidence given in the proceedings if he or she is of the opinion that it is in the public interest to do so. Section 74(3) provides that it is an offence to breach such an order.

The primary function of a coroner at an inquest is set out in Section 81(1). That section requires that at the conclusion of the inquest the coroner is to establish, should sufficient evidence be available, the fact that a person has died, the identity of the deceased, the date and place of their death and the cause and manner thereof.

Section 82 (1) of the Act provides that a coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths.

Section 81(1) issues:

Identity, Date and Place of Death:

The fact that James was the rider involved in the collision on Banks Road on the evening of 8 October 2013 and who subsequently died at Liverpool Hospital, Liverpool was not a matter of contention.

James's body was identified by his father Jeffrey Ciappara at Liverpool Hospital on 9 October 2013 and Dr Matthew Stononski, a medical practitioner employed at Liverpool Hospital, declared him deceased at 1am on 9 October 2013. I am satisfied that James Ciappara, who was born on 3 December 1998, died on 9 October 2013 at Liverpool Hospital, Liverpool in the State of New South Wales.

Cause of Death:

Following James's death being reported to the Office of the NSW State Coroner the medical and other records available were reviewed by Dr Istvan Szentmariay, a Staff Specialist Forensic Pathologist employed at the Department of Forensic Medicine at Glebe.

Dr Szentmariay formed the opinion that the direct cause of James's death was *„massive blood loss and pulmonary haemorrhage due to severe trauma"* following a motor vehicle collision.

On 15 October 2013, having received Dr Szentmariay's advice, I accepted that conclusion and issued a coroners certificate of death to that effect. The evidence at inquest has not given rise to any reason to change that decision.

Issues for Inquest:

The evidence at Inquest focused on the manner of, or the circumstances that led to, James' death, the involvement of police in those circumstances and whether it was necessary or desirable to make any recommendations in accordance with Section 82 in relation to any matter connected with James' death.

Police Involvement:

Where a death occurs and there is a police involvement in the circumstances of that death it is important that such involvement be independently and publically examined following such death so as to ensure that the actions of police officers in the course of their duties are fully accountable to the public. This is why the NSW Parliament has enacted in the Coroners Act 2009 a requirement that all deaths arising out of or in the course of a police operation are to be the subject of a mandatory inquest. The rational for this being that, as described by former State Coroner Waller, it provides a positive inventive to (police to act appropriately) and satisfies the community that deaths in such (circumstances) are properly investigated. It also has the effect of protecting the police involved in such circumstances from false or malicious allegations.

Critical Incident Guidelines:

Detective Inspector Darren Newman was the officer in charge (OIC) of the investigation of the circumstances of James' death. The circumstances of the death had been declared by police as a critical incident and the relevant NSW Police Force (NSWPF) protocols relating to the investigation of critical incidents were followed.

Mr Newman was an officer from a police command other than that in which the officers involved were members. The involvement of Mr Newman as OIC was to ensure that the death was independently investigated. Compliance with the Critical Incident guidelines was not an issue at the Inquest.

The Evidence:

A two volume brief of statements of evidence that had been assembled during the course of Mr Newman's investigation was tendered as an exhibit in the proceedings. In addition oral evidence was taken from 8 witnesses.

Jamine Thorne met James in June 2013 initially through school and then the Miller PCYC. They became good friends. At about 9pm on 8 October 2013 Thorne was walking in Cartwright Avenue, Miller. He heard a 'Gasman' travelling behind him. He turned around and noticed that James was riding the Gasman. He could tell it was James because he wasn't wearing a helmet. James stopped the Gasman and they spoke for a time. Thorne said that James was normal, didn't appear to be angry about anything. James told Thorne that he was 'cruising around.' After speaking James drove off in the direction of the Miller shops. Thorne described the speed at which he drove off as being '*pretty fast*".

Constable Jacob Strzelecki said that he was the driver of GV37 on 8 October 2013. He had commenced his shift at 2pm that day. He said that before 2013 he had become aware of motorised bikes and their dangers. He was also aware that, depending on the capacity of the engine, they might be unlawful to ride on the road. He had had no previous dealing with James. He said that about 9.15pm a motorised bike crossed harshly from the left to right side of the road in front of his vehicle onto Miller Road. The bike was not exceeding the speed limit but because of the manner of the riding he decided to try and stop and speak to the rider.

Strzelecki said that as he turned into Miller Road he put his police lights on for 2-3 seconds and then he followed that with both his lights and siren. He said that the rider looked back at the police car and then 'took off.' Strzelecki said that he realised the rider was not going to stop so he turned off the lights and sirens but continued to followed the bike. He decided not to commence a pursuit because he considered it too dangerous to do so.

The rider continued along Miller Road and then turned into Southdown Street. Strzelecki said that he followed the rider into Southdown Street so that he could see where the rider was going in order to advise other police in the area to look out for him. At the time the rider was pulling away from the police car.

As Strzelecki was driving up Southdown Street he observed the bike enter Banks Road and the subsequent collision. At the time of the collision his vehicle was about 50 metres away from the bike. He drove to the intersection, stopped his vehicle and then rushed to the rider to render aid. Ambulance officers were also called to assist. He estimated that there was a period of between 10 to 15 seconds when he turned off the lights and sirens on his vehicle and the collision occurring.

Constable Miguel Davila gave evidence that on 8 October 2013 he was working in police vehicle GV37 with Constable Strzelecki. He had had previous dealings with James but did not know that James was involved in the events of the evening until after they had occurred. He was also aware of motorised bikes and understood that they might be illegal depending on the size of the motor. He thought that they were dangerous.

He said that he saw the motorised bike in front of them in Cartwright Avenue. As they approached Miller Road the bike veered in front of their vehicle. He observed that the rider was not wearing a helmet, and there were no light reflectors on the bike. The police vehicle followed the bike. Davila said he thought that the police vehicle was doing about the speed limit (50km/ph) and that the bike was going a little bit faster.

He said that the police vehicle turned into Miller Road and caught up to the bike near the intersection of Ryeland Street with Miller Road.

The police vehicle was in the left lane of the road and the bike was in the right lane of the road. He said that Strzelecki turned the lights on for 2-3 seconds and then the 'yelp' siren for 3 or 4 seconds. Both lights and sirens were then turned off. He saw the rider turn around look at them and then travel down Miller Road at speed.

Davila said that the police vehicle then slowed down to between 20 and 30 km/ph and the bike moved away from their vehicle. They followed the bike into Southdown Street. As the bike entered the intersection with Banks Road he saw it come into minute between the lights and siren being turned off and the collision. He did not think that the police vehicle was in pursuit of the bike at any time.

Thi Hong Lieu Nguyen gave evidence. Ms Nguyen said that on 8 October 2013 she was driving in Banks Road on her way home. She had her children in her vehicle and they were asleep.

She said that when her vehicle was between 2 and 5 metres from the intersection with Southdown Road she saw a bike on her left. She said *„it looked like it was going to go straight through (the intersection)"*. She said that she put the brakes on but was unable to avoid a collision. She said that she saw the lights of a vehicle travelling towards her in Banks Road but did not see any other vehicle in Southdown Street prior to the bike entering her lane. She did not see any red and blue flashing lights or hear a siren at that time.

After Ms Nguyen had stopped she was looking for her shoes so that she could get out of her vehicle she said that she then saw a police vehicle driving towards her at low speed in Southdown Street.

Mohamad Al-Achrafe gave evidence. He said that he was driving a vehicle in Banks Road on 8 October 2013 a little after 9pm.

His brother and a friend were also in the car. He was slowing down to turn right into Southdown Street. He said that between 30 and 50 metres from the intersection he put his indicator on and about 25 metres from the intersection he saw a police car with its blue and red flashing lights on. He did not see a bike. He felt that he had driven over something so he stopped to see what it was. He realised that it was a young person.

He was in shock when he discovered what had happened. He then saw a police officer and accused the officer of chasing the bike. The officer denied that was the case. He then went over to the lady in the other vehicle involved to see if she was okay.

On the evening of the collision Al-Achrafe spoke to Leading Senior Constable Wade Goddard. Goddard asked him what had happened. Al-Achrafe said to him:

> *I was driving down Banks Road form Hoxton Park Road towards Miller. I started to slow down because I was about to turn into Southdown Street. When I was about twenty metres from the intersection of Southdown I saw a black bike with a motor on it come out of the street really fast. He hit the front of the Silver Honda van which was going in the opposite way to me. I hit my brakes, but the impact threw the rider of the bike to my side of the road and I ran over him. I felt more than two bumps and it felt like he went under my right hand side wheels. I stopped the car straight away and saw a police car chasing him with no lights and sirens. Just headlights. I waited until the police were ready to talk to me.*

Kaled Hamzi Al-Achrafe is the younger brother of Mohamad Al-Achrafe. He was a passenger in the vehicle being driven by his brother in Banks Road on the evening of 8 October 2013. He was in the front passenger seat. He gave evidence at the inquest. He said that he did not see the bike involved in the collision until he got out of the vehicle he had been travelling in.

Kaled Al-Achrafe said that observed that his brother was in shock following the collision. He also said that after they stopped he saw a police car coming towards them in Southdown Street. It was about 15 or 20 metres away. He said he could see that it was a police car because of the police markings on it. He said that as the police vehicle approached its high beam lights were on but the red and blue lights were not on.

Following the collision police undertook a canvas of the area to identify any witnesses who might be able to provide evidence as to the events that occurred prior to the collision. The statements of those witnesses were contained in the brief of evidence tendered at the Inquest. Police also conducted a drive through of the route taken which was video recorded and that recording was also played at the Inquest.

Superintendent James Johnston was in 2013 the Commander of the Green Valley Local Area Command of the NSWPF. He gave evidence. He said that he had been aware of the problem of motorised bikes since about 2012. There had been complaints from numerous members of the community in various forums about the safety of the vehicles, the noise that they made and the manner in which they were driven.

Such vehicles were not illegal if their engines produced power under 200 watts. He had personally pulled over riders of such bikes on three occasions.

Mr Johnson was concerned about the safety of motorised bikes and their stability. He had spoken to officers within his command about the dangers of the equipment and had advised that when officers observe them being used on the roads they should not engage in the pursuit of them. He had expressed his opinion at change of shift parades within the command and by email to officers within the command on a number of occasions.

He said that on 1 October 2014 the law had changed so that all petrol driven push bikes are now illegal on roads and road related areas.

He considered that this change was a positive one and had observed that the problem of motorised bikes in his area had decreased but was still a problem overall. He said that he would like to see the law changes so that:

> *All motorised bikes manufactured to Australian standard and anything else be barred by the Trade Practices Act with appropriate penalties.*

Following the collision the bike that James had been riding at the time of the accident was examined by Constable Stuart Davenport from the NSWPF Engineering Investigation Section. Mr Davenport examined the mechanical and other aspects of the bike to determine if any design or mechanical issues might have contributed to the cause of the collision. Mr Davenport concluded:

> *As a result of my examination and based wholly or substantially on specialised knowledge I am of the opinion that there was no mechanical failure with the bike that may have caused the collision. Issues that may have contributed and cannot be discounted in my opinion are the removal of the rear brake, therefore increasing the stopping distance in the event of an emergency stop. Plus absence of any form of lighting or reflectors.*

Grant Johnston, a consulting engineer, was also asked to examine the bike that James had been riding and prepare a report outlining the performance characteristics of an exemplar motorised bicycle. His report was part of the brief of evidence. It is not necessary to deal with the difficulties relating to the task that he was given however I note that he formed the opinion that the bike was one that would produce more than 200watts and was therefore prohibited at the time from driving on roads or road related areas.

Mr Johnston also concluded that the achievable acceleration rates were what he described as moderate. He also concluded that the achievable breaking rate with only the single front wheel cable operated disc brake was about 60% less than the typical value achieved with two-cable operated disc brakes. Senior Constable An Nguyen is a member of the Cabramatta Local Area Command and a member of the Cabramatta Pro-Active Bicycle police Unit. He has undertaken the Certificate 3 in Bicycle patrol Operator.

On 4 November 2014 Mr Nguyen attended the Hart Driver Training Centre at St Ives in order to undertake a number of tests on a motorised bicycle. His statement dated 20 November 2014 outlines the nature and design of that testing. Mr Nguyen was to test the bicycle designed by Mr Johnston that was, as best as could be achieved, a comparable design, quality and performance to that James rode on the night of the collision.

Mr Nguyen stated that whilst riding the motorised bike:

> *My full concentration was on the road in front and maintaining a safe ride while travelling at top speed on the motorised bicycle. This would prove extremely difficult and physically and mentally exhausting, as the concentration and control needed to handle the motorised bicycle is far greater than a normal bicycle or normal motorbike. The motorised bicycle would vibrate and move around a lot, and the vibration in the motorised bicycle would only worsen the faster the motorised bicycle travelled.*

The specific conclusions Mr Nguyen reached following his testing were as follows:

- *The engine and petrol tank off balance the bike, making it harder to balance the bike when stationary and at speed,*
- *Both the engine and the petrol tank feel like they are a foreign object on the bike, not a part of the bike like a standard motorcycle engine does,*
- *When the bike is moving, the frame and components can be felt vibrating and can be heard rattling, you can feel the vibrations through the handle bars,*

- *The higher the speed the greater the vibration and movement of the components attached to the bike,*
- *With the higher speed and in general it requires more control and concentration to keep the bike steady,*
- *At either high or low speed turning was difficult due to the weight of the engine and petrol tank,*
- *At slow speed on a normal bike you can make a sharp turn safely by counter balancing with your body weight however on this bike with the weight of the engine and petrol tank it was very difficult, and*
- *The effect of this is crucial because if you are trying to make a sharp turn at high speed the mid and rear of the bike will slide out because of the weight and normally if a rider feels the bike sliding out he would counter act that by straightening up.*

Mr Nguyen summed up his testing conclusions in the following way:

> *The riding of the motorised bicycle is very physically and mentally demanding, more so than riding a normal motorbike which is purposely designed to travel on Australian roads at high speeds. The motorised bicycle is not designed to be ridden at high speed, therefore when riding the motorised bicycle it feels like it is actually going to fall apart at any time while you are riding. The motorised bicycle feels extremely unsafe; control of the motorised bicycle could be lost at any time.*

Consideration and Conclusions:

James' death is undoubtedly a tragedy for both his family and the community in general. His death was completely avoidable. It came about as a consequence of youthful bravado mixed with access to an inherently dangerous piece of machinery.

The events on the evening of 8 October 2013 were not greatly in contention. There is no doubt that James was riding the Gasman bicycle that he had exchanged for his BMX bicycle. At about 9.15pm, when he was in Cartwright Avenue, he rode in a manner that brought him to the attention of the police officers in GV37. He was not wearing a helmet nor did the bike have any lighting or reflectors on it. I accept that in the circumstances it was reasonable and appropriate for officer Strzelecki to try and stop James in order to talk to him about his riding and the bike.

I accept that GV37 followed James into Miller Road and whilst following him officer Strzelecki used the police red and blue warning lights and then the police siren in order to indicate to James that he should stop. I also accept the evidence of officers Strzelecki and Davila that at about that time James looked around at the police car and then rode off at speed. I am satisfied that James was aware of the presence of the police, that he understood that they wanted him to stop for them and that he then decided to try and avoid doing so.

I accept that the police warning lights and siren was used for a short time and only in Miller Road. I am satisfied that it was not used in Southdown Street prior to the collision. I do not accept the evidence of Mohamad Al-Achrafe on this matter. Mr Al- Achrafe said that the effect of the collision was very stressful for him and he was in shock. His brother confirmed this during his evidence. I am satisfied that he was doing his best to recall what occurred but that his memory is incorrect. I accept the evidence of officers Strzelecki and Davila as well as that of Mrs Nguyen and Kaled Hamzi Al-Achrafe on this issue.

I accept the evidence of officers Strzelecki and Davila that after the police warning lights and sirens were discontinued the police car slowed down but still followed James, but at an ever increasing distance, from Miller Road into Southdown Street. I am satisfied that James rode out of Southdown Street across Banks Road into the path of the vehicle driven by Mrs Nguyen resulting in the collision of the two vehicles and James being thrown from the bike into the path of the vehicle driven by Mr Al- Achrafe.

There is nothing in the evidence available to me to suggest that Mrs Nguyen or Mr Al-Achrafe were in any way to blame for the collision or the injuries that James suffered. The evidence makes it apparent that there was nothing either of them could have done to avoid the collision.

I accept the evidence of Mrs Nguyen that James rode the bike directly in front of her vehicle. The intersection of Southdown Street and Banks Road is a 'T' intersection however on the opposite side of Banks Road is a park and it would seem that it is probable that it was James' intention to enter the park. If James had seen Mrs Nguyen's vehicle, and it is likely he didn't, the braking system on the bike he was riding would have made it difficult for him to stop the bike. There was, however, no evidence available that would allow me to make a finding that he had tried to do so.

James' death was completely avoidable but unfortunately a product of his own actions. I have no doubt that James was seeking to avoid contact with the police who had directed him to stop so that they could speak to him. As I have already said I am satisfied that it was reasonable for officer Strzelecki to try and get James to stop. I accept the evidence of officer Strzelecki that, when he concluded that James was going to ignore the direction to stop, he decided that he would not pursue him because it was too dangerous to do so. I also accept that officer Strzelecki then slowed his vehicle but followed James in order to see where he was intending to go. I am satisfied that this was a reasonable course of action for him to take in the circumstances.

Compliance with NSWPF Safe Driver Policy (SDP):

During the inquest counsel for James' mother submitted that officers Strzelecki and Davila failed to comply with the SDP in their interaction with James on the evening of 8 October 2013 and that I should recommend that they be disciplined for that failure.

It was submitted that the events as occurred amounted to a pursuit under the SDP and that the officers failed to comply with their obligations when engaged in a pursuit. The SDP is the policy of the NSWPF which, among other things, governs the use by police officers of police vehicles. Of relevance to this consideration the policy provides a series of obligations that a police officer who engages in a pursuit must comply with.

Those obligations are, in general, established to ensure that officers engaged in pursuits are accountable and that more senior officers are aware of what is occurring and are able to intervene if it is thought appropriate to do so.

It is not necessary for my purposes for me to outline in detail the various obligations that an officer is required to comply with in the event that he or she engages in a pursuit.

It was submitted that the events on the evening of 8 October 2013 amounted to a pursuit as defined by the SDP and that officers Strzelecki and Davila failed to comply with their obligations under the policy.

The SDP defines a 'pursuit' in the following terms:

> *PURSUIT: A pursuit commences at the time you decide to pursue a vehicle that has ignored a direction to stop.*
>
> *An attempt by a police officer in a motor vehicle to stop and apprehend the occupant(s) of a moving vehicle when the driver of the other vehicle is attempting to avoid apprehension or appears to be ignoring police attempts to stop them.*
>
> *A pursuit is deemed to continue if you FOLLOW the offending vehicle or continue to attempt to remain in contact with the offending vehicle, whether or not your police vehicle is displaying warning lights or sounding a siren.*

It was accepted by counsel for James' mother that it was reasonable for officer Strzelecki to direct James to stop. It was also accepted that the use of the warning lights and siren constituted a direction to stop and that on the evidence available James was aware of the direction to stop and ignored that direction. The point of the submission was that to follow James after he ignored the direction was to continue a pursuit and as such the obligations that arise in a pursuit come into force and that the officers failed to comply with those obligations.

I do not accept this submission. A pursuit can continue only after it has commenced. It can only commence it the officer decides to commence a pursuit after a vehicle has ignored a direction to stop. In this case I accept the evidence of officer Strzelecki that, after he concluded that James was ignoring the direction to stop, he specifically decided not to engage in a pursuit. The pursuit having not commenced it could not be continued by the officers following him as they did. I do not consider that the evidence displays any failure on the part of either officer to comply with the SDP on the night of 8 October 2013.

Compliance with NSWPF Critical Incident Guidelines:

The NSWPF Critical Incident guidelines require that officers involved in a critical incident undergo alcohol and drug testing following such an incident. Constables Strzelecki and Davila underwent the required testing following the incident on 8 October 2013.

No issue arose following Constable Davila's testing however the testing of Constable Strzelecki showed that at the time of the testing there was found in his blood Morphine at a concentration of 580ug/L and Codeine at a concentration of 1560ug/L. Constable Strzelecki explained this finding by stating that he had taken some medication for pain relief some time before the events.

Dr John Lewis, a consultant toxicologist was asked to review the findings and provide advice as to whether or not such findings might have affected the driving ability of Constable Strzelecki on 8 October 2013. It was Dr Lewis's opinion that the morphine level found was a 'trace amount' and could not be correlated to the use of either morphine or heroin but could have come from the consumption of a variety of foods that contain poppy seeds. The amount was such that it would not have had any pharmacological effect. He said that there was no evidence to suggest that Constable Strzelecki had consumed any illegal substance. As far as the concentration of codeine was concerned Dr Lewis was of the opinion that the concentrations were small, were consistent with their use as analgesia and would not have affected the officers' ability to drive his vehicle safely. I accept the evidence of Dr Lewis and am satisfied that there is no evidence to suggest Constable Strzelecki's actions were affected by any drug on the night of 8 October 2013.

Section 82 Recommendations:

As mentioned above Superintendent Johnson gave evidence that whilst he was pleased that since 1 October 2014 all petrol-powered bicycles had been banned on NSW roads and road related areas (Road Transport Legislation Amendment (Power Assisted Pedal Cycles) Regulation 2014) he was concerned that such bikes could still be used in areas not defined as a road or road related area. His concern arose because of the inherent dangers associated with the riding of such bikes and he considered that they would be even more dangerous on private lands where the terrain would not necessarily be as good as on a road or road related area. He was of the opinion that such vehicles should be banned altogether. Counsel Assisting and counsel for James' mother joined in Superintendent Johnson's suggestion that a recommendation be made in accordance with Section 82 to this effect.

The evidence available to me at Inquest made it abundantly clear that such vehicles are dangerous. I would think that Superintendent Johnston's assessment that if they are dangerous on roads and road related areas then motorised bicycles would be even more dangerous on private property is correct.

As I have mentioned above such vehicles are cheap to obtain and can be assembled with relative ease. They can thus come into the possession of young people who do not necessarily have the maturity and experience to ride them safely – if that is possible.

I am satisfied that it would be in the public interest for consideration to be given to implementing a ban on the sale of such vehicles and the conversion kits necessary to convert ordinary bicycles to motorised bicycles. I propose to make a recommendation to this effect in accordance with Section 82.

Formal Finding:

James Ciappara (born 3 December 1998) died on 9 October 2013 at Liverpool Hospital, Liverpool in the State of New South Wales. The cause of his death was massive blood loss and pulmonary haemorrhage due to severe trauma following a motor vehicle collision on 8 October 2013. The motor vehicle collision occurred whilst James was attempting to avoid police but not during the course of a police pursuit.

19. 331891 of 2013

Inquest into the death of Leif James finding handed down by Deputy State Coroner Forbes at Glebe on the 28th August 2015.

NON PUBLICATION ORDER PURSUANT TO SECTION 74 *CORONERS ACT NSW 2009* OF THE NSW POLICE FORCE SAFE DRIVING POLICY

Introduction

Leif James died on 31 October 2013 as a result of injuries he suffered as a passenger in a motor vehicle collision. The vehicle he was in was a stolen vehicle and was being pursued by police.

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

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

The Act also requires a Senior Coroner to conduct an inquest where the death appears to have occurred "*in the course of police operations".* (s.23, s.27).

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

This inquest is not a criminal investigation, nor is it civil liability proceedings intended to determine fault or lay blame on persons involved in the incident.

This Inquest has been a close examination of the police actions on the day of Mr James's death and pursuant to s.37 of the Act a summary of the details of this case will be reported to Parliament.

Section 82 of the Act also permits a Coroner to make recommendations that are necessary or desirable in relation to any matter connected with a death that relates to issues of public health and

Leif James

Mr James was only 18 years old at the time of his death. He was the only child of Rachel James and Desmond Poutama. He was born in New Zealand.

In primary school in New Zealand Mr James demonstrated his sporting ability at rugby union, rugby league and touch football. During his high school years he lived between New Zealand and Sydney. Throughout his high schooling he did well at sport.

Most recently Mr James had been living with his mother and stepfather in Queensland and was working as a casual labourer. His death occurred during a visit to friends in Sydney. His death came as a completely unexpected and devastating shock to his family and they continue to grieve.

Facts in outline

During the night of 29 October 2013 the blue Subaru Liberty that Mr James was in when the fatal collision occurred, was stolen from outside a house at Narrabeen.

At about 10am the following morning Mr Peter Simon arrived at Mr Jaden Rose's house driving the vehicle. Mr James was at Mr Rose's house and accepted an offer to go with Mr Simon in the car. There is no evidence to establish whether Mr Simon discussed whether the car was stolen or whether Mr James at any point knew that the car was stolen.

Shortly after 1pm that day, the owner of the car's father-in-law rang and told the owner that he'd seen the car driving in Frenchs Forest. The owner rang "000" and reported the sighting.

The VKG log shows that a broadcast was made at 1:34pm about the stolen Subaru. The VKG log then shows a broadcast from "Northern Beaches 131", advising they were in pursuit of the stolen vehicle, and were turning left onto Warringah Rd. Shortly after "Northern Beaches 270" broadcast that it was also in pursuit, and was travelling on the Wakehurst Parkway. "North Western Metro 275" then came on the radio advising it was pursuing the Subaru eastbound on Wakehurst Parkway. Almost immediately following there was a broadcast that the Subaru had crashed.

The pursuit lasted 80 seconds. In-car video is available from 2 of the 3 police vehicles involved in the pursuit and VKG transmissions during the course of the pursuit are also available.

The first car to be involved was "Northern Beaches 131", a Lancer driven by Constable Harte, with Constable Thompson as passenger. They spotted the Subaru on the Forest Way and activated their lights and sirens and announced they were in pursuit. They passed Senior Constable Gifford, who was waiting in "North Western Metro 270" at the intersection of Forest Way and Warringah Rd. He then followed them by turning left onto Warringah Rd, also under lights and sirens. The third car, "North Western Metro 275" driven by officer Caracoglia followed under lights and sirens from Warringah Rd onwards.

At the intersection of Warringah Rd and Wakehurst Parkway, the Subaru suddenly veered left into Wakehurst Parkway. This left "Northern Beaches 131" in the right hand lane, but allowed "North Western Metro 270' and "North Western Metro 275", both Highway Patrol cars, to pursue. The Subaru then proceeded through a red light, at the intersection of Wakehurst Parkway and Frenchs Forest Road West, followed by the two police vehicles who slowed to go through the intersection. The Subaru then lost control on a right hand bend and slid into the path of an oncoming ute, causing the fatal injuries to Mr James.

Crash investigation reconstruction estimated the speed of the Subaru immediately prior to impact at about 120kph, having lost control at about 135kph. The posted speed limit for that section of road was 80kph.

Mechanical and visual inspection of the Subaru revealed no defects that would have contributed to the collision.

Issues

The issues in this Inquest are whether the pursuit of the Subaru was carried out in accordance with the NSW Police Force Safe Driving Policy, Pursuit Guidelines and whether the subsequent investigation was in accordance with the Critical Investigation Guidelines.

NSW Police Force Safe Driving Policy, Pursuit Guidelines

The police pursuit policy is set out in the NSW Police Force Safe Driving Policy, Pursuit Guidelines. These guidelines were the subject of comprehensive scrutiny in the Inquest into the death of Hamish Raj by Deputy State Coroner Dillon on 7 April 2014. That inquest resulted in a series of recommendations that are now being considered at ministerial level. I endorse the recommendations that were made and particularly relevant to this inquest is the question of whether police should pursue suspected stolen vehicles.

In this case it is not in dispute that "Northern Beaches 131" was in technical breach of the Safe Driving Policy for the very short period of time when it was a third police car on Wakehurst Parkway in pursuit of the Subaru without authorisation. The policy stipulates that there must only be primary and secondary police vehicles involved in a police pursuit unless a further vehicle is expressly permitted by the Duty Operations Inspector, the VKG SC, a supervisor or the holder of a Gold classification. This breach had no impact on the pursuit or the tragic outcome of the pursuit. It did not create any additional risk or danger to the Subaru. I am informed by the representative for the NSW Commissioner of Police that the breach has been noted and the relevant parties have been informed to ensure that there is no repetition of this.

The other possible relevant issue in this pursuit was whether the decision to continue the pursuit after the Subaru drove through a red light was appropriate. I note that even if police had terminated the pursuit at this point the Subaru was already approaching the point where the collision occurred. The collision occurred 7 seconds after the red light.

Even though in this case it is unlikely that a termination of the pursuit when the Subaru went through the red light would have changed the outcome it is important that the wording of the policy is clear and unambiguous in guiding police as to when it is appropriate to terminate a pursuit. Once again I endorse the recommendations made by Deputy State Coroner Dillon in the Hamish Raj inquest, that relate to termination of pursuits.

Critical Incident Guidelines

The Critical Incident Guidelines require an independent investigation of police involved in Critical Incidents. A "Critical Incident" means an "incident involving a member of the NSW Police Force which resulted in the death of or serious injury to a person" arising from a number of circumstances, including, for example (but not exhaustively), a police pursuit, while the person was in police custody, or arising from a NSW Police Force operation . The Critical Incident Guidelines provide a definition as to when an officer is to be considered a "directly involved officer" under the Critical Incident Guidelines for the purpose of the investigation. A "directly involved officer" is defined in the Critical Incident Guidelines as:

"A directly involved officer is any officer who by words, actions or decisions, in the opinion of the SCII, contributed to the critical incident under investigation. An officer who is present, and does not involve themselves in activities which has contributed to the incident occurring is not directly involved. Mere presence at the scene is not enough."

The two officers who initiated this pursuit in Northern Beaches 131, Constable Harte and Constable Thompson, were determined to be "witnesses" and not "directly involved officers" in the critical investigation of this matter. Those officers provided statements, rather than participating in an interview. Those statements appeared to include a less detailed account of the circumstances of the pursuit, and the decisions made, than the evidence provided in the directed interviews conducted with the "directly involved officers", Senior Constable Gifford and Senior Constable Caracoglia.

There are further differences in the way "directly involved officers" are managed during a Critical Incident Investigation, when compared to "witnesses." For example, "directly involved officers" participate in a directed interview pursuant to Regulation 8 of the *NSW Police Regulations 2008*, (which has certain possible legal implications in any later disciplinary or legal proceedings), have a support person present, and have mandatory drug and alcohol testing.

Whilst not appearing to impact upon this matter, that determination could have had significant consequences for an officer who is determined to be a “witness” rather than a “directly involved officer” and whose conduct is later examined in disciplinary or legal proceedings.

The determination to treat officers Harte and Thomson as “witnesses” rather than “involved officers”, in circumstances where they were in the vehicle that commenced the pursuit, was a poor decision. The decision to initiate a pursuit will be reviewed by a Coroner at Inquest. In my view, any police officer in a motor vehicle involved in a vehicle pursuit should be treated as “directly involved officer” for the purpose of the Critical Incident Investigation. Mr Hood has informed me that the Commissioner of Police and New South Wales Police Force agrees with that position and that the Police Force will incorporate this into Critical Incident Investigation training. Accordingly, I need not make a recommendation in that regard.

Formal Finding:

I find that Leif James died on 31 October 2013 at Royal North Shore Hospital, St Leonards, NSW as a result of a head injury he received in a collision that occurred during a police pursuit on 30 October 2013.

Recommendations: s 82 Coroner’s Act 2009

To the Minister for Justice and Police

I recommend that a copy of these findings be forward to the Minister for Justice and Police for consideration together with the recommendations in the matters of Hamish Raj, Jason Mark Thomson and Trent Lenthall.

20. 365275 of 2013

Inquest into the death of AA finding handed down by Deputy State Coroner Freund at Glebe on the 28th April 2015.

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

These are the findings of an inquest into the death of AA.

Introduction

AA was 60 years old when he passed away as an inpatient of the Dee Why ward at the Forensic Hospital located at 1300 Anzac Parade, Malabar.

AA was born in the former Yugoslavia on 8 November 1953 and immigrated to Australia in 1974. His family still reside in Eastern Europe and his records indicate that he had little contact with them. It is believed that he has a daughter who lives in NSW but with whom he had no contact. However, extensive inquiries by police were unable to locate her whereabouts.

The Inquest

At the time of his death AA was a Forensic Patient pursuant to section 97 of the Mental Health Act. He was ultimately found not guilty of a number of offences by reason of his mental illness. Accordingly, this is a mandatory inquest pursuant to section 23 of the Coroners Act 2009 as his death occurred whilst in Custody.

The role of a Coroner as set out in s. 81 of the *Coroners Act 2009* is to make findings as to:

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

A Coroner, pursuant to s. 82 of the *Coroners Act 2009*, also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

The Evidence

Background

After moving to Australia AA held a number of labouring jobs. The evidence indicates that he was involved in a serious motor vehicle accident in 1975 in Port Hedland Western Australia which resulted in a back injury and subsequent disability support pension.

AA had an extensive criminal history. On 26 June 1987, he was convicted of the 1986 murder of his partner and sentenced to 20 years imprisonment with a non-parole period of 14 years. He was released in April 2000.

In September 2002, he was charged with detain person with intent to gain advantage, malicious wounding, use of an offensive weapon with intent to prevent apprehension and assault officer in the execution of duty in September 2002.

AA was made a forensic patient under section 97 of the Mental Health Act on 12 December 2002 whilst on remand, due to concerns regarding his mental state and risk of suicide. He was found not guilty of the offences by reason of mental illness on 17 June 2003. Around this time he was diagnosed with Schizophrenia and a substance abuse problem.

The Forensic Hospital at Malabar is a facility attached to Long Bay Correctional Centre. The facility is operated by NSW Justice Health and Forensic Mental Health Network. It is a mixed long stay facility housing patients who have committed criminal offences but have been found to not have the mental capacity to be tried for the offences. AA was transferred to the Dee Why Unit at the Forensic Hospital in March 2009. Since this time, Justice Health had sought to refer him to other units of differing security levels. When advised of the pending transfer AA would deliberately act out to postpone or stop the transfer. Such behaviour included drinking 250mls of liquid Rexona deodorant in a deliberate act of self-harm.

AA remained at the Dee Why Unit until his death. The evidence indicates that AA was advised by nursing staff of a pending transfer to another facility prior to his death.

A report by Dr Anna Farrar dated 05 April 2013 prepared for a mental health tribunal outlines AA's mental state as at 15 March 2013. This report in my view is the best assessment we have of his mental health prior to his death.

The report indicates inter alia that "he was making improvements in his overall well-being, appearing less frail and more alert than previous reviews. He had accepted the Schizophrenic diagnosis and there was no evidence of thought to harm himself or others".

During August and September 2013, the evidence also indicates that there were a number of reports of AA acting aggressively towards staff. This behaviour was considered out of character from his recent behaviour. An incident report dated 3 September 2013 outlines that AA was located in his room with his head on a desk in a pool of saliva in a reduced state of consciousness. A tablet which appeared to be 50mg quitiapine (an antipsychotic prescribed to AA) was located under the desk in vomit. This incident was recorded as a possible self-harm/suicide attempt.

The Incident

About 6:00am on 03 December 2013, AA was discovered unresponsive, supine in a large pool of blood on the tiled floor of the ensuite bathroom in his room at the Forensic Hospital. He was not visible on his bed during a routine check by a nurse who noticed the light on in the ensuite and went to check on him. Upon discovering the body, the nurse activated her duress alarm.

The responding team observed no signs of life and accordingly, resuscitation attempts were not instituted. He was formally pronounced life extinct at 6:25am by Dr Eugene Ho.

The investigation

Investigation revealed a small razor blade covered with blood on the floor of the ensuite. Hesitation marks appeared to be present on the left side of the neck and a more substantial wound was on the right side of the neck.

There was no indication that the death was suspicious in nature.

After reviewing the Forensic Hospital Procedure – Razor Blades – Patient Access along with the razor issue record documentation dated 03 November 2013 until 02 December 2013, it appears that all razors have been accounted for. All razors that were signed out have been returned to a nurse a short time after being issued to a patient. All entries have a time returned with a nurse's signature or initials in the column adjacent. The razor issue record documentation indicates two entries in relation to AA. He signed out a razor on 03 November 2013 at 9:35am which was returned at 9:45am that same day. He also signed out a razor on 16 November 2013 at 9:45am which was returned at 10:00am that same day. There are no other entries relating to AA.

There is no evidence as to how AA came to be in possession of the razor blade he used to harm himself with. All procedures appear to have been followed by staff in terms of issuing and returning razor blades and all razor blades were accounted for in the month leading up to his death. It appears AA was managed appropriately whilst in custody. All protocols were followed by Justice Health and it appears he received satisfactory treatment.

Autopsy Report

The post mortem examination was conducted by Dr Rebecca Irvine. Her report dated 15 May 2014 opined that the cause of his death was incised wounds of the neck.

Formal Finding:

The identity of the deceased
The deceased person was AA
Date of death
Died on *03 December 2013*
Place of death
Died at *Dee Why Mixed Long Stay Ward, Forensic Hospital Malabar*
Cause of death
The death was caused by *incised wounds of the neck*
Manner of death
Suicide

21. 387501 of 2013

Inquest into the death of Aaron Magarry finding handed down by Deputy State Coroner Freund at Moree on the 18th August 2015.

Introduction

This is an inquest into the death of Aaron Magarry, who was only 23 when he died on 23 December 2013. Mr Magarry who was described by those that knew him as a "gentleman" and a "caring and giving man" he is survived and clearly much missed by his mother Tanya Magarry, father Troy Wilson, brother Blake, sister Kiara, his young daughter and a clearly loving extended family.

Mr Magarry died as a result of the injuries he sustained when he was ejected from the motor vehicle registration number QYW052 ("**the Motor Vehicle**") when it hit a tree at about 11pm on 23 December 2013 on the Carnarvon Highway, Moree ("**the Accident**") In the car with Mr Magarry was Jesse Girard who was also ejected from the Motor Vehicle as a result of the Accident.

He survived with serious injuries however has very little memory of the events leading up to or of the Accident.

At the time of the Accident the Motor Vehicle was being followed by a Highway Patrol Vehicle driven by Senior Constable Brendan Kross with its warning lights activated. Accordingly, as this is a death that occurred during the course of a police operation, this is a mandatory inquest pursuant to section 23 and 27(1)(b) of the *Coroners Act 2009.*As outlined by Counsel Assisting, Mr Harris this inquest has considered the following issues:

- Who was the driver of the Motor Vehicle?
- Whether Mr Magarry was under the influence of alcohol or drugs at the time of the accident?
- Whether Senior Constable Cross engaged in a pursuit of the Vehicle?
- Did Senior Constable Kross act appropriately in the circumstances? and
- Are there any recommendations arising out of this inquest?

The function of the Coroner and the nature of the inquest

The role of a Coroner as set out in s. 81 of the *Coroners Act 2009* is to make findings as to:

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

The Coroner is also able to make recommendations pursuant to section 82 of the Act in relation to any matters to improve public health and safety.

Background and Events leading up to the Accident

In December 2013, Mr Magarry was on bail and was due to appear at Moree Local Court on 15 January 2014. His bail required him to report to Moree police station every Monday between 8am and 8pm, which he had been doing. However, on Monday 23 December 2013 he failed to report as he was required to do. This is the first time he had failed to report and the reason why is not clear.

The evidence indicates that on 23 December 2013, Mr Magarry had spent some of that evening at an area called "the Tree", which is a local hangout on Balo Street, Moree. He was with his friend Jesse Girard and they were sitting in the Motor Vehicle which was a blue Holden V8 Commodore with Victorian plates. The Motor Vehicle was owned by Mr Girard, who had obtained it in Victoria and driven it to Moree a few weeks previously.

Who was driving the car at the time of the accident is an issue to which I will return. Neither Mr Magarry nor Mr Girard held a licence that allowed them to drive a "high performance vehicle" such as the V8 powered Commodore. Moreover, Mr Magarry's licence had been suspended for 3 months from 5 November 2013.

Sam Phelps, a friend of Mr Magarry gave evidence that:

"On 23 December 2013, I went into town about 8:30pm. I drove my ...motor vehicle ..and parked near the tree....When I got there, Jesse and Aaron were already out the tree in Jesse's car... I stopped and spoke with both Jesse and Aaron. Aaron was seated in the driver's seat and Jesse in the front passenger. Aaron and Jesse looked normal and didn't appear to be on anything. We spoke for awhile before Aaron and Jesse left to get a packet of smokes...

About 30 minutes later, Jesse and Aaron came back to the tree. Aaron was still driving the Vehicle. I walked over and spoke with Jesse and Aaron. I noticed then it looked like both of them had taken something. They had red eyes...

Shortly after this, Mr Magarry and Mr Girard drove off.

It is uncontroversial that at this time police were conducting stationary random breath testing ("**RBT**") on either side of Boggabilla Road, Moree near Webb Avenue. The RBT site was about 2km further north from "the Tree".

Constable Hildrew, was stationed at the RBT and her role was to signal vehicles to pull into the RBT. A number of cars ahead of the Commodore did so - including one driven by Mr Phelps.

It was the evidence of Constable Hildrew inter alia that She heard and saw the Motor Vehicle approach the RBT; She signalled to it to pull over into the RBT;

The Motor Vehicle appeared to initially pull in however it then accelerated heavily and continued past the RBT heading north; She saw two people in the car and could give a brief description of the driver; Despite having prior dealings with Mr Magarry she did not recognise the driver of the Motor Vehicle as Mr Magarry;

As part of her night shift duties on 23 December 2013 she had checked who had and had not reported pursuant to their bail requirements that day. She had noted that Mr Magarry had failed to report however, had yet to create an event to advise other officers about his failure to appear

Coincidently, as Mr Magarry and Mr Girard failed to stop at the RBT and accelerated past, Mr Phelps and his girlfriend Georgina Brooker had been pulled over at the RBT. He corroborates the evidence of Constable Hildrew and stated in evidence inter alia that: he was sitting in his car at the RBT with his driver's window down; he heard the Motor Vehicle which was being driven by Mr Magarry with Mr Girard in the passenger seat before he saw it because it was a loud vehicle he turned to watch them coming; he then observed "he boosted it, her revved the guts out of the engine and dropped the gear to make it go faster, he would have been travelling at least 110km per hour, the female police officer was standing in the middle of the road, and turned looking at the car, she shook her head at the vehicle" his girlfriend Ms Booker, then called Ms McMechan and told her that Mr Magarry had just driven through the RBT;

At about this time Senior Constable Kross, who was alone in a marked Highway Patrol car, had just finished dealing with an unrelated driver who had stopped just north of the RBT and had pulled into a car park near the junction with the Carnarvon Highway.

The evidence of Senior Constable Kross was inter alia that: he just pulled in to the car park outside "Sig's Takeaway" with the patrol car facing towards the road and facing Northbound toward Boggabilla Road.

The officer had switched off the lights of the patrol car; he had stationed himself at a position in order to both observe people stopping short of the RBT or observe people failing to stop at the RBT.

He heard the Motor Vehicle approach prior to seeing it pass at speed and then turn left onto the Highway.

He immediately activated his warning lights and siren and drove off onto Boggabilla road to begin following the Motor Vehicle; although he initially activated both the lights and sirens of the patrol car he almost immediately deactivated the sirens, the reason he followed the Motor Vehicle was he intended to stop it. He was concerned about its speed and the way it was being driven and he conceded that he thought it may have gone through the RBT; while following the Motor Vehicle he made no contact with police radio or with any of the police conducting the RBT as to what was happening.

The Highway Patrol car had an In Car Video ("**ICV**") which was activated at the same time as the lights and sirens. It back captured a few seconds of footage. The ICV shows: the Motor Vehicle passing the patrol car and Senior Constable Kross starting to follow the Motor Vehicle at about 11.02pm; the patrol car turn left onto the Highway and attempt to catch up with the Motor Vehicle which can be seen in the distance; the Motor Vehicle increasing speed away from the police patrol car, as there are points within the footage that the tail lights of the Motor Vehicle are not visible; the patrol car reaching speeds of up to 185 kmph as it follows the Motor Vehicle; at no time does the Patrol Car catch up with the Motor Vehicle until after the accident.

In less than a minute, and at a point approximately 1.9km along the Highway, the ICV shows the brake lights of the Motor Vehicle as it approaches a left hand bend and then it goes out of sight. At just before 11.03pm, Senior Constable Kross arrived at the scene of the Accident. It was 57 seconds after he had commenced driving.

Senior Constable Kross exited his vehicle and at that point a Body Worn Video ("**BWV**") on his personal radio was activated. That video was not played at the inquest but it forms part of the brief of evidence. The video shows Senior Constable Kross approaching Mr Magarry's body, which was in front of the police car by the roadside. He had obviously not survived the Accident.

Around a minute later, Senior Constable Kross informed police radio about the accident and an ambulance was called. The ambulance officers arrived at the scene at 11.17pm. Mr Magarry was confirmed deceased and was not taken to hospital.

Other police attended and a critical incident was declared.

Was Mr Magarry the driver of the Motor Vehicle?

Although both Mr Magarry and Mr Girard were ejected from the Motor Vehicle on its impact with the tree, the following evidence clearly indicates that Mr Magarry was the driver at the time of the Accident: Firstly, the evidence of Mr Phelps who saw the Motor Vehicle as it failed to stop at the RBT and drove past: *"I looked at the car and saw Jesse seated in the passenger seat and Aaron driving the vehicle as it drove past me, they continued on the Boggabilla road, turning left into the Carnarvon Highway after Sigs Café.*

Secondly, the evidence of Senior Constable Gretel Robertson whose evidence was during the course of the inquest that as a result of an analysis of the trajectory of the debris from the vehicle and the location Mr Magarry, who was thrown over 74 metres from the site of the impact, was found, indicated that he was the driver; and finally, the injuries sustained by Mr Girard are consistent with him being seated in the front passenger seat and wearing a seatbelt (he has significant injuries to his left arm and shoulder) whilst the injuries to Mr Magarry, which included the amputation of his right arm at the shoulder are consistent with him being in the drivers seat and wearing a seatbelt.

Accordingly I am satisfied on the balance of probabilities that Mr Magarry was the driver of the Motor Vehicle at the time of the Accident.

Was Mr Magarry under the influence of alcohol or drugs at the time of the accident?

The Post Mortem report dated 7 February 2014 revealed that the blood sample taken from Mr Magarry post mortem was found to have present 0.013 g/100ml alcohol, 0.04 mg/L amphetamine and 0.19 mg/L of methylamphetamine. Expert opinion was obtained from Dr Judith Perl, Forensic Pharmacologist her report dated 16 July 2014 found inter-alia that:

As the amount of alcohol detected in Mr Magarry's blood was very low and was only detected in his femoral blood, it was likely due to post mortem changes and not to Mr Magarry consuming alcohol prior to the Accident.

The blood concentrations of methylamphetamine and amphetamine detected in Mr Magarry would have been reflective of the concentrations at the time of his death and accordingly at the time of his driving.

The methylamphetamine concentration was in the toxic to potentially fatal range high doses of methylamphetamine are associated with "altered perceptions and judgment and increased aggressive or risk taking behaviour during the acute phase of intoxication" Methylamphetamine is metabolised partially to amphetamine, although illicit preparations of "speed" may contain a mixture of both methylamphetamine and amphetamine.

Accordingly, I am satisfied on the balance of probabilities that Mr Magarry was under the influence of methylamphetamine (also known as "ice") at the time of the Accident.

Was Senior Constable Kross engaged in a pursuit as defined by the NSW Police Safe Driver policy?

It is uncontroversial that at the time of the Accident the Motor Vehicle being driven by Mr Magarry was being followed by a patrol car driven by Senior Constable Kross. The issue is whether Senior Constable Kross was engaged in a pursuit at the time.

It was the initial opinion of the Officer in Charge of the investigation, Detective Senior Constable Rebecca McKenzie that:

"*At the time of the incident... highly likely that Magarry was fully aware of the police vehicle following him and would have known the intention of the police was to stop his vehicle due to his manner of driving. I believe Magarry was driving at excessive speed in an attempt to avoid apprehension by the police as he was aware he was a suspended driver and was in breach of his bail. As such, I believe this incident would be deemed to be a police pursuit"*

A pursuit is defined under the Safe Driving Policy under part 6 which states:

*"**PURSUIT**: A pursuit commences at the time you decided 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 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"

However I note that The Safe Driving Policy also makes reference to Traffic Stops, and states:
"***Traffic Stops***

It is permissible for police to perform traffic stops...or reduce the distance to an offending vehicle without informing VKG of a response code or activating warning devices. However police must take reasonable care and it must be reasonable that warning devices are not used...."

It was the evidence of Senior Constable Kross that at the time he was following the Motor Vehicle he: Intended to stop the Motor Vehicle. He immediately turned off his sirens off as "that's what I do um every time I go to stop a car. He drove out onto the road and onto the Carnarvon Highway and "all I could see ahead was a set of tail lights"...."So I accelerated and tried to catch up to him. That he "was just trying to um, catch up to the vehicle. I thought if I get, catch, close enough to it, it's going to be a pursuit obviously um, I would've had to call a pursuit, and I would have called a pursuit."

Senior Constable Kross's evidence in this regard is in my view corroborated from the recording of the audio that occurred when he came across the scene of the accident where he stated to VKG "I was just trying to catch up to it. Was almost about to call a pursuit when they've appeared to have lost it"

I found Senior Constable Kross to be a witness of truth, he did not seek to embellish any of the answers during the course of the inquest or the interview he gave to investigating officers. His evidence is clearly corroborated by the BVW transcript. Accordingly, I am satisfied on the balance of probabilities that Senior Constable Kross was not engaged in a pursuit at the time he was following the motor vehicle.

However, even if I had been satisfied that he was engaged in a pursuit (which I do not accept that he was) as defined by the Safe Driver Policy, the tragic outcome would not have been avoided.

There was all of 57 seconds between Senior Constable Kross pulling out after observing the Motor Vehicle speeding past his location at the car park outside "Sig's takeaway" and the Accident. If he had contacted VKG as he was required to do under the Safe Driving Policy there was little if any time for them to respond.

Did Senior Constable Kross act appropriately in the circumstances?

Senior Constable Kross on 23 December 2013 observed the Motor Vehicle being driven by Mr Magarry being in a manner that could only be described as dangerous. It was speeding.

He sought to stop it. To do so he attempted to catch up to it. The evidence indicates he was unable to do so. He has clearly been deeply affected from this terrible tragedy but he is not to blame. He was simply carrying out his duties that fateful evening.

Accordingly, I am satisfied on the balance, that his actions that evening were appropriate in all the circumstances.

Recommendations

Having considered in detail the Safe Driving Policy, I note that there are some inherent ambiguities contained with in it, particularly in relation to the definition of a pursuit. However, I note that Deputy State Coroner Magistrate Dillon in his findings in relation to the death of Hamish Raj made a comprehensive list of recommendations to the Commissioner of Police and I note from the submissions of Mr Haverfield that those are currently being reviewed. For those reasons I decline to make any recommendations.

Conclusion

The death of Mr Magarry is a tragedy. He leaves behind a loving family wondering why he was driving a car under the influence of toxic drugs in a manner that only could be described as foolhardy. If only he could have foreseen the ramifications of his actions that night. Drugs and reckless driving are a lethal mix and unfortunately for Mr Girard and Mr Magarry's family they will live a lifetime with the consequences.

Formal Finding:

I find that Aaron Stanley Magarry died on 23 December 2013 at Carnarvon Highway, Moree from multiple injuries as a result of a single motor vehicle accident.

22. 389043 of 2013

Inquest into the death of Farin Daley finding handed down by Deputy State Coroner Truscott at Glebe on the 27th July 2015.

This inquest concerns the death of Farin William Daley. He was a 43 year old man who was an inmate at Long Bay Correctional Facility.

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

- the identity of the deceased;
- the date and place of the person's death;
- the physical or medical cause of death; and
- the manner of death

The Act also requires a Coroner to conduct an inquest where the death appears to have occurred while a person is in lawful custody. (s.23, s.27).

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

Mr Daley was born on 19 May 1970. His father died when he was young and he was raised by his mother and step father. In September 2000 his mother passed away and a few years later his stepfather also passed away.

Mr Daley was a fit teenager who played rugby league for the local football team.

He never had any health issues growing up except for when he was about 28 years of age playing a game of football when he just dropped to the ground. His family later found out he had suffered a heart attack and was conveyed to Brisbane Hospital. He remained in Hospital for several weeks and eventually recovered and was not sick again.

Mr Daley resided in the Casino district and was in an on and off relationship for about ten years. The relationship was volatile and had many domestic violence issues. Eventually Mr Daley went to prison as a result of those issues. He first came into contact with the criminal justice system in 1990. From 1998 to 2005 he was charged with numerous offences and he served about 8 periods of imprisonment, usually short sentences.

In 2005 while he was serving a term of imprisonment, he was charged and later convicted of serious offence committed in prison and he was sentenced to a term of imprisonment of seven and a half years with a non-parole period of 4 years and 8 months. His release date was 17 October 2011. Whilst serving this sentence he committed a further similar offence in custody. He was sentenced at Bathurst District Court in 2009 to five years imprisonment and his earliest release date on parole was 28 November 2014.

Mr Daley's sister, Karen Daley, visited her brother in Junee Correctional Centre in 2010 and visited him occasionally until about 2012.

In her statement Karen said her brother was always happy and looking forward to his release in 2014. He told her he was going to Church and getting into his music. He appeared to have changed dramatically since being in custody. He did not mention that he had any medical issues or had been sick. He wrote numerous letters in which he sounded happy and never mentioned any issues.

Every time a prisoner is received on sentence, Corrective Services creates a case management file and warrant. These files contain documents including inmate requests, alerts, program or further education plans and behavioural type offences committed within Corrective Services custody. Mr Daley's case management file contains nothing of great note. He had made numerous requests to be placed into protective custody due to the nature of his charges. It appears these have been received and acted upon appropriately in each instance, with Mr Daley being classified to varying degrees of protection during his time in custody.

Justice Health provides medical care to inmates within the Correctional System. They maintained five volumes of medical records relating to Mr Daley. The records indicate that Mr Daley rarely required medical assistance or attended the medical clinic. The records show two visits in 2013, one for back pain and the other was to request a day off work as he had not been sleeping. Additionally, he only had two visits in 2012 which were for back pain and a rash. On 11 August 2011 Mr Daley reported to a nurse that he was lethargic, dizzy and suffering from headaches. He was treated with paracetamol. He was monitored and assessed by the clinic. The following day he reported that he was feeling a lot better.

A 'Clinical Reception Assessment' was completed by Mr Daley on his arrival each time into prison. At no time did he inform Justice Health that he suffered a previous heart attack or had a medical condition. In the questionnaire there are specific questions relating to heart disease. Mr Daley answered these questions in the negative and stated he had never suffered chest pains or tightness of the chest. In relation to the question *"do you have a history of heart disease"* he marked the question with a *"No".*

About 2:30pm on Saturday 28 December 2013 Mr Daley was secured in cell 32 with another inmate. Mr Daley cooked up some food in the early evening. About 8:45pm he had a smoke whilst sitting at the table before retiring to the lower bunk. His cellmate heard Mr Daley sneeze once and then a funny sound like he was trying to sneeze. Mr Daley asked his cellmate to hit the knock up button as he was not feeling well.

The cellmate hit the knock up button and was waiting at the door for Corrective Officers when he turned and saw Mr Daley holding his head. All of a sudden he fell forward off the bed onto the floor. He feel face first and hit the floor hard. His glasses were under his head and there was blood coming from his nose or mouth. The cellmate pushed the knock up button several more times. He heard Mr Daley take a big breath through his nose and heard gurgling sounds. Mr Daley attempted big breaths in an effort to get oxygen into his lungs.

Corrective Services staff entered the cell and found Mr Daley lying face down struggling to breathe. CPR was commenced and ambulance and the night nurse were summoned. Ambulance arrived about 9:19pm and worked on Mr Daley before transporting him to Prince of Wales Hospital. Life was pronounced extinct by Dr David D'SILVA at 10:34pm.

A forensic crime scene examination was conducted of cell 32. There were no signs of a struggle. The cell appeared neat and tidy. There was a fresh blood drop on a desk and a small pool of blood on the floor adjacent to the bed. There were no suspicious circumstances surrounding the death.

A post mortem examination was conducted by Dr Kendall BAILEY. I accept her opinion that the cause of death was Ischemic Heart Disease.

All protocols were followed by Corrective Services with regard to deaths in custody. The Crime Scene was managed by Corrective Services staff in an efficient and competent manner. Justice Health it appears he received satisfactory treatment.

Karen DALEY is aware that Farin William DALEY never disclosed a previous heart condition to Corrective Services or Justice Health. She writes that she would like to see all incarcerated inmates have compulsory yearly check-ups. She would further like to see medical background checks being conducted on new inmates when they are first entered into custody. Karen believes this would help identify previous medical conditions which inmates do not like to disclose and believes if this procedure were in place her brother's medical condition may have been able to be treated. Comment was sought from Justice Health in relation to these issues.

Justice Health report that as part of the Reception Screening Process the Patient Administration System (PAS) is now checked for relevant alerts, both inactive and active, from previous periods of imprisonment. Additionally as part of staged health care, all patients are requested to complete a 'Consent to Obtain Health Information' form in order for Justice Health and Forensic Mental Health Network to be able to contact their regular health provider. All information is scanned and made available on the Justice Health electronic Health System. Justice Health has developed a centralised model of coordinating access to patient's health information through this process. Further there are additional health care and health screening requirements being implemented for Aboriginal patients.

Justice Health and Forensic Mental Health Network continue to work to identify and treat patients who require health interventions within the correctional environment, however also respect the rights of patients to refuse treatment in line with existing community standards. During the assessment process it is not always possible to identify existing health concerns without the cooperation of the patient.

Any health concerns that are identified are referred for appropriate treatment with patient's encouraged to engage in such treatment.
This proactive approach to transitioning health care facilitates a more integrated and comprehensive assessment of patients within the corrections system.

On my review of the evidence contained within the file, there does not appear to be any relevant matters in relation to Mr Daley's care and treatment during his sentence, which would cause me to consider recommending any changes to policy or procedure in either the Correctional or Justice Health.

Formal Finding:

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was Farin William Daley

Date of death

He died on 28 December 2013

Place of death

He died at Prince of Wales Hospital

Cause of death

The death was caused by Ischaemic heart disease

Manner of death

Natural causes

23. 22127 of 2014

Inquest into the death of JX finding handed down by State Coroner Barnes at Glebe

Pursuant s75(2)(b) I order that no information tending to identify the deceased be published.

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

- **Introduction**
- On 21 January 2014, while at work, JX sought assistance from his boss, Matthew Dyson, as he realised he was suffering a relapse of the mental illness he had been treated for sporadically over a number of years. He went with Mr Dyson to the rooms of a psychologist who had treated him previously and then to the emergency department of a large public hospital.

- There JX was triaged but left before he was seen by a doctor. Despite Mr Dyson and police trying to locate him, JX was not seen again by those trying to help him until his body was found floating in the ocean at Maroubra the next morning.

<u>The Issues.</u>

- As with all inquests, it was necessary to find, if possible, the identity of the deceased person; the date and place of their death; and the manner and cause of the death. In this case, there was little doubt about most of those issues. Rather, the inquest focused on:

- Whether staff attached to the Ryde Mental Health Acute Team responded appropriately when contacted by Psychologist Mr Geoffrey Dawson on the afternoon of 21 January 2014.

- Whether the Mental Health Acute Team policies and procedures concerning responses to contact of that kind were (are) clear, consistent and appropriate.

- Whether staff attached to the Royal North Shore Hospital responded appropriately when JX presented at the Emergency Department on the afternoon of 21 January 2014.

- Whether staff attached to the Royal North Shore Hospital responded appropriately when JX left the Emergency Department on the afternoon of 21
- January 2014.

- Whether Royal North Shore Hospital Emergency Department policies and procedures concerning responses to persons presenting at the Emergency Department, who are reported to be exhibiting signs of psychosis, were (are) clear, consistent and appropriate.

- The nature and appropriateness of the response by NSW Police Force after being advised on 21 January 2014 of concerns for the welfare of JX

The Evidence

Social History

JX was born 18 February 1982. He was the son of DJX and PJX and the older brother to a sister, born in 1992. His mother describes him as a gentle, easy-going, untidy and very kind person who was genuinely interested in other people's opinions.

JX grew up in Rozelle, NSW, and attended Balmain Primary School. He commenced his secondary schooling nearby at Hunters Hill High School. When JX was in year 9 the family moved to Sydney's northern beaches and JX transferred to Pittwater High School. As an adult, JX reflected on the move and felt that he did not cope well with it.

JX completed the HSC in 1999 and commenced a Bachelor of Science degree the following year. After one year of study he transferred to a Bachelor of Mechanical Engineering degree and completed two years of the course.

JX had reservations about pursuing his studies further and took a gap year, during which he travelled to the USA to work as a summer camp counsellor and also travelled to Europe and Asia. He returned in December 2003 and was accepted into a Bachelor of Renewable Engineering degree at the University of New South Wales ("UNSW").

The course appears to have suited JX‟s interests and abilities. He had displayed keen interest in invention and the environment since childhood. His academic results had always reflected his aptitude for mathematics and science. However, he struggled somewhat to meet the demands of his course and consequently, he was suspended from study for one year in 2009. JX‟s poor academic results that year may be symptomatic of his recognised difficulty reading and writing (apparent since childhood and for which he had obtained occasional learning support and speech pathology) and his distractibility and disorganisation. Testing in 2012 suggested that JX may have Attention Deficit Disorder (ADD) and in 2013, he was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

In about 2005, JX experienced a difficult relationship break-up with a girlfriend. He appears to have drunk alcohol heavily and used ecstasy around this time. There is evidence that at least from this time, like many young men his age, JX drank alcohol and used illicit drugs, including cannabis. While the amount and frequency of his intake seems to have varied and is not quantified on the evidence, it appears that JX never consumed either to the extent that it was of acute concern to his friends and family.

The relationship breakdown in 2005 also caused JX to feel suicidal. This led to three months of medication on the anti-depressant Zoloft (sertraline). Between 24 April 2006 and 25 January 2011 he was treated by a number of general practitioners and a psychiatrist attached to the UNSW University Health Service. From that first consultation JX was prescribed the anti-depressant medication Efexor XR (venlafaxine). He continued to be prescribed venlafaxine more or less regularly, and in varying dosages, from that date onwards.

Medical History

First psychotic episode and subsequent treatment

In 2011, JX was 29 years old. He had recommenced his studies at the UNSW; however, he continued to struggle to meet the demands of the course. Prior to 5 August 2011 he became aware that he would or had failed a subject and, prompted by this news, he increased his cannabis use.

At the time, JX was living in a share house in Waterloo. On 5 August 2011, JX‟s housemates observed him to be very anxious and to have difficulty sleeping. He was saying things that did not make sense and expressed thoughts about being followed and about a conspiracy involving a Chinese businessman. Concerned, they called his parents, who took him to their home in Newport.

JX‟s parents arranged for him to consult with psychiatrist Dr Andrew Smallman at the Mona Vale Community Health Centre on 9 August 2011. Dr Smallman saw JX as arranged and noted that he made some indirect references to self-harm.

It was reported that JX had used cannabis several days ago. Dr Smallman concluded that JX had experienced a psychotic episode precipitated by cannabis use and university exams. He prescribed the anti-psychotic medication Zyprexa (olanzapine). JX‟s mother noticed an improvement within one hour of its administration. JX declined to see Dr Smallman again.

JX‟s father took him to see registered psychologist Geoffrey Dawson on 11 August 2011. He was then formally referred to Mr Dawson by his general practitioner, Dr Kate Norris, who formulated a mental health care plan for JX which included consultation with Mr Dawson and psychiatrist Dr Brian Gutkin.

JX saw Dr Gutkin approximately every two to four weeks between August 2011 and 26 June 2012. While JX was still psychotic when seen by Dr Gutkin for the first time, he was considerably improved on the olanzapine. Dr Gutkin increased the dose of olanzapine from 5mg to 10mg nightly. After the first consultation, Dr Gutkin prepared a report dated 18 August 2011. In that report, he considered and discounted a diagnosis of bipolar disorder in favour of the view that JX‟s psychosis was either drug induced or was due to an underlying Primary Psychotic Disorder such as Schizophrenia or Schizoaffective disorder. In a letter dated 6 August 2014 (prepared for the purposes of this inquest), he expressed the view that JX‟s condition was probably a type of Schizophrenia – either Schizophrenia itself or Schizoaffective Disorder.

In that same letter, he said that although it was possible this condition was drug induced or exacerbated by substance abuse, overall, he felt that there was very strong evidence for a primary psychotic disorder. Dr Gutkin continued to treat JX until 26 June 2012, after which JX declined to attend.

JX saw Mr Dawson four times between 11 August 2011 and 1 September 2011. Mr Dawson gave evidence that he viewed this as *"supportive counselling and reality testing"* following JX‟s recent mental disturbance. Mr Dawson diagnosed JX with drug-induced psychosis (because the episode was precipitated by cannabis use) and depression.

During those sessions, JX continued to exhibit the psychotic ideation that Chinese spies were monitoring him. He did not have any suicidal intent. Mr Dawson's short term prognosis was that JX had a good chance of recovering from the psychosis provided he stopped smoking cannabis. Mr Dawson was unsure of JX‟s long term prospects of recovering from depression because it was a long standing mental illness which had not been resolved by medication. On the last session, JX expressed the view that he did not want to continue with counselling. JX missed the next two scheduled appointments on 15 and 20 September 2011.

Medical treatment in 2012 and 2013

JX next saw Mr Dawson on 21 August 2012, when he presented for counselling with a renewed referral from Dr Norris. JX expressed a desire to receive counselling to learn how to regulate his emotions more effectively and to help achieve some of his life goals of having a career, a place to live where he felt comfortable, and to develop a romantic relationship with a woman. Mr Dawson had some reservations as to whether JX was invested in the process or whether he was attending counselling at his mother's behest. Mr Dawson noted that JX did not exhibit any psychotic symptoms. JX denied smoking cannabis.

It was around this time, in August or September 2012, that JX obtained a job at the Carbon Reduction Institute. It was a workplace that was clearly suited to JX‟s abilities and interests and it appears to have been a supportive workplace.

His mother thought JX seemed very happy and positive about the job. However, in subsequent sessions with Mr Dawson, JX spoke about feeling out of his depth and being unable to concentrate at work.

The job required JX to complete many written reports, which he struggled with. Mr Dawson suspected that JX may have undiagnosed ADD and in September 2012, he referred JX to neuropsychologist Dr Robin Murray.

Dr Murray came to the opinion that JX probably met the diagnosis for ADD and perhaps also had some kind of learning disorder. Dr Murray prepared a report which was provided to Mr Dawson. Consequently, Mr Dawson spoke with Dr Gutkin informally about medical intervention. He says that Dr Gutkin stated that he was uncomfortable prescribing Ritalin (methylphenidate) or dexamphetamine to JX because it may trigger a psychotic episode.

JX last saw Mr Dawson for counselling on 26 February 2013. He informed Mr Dawson that he wished to cease counselling because he felt he was no longer psychotic and he had achieved some of his goals, including obtaining employment in his field of expertise and living in a share house with friends. Mr Dawson was of the view that JX was not suicidal and that he had improved but he had not entirely resolved his depression. Mr Dawson suggested that JX continue to see a psychiatrist for medication review. He had no further contact with JX until 21 January 2014.

On 2 May 2013, JX saw psychiatrist Dr Kam Seng Wong at the Metta Clinic in Pymble. He attended without a referral (despite Dr Wong's request for one) seeking treatment for ADHD which he said Dr Murray had diagnosed him with. Dr Wong's detailed note of the initial consultation shows that JX provided a history that was generally consistent. JX said that he was not taking any illicit drugs. Dr Wong diagnosed JX with ADHD and recommended that he manage it medically with Ritalin (methylphenidate) coupled with therapeutic treatment in the form of supportive counselling. He explained the side effects of taking Ritalin including *"that, in rare cases, Ritalin had triggered a psychotic episode if the person had an underlying psychotic condition such as schizophrenia or bipolar disorder with psychotic features."* Dr Wong asked JX to consider whether he wanted to try Ritalin.

JX called Dr Wong's rooms on 7 June 2013, stating that he wanted to commence on Ritalin because he was concerned about his performance at work. Dr Wong issued a prescription to JX for Ritalin on the proviso that JX provide him with Dr Murray's report and a referral at the next consultation on 17 June 2013. That prescription was filled on 13 June 2013.

JX was reviewed by Dr Wong four days after receiving his first supply of Ritalin. Although JX was still concerned about his performance at work, he reported an improvement in his concentration and a new ability to self-monitor. JX was specifically asked whether he experienced any side effects, including perceptual disturbance and suicidal ideation, and reported that he had not. He affirmed that he was not taking any illicit drugs. Dr Wong noted no signs of depression, psychosis, or suicidal thoughts.

Some time after the second consultation, Dr Wong received Dr Murray's report. He noted that JX had told Dr Murray about his psychotic episode after smoking cannabis.

He states that this did not cause him to alter his management plan as, based on the history provided, his clinical assessment and his observations of JX, he was of the view that JX was no longer taking any illicit drugs and JX was not exhibiting any signs or symptoms of psychosis or a drug induced psychosis.

JX last saw Dr Wong on 12 August 2013. He reported great improvement and no side-effects from Ritalin, although he reported taking the medication only 80% of the time. JX again confirmed that he was not taking illicit drugs. Dr Wong's notes record JX's mood was – *"stable, no depression, not suicidal, oriented, not psychotic".* Dr Wong issued another prescription for 100 Ritalin 10 mg tablets to be taken twice daily. He subsequently used this script to obtain Ritalin on 23 August 2013.

JX did not attend a scheduled appointment with Dr Wong on 10 October 2013.

On 12 December 2013, he telephoned Dr Wong's rooms, asking for a prescription for Ritalin as he had run out. Dr Wong arranged for this prescription to be sent to him. It appears that JX lost this prescription.

Medication

Relevantly to this inquest, JX was treated with three main types of medication – olanzapine (Zyprexa – an anti-psychotic), venlafaxine (Efexor or Altven – an anti- depressant) and methylphenidate (Ritalin – a stimulant).

As noted above, JX was prescribed olanzapine (Zyprexa) by Dr Smallman and Dr Gutkin to treat his psychosis in August 2011. He responded very well to it. However, it had significant side effects: in her report of 2 October 2012 Dr Murray noted that JX had gained 15kg since starting on Zyprexa and that he was sleeping about 12 hours each night. On 25 September 2012, when JX first saw Dr Murray, in response to the question: "Would you briefly describe your 3 main concerns at this time?" JX wrote only: "Zyprexa causes weight gain". JX appears to have stopped taking olanzapine around December 2012 or January 2013 with the last supply (according to his Medicare records) being on 4 December 2012. Although police found three olanzapine tablets in JX"s bedroom after his death, it does not appear that he was using it at that time

JX was prescribed venlafaxine (Zyprexa or Altven) from his first consultation with a UNSW University Health Service doctor on 24 April 2006. On at least one occasion he ran out of the medication and had to obtain it urgently. It seems he obtained prescriptions from a number of doctors (including various doctors at the UNSW University Health Service, GP Dr Norris, and doctors at the Maroubra Medical Centre). However, JX was prescribed it more or less regularly. He was also taking it around the time of his death. Police found venlafaxine tablets in JX"s bedroom after his death and post-mortem toxicology screening detected venlafaxine in JX"s system.

JX was commenced on methylphenidate (Ritalin) relatively recently. It was prescribed for him by Dr Wong in June 2013. Medicare records show that he purchased 100 tablets on 13 June 2013 and on 23 August 2013. It appears that on the first prescription, JX advised to take the Ritalin three times a day. The dosage was changed to twice daily in August. Assuming that JX took the medication twice daily as advised from about 23 August 2013, his supply should have lasted until about mid-October 2013 (this also coincides with JX"s scheduled appointment with Dr Wong on 10 October 2013 which he did not attend). Even if, as some evidence suggests, JX had only taken the medication on weekdays it is possible that he had run out of Ritalin by October or November 2013.

On 12 December 2013, JX called Dr Wong's rooms and asked for a prescription for Ritalin because he had run out. Dr Wong arranged for it to be sent to JX. However, it appears that JX lost the prescription while cleaning his bedroom in the beginning of 2014. On 6 January 2014, he called Dr Wong's rooms requesting a replacement prescription because he had lost the earlier one.

Quite reasonably, Dr Wong advised JX that he would not supply it unless JX provided a statutory declaration confirming that he had lost the earlier prescription. No statutory declaration was ever received by Dr Wong. That being the case, it appears the last supply of Ritalin received by JX was purchased on 23 August 2013 and which he had expended by 12 December 2013. Police did not find Ritalin in a search of JX"s room and post-mortem toxicology screening did not detect methylphenidate.

General circumstances in 2014

JX last spoke to his mother on a Thursday in January 2014. They attempted to make plans to have dinner. His mother thought that JX"s life was going very well. He was still working as a Sustainability Engineer at the Carbon Reduction Institute and he was preparing for a presentation in Melbourne. He had recently started a relationship with Elise Newton, who he had known through mutual friends for about two years. After moving house four times in as many years he appeared settled at Maroubra. He lived there with a number of good friends, among them Jonathan Pye and Nicholas Clark.

According to Mr Clark, in the days and weeks prior to his death, JX was apparently quite disorganised and using cannabis a few times a week with friends. He says he noticed a change in JX after he reportedly lost his Ritalin prescription – JX became disorganised and had difficulty holding a conversation.

On Saturday, 18 January 2014, JX and Nicholas attended a farewell party in Erskineville. Nicholas gave evidence that JX drank "*a lot*" of alcohol and planned to "*kick on*" elsewhere and smoke cannabis with friends.

The next day, JX arrived late (at about 4.30pm or 5.00pm) to meet Elise for coffee because he had slept in. Elise thought that JX had a *"big night"* at the party.

She noticed that JX had trouble focusing when she was talking but she attributed this to his dyslexia, which he had told her he had been diagnosed with, or the effects of the previous night. She did not otherwise think anything was wrong with him.

On the evening of Monday, 20 January 2014, Jonathan observed JX to be *"a bit depressed*" during dinner at home with friends. He describes JX as having sunken and wide eyes and staring off into space. Jonathan states that he was not engaging in conversation and could not remember where anything went while putting away the dishes.

The events of 21 and 22 January 2014

Jonathan was sufficiently concerned about JX"s behaviour to make an effort to wake early on 21 January 2014 to check on him. He saw JX and thought he seemed completely different to the night before and looked normal. He says that JX had risen early and gone for a run and he was, unusually, on time to leave for work. Jonathan mentioned to JX that he had seemed down the day before and JX said it was because of the big weekend. Nicholas has a different recollection of JX"s behaviour that morning – he recalls that JX was "*running late for work, as usual."* Nicholas states that he handed JX a slice of pizza to eat on his way to work.

At an unknown time, JX left his home at Maroubra to attend work at the Carbon Reduction Institute in North Sydney.

JX goes to work

JX arrived late to work at about 1.00pm. It is not known where he spent the morning after he left home. On arrival, he entered the office of the General Manager, Matthew Dyson. Mr Dyson asked JX how he was going, to which JX replied, *"Not so good"*. JX said he wanted to have a chat.

The two proceeded to a loading dock in the building where they could chat in private and have a cigarette. JX told Mr Dyson that he had encountered a "*crazy"* individual in Maroubra earlier that day who was trying to get JX to choose a range of books that he wanted to donate to UNSW. JX said he had a coffee with him. JX told Mr Dyson that this person had "*set him off"* and that he wished he had not met him.

JX repeated his account of this meeting. He also discussed a range of other topics, including magazines in the office which he thought were about conspiracies. Mr Dyson recognised that JX was speaking randomly about various subjects, noticed that JX appeared to be quite anxious and that JX was perspiring and had an absent focus.

He became concerned for JX‟s welfare and enquired about his past mental health. JX told Mr Dyson he had behaved this way previously and that he had *"some occasional depression and psychosis".* In answer to Mr Duson's enquiry: *"Have you in the past or even now thought about hurting yourself or someone else?"* JX replied "*Yes"*. Mr Dyson asked JX if there someone he could call, and JX mentioned "*a psychotherapist named Geoff*" in North Sydney (referring to Mr Dawson). It was agreed that they would visit him.

JX and Mr Dyson retrieved JX‟s bag from the office then left work at about 1.20pm. They walked to Mr Dawson's rooms which were nearby. *En route*, JX continued to repeat himself and was sweating. They stopped twice – once at a café to buy JX coffee and an orange juice and a second time so that JX could sign up to donate to Lifeline. Mr Dyson appears to have been fearful of inadvertently triggering an unexpected reaction from JX and accordingly, did not interrupt these excursions.

JX and Mr Dyson attend Mr Dawson's rooms

They arrived at Mr Dawson's rooms at around 2.10pm. Mr Dawson was with a patient at the time. They spoke briefly with another psychologist, David Brennan, who observed JX to be sweating, agitated and displaying an inappropriate level of emotion. As a result of this brief interaction, Mr Brennan formed the view that JX was in a mild psychotic state, although he did not think that JX was suicidal.

Mr Dawson's wife, Diana Devitt-Dawson, who is a registered nurse and midwife with rooms in the same office complex, also spoke to JX. She recalls that JX spontaneously said, "*There's a problem. There is hot water coming out of the cold tap, and cold water coming out of the hot tap"*. She states that besides this abnormal conversation, JX did not display any signs of concern. However, Mr Dawson recalls that his wife later told him that she had thought JX was in a psychotic state.

Mr Dyson states that he gave Mr Brennan his and JX‟s full names and mobile telephone numbers and asked him to request Mr Dawson call as soon as his consultation finished. JX and Mr Dyson then left to wait in a nearby café from about 2.20pm.

They headed back to Mr Dawson's rooms at about 3.15pm. *En route*, Mr Dawson – who had been advised of JX"s presentation by Mr Brennan – called Mr Dyson and told him that he could see JX prior to his next appointment at 4.00pm. Mr Dawson then called Dr Gaskin's mobile number but it went to voicemail.

JX and Mr Dyson arrived at Mr Dawson's rooms at about 3.20pm. JX was seen by Mr Dawson immediately and alone for about 15 minutes. Mr Dawson observed that JX *"was sweating profusely, he had a wild look in his eye, he had difficulty controlling his facial features, he had an elevated mood, he was giggling and smiling inappropriately, his speech was disorganised and jumping from topic to topic and not making sense".*

Mr Dawson very quickly formed the opinion that JX was in a psychotic state and required medical assistance. He told JX of his opinion. He asked JX whether he was feeling suicidal, to which JX hesitated and then said; "*everything is clear now".* When Mr Dawson asked JX the question again, JX denied any suicidal thoughts. Mr Dawson was unconvinced by his response.

Mr Dawson, with JX"s consent, then invited with Mr Dyson into the room. Mr Dyson recounted the events since JX"s arrival at work. Mr Dawson told Mr Dyson that he thought that JX was in a psychotic state and required immediate medical intervention. Mr Dawson asked them to wait while he attempted to contact Dr Gutkin.

At 3.40pm, Mr Dawson called Dr Gutkin again, this time on his office number. He was again unable to reach Dr Gutkin.

Mr Dawson contacts the Mental Health Acute Team

At 3.42pm, after being unable to reach Dr Gutkin, Mr Dawson called the Mental Health Line. Mr Dawson was aware of the existence of the service but had not had cause to call it previously. He searched the internet for the number.

Exhibited before me was a NSW Health – Northern Sydney Local Health District webpage entitled „Acute Team – Lower North Shore" and dated 13 August 2014. Mr Dawson saw the webpage at the inquest and although he did not recall whether that was the webpage he found on 21 January 2014, he recalled that it was similar.

Under the heading „*Urgent cases*" was written:

There are several options to access urgent mental health care:

Ring the ***Mental Health Line on 1800 011 511.*** *This line is staffed 24 hours a day, 7 days a week. You will be able to speak with a clinician who can provide recommendations about how to manage the situation or put you in contact with the appropriate mental health team.*

In urgent cases you can attend the ***Emergency Department at Royal North Shore Hospital*** *where there is 24 hour access to specialist mental health care and support.*

If the situation is urgent or becoming dangerous ring ***Triple Zero (000)*** *and request ambulance and/or police. They will be able to assist the person safely to the hospital Emergency Department to access mental health care.*

The call charge records show that Mr Dawson called the Mental Health Line on the number provided. That call lasted 13 or 14 seconds. The call charge records also show that Mr Dawson called 1800 116 282 three or four seconds after calling the Mental Health Line. The same records show that Mr Dawson called (02) 9585 7777 at 3.43pm and that call lasted 450 or 451 seconds. Mr Dawson does not recall whether he called that number or if he was transferred to it from either of the 1800 numbers.

Mr Dawson thought that he was speaking to a person attached to the Lower North Shore Mental Health Acute Team. However, just prior to the inquest convening, it emerged that the telephone number is that of the Ryde Community Mental Health Centre from which the Ryde Mental Health Acute Team operates. The confusion may have been caused by the Ryde Community Mental Health Centre being the nominated referral point for non-urgent matters on the webpage entitled „Acute Team – Lower North Shore". This has now rectified to refer to the Lower North Shore equivalent.

As a consequence of the late identification of the telephone number being that of the Ryde Community Mental Health Centre, there was also late identification of the social worker and intake officer, JVB who spoke to Mr Dawson. Mr Dawson and JVB give different accounts of the discussion between them.

Mr Dawson had the advantage of providing a near-contemporaneous account in a statement dated 25 January 2014. JVB did not prepare a statement until 30 August 2014.

When Mr Dawson called, relevant staff members were in a handover meeting which regularly took place between 3.30pm and 4.00pm. Mr Dawson spoke to a person who he believed was a receptionist and was initially asked to call back in an hour.

JVB was called out of the meeting and took the call after Mr Dawson indicated that he was calling in regard to an emergency and he needed to speak to someone before his next client arrived at 4.00pm.

On Mr Dawson's account, JVB came to phone and asked, *"Who are you and what do you want?"* She did not identify herself to him. JVB gave evidence that she would not be so brusque to a caller but I have no reason to reject Mr Dawson's account.

It is agreed that Mr Dawson told JVB that he was a psychologist and he was with a client. It is also agreed that Mr Dawson gave her some information about the client. Mr Dawson recalls describing JX"s symptoms and advising that in his opinion JX was in a psychotic state. JVB could not recall whether Mr Dawson detailed the client's symptoms. In any event, JVB recalls that she formed the opinion that the client was psychotic.

Mr Dawson asked JVB what assistance she could provide. He had spoken to a member of a Mental Health Acute Team once prior, although in circumstances following a crisis. He expected that the Mental Health Acute Team would *"take over the situation"* by coming to his premises or speaking to JX and making an assessment.

He gave oral evidence that he was willing to stay on the phone as long as was required to provide the background information necessary for the service to perform its functions and that, despite not having seen JX for a year and having no access to JX"s file at the time, he had sufficient recall of JX"s history to inform JVB of the salient aspects. Mr Dawson says that he was told the Mental Health Acute Team could not assist.

This is disputed by JVB, who gave evidence that she would *"never*" inform a caller that the service could not help. Again, I have no basis on which to reject Mr Dawson's account, although it could be that they were at cross purposes and JVB was merely trying to convey that the service could not send somebody to assess JX at Mr Dawson's rooms.

JVB states that from the description that Mr Dawson was providing, she formed the opinion that JX should attend a hospital emergency department where he could undergo an assessment by a mental health practitioner in a safe environment. She does not recall the exactly what she said but she believes she said words to the effect; "*You need to call an ambulance to take him to an ED so that he can be assessed by a mental health person".* Mr Dawson agreed that he was advised to have JX taken to hospital by ambulance. He also recalls he was warned psychotic patients often *"do a runner"*.

Mr Dawson recalls discussing the possibility of having Mr Dyson take JX to the hospital because JX seemed to have a good and trusting relationship with Mr Dyson and JX appeared to want help because he came to his rooms. Mr Dawson gave evidence that JVB agreed with his suggestion and said that the most important thing was that JX was safe. JVB does not recall being told about any alternative plan for JX to be taken to hospital by his boss but concedes that it could have been said. She gave evidence that she would not have encouraged transport by any means other than by ambulance.

In her opinion, whether a psychotic patient should be transported privately was a matter of clinical judgment and she would not have made that judgment call without having assessed the patient.

Mr Dawson returned to JX and Mr Dyson. He recommended that JX attend the Royal North Shore Hospital Emergency Department ("RNSH ED"). JX hesitantly agreed to Mr Dyson accompanying him there.

Mr Dyson recalls that at some point prior to them leaving Mr Dawson's rooms, Mr Dawson asked JX whether he wanted him to contact his family, to which JX replied, *"No".* Somewhat in contradiction to this, Mr Dawson states that he went into his office to search for JX‟s file with the intention of informing them of JX‟s visit.

Upon doing so, he realised that he had archived the file since he had not seen JX for a year. Mr Dawson gave evidence that when he took steps to contact JX‟s parents later in the evening it was an emergency situation which overtook any confidentiality concerns and did not mean that the conversation did not take place.

Meanwhile, JVB had returned to the handover meeting. At some point, an „Intake Log‟ was complete which recorded *"Jeff Dosan*" (sic) called at 3.45pm on 21 January 2014 and the "Brief Reason" for the call was recorded as *Call to Julia".* The note was initialled *"JB".* This was to be the Ryde Mental Health Acute Team's only record of the telephone call between Mr Dawson and JVB. Not even JX‟s name was recorded.

JVB stated that she probably intended to complete the paper triage module after the handover meeting but it slipped her mind. She gave evidence that it was her usual practice to do so after finishing a call. However she also said she would not normally attempt to alert a hospital of a patient's impending arrival because, if transported by ambulance, it was impossible for her to know which hospital they would be taken to.

JVB noted that she would often expect a referring clinician (like a psychologist) to provide a referral letter which would accompany the patient to hospital.

I will return to this issue in the recommendation section of this report.

JX attends the RNSH

JX and Mr Dyson travelled by taxi to the RNSH in St. Leonards (a distance of less than 2km).

Although the time stamp on the taxi receipt shows that they arrived at 3.59pm, according to the RNSH CCTV recorded vision they walked into the Emergency Department at about 3.56pm. On arrival, they spoke to a person at the reception area and then waited in the waiting room for a triage nurse to attend to JX.

The electronic triage record notes that JX was triaged by registered nurse Angela Becker. JX was in fact triaged by registered nurse Emma Curtin who appears to have entered the record while RN Becker remained logged into the system.

Both recall that the shift was busy. RN Becker has provided a statement to the effect that she has amended her practice to ensure that she logs out of the system on completion of each entry.

She no longer provides her password to other staff. RN Curtin states that she now ensures all of her entries are entered under her password. No issue arose from this record-keeping error.

According to the electronic triage record, triage commenced at about 4.08pm. The record notes the following in relation to JX"s presentation:

PRESENTS WITH WORK COLLEAGUE, REPORTS ANXIETY TODAY WHILE AT WORK, WALKED INTO EMPLOYER AND REOPORTED [sic] *HE FELT HE WAS NOT DOING WELL, O/A PT ALERT, TALKING, GCS 15/15, PEARL, VAGUE AT TIMES, NIL PRESSURESED* [sic] *SPEECH, DENIES ANY CHEST PAIN/SOB …*
FVERS/VOMITING [sic], *MILD HEADACHE AT TRIAGE, PMH: DEPRESSION, ADHD, ANXIETY, PT CALM AT TRIAGE, DENIES ANY HALLUCINATION, NIL ETOH, HAD "JOINT" AT WEKEND* [sic]

JX had appeared reluctant to admit to drug use when seen with Mr Dyson. He admitted to having a "joint" when spoken to alone. RN Curtin recalls that JX remained calm and alert and was walking and talking throughout the triage process. She gave evidence that the triage probably concluded at about 4.14pm.

Mr Dyson was concerned that JX was downplaying the seriousness of his condition and so, according to his statement, following the assessment, he approached RN Curtin and the following is said to have occurred:

…I approached the nurse on my own and said that whilst I didn't want to overstate the events of the afternoon I also wanted to make sure that Royal North Shore wasn't getting a lessened version from JX. I further stated that JX"s psychologist Geoff DAWSON, who we'd just come from, had said he thought JX experienced a psychotic break.

I gave the nurse Geoff's card which he had given to me to give to the hospital if needed. The nurse was thankful and said she was going to have a member of the mental health team come down to Emergency and evaluate JX as soon as possible.

In her statement, RN Curtin makes no reference to this discussion with Mr Dyson and said in evidence that she did not recall it occurring. Mr Dawson's business card was apparently not on the patient file and Mr Dyson's account could not be tested by cross examination as he was not available to give evidence. Nevertheless, his statement was made only eight days after the events and I have no reason to doubt its accuracy. Accordingly, I accept Mr Dyson's version of what occurred.

RN Curtin recorded the reason for the triage visit as *"MH* [mental health] – *behavioural disturbance".* She gave JX a triage category of "3". She said in evidence that she categorised JX as such because he had *"a change in his behaviour that day and he had a past history of depression".* This meant that JX should be assessed by a doctor within 30 minutes from the time at which triage commenced.

The RNSH Emergency Department uses the Australasian Triage Scale which classifies patients presenting to it into categories 1 to 5 according to urgency (with 1 being the most urgent). On a NSW Health webpage describing the triage process, a Category 3 patient is described as follows:

People who need to have treatment within 30 minutes are categorised as having a potentially life-threatening condition. People in this group suffer from severe illness, bleed heavily from cuts, have major fractures, or be dehydrated.

RN Curtin states that at approximately 4.20pm she spoke to Mental Health Clinical Nurse Consultant ("CNC") Colleen Olmstead. They discussed JX"s presentation in terms generally consistent with that recorded in the electronic triage record. CNC Olmstead states that, based on that information, she had no reason to think that JX presented as a risk of suicide or a risk to others.

RN Curtin says that after speaking to CNC Olmstead she asked Mr Dyson to stay with JX as his account of the events would be important for the mental health team and medical assessment. She then escorted JX and Mr Dyson to the waiting room and asked them to wait for further assessment.

The medical assessment of JX was initially assigned to Dr Jacqueline Ward at about 4.22pm. However, Dr Ward was called away to an emergency resuscitation and it was not until about 5.03pm that JX was reassigned to another doctor. By that time, the recommended thirty minute period had elapsed and JX had left the hospital.

JX leaves the Royal North Shore Hospital

JX was restless while waiting to be seen. He told Mr Dyson that he intended getting a cold drink. Mr Dyson thought nothing of the plan, as JX had felt hot and dehydrated throughout the afternoon and the coffee shop was adjacent to the waiting room. No one had told Mr Dyson that JX was at risk of absconding.

RNSH CCTV footage shows that at about 4:41pm, JX walked out of the Emergency Department. In that footage, JX appears to be calm and walking steadily. The waiting room was accessible by administrative staff, the triage nurse and a Clinical Initiatives Nurse ("CIN") who is a registered nurse assigned to that area to visually observe patients, perform formal observations and start treatment. This inquest did not identify the administrative staff and CIN and accordingly, no evidence was obtained by them as to whether they observed JX leaving the hospital.

JX did not return to the Emergency Department. At about 4:52pm (according to the RNSH CCTV footage) Mr Dyson left the waiting room looking for JX. He told staff at reception that JX had left. From 4.58pm, Mr Dyson called and sent text messages to JX to attempt to find out his whereabouts and ensure his safety.

At 5.03pm, Dr Thomas Uebergang, after consultation with Dr Ward, assigned JX‟s medical assessment to himself. He called JX‟s name twice but by that time, unbeknownst to him, JX had already left. He said that the ward clerk told him that JX had gone out with his friend to buy a drink. Dr Uebergang gave evidence that he called JX‟s name again about 15 minutes later but there was no response. He states that he may have asked the ward clerk whether there was a mobile telephone number to contact JX or Mr Dyson, which either they could not find or they had tried with no success.

As noted previously, Mr Dawson's card, which Mr Dyson states was provided to RN Curtin was not included in JX‟s RNSH medical records produced for the purposes of this inquest.

Dr Uebergang said he enquired of the triage nurse as to whether JX exhibited any sign of suicidal ideation or risk of self-harm, to which he was told *"No".* He said that, after discussing the matter with an ED Registrar (who told him that he had done all that he needed to do), he asked the ward clerk to mark JX on the system as "*did not wait".*

Staff at the reception desk told Mr Dyson that a doctor had called for JX. Mr Dyson left the hospital just before 5.30pm in a taxi and returned to the Carbon Reduction Institute to collect his belongings. He then headed to a local pub to meet with friends. He spent the evening attempting to locate JX via his mobile telephone.

JX travels to Kingsford and Maroubra

JX‟s precise movements after he left hospital are unknown. However, his bank records show that at about 6.45pm, he bought beer, whisky and cigarettes in Kingsford.

It is apparent that JX later travelled to Maroubra.

Mr Dyson and Mr Dawson attempt to locate JX

Between 4.58pm and 11.41pm, Mr Dyson made many attempts to contact JX and his friends and colleagues by telephone. After Mr Dyson told Mr Dawson that JX had left the RNSH before being seen, Mr Dawson also attempted to locate him and his parents by telephone. It is clear that both were concerned for JX‟s welfare and took steps to try and to ensure his safety.

Mr Dawson sent a text message to JX at 6.30pm. He let JX know that he had his and Mr Dyson's support. At 7.01pm, Mr Dawson received two text messages from JX which read: *"Hey. Might go sit on cliff and stare at the see"* and *"Sorry sea".*

Following this, Mr Dawson used Google to search for JX"s parent's phone number. Mistakenly believing them to live in Avalon, he searched for the family name in Avalon to no avail. At around this time he contacted Dr Gutkin and left a message. Mr Dawson states that Dr Gutkin called him later that evening and said that the best thing for JX was to get him to a casualty ward. Dr Gutkin otherwise had no involvement in the events of 21 January 2014.

At around 7.36pm, JX"s friend and colleague, Dean Redman, spoke to JX by telephone. JX told Dean that he had had a strange day, but *"everything is normal"* and he would not be at work the next day. Mr Redman reported this to Mr Dyson.

After numerous calls and text messages went unanswered, Mr Dyson was finally able to make contact with JX at 7.53pm. The call was of about four minutes" duration. Mr Dyson recalls the conversation as follows:

After several attempts JX took my call initially asking, "Who is this?" which I found odd given I was confident my number was programmed in his phone. My goal on this call which ended up being the last was to find out where JX was so I could go to him. The best I could determine was that he was most likely down towards his home at Maroubra. I determined this as throughout the conversation I asked whether JX was on the north or south of the Harbour and he said "South". I said "Oh so you're close to home then?" and JX said words similar to "Something like that". During the call he mentioned he was on the edge of a cliff. I told him I'd like to have a beer with him [to] which he replied that he was having a beer. After a bit of back and forth and doing the best I could to let him know everything would be okay, JX said "I fucked everything up". He then said "I am going to do the wrong thing" insinuating suicide. I was constantly trying to reassure JX that everything would be alright. I just wanted to find out where he was. JX ended up hanging up on me. I cannot recall the last words spoken.

Between 8.00pm and 8.05pm, the following text messages were exchanged between JX and Mr Dyson:

Dyson: *JX you're a great guy mate with plenty of friends including myself so would you please go home and either call or text me from there? Thanks Matt*
JX: *Shit happens*
Dyson: *Come on mate*
JX: *I hate everyone*

Dyson: *Let's have a beer. Where are you?*

Mr Dyson immediately reported the contents of his recent communication with JX to Mr Dawson in a text message which read:

Hi Geoff sorry to call and text you again but I just spoke with JX and in short he is now threatening suicide, more specifically jumping off a cliff because he's screwed everything up. I also know from the conversation that he's having a beer and he's down near home near Maroubra. Below is my text to him just now with which he replied „Shit happens" so I think a call to family is needed.
Thanks Matt

Mr Dyson missed a call from JX at about 8.20pm. He returned the call one minute later but that went to voicemail. At 8.22pm Mr Dyson received a text from JX which simply said *"Hello".* Despite Mr Dyson's continued attempts to contact JX he heard nothing further.

Mr Dawson was leading a meditation group between 7.00pm and 9.00pm. During a break at around 8.30pm he saw the text message sent by Mr Dyson advising him of his fear that JX was contemplating suicide. They each tried to make contact with the other and managed to do so at 9.03pm. At that point, Mr Dyson reiterated the contents of the text message and said that he had now lost telephone contact with JX and his calls were going to voicemail. Mr Dawson told Mr Dyson that he was going to call 000.

Mr Dawson then tried to call JX. He also got JX"s voicemail. He did not leave a message. He searched again on Google for JX"s parent's phone number and this time, managed to find a number which might have belonged to them; however, he got voicemail when he called it and did not leave a message because he was unsure whether it was the right number.

Mr Dyson calls 000

Mr Dawson called 000 at 9.16pm. He identified himself by name and occupation. He reported that JX was a 29 or 30 year old patient of his with a history of depression and schizophrenia who was taken to RNSH by his boss to be admitted in a psychotic state but he *"did a runner".*

He said that JX‟s boss had told him that JX was sitting on a cliff hear his home in Maroubra drinking beer and in the last conversation JX said he was feeling suicidal.

Mr Dawson provided his and Mr Dyson's name and contact details. He provided JX‟s name (emphasising that his surname was hyphenated) and JX‟s mobile telephone number. He did not know JX‟s street address.

Police search for JX

The information passed on by Mr Dawson in the 000 call was broadcast over the NSW Police Force VKG radio system and the NSW Police Force Computer Aided Dispatch (CAD) system at 9.27pm. Similar information was broadcast over both. The narration of the CAD log entry „Incident Header‟ relevantly reads as follows:

INFT HAS RX INFORMATION THAT CLIENT JX 29 OLD – PH:0000000000 IS SITTING ON A CLIFF FACE DRINKING BEER OVERLOOKING SEA – IN PSYCHOTIC STATE – FEELING SUICIDAL – PERSON OF INTEREST HISTORY DEPRESSION – SCHIZOPHRENIA – INFT HAS RX CALL FROM POIS EMPLOYER MATT DYSON [mobile number entered] WHO HAS BEEN IN CTC WITH PERSON OF INTEREST. PERSON OF INTEREST BELIEVED TO RESIDE IN MAROUBRA. IS POSS IN MAROUBRA AREA – NFI RE PERSON OF INTEREST LOC. CHKS OTW.

Despite the reference to JX possibly being in the Maroubra area, the CAD job was allocated to North Sydney, possibly because that was the location from which Mr Dawson had called or JX was last seen. It was also broadcast on the Rose Bay list instead of the Maroubra list, possibly because Rose Bay would encompass The Gap. Because of this, the early police response involved a number of Local Area Commands.

By 10.15pm (i.e. 48 minutes after the incident was broadcast on VKG and CAD), police had taken the following steps:

- At 9.28pm, a link to JX‟s CNI record was found and broadcast on CAD;
- At 9.29pm, police had searched COPS and found JX‟s last recorded address,
- being the Waterloo address.

- Constable Daryl Johnson, who was stationed at North Sydney, contacted Mr Dawson. Mr Dawson provided a physical description of JX. He said that he did not think JX was violent.
- Constable Johnson contacted Mr Dyson who provided him with information about JX"s presentation that day and him leaving the RNSH before being seen. Mr Dyson continued to make attempts to contact JX by telephone,
- without success, until 11.14pm.
- By 10.13pm, police were aware that JX"s last known address was in Maroubra. Constable Johnson with his supervisor, Senior Constable Stephen Bell, requested triangulation of JX"s phone.
- An "all resources" broadcast was made at 10.13pm.
- By 10.15pm, Rose Bay police were monitoring cameras at The Gap for any sign of JX.
- By 10.15pm, Acting Sergeant Ashley Callaghan of Maroubra Police (who was rostered on duty as the external supervisor) had arrived at the cliffs at Maroubra beach to look for JX.

Acting Sergeant Callaghan was notified of the incident by Inspector Stephen Egbers, the Duty Officer for Eastern Beaches Local Area Command, which includes Rose Bay and Maroubra. He was monitoring the Rose Bay channel for an unrelated matter. While monitoring that incident, he noticed the CAD message relating to JX. Confused as to why it did not appear on the Maroubra list, he monitored the message for a short time as it appeared that Harbourside LAC (which includes North Sydney) was making enquiries. At about 9.55pm, Inspector Egbers brought the incident to the attention of Acting Sergeant Callaghan and directed her to gather some police and arrange for a search of the coast line south from Mistral Point in Maroubra. He told her that police should start searching for JX despite there being no confirmation that JX was in Maroubra.

The area specified by Inspector Egbers is known by police as an area frequented by those contemplating taking their lives. Maroubra beach spans a reasonably large area of shoreline east of Marine Parade. To the north is the Jack Vanny Memorial Parklands which leads into the cliffs on the east side of the park.

The Arthur Byrne Reserve is situated to the west of the beach. At the southern end of the beach, there are cliffs which lead into the Malabar Rifle Range.

An area of cliffs on the southern end of the beach is known as Magic Point. Photographs of Maroubra beach, Magic Point and its surrounds show areas of steep cliff faces and scrubby bush. Unbeknownst to police at the time, JX would sometimes walk with friends to old, abandoned WWII bunkers at Magic Point.

On arrival at Maroubra beach, Acting Sergeant Callaghan asked police radio to check whether JX had any vehicles registered to him and was told that he did not. She proceeded to conduct mobile patrols around Marine Parade and the Jack Vanny Memorial Parklands, the latter using high beam lights on the police vehicle to search the cliffs on the northern end of the park.

After she heard the all resources job broadcast, she requested Eastern Beaches vehicles meet her to assist with a search.

A short time later, Constables Timothy Bujeia and Greg Adams arrived in one vehicle and Senior Constable Danielle Rogers and Senior Constable Tegan Smith in another. The Constables were directed to search the northern cliff top by foot. The others were directed to patrol further south including the beach and Arthur Byrne Reserve. Acting Sergeant Callaghan conducted a foot search easterly through the parklands to the cliffs and the Jack Vanny Memorial Park. She made enquiries of members of the public who reported that they had not seen JX.

By 10.36pm the searches by the Maroubra police had proved fruitless. Acting Sergeant Callaghan then directed Constables Bujeia and Adams to attend a Clovelly address to which JX was linked. They returned having found out that JX did not live there.

Police received the results of triangulation of JX"s mobile telephone at 10.54pm. It showed that JX"s mobile telephone was bouncing off the Village Green shopping centre on Malabar Road, Maroubra. The triangulation suggested that JX could be within 500m of that location. This was the first direct evidence confirming that JX was in Maroubra.

Senior Constable Bell contacted Acting Sergeant Callaghan and told her of the triangulation results. Responding to that information, Acting Sergeant Callaghan directed Constables Bujeia and Adams to search the southern end of Maroubra Beach, while she and other police searched other locations surrounding Maroubra beach.

While conducting a foot search of the south end of Maroubra beach, Constable Bujeia, on his own initiative, attempted to contact JX using his personal mobile telephone. JX answered at 11.14pm. Constable Bujeia told him that he was from Maroubra Police Station and asked JX to meet him so they could have a chat. They spoke for about 11 minutes while Constables Bujeia and Adams tried to work out where JX was. Although a precise location was never revealed, JX did say that he was near cliffs on the headland near the shooting range. JX, at one stage, said that he could see a torchlight (held by Constable Adams) and agreed to walk towards it. However, shortly after this JX"s mood seemed to change and he told Constable Bujeia that he was *"getting his things together".* He said; *"it just has to be done", "it's too late"*, and that he was *"going to end it"* or *"going to do it"*. Constable Buejia told him that *"nothing is ever that bad"* to which JX responded *"I have to go"* and hung up.

JX had told Constable Bujeia that he had been drinking whisky. Constable Bujeia later said that he sounded drunk and depressed.

The officer not unreasonably formed the impression that JX had suicidal intent and soon after told Acting Sergeant Callaghan and Inspector Egbers of this.

It was at about 11.25pm that JX terminated the call. Triangulation of JX"s mobile telephone shows that it was last active at 11.26pm, meaning that, at that time the telephone was either switched off or destroyed. Subsequent attempts by Constable Bujeia, Inspector Egbers and Mr Dyson to call JX went to voicemail.

Maroubra police continued their search and were joined by Inspector Egbers. However, they were restricted by the dangerous conditions facing them as they searched around cliffs at night time. A police dog who attended at about midnight also faced a similar difficulty; „Horace" had to be kept on a leash during the search as he would be unable to sense depth and could fall. Due to what Inspector Egbers assessed to be dangerous surf conditions he decided not to request the assistance of water police. His request for an air search by PolAir was met with the response that they were no longer on duty.

Further, evidence obtained in this inquest indicated that it could not have flown in any event due to the weather conditions. Inspector Egbers states that he considered whether to instruct police to conduct further searches but decided against it because he was satisfied as to the searches undertaken and because of the risk to officers" safety.

Inspector Egbers stayed at Maroubra beach until 1.00am on 22 January 2014. He then returned to Maroubra Police Station and conducted computer searches to locate JX"s current address. In his experience, searching with a hyphen can produce an inaccurate result. Inspector Egbers managed to find an address in Glebe and then located JX"s, Maroubra address on Roads and Maritime Services records. Inspector Egbers checked the address against the triangulation maps and saw that while it was outside of the area logged at 12.28am, it was within the area logged at 12.10am.

Inspector Egbers attended the Maroubra address at about 1.10am. He saw lights on upstairs but there was no answer to his knock. Other police attended the Glebe address at his direction with nil result.

Further triangulation showed that JX"s mobile telephone was still turned off at 3.30am.

Inspector Egbers shift was rostered to conclude at 6.30am. At a handover at about 5.30am, he instructed the incoming Duty Officer, Acting Inspector Daniel McKerrow, to conduct an air and ground search at the earliest opportunity after day break.

Those instructions were followed. Constables Dean Byrne and Kyle Thompson attended the Maroubra address at about 6.00am. They entered the residence (which was unlocked) and spoke to Nicholas Clark, who told them that he had not seen JX since the previous day. They inspected JX"s bedroom and saw that the bed was made and looked like it was not slept in. From about 7.20 am, Maroubra police continued searches of Maroubra beach and its surrounds. A request for assistance was made to PolAir at 9.41am. Polair was in the air and searching at 10.58am.

JX's parents are notified

The events of 21 January 2014 unfolded unbeknownst to JX‟s parents. It was at about 7.30am on 22 January that they first became aware of his disappearance, after one of JX‟s friends contacted them to advise that Maroubra police were looking for JX. The family then travelled together to Maroubra beach and Maroubra Police Station to make inquiries.

Mr Dawson contacted Dr Gaskin's rooms the following morning and obtained JX‟s fathers mobile telephone number. He called JX‟s father at about 9.30am and informed him of the situation. JX‟s father told him the family was already aware of the situation.

The death is discovered

At about 10.58am, PolAir 3 arrived and commenced searching around Magic Point and Maroubra generally. At 11.06am, PolAir officers sighted a naked body floating about 300 metres north of Magic Point, Maroubra

The investigation

The NSW Police Force initiated Strike Force Pavlo to investigate the circumstances surrounding JX‟s death. Detective Senior Constable Andrew Sheehy was assigned to that investigation.

Scene examination

Although searches on foot and by air were subsequently conducted of the land around Magic Point and Boora Point (to the south) no signs of any property associated with JX were ever found. The exact location from which JX entered the water is therefore unclear.

A police search of JX‟s bedroom relevantly found medication, including Altven and an empty Talisker whisky bottle. Nicholas Clark gave evidence that they collected spirit bottles to use as water bottles.

It is unknown whether the bottle found in JX‟s bedroom was that purchased by him on 21 January 2014. JX‟s body was identified by his mother on 23 January 2014.

Autopsy results

Forensic pathologist Dr Liliana Schwartz conducted a post-mortem examination on 23 January 2014 limited to an external examination, radiography and toxicological sampling. Following receipt of a Certificate of Analysis showing the results of toxicology screening, Dr Schwartz prepared a Limited Autopsy Report dated 3 June 2014. Dr Schwartz also prepared a letter dated 8 August 2014 addressing specific questions.

Dr Schwartz summarised the contents of her report as follows:

At autopsy, there was evidence of extensive multiple injuries including bruises and abrasions of the face, bruises, abrasions and lacerations of the trunk and limbs, and fracturing of long bones.

The x-rays taken from the skull and neck showed compound fractures of the calvarium and base of skull with possible frontal bleeding and possible fracturing of the upper cervical spine.

The toxicological analysis of the post mortem blood and ocular fluid specimens showed small amounts of alcohol and venlafaxine.

It was certified that alcohol (0.084g/100mL in the femoral blood preserved and 0.057g/100mL in the vitreous humour preserved) and venlafaxine (<0.05mg/L in the femoral blood preserved) were detected.

Despite the evidence that JX had smoked cannabis at the farewell party on 19 January 2014, no metabolites of cannabis were detected. Supplementary toxicology screening did not detect olanzapine or methylphenidate.

Dr Schwartz expressed the opinion that the level of venlafaxine detected was "*very likely below the therapeutic range*" and that the level of alcohol detected "*may have caused an increasing impairment of reaction times, visual acuity and judgment*".

In her report, Dr Schwartz concluded that JX died from multiple injuries. She supplemented this opinion in her letter, in which she expressed the opinion that if JX‟s head injuries were caused at the time of the fall from a cliff, the cause of death would be "multiple injuries".

If however, the injuries were caused during the peri- mortem or post-mortem period, then the cause of death would be "drowning complicating multiple injuries" because the other injuries would have incapacitated him causing the drowning.

Expert reports

The inquest received the expert report and oral evidence of consultant psychiatrist, Associate Professor Michael Robertson.

Associate Professor Robertson was asked to provide a report on the following questions:

1. ***Is cannabis, alcohol, Ritalin, Zyprexa (olanzapine) or Efexor (venlafaxine) and/or any combination of them, known to contribute to or cause a psychotic episode?***
2. ***Was it appropriate for Dr Kam Seng Wong to prescribe Ritalin to JX?***
3. ***Was JX in a psychosis or other altered mental state at any time on 21 January 2014?***
4. ***Were the actions of Mr Geoffrey Dawson on 21 January 2014 appropriate?***
5. ***Was the response of the Lower North Shore Mental Health Acute Crisis Team appropriate?***
6. ***Were the actions of staff at the Royal North Shore Hospital appropriate?***
7. ***Are there any recommendations that the State Coroner could make to prevent similar deaths occurring in similar circumstances?***

He was also invited to make any other relevant comments.

In answer to the first question, Associate Professor Robertson expressed the opinion that:
Of the listed medications, cannabis and methylphenidate are associated with induction of psychotic symptoms.

Excessive consumption of alcohol can exacerbate an underlying diathesis to psychosis and in some circumstances alcohol withdrawal delirium may be associated with psychosis. A rare syndrome, known as „alcoholic hallucinosis" is usually seen when there is an abrupt cessation of consumption of alcohol or reduction of alcohol.

Venlafaxine and other newer antidepressant medications have been associated with some psychotic symptoms, de novo (much of this evidence is anecdotal).
Antidepressants such as venlafaxine can induce mania or hypomania in vulnerable patients as part of a so-called „anti-depressant switch".

> *Olanzapine is an anti-psychotic medication and rarely contributes to psychosis unless there is a severe complication to treatment such as neuroleptic malignant syndrome.*

Associate Professor Robertson noted that whether it was appropriate for Dr Wong to prescribe Ritalin to JX is a *"controversial issue which could divide opinion".* He referred to the fact that Dr Wong was not availed of JX"s history of the psychotic episode in August 2011 (although I note that he was sometime after the initial prescription of Ritalin when he received Dr Murray's report). Importantly, he also notes that Dr Wong "*was able to justify the decision to use methylphenidate post hoc in that lived experience of JX"s use of methylphenidate was not associated with any destabilisation of his mental state or the onset of psychotic symptoms".* Associate Professor Robertson expressed some disquiet as to the manner of Dr Wong's second Ritalin prescription without clinical review. However, he formed the opinion that this did not *"necessarily deviate from a reasonable standard of care as Dr Wong had been quite thorough in identifying any potential side effects to therapy with methylphenidate."*

Associate Professor Robertson concluded that JX was, in all probability, amidst a psychotic episode at the time of his death. He gave oral evidence that:

Some severe mental illnesses, such as bipolar disorder or better prognosis forms of paranoid schizophrenia are characterised by an episodic clinical course. What is evident was that JX suffered an acute severe deterioration in his mental state in the period from 18 to 21 January 2014. The presentation was likely significant of an affective psychosis and the only factor that can be established was that he had consumed alcohol at the time of his death…
he had consumed alcohol habitually and… this may have been the permissive substance which accounted for the deterioration in his mental state. He also gave evidence that in light of the toxicology results, it was highly unlikely that
JX had consumed any cannabis.

Associate Professor Robertson had no criticism of the actions of Mr Dawson or staff at the RNSH Emergency Department. Indeed, he refers to the actions of Mr Dawson and Mr Dyson on 21 January 2014 as displaying *"a supererogatory commitment to JX"s welfare".* I agree with that assessment.

In relation to staff at RNSH, he noted that JX presented with an acute mental health crisis, was categorised appropriately (with the only alternative being JX having been admitted under the *Mental Health Act 2007,* which was not considered at the time). Save for JX being seen within the benchmark 30 minute timeframe for a category 3 patient, Associate Professor Robertson could not see how any other action could have brought about a different outcome.

Conclusions

Before proceeding to my conclusions, I pause to note that while JX"s family and at least some of his friends and colleagues knew of his previous psychotic episode and his ongoing treatment for mental health issues, his death was nevertheless unexpected. It is clear that his loss remains deeply felt by them. I extend to his family my sincere condolences for their sad loss.

There is little uncertainty about most of the matters on which findings must be made. The identity of the deceased, the place of death and its medical cause are clear on the evidence.

Because JX"s body wasn't found until the day following the incident it is not completely clear when he died. However, the evidence indicating his phone was switched off or destroyed a minute after the last call was terminated at 11.25pm on 21 January leads me to conclude that is when he went into the water.

I accept the submission that it is possible that JX was so psychotic that he did not intend to end his life when he went into the ocean. I am unable to reach a firm conclusion as to the cause of that psychosis.

However, having regard to the comments he made in his last phone conversation, I conclude JX did have sufficient presence of mind – cognitive capacity - to form the intention to take his life and that he put that into effect by deliberately jumping from the cliff-top at Magic Point.

There are however, other aspects of the circumstances of the death – its manner – which require more detailed analysis to determine whether they may have contributed to the death and/or whether they raise prevention issues which might warrant recommendations being made. I will deal those matters after recording my findings in relation to the particulars of the death.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased
The person who died was JX.

Date of death
JX died on 21 January 2014

Place of death
He died in Maroubra, NSW.

Cause of death
He died from multiple injuries sustained in a fall from height

Manner of death
JX intentionally caused his own death by jumping from a coastal cliff-top near Maroubra while suffering a psychotic episode.

Recommendations

Pursuant to s 82 of the *Coroners Act 2009*, Coroners may make recommendations connected with a death investigated at an inquest. This case raises a number of issues that warrant consideration from that perspective.

In particular:-

- Whether the staff member of the Ryde Mental Health Acute Team called by JX‟s psychologist responded appropriately to the information about JX‟s psychosis;

- Whether JX was treated appropriately when he presented at the emergency department of the Royal North Shore Hospital; and

- Whether police to whom JX‟s absconding was reported reacted reasonably in
- discharge of their duty to preserve life.

These issues naturally require consideration of the policies and procedures of NSW Health and the NSW Police Force, both in terms of assessing the adequacy of the actions taken and whether any improvements could be made.

The response of the Ryde Mental Health Acute Team

There is some inconsistency in relation to the precise details of the call by Mr Dawson to the Ryde Mental Health Acute Team. However, I accept he told the intake officer he had with him a patient who was psychotic and she told him the patient should be taken to an ED. There was some discussion about whether an ambulance should be utilised. I am unable to be sure as to what was said, but in any event I am of the view that the decision for Mr Dyson to take JX to hospital was reasonable having regard to the obvious rapport between them.

As detailed earlier, the intake officer who was called out of a hand-over meeting to take the call, made no note of its content and passed on no information to any hospital ED where JX was likely soon to be taken.

The NSW Health *Mental Health Triage Policy* in force at the time required, among other things, that the *Mental Health Clinical Documentation* triage module be completed whenever it is considered that a caller may need further mental health service intervention, including but not limited to admission to a hospital. One of the reasons for that is because that policy provides:

When a consumer has been asked to self-present to an emergency department, or is to be brought to an emergency department by police or ambulance, the triage clinician is to ensure that the emergency department staff are notified by telephone of the expected presentation and provided with a copy of the completed triage. The responsible local mental health team is also to be notified of the presentation.

This policy was not complied with. It seemed to me that the intake officer was not fully aware of her responsibilities under it: she could not otherwise adequately explain her failure to implement it.

The intake officer did not recall completing the mental health triage training program or equivalent training programs referred to in the Mental Health Triage Policy and required to be completed by clinicians undertaking the telephone triage function. Absent any evidence to the contrary, I conclude she had not been given this training.

Counsel Assisting submits that it is not possible to say the failure to follow the mandatory telephone triage procedures made a difference to the outcome; however, nor can the converse be dismissed.

I also accept the submission made on behalf of JX"s family that the gathering of clinical information by the Acute Team members by telephone could in many cases be critical to good risk assessment; effective triaging at the ED; and ultimately a good outcome.

The intake officer gave evidence that an electronic triage module has since been implemented. Her practice is now to complete the triage module while she is taking a call. That record can be accessed by staff at another part of the Northern Sydney Local Health District, including the RNSH Emergency Department.

The Clinical Director of the Lower North Shore Ryde Mental Health Service, Dr Nick O'Connor, wrote to the court advising that the relevant policies were to be discussed at a Ryde Mental Health Acute Team staff meeting and all clinicians were to be asked to acknowledge that they have read and understood them. This action, taken very late in the piece, may obviate the problem but I feel obliged to make a more formal response.

Recommendation 1- Training in telephone triage services

I am satisfied the existing policies for telephone triaging of mental health calls for service to the Ryde Mental Health Acute Team are sound and appropriate – the deficiency apparent in this case relates to their implementation.
That the intake officer who dealt with JX"s case did not appreciate even by the time of the inquest that she had failed to comply with significant aspects of relevant guidelines suggests that she is probably not the only intake officer who had an inadequate understanding of what is required in cases such as this.

Accordingly, I recommend the Chief Executive of the Northern Sydney Local Health District cause to be undertaken a training needs analysis of the intake staff members of the Ryde Mental Health Acute Team and address any identified gaps in knowledge of the relevant policies and procedures.

Response of the Royal North Shore Hospital ED staff

The triage category 3 given to JX‟s case soon after he presented at the RNSH ED was appropriate, having regard to JX‟s presenting symptoms and the limited history available to the triage nurse.

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The triage category meant that the benchmark for JX being seen by a doctor was 30 minutes after the triage commenced. That did not occur. JX left the hospital about 3 minutes after the 30 minute benchmark had passed and a doctor did not seek to see him until 5.03pm – 25 minutes after the expiration of the target time-limit and over an hour after he had presented at the hospital.

There is evidence that on the day in question, the ED was relatively busy. In the circumstances, I do not consider the failure for JX to be seen within the benchmarked time-limit indicates any inadequate performance by the staff involved or systemic failing at the hospital.

However, a policy directive current at the time, *Emergency Department Patients Awaiting Care,* lists as a mandatory requirement that*: All waiting patients should be regularly reassessed, particularly if they wait longer than the allotted triage category time* by the Clinical Initiatives Nurse in departments that have this position.

No re-assessment of JX‟s case was ever conducted, although, as noted above, he left the ED only three minutes after the target time limit expired and in the period he was at the hospital there was nothing observed by Mr Dyson or obvious on the CCTV vision that indicated that JX was in need to immediate attention. It is of some concern that his absence was not even noticed until the assessment time-limit target was well passed. There does not seem to be any policy in place at the hospital to operationalize the need to monitor and reassess mental health patients in particular as their wait to be seen by a medical officer is prolonged.

The circumstances of this case also brought into focus whether the hospital should have been more proactive once it became apparent JX had left without being assessed by a doctor.

In fact, in this case there was little they could have done and there is no basis to conclude that even had they alerted police or tried to contact JX directly a different outcome would have ensued.

Recommendation 2 – Re-assessment of mental health patients

As the mental health patient in this case was not seen within the target time-limit of his triage category, was not reassessed as that time limit approached and was exceeded and as staff in the RNSH ED did not notice for a further significant period that he had left without being seen by a medical practitioner, there is cause for concern about the efficacy of patient monitoring in the ED.

Accordingly, I recommend the Chief Executive of the Northern Sydney Local Health District cause to be undertaken a review of the implementation of policies in place at the RNSH ED for monitoring mental health patients awaiting psychiatric review.

Response by NSW Police Force

Police responded promptly to the 000 call indicating JX was suffering from psychosis and had absconded from the RNSH ED. Although the job was initially allocated to North Sydney and Rose Bay for action, it was soon identified as a matter warranting a response from Maroubra police and that occurred.

In view of the ultimate tragic outcome, it is understandable the family would query the wisdom of an untrained junior officer making telephone contact with the at-risk person, rather than having a trained negotiator involved from the outset.

I accept that the first priority was to locate JX and ascertain his situation. The best way to do that was to telephone him. It may have been advisable for the junior officer concerned to have sought in-put from a more experienced colleague but I do not consider his actions to have been unreasonable or unwarranted.

Nor do I accept that a negotiator should have been called out before the then current situation was established. I accept the evidence that the volume of similar matters that are effectively deescalated without harm to the persons involved indicates such a resource intensive approach would be impractical.

Further, although no expert evidence was received on the issue, having reviewed numerous cases in which trained negotiators have been involved, I am inclined to the view that the Constable who spoke with JX attempted to establish a rapport and sought to move him to a future focus as effectively as a negotiator would have in the limited time during which contact was maintained. I have no confidence that involving of a negotiator or a psychologist would have led to a different outcome.

I readily accept and appreciate the distress of JX"s parents that they were not sooner notified of the incident unfolding. They did not become aware of their son even being at risk until some 8 hours after his death and 10 hours after police were first alerted to his situation. I accept that police assiduously attempted to locate them. Part of the problem involved digital data searching challenges which are not something that the NSW Police Force can readily resolve. However, I do see merit in a voluntary next of kin register.

Recommendation 3 – Voluntary next of kin register

In numerous circumstances, ready access to contact details for a person's next of kin could enable police to more effectively preserve the person's safety and provide to the person's next of kin timely information they would want to know. Individuals would need to consent to information being disseminated in stipulated circumstances to nominated people and there would be technological challenges in storing and retrieving the data. However the potential benefits warrant the matter being further investigated in my view.

Accordingly, I recommend that the Minister for Police consider establishing a project team to investigate the benefits, costs and practicalities of such a facility.

24. 38053 of 2014

Inquest into the death of Jason William Rea finding handed down by Deputy State Coroner MacMahon at Gosford on the 26th June 2015.

Jason William Rea (born 15 February 1975) died on 5 February 2014 whilst en-route by ambulance from the M1 Freeway, near the Brooklyn Bridge, to Gosford Hospital, Gosford in the State of New South Wales. The cause of his death was the combined effect of Methylamphetamine Toxicity and prolonged restraint in a person suffering from single vessel coronary artery disease. The Methylamphetamine had been self- administered without the intention of ending life.

Reasons

Jason William Rea (who I will refer to in these reasons as 'Jason') was born on 15 February 1975. In February 2014 Jason resided in Woy Woy on the central coast of New South Wales. On 5 February 2014 Jason was the driver of a motor vehicle on the M1 freeway north of the Brooklyn Bridge that was involved in a collision. As a result Jason, and the occupants of the other vehicle involved, sustained serious injuries.

Notwithstanding the injuries he suffered Jason extricated himself from his vehicle and began moving towards the freeway. Persons nearby became concerned and restrained him until police arrived. Jason resisted the restraint. He was aggressive and confrontational. Jason was handcuffed and held face down with his hands behind his back. Shortly after paramedics arrived Jason went into cardiac arrest. Jason was subsequently declared deceased as he was being transported to Gosford Hospital.

Jason's death was reported to the Office of the State Coroner on 6 February 2014.

Role and Function of the Coroner

The Coroners Act 2009 (the Act) governs the role and function of a Coroner. The Objects of that Act are set out in Section 3 and include the jurisdiction:

(c) To enable coroners to investigate certain kinds of deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths, and

(e) To enable coroners to make recommendations in relation to matters in connection with an inquest

The certain kinds of death that a coroner is able to investigate are *reportable deaths*.

Section 6 defines a *reportable death* as including one where a person died a *violent or unnatural death* or under *suspicious or unusual circumstances.*

Section 35 requires that all *reportable deaths* be reported to a coroner.

Section 18 gives a coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or where the person who has died, or is suspected to have died, was ordinarily a resident of New South Wales.

Section 27(1) (b) provides that if it appears to a coroner that a person died, or might have died, in circumstances to which Section 23 applies then an inquest is mandatory.

Section 23 gives exclusive jurisdiction in respect of the investigation of certain deaths to Senior Coroners.

Section 22 (1) defines a Senior Coroner as being the State Coroner or a Deputy

The exclusive jurisdiction given to Senior Coroners includes the investigation of deaths that occur *as a result of or in the course of a police operation* (Section 23 (c)).

The primary function of the coroner when an inquest is held is to be found in Section

81(1). That section requires that, at the conclusion of the inquest, the coroner is to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

In addition to the matters to be determined in accordance with Section 81(1) in a case where a death occurs *as a result of or in the course of a police operation* it is important that the contribution of police action, if any, to the circumstances of the death be the subject of a full and public inquiry.

The Parliament requires that inquests in such circumstances be conducted so as to provide a positive incentive to police to ensure that their actions, in the course of the performance of their duties, are appropriate in all situations and to satisfy the community that those deaths that occur when police are involved are properly investigated. It is also in the interest of the police that such deaths be properly investigated so as to ensure that the officers involved, and police in general, are not the subject of unsubstantiated or malicious allegations.

Section 82 (1) of the Act provides that a coroner conducting an inquest may make such recommendations, as he or she considers necessary, or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths.

Issues for Inquest

Jason's identity as well as the date and place of his death were not issues of controversy at the inquest.

Jason's mother, Jacqueline Norma Rea, identified his body at the Department of Forensic Medicine, Newcastle on 7 February 2014. I am satisfied that the evidence discloses that the person involved in the incident on the M1 Freeway on 5 February 2014 was Jason William Rae.

The evidence is that Jason, having crawled out of his vehicle was unable to stand because of a fractured left leg/ankle. He became aggressive towards bystanders and appeared to be delusional. He was restrained firstly be bystanders and then by police. He was handcuffed. A decision was made to sedate him however before this had occurred he became limp and went into cardiac arrest. CPR was commenced by ambulance officers' and continued until his arrival at to Gosford Hospital.

On arrival at Gosford Hospital he was found to have bilateral air entry but no cardiac output. His pupils were dilated and non-reactive. He was declared deceased soon after arrival in the Emergency Department. I am satisfied that it is more probable than not that Jason died en-route to Gosford Hospital.

As a consequence the issues for inquest concerned the cause and manner of Jason's death and the contribution, if any, of the actions of police officers, and others, to the death. To assist me in determining this matter I had available an extensive, and well-constructed, brief of evidence prepared by the officer in charge of the investigation of Jason's death, Detective Inspector Grant Taylor, and heard oral evidence from Detective Inspector Taylor and fourteen other witnesses.

The Evidence

The evidence assembled shows that Jason had a troubled adolescence and got into trouble with the law from about the age of twelve. The matters that resulted in Jason coming before the Courts, both as an adolescent and as an adult, were those that are commonly associated with illicit drug use. By 2014 Jason had been using Amphetamines for many years and this adversely affected his mental health.

One of Jason's partners described Jason's state of mind when he was on amphetamines as follows:

Jason would get paranoid when he used 'gas' (amphetamines). The more 'gas' he used the more paranoid he would get. When Jason was paranoid he would always say that people were following him. He did not say who exactly. Jason would also get paranoid when I used my phone as he thought I was telling people where he was. He would always want to walk through the door first before me to make sure I was safe and he would always keep looking out windows all the time to see if people were following him. Jason would also say things that did not make sense. I remember he would say the word 'Nimitz' and 'deployment.' It sounded like army stuff that made no sense. Jason would also flap his arms about in jerky movements when he was paranoid.

Evidence also showed that when Jason was using amphetamines, alcohol or other drugs he could become violent. In 2010 he was convicted at Coffs Harbour Local Court of Common Assault and Assault Occasioning Actual Bodily Harm (2) following an incident in which he assaulted his de-facto and his daughter after a lengthy session of alcohol consumption.

In March 2013 at Gosford Local Court he was again convicted of in respect of further acts of violence.

In the period immediately prior to the events of 5 February 2014 Jason's life was out of control. In 2013 he had commenced a relationship with a Michelle Stoken. She described Jason's drug use during the course of their relationship as follows:

I first met Jason Rea about ten months ago at the Ettalong Hotel playing the card machines. I was using speed at the time and asked Jason where I could get on. Jason helped me score some speed.

I was using speed about once a week and Jason probably three times a week. We were both shooting it up. Sometimes Jason would be on the gear for a full week. Four months after going out I broke up with Jason and went into a rehab place at Canton Beach, Toukley. We broke up because of Jason's drug use. I wanted to stop it but I knew that Jason couldn't.

When Jason was using he was in a mess, by that I mean that he would often start talking about spun out shit. Saying stuff like he was 'trying to work out who the enemy was' and paranoid that people would be talking about him. When he was sober he was a completely different person.

Jason's mother, who was a continual witness to the cycle of Jason's life summed up to investigators Jason's situation in the period prior to 5 February 2014 as being *'controlled by his addiction to narcotics'* and that he '*was spiralling downwards and out of control.'*

Jason's actions immediately prior to 5 February 2014 followed a similar pattern of illicit drug usage and associated criminal activity. I do not need to go into the events in detail other than to note the following:

- Jason was described by people who knew him as being affected by drugs,
- Jason, whose only lawful source of income was the Newstart pension, was suspected to have been involved in the theft of a safe containing $15,000 and a rare coin collection worth about $200,000 form a property at Umina Beach,
- Shortly after the theft at Umina Beach Jason paid $2,000 in cash for a silver Ford Falcon motor vehicle,

- When Jason attended the Roads and Maritime Office at Woy Woy to register the car his demeanour was described by a witness as being: *I thought he was drunk by the way he was acting. The guy appeared to be on edge and was talking fast and he made me nervous because he just didn't seem normal.*

- On 4 February 2014 Jason, and a friend, travelled to Sydney where he was in contact with a person who was suspected by police to be a drug dealer. Jason also attended the Westmead Hospital and whilst there asked his friend to purchase needles for him,

- Jason returned to the Central Coast later that evening and went to his mother's home. Jason's mother described his demeanour at the time as follows:

- *Jason appeared to be hyperactive again and was pacing back and forth. He had gotton up a number of times and was opening and closing doors. He was turning lights on and off and moving about the house continuously. It was getting late in the night and I wanted to get some sleep but couldn't sleep if Jason was going to be opening and closing doors all night. I believed that Jason had used drugs again due to his behaviour and mannerisms.*

- Jason subsequently left his mother's home and at about 22:30pm, with a female friend, Jason attended the home of an acquaintance who he gave$2000 in cash for him to look after. The acquaintance thought that Jason was drug affected at the time.

- Jason, and his female acquaintance, then attended the McDonald's outlets at Woy Woy (04:12am on 5 February 2014) and subsequently Wyoming. Sometime later Jason then went to his mother's home and had breakfast with her. He then left her home at about 09:00am on 5 February 2014.

- Jason then returned to his friend's home and retrieved the $2000 he had asked him to mind for him. He was once again with the female friend that he had been with the previous night. The investigation has shown that Jason and his female friend then travelled to the Westfield complex at Tuggerah.

- Whist at Westfield Jason made a phone call to the person, who he had called the day before, who was a suspected drug dealer. Having done so Jason then travelled to Sydney.

- At 2.00pm he again called the suspected drug dealer from a location near that person's residence in Wentworthville. It is believed by the investigators that Jason then obtained Methylamphetamine.

- Jason then drove to the Prospect Hotel in western Sydney where he and his female friend checked into a room for one night. Sometime later Jason left his female friend for a short time. She described him as being different when he came back. She said: *Jason left me in the bar. I'm not sure where he went, but he came back about twenty minutes later. When Jason came back he was different. It is difficult to describe, but he had this black evil look on his face and in his eyes. I was scared. I have seen this look before and it was the same look he had when he pulled me off his bike. I did not see Jason use any drugs, but he had used something*.

- Jason then decided to leave the hotel. His friend said that she had become scared of him and hid. Jason searched for her until he was told by the manager to leave the hotel. He then left. The manager described Jason's demeanour as follows:

- *From the very first moment I saw this male person get out of the car I formed the opinion that he was heavily affected by something. During my interactions with him I formed a stronger opinion that he was drug affected and appeared to be suffering from mental health issues.*

- Jason drove out of the hotel car park by himself at 17:52.

- At 18:35 Jason was in South Toongabbie and made a phone call to another person who was known by police to be a drug dealer.

- At 18:49 Jason phoned his ex-girlfriend Michelle Stoken. Stoken records that during the conversation Jason told her *that police and detectives were looking for him and following him.* Stoken described Jason as being *paranoid.* She suggested that he return to the hotel and get some sleep.

- He replied that he could not do so as: *That was red hot there and police would get him for sure.* Stoken told investigators that: *He sounded like he hadn't had any sleep. I got the impression he may not have slept for about six days.* Stoken had some further contact phone with Jason after that but then lost contact.

- Jason then appears to have decided to return to the Central Coast. At 19:36 CCTV situated at the Mount White Heavy Vehicle Checking Station captured a vehicle that fit the description of Jason's vehicle travelling north towards to Central Coast on the correct side of the road.

- It would seem that Jason travelled towards the Central Coast and then, for some unknown reason, turned around and began to travel south in the direction of Sydney.

I have recited the above history to record Jason's erratic behaviour in the period leading up to the circumstances of his death in order to show that Jason was drug affected for an extended period and that the effects of his drug use were apparent to those with whom he came into contact and, over time, became more pronounced. It is also clear that by the time Jason commended his journey to return to the Central Coast he appeared to have become both paranoid and delusional. The investigation established that Jason was not the subject of a police attention at the time although it is clear from what he said to Stoken that he believed he was.

The Motor Vehicle Collision:

On 5 February 2014 the Roads and Maritime Services (RMS) planned to undertake road works on the M1 Freeway. At 19:45 RMS employees had placed witches hats and signage just before the work which reduced the speed limit to 40km/h. The Witches hats started about a kilometre before the Jolls Bridge.

Jason drove across Jolls Bridge at about 20:18. He was observed by a witness, Fred Hendricks, to be driving erratically. Mr Fredericks told investigators that: *It looked like the vehicle turned off its headlights immediately before it reached the workmen – the workmen were scrambling out of the path of the car and jumping into the side barriers lining the road itself.*

One of those workmen, Troy Laws, described what happened:

As soon as I saw the silver falcon, I ran up against the guard rail closest to lane one, the car swerved directly at me missing me by no more than half a metre. The car then swerved back towards Gavin who was standing in the middle of lane one about five metres in front of me towards the bridge, the car missed Gavin by about the same amount as me.

Jason then continued south towards the Hawkesbury River Bridge. He was observed by Gregory Illingworth, who was driving towards Sydney, when Jason accelerated past him down to Mooney Mooney towards the Hawkesbury Bridge. Mr Illingworth described what happened next in the following terms:

As the sedan approached the left hand exit lane near the bottom of the hill which gives access to the Old Pacific Highway, the sedan seemed undecided as to whether or not to take the exit lane or stay in the left lane of the freeway, and hence it was slowing. As the sedan approached the exit alternative the sedan steered straight towards the divider that separates the exit from the freeway. At the last minute the sedan suddenly swerved right, back onto the left lane of the freeway.

Mr Illingworth then continued across the Hawkesbury Bridge with Jason's vehicle ahead of him. Jason then did a complete U-turn and began to drive his vehicle to the north towards the vehicle driven by Mr Illingworth. Mr Illingworth described what happened in the following terms:

When perhaps a third of the way up that long hill, still in the right lane, the sedan braked hard and then, incredible, took the full width of the freeway to U-turn anti-clockwise and then come, accelerating flat out, with its headlights on high beam, straight towards the front of my car. That was the most heart- stopping moment of my fifty six year driving experience.

Megan Simmons, at the same time, was also travelling south bound on the M1 nearing the Hawkesbury Bridge. She described her experience as follows:

I realised that there was a vehicle travelling on the wrong side of the motorway in my direction. I thought it was either a police car or the driver of the vehicle had made a mistake. I stayed in the middle lane and slowed to about 80km/h.

The vehicle continued to travel in the right lane building up speed as it got closer it moved into my lane, the middle lane. When I saw this I thought that the driver was doing this deliberately to crash into my car. The vehicle got closer to my car I could see that the vehicle was a light coloured sedan. I realised that if I did not move the vehicle was going to crash into my car. I suddenly moved into the left lane. I did not have time to check if there were any vehicles travelling in the left lane – the vehicle passed me in the middle lane. I continued in the left lane. I slowed down to about 70km/h and watched the vehicle in my rear view mirror. I saw the vehicle deliberately try and hit the cars that had been behind me.

Shortly after this Jason stopped his vehicle and witnesses said that they thought he may have been going to turn around and travel in the correct direction. This was however not the case.

He, in fact, crossed to the north bound lanes and began to travel south on the wrong side of the freeway travelling down the hill towards the Hawkesbury Bridge during which time he narrowly missed a number of vehicles.

Shortly before this the O'Donnell family had completed a family dinner at the Mooney Mooney Workers Club. The family were from the Central Coast area of New South Wales and had other family members at the dinner who were from Sydney and Western Australia.

Christine O'Donnell had driven from her home on the Central Coast with her sons Benjamin and Andy, and Andy's wife Stephanie. Andy and Stephanie were from Western Australia. Christine was the designated driver and had not consumed any alcohol at the family dinner. They left the car park of the Club at about 20:20 with Christine driving, Benjamin in the front passenger seat and Andy and Stephanie in the rear seats.

Ms O'Donnell drove onto the Old Pacific Highway and then onto the entry ramp of the M1 freeway northbound. She travelled along the merging lane increasing her speed to about 85km/h in order to merge onto the M1. She described what happened as she began to merge onto the freeway as follows:

I saw some headlights facing towards me in the distance in the same lane as me coming towards me. I couldn't believe the car was travelling in the wrong direction going faster than what I was travelling. The car beside me braked so I was to move over into the second lane to get out of the way of the oncoming lights.

As I swerved across, the other car approaching me mirrored my actions and was coming straight for us.

Mark Porter, a member of the Rural Fire Brigade, was travelling north on the M1 at the time. His description of the events that followed was clear and precise. He said: *I had just hit the deck of the bridge, I was in lane one of three, travelling at 110km/h. There were no cars travelling in front of me on the motorway. I saw a Holden Captiva driving on the looping section of the ramp towards the merging lane, it was travelling slowly. I would estimate it was travelling about 80-90 km/h. I moved into lane two so that the Holden Captiva could merge safely.*

I was two thirds the way across the bridge when I noticed a set of bright lights. The lights were on the left hand side of the north bound lanes, about 100 metres north of the bridge where the road starts to rise to travel up the hill.

The lights were very bright. I initially thought that a road work crew had set up a spot light facing in the wrong direction. The lights were stationary for a couple of seconds then the lights started to move slowly. I realised that it was the headlights of a motor vehicle.

The vehicle was travelling south in the north bound lanes. Because the vehicle was moving slowly I thought it was a roadwork vehicle. The vehicle accelerated harshly, I know because the angle of the headlights changed moving upwards as the front of the vehicle went up. I believe this is when the driver of the vehicle would have first seen me. At that time the Holden Captiva was in the merging lane, there was a slight left bend at that section of the road which may have prevented the driver of the Holden Captiva form seeing the vehicle.

The vehicle was accelerating rapidly in the left lane leading towards me. I checked my rear view mirror and saw that there was a semi-truck travelling behind me. I started to tap my brakes to warn the semi-trailer driver that something was wrong and that I may have to stop in a hurry.

I looked forward. The street lights had illuminated that section of the roadway. The Holden Captiva had just merged onto the motorway and was now travelling in lane one. I saw that the vehicle that was travelling south was a grey BA Ford Falcon sedan and that it was going to crash head on into the Holden Captiva. I braked heavily and stayed in lane two.

The driver of the Holden Captiva turned right trying to avoid the collision. The Ford Falcon did not make any attempt to avoid the collision and it crashed head on into the Holden Captiva, on impact I saw white powder come out of both vehicles, which I believe was when the airbags were deployed. The back of the Holden Captiva was lifted off the road. It was pushed backwards towards the merging lane. The Ford Falcon rotated slightly sideways and stopped blocking lanes two and three. As the cars separated the engine bay of the Ford Falcon caught on fire.

The above events were dramatically captured by a video recording, which formed part of the evidence, from a vehicle travelling behind Mr Porter's vehicle.

As a result of the collision members of the O'Donnell family received significant injuries, some of which were life threatening. Some members of the O'Donnell family were trapped within their vehicle and required rescue personnel to extract them in order to render adequate medical aid. Christine O'Donnell was taken by helicopter to Royal North Shore Hospital at St Leonards in a critical condition.

Mr Porter also observed what happened to Jason. He said:

I heard the male in the Ford Falcon he was screaming and yelling. I started to move towards the car. There were a number of bystanders near the Ford Falcon they were yelling at the male. The male was banging on the inside of the Ford Falcon. It sounded like he was hitting the centre console and dash board. I thought that he was trying to get out of the vehicle. The male was aggressive. I could not determine what he was trying to say but I remember that he was swearing. Other bystanders and I were yelling at the male telling him to stay in the car. I was concerned that he was going to get out of the vehicle. I formed the opinion that the male was drug affected due to his behaviour in the vehicle and the manner of driving. I was concerned that he was going to get out of the car and that we would not be able to control him because he was way too angry and aggressive.

Mr Porter phoned his supervisor in the RFS and asked that police be called as at the time Jason was *going off his head*. Mr Porter then assisted the O'Donnell family members. Shortly after that Mr Porter looked over towards the Ford Falcon. He noticed that Jason was out of his vehicle and was moving towards the carriageway of the freeway. He went on to say that:

A couple of male bystanders, I think that one was a road worker and the other was possibly a truck driver, they grabbed the male driver and held him face down on the ground. I don't know how they got him on the ground. I am not sure how they were holding the male down. They were positioned towards the male's back. The male was struggling with them moving and trying to get up from the ground.

Ryan Fisher was a traffic controller who left the north bound road works further along the M1 and travelled to the crash scene. He approached the Ford Falcon and observed what was occurring. He described it as follows:

While I was standing there the driver was attempting to reach across to the glove box. The airbag was deployed and I could not see the glove box. When he did this I moved back as I was concerned about what he was trying to get from the glove box. I thought he was drug affected; he was restless scratching his arms and head. He would continually rub the top of his head. He was rambling and saying I've done nothing wrong. The Emergency Traffic Control vehicle (ETC) arrived at the scene and commenced setting up.

A 4WD Ambulance vehicle arrived first with it and had its red and blue warning lights activated.

I noticed that, when the Ambulance arrived, the driver's behaviour changed, he became more agitated and aggressive in his movements. He was trying to get out of the vehicle by pushing up on the central console, the driver's door and the steering wheel. He said 'Get me out!'

I said to the male with the English accent, to go and get the Ambulance officer to turn off the flashing lights because it was making the driver 'hyped up', agitated and aggressive. The Ambulance officer turned the flashing lights off, when he did this the driver calmed down.

When more emergency vehicles arrived; Jason, once again, reacted to them by becoming aggressive and agitated. He got himself free and left this vehicle. Mr Fisher saw this and described what then happened. He said:

The driver was able to get out of the vehicle; he put his right leg on the ground and then attempted to stand on his left leg. I noticed that his left leg was broken, the bone was at an off angle and his foot was moving freely.

The driver fell to the ground and rolled onto his back. He said 'Fuck, my ankle.'

Shortly after that police arrived. Jason then became more agitated and aggressive. Mr Fisher observed a police officer approach Jason who said *I'm on fire, I'm on fire*. The police officer said to him *No you are not, calm down*. At which point Jason started swinging his arms and legs around and repeating himself about being on fire.

Intervention by Police:

All police officers involved in the incident gave evidence at the inquest. I do not propose to recite their evidence in these reasons as it was in accordance with the evidence of the lay witnesses who observed the events that occurred following the police intervention. I will, however, outline those events through the words of the lay witnesses.
Mr Fisher's evidence was as follows:

Myself and another person I don't know who this person was stood near the driver. The driver was lying on the left side of his body, his chest and back was off the ground.

The first police officer was standing behind the driver and the officers legs were near the drivers back. I was standing with my legs on one side of the driver and another person was standing opposite me.

We were trying to stop the driver from kicking his legs around and hurting himself. The driver swung his right arm across his body and hit the first police officer's legs. The police officer told him to stop.

The driver swung his right arm again and hit the first police officer in the leg. The first police officer bent down into a squatting position. He had his body next to the driver and attempted to grab hold of the driver's right arm. The driver kept swinging his arm around and the police officer was unable to grab hold of the arm. The first police officer put one of his knees on the ground next to the drivers back, his other leg was parallel behind him and his chest was resting on the right shoulder of the driver. The driver was moving his body around and struggling with the first police officer. The first police officer repeated 'Calm down, calm down stop resisting.' The driver's legs were moving around.

So I put my left knee on both of the driver's knees to stop him moving about. Another male put his knees on the lower part of the driver's legs. I told that person to be careful of the driver's ankle. A third male was near me, he was trying to help the first police officer. I could not see what this person was doing.

The evidence is that eventually Jason was handcuffed behind his back and was lying on the ground on his stomach. The police used two handcuffs, one on each wrist, and then the handcuffs were joined together. Jason, however, continued to struggle and lash out at those around him.

Mr Fisher expressed his view of the actions of the police as follows:

When the police officers were dealing with the driver they were calm and controlled in their actions. They only used their body weight to restrain him; at no time did they strike or hit the driver. I thought the level of force the police used was reasonable as they were just trying to restrain him for his own safety. It was clear that he was trying to get up and move away.

Ms Robyn Collins, and her husband, were travelling north on the M1 at the time of the collision. They stopped their motor vehicle. Ms Collins described what she saw as follows:

I saw people around him trying to hold him down, because he was thrashing around uncontrollably and appeared to be very aggressive.

I immediately thought that he was on some kind of illicit drugs because he seemed so strong and powerful and making it difficult for the people around to hold him still and calm him down. I cannot recall who the people were trying to calm the driver down, but I know I saw high visibility vests on them.

The driver continued to scream out he was burning, and continued to thrash around aggressively. The people trying to calm him down were having a very hard time, trying to control him.

Ms Lana Middleton was also a person who stopped at the scene of the collision. She described what she saw as follows:

Based on my observations of the male's movements and general behaviour and speech, I drew the conclusion that he was having a psychotic break. He was quite manic.

I next looked across to the male who, at that point in time, was lying face down on the roadway. I saw that there were now five police officers with the male. Four of these officers were positioned around the upper body of the male driver, with all officers either kneeling down or crouching over the male driver and using their upper bodies to hold the make driver in place on the road. I couldn't see where their hands were.

I heard the police officers talking to the male driver but can't recall what was said to him. I can recall that they appeared to be trying to calm him down and their tone of voice was reassuring and not forceful or aggressive in any way.

John Swan was an employee of Tropic Asphalt and was preparing to start work on the northbound lanes of the M1 north of the collision scene. He attended the scene. He gave an extensive statement as to what he saw. The following sums up his observations of the actions of Jason and the police:

I saw that there was a small blond female police officer helping to hold down the male driver and I saw him throw her off him.

When the Police Officers were holding the male driver down, I did not see any of them punch or kick the male driver. I did not see any Police Officer be excessive with the male driver and I thought they treated him with care.
When the Police were trying to restrain the male driver they were only using body mass. He was throwing the Police Officers around and they were just holding him down.

The evidence of other lay witnesses who observed the events was generally consistent with that outlined above.

Intervention by Paramedics:

Lee Matthews was working with the road works north of the crash site. He attended the site and provided the police with his observations. He was there when police were restraining Jason and a paramedic was *standing nearby trying to look over the police at the male. It appeared he was trying to assess the male's condition.* Mr Matthews said:

I saw the male on the ground stop trying to wrestle with the police and he went limp. One of the police officers felt the male's neck, and then the police rolled him straight over onto his back. A female paramedic began Cardio Pulmonary Resuscitation (CPR).

James Blackwell was the Deputy Fire Captain with the Rural Fire Service. He responded to the crash site. He described his observations in detail. He sought to assist the police to restrain Jason. He observed the action of the police and paramedics who were involved. He said:

The male was still struggling with us when the Paramedics walked over to assess the scene. I recall at least one of the Paramedics who walked over to us being male. The Paramedics started speaking with one of the male police officers, explaining that they needed to access a vein on the male to insert a needle. I cannot remember the name they referred to the actual needle. I thought that they might need to sedate the male to calm him down he was too dangerous and aggressive to let go of. I did not know how else they were going to be able to assess his condition if he remained thrashing around and acting so aggressive.

I watched and heard the Paramedic decide to try and access the male's right forearm. Each time the male tensed and attempted to struggle out of our grip, the veins in his forearm pumped up. The same Paramedic yelled out to someone nearby that he needed more light, because he couldn't find a vein. Ian Wells … got his torch out and shone it down on the male's body.

The male Paramedic waited poised with the needle above the male's arm. During one of the occasions the male attempted to break free from our hold on him, the Paramedic inserted the needle into that forearm.

The Paramedic also taped up the needle to secure it to the male's arm. This entire time, the male continued to struggle and yell out, he never stopped, I just cannot explain how he had the energy to do so; it was so unnatural.

It seemed like only a few seconds (approx. 10) after the needle was placed into the males arm, that he stopped struggling and yelling out. I was relieved at the time, because I thought he had given up trying to escape. I eased my grip on his legs, but maintained contact with him, just in case he was getting ready to start again.

Jeremy Morris was the Deputy Captain of the Rural Fire Service who attended the crash site as part of the emergency response. He was observing the actions of the police and paramedics. He stated that:

I saw two Ambulance officers one was male and the other a female. The male was still face down in the same position on the road. There were 3 police officers now holding the male and Jim was still helping hold the feet of the male on the ground. The two Police officers that had been holding the right shoulder and torso had moved back to allow the Ambulance officers some room. The Ambulance officers had a kit bag it was about a foot and a half long and was red. The male ambulance officer was on his hands and knees beside the male on the ground. The Ambulance officer had hold of the man's right arm and it looked like he was putting a line in. It was not a syringe it looked like a line that they would use for fluids. The line was at the back of his right forearm. The female Ambulance officer was reading out dates to the male Ambulance officer. I do not remember what those dates were. One of my RFS crew Ian Wells was standing beside the female Ambulance officer with a torch shining it in the vials for the Ambulance officer.

Ambulance Officer Stuart Billins was the first Ambulance officer to arrive at the collision site. He was working as a solo ambulance officer at the time. He had been a Paramedic for more than nineteen years. He was a qualified intensive care Paramedic and Special Operations Responder. He arrived shortly after the collision.

Mr Billins approached the car in which Jason was. He said that: *I saw a male person sitting in the driver's seat.*

As I approached, I saw him throwing his arms in a frenzied fashion, screaming out and appeared to be behaving in what can only be described as 'Psychotic.' He was so aggressive.

I asked them to restrain the male driver of the silver sedan. He was screaming and I believed he was too aggressive for me to treat at this point of time.

Mr Billins then attended to the needs of the O'Donnell family who he believed had priority because of the injuries that they had suffered.

When Ambulance Duty Operations manager Greg Wiggins arrived on scene Mr Billins was asked to attend to Jason. Mr Billins outlined what happened after that as follows:

Officer Wiggins directed me to assist with the treatment of the male driver of the silver sedan. He requested that I use some Midazolam (sedative) for patient management. The male was still acting in an aggressive manner and was combative towards the police and Paramedics nearby. I could still hear the male screaming and yelling out at everyone as I approached.

As I got closer I saw Paramedic officer Mark Lanning with the male driver. The male driver was lying face down on the roadway with handcuffs on his wrists. I did not take much notice of who was standing around because he was still moving around. I asked Officer Lanning for an update on the male's condition so that I could assess the appropriate ongoing treatment. Mark stated that he had cannulated the male patient. At this point I noticed the male patient stop yelling and thrashing about. Mark and I rolled the male patient over onto his back and Officer Carol Bryan came over to assist. I think that Carol checked for a pulse. The patient was in cardiac arrest.

Paramedic Mark Lanning was one of the ambulance officers attempting to care for Jason. He was the ambulance officer who inserted the cannula into Jason's arm. His evidence was that:

From the time I arrived at the patient to the time I inserted the cannula it would have been about 4 to 5 minutes. As I was completing the tape for the cannula, a female voice said something like 'Is he breathing?' There was no indication the patient went limp so I said 'Everybody off.' The officers removed themselves slowly form the patient just in case he started thrashing again. The patient wasn't moving as the police officers stood up.

Paramedic Carol Bryan was working with officer Lanning. She said that:

While Mark inserted the cannula, I prepared Midazolam. I was required to focus on the drug kit to do this, so I was concentrating on drawing the drug and briefly took my focus off the male. While I was measuring the drug dose, I heard Mark say, 'He's Code 2 (Cardiac Arrest), get the stretcher'. I dropped the drugs back into the kit and ran over to get the stretcher.

At this point Officer Lanning described what he did then as follows:

I rolled the patient over onto his back with some assistance of others. It was only at this time I saw that the patient was in handcuffs with 2 sets locked together. I looked at his face and there didn't appear to be any signs of life. His eyes were open; there was no chest movement or response what so ever. I said, 'He's gone code 2, he's not breathing.

Ambulance officers thereafter performed CPR and applied other attempts to resuscitate Jason as he was transported to Gosford Hospital. They arrived at the hospital at 21:46 where hospital doctors continued those efforts. Unfortunately the efforts were to no avail and Jason was declared deceased at 21:58 on 5 February 2014 by Dr Martin Pallas, a member of the emergency staff, at Gosford Hospital.

Cause of Jason's Death:

Following Jason's death his body was transported to the Department of Forensic Medicine at Newcastle where an autopsy was performed by Dr Brian Beer a senior staff specialist in Forensic Medicine. Dr Beer prepared a report setting out his findings during that examination and his conclusions as to the cause of Jason's death. Dr Beer also gave evidence at the inquest.

At autopsy the pathology summary identified by Dr Beer was as follows:

- *Upper one third sternum, right anterior 4-6 rib and left anterior 3-5 rib fractures,*
- *Focal mild central Mediastinal haemorrhage, and 50ML of Haemorrhage in each of the right and left pleural cavities,*
- *Lung congestion, acute pulmonary oedema and focal intra-alveolar haemorrhage,*
- *Focal superficial fresh haemorrhage in the subcutaneous soft tissues in the small of the back,*
- *75-80% narrowing by stable athermanous plaque in the left anterior descending coronary artery,*

- *The toxicology showed massively raised Methamphetamine (Methylamphetamine) levels (greater than 10MG/L, 7.4ML/L in two separate specimens), with low levels of Amphetamine (a metabolite of Methamphetamine) and Midazolam, there was no alcohol detected,*

- *Fractured lower left Tibia and Fibula (non-compound) with associated haemorrhage in adjacent soft tissues,*

- *Wide spread abrasions; face, arms and legs, with facial abrasions very marked,*

- *Diagonal and lap seatbelt abrasions and bruising,*

- *Wrist abrasions consistent with handcuff marks, and*

Relevant negative findings: normal anterior and posterior neck dissection, no evidence of head injury, no external skin bruising on the back.

Dr Beer commented that, from a forensic pathologist's point of view, the case was a complex and difficult one. He said that there were aspects of the case that were contentious and open to differing views and interpretations.

There were a range of potential causes of death without definite evidence that any of the causes either alone or in combination caused the death. In addition he considered that the likely mechanism of death was a physiologic one without morphological findings.

In summary Dr Beer opined that there had been a complex interaction of drug toxicity, natural disease, restraint, and possibility respiratory compromise resulting in the death.
As to the relative contribution of the various factors (drug toxicity, coronary artery disease, the restraint process and respiratory compromise) Dr Beer considered that these were open to debate and that there would be differing views amongst forensic pathologists.

Dr Beer considered, however, that the contribution to the death of respiratory compromise both from the chest injuries and the period of restraint in the prone position was of a low magnitude in comparison to the factors leading to the fatal arrhythmia.

Dr Beer recommended that the cause of Jason's death was due to the complex interaction of:

a) Acute methamphetamine toxicity,

b) A single focus of significant coronary atherosclerosis in the left anterior Coronary artery,

c) A prolonged period of active agitated resistance to the restraint, and

d) +/- A minor contribution from respiratory compromise.

It was Dr Beer's opinion that there was a significant component of direct Methamphetamine toxicity in the death however the cause of Jason's death was multifactorial and not solely due to the methamphetamine use.

The period of prolonged restraint that Jason experienced, in Dr Beer's opinion, would have been a further significant adrenergic stimulus to Jason's already highly stimulated sympathetic nervous system that was secondary to the effect of the methamphetamine Jason had consumed.

These factors were superimposed on the existing heart condition of significant focus narrowing (75-80%) narrowing by atheroma of the left anterior descending artery which would have been a significant factor in increasing the 'ischaemic' stress on the heart adding to the other factors predisposing towards a cardiac arrhythmia and death.

In his autopsy report, and also when giving evidence, Dr Beer discussed the syndrome known as *Excited Delirium*.

The existence of this syndrome, as Dr Beer acknowledged, is a controversial issue and one that it is not necessary for me to delve into in undertaking my function as a coroner and making findings as to the manner and cause of Jason's death. I do not need to discuss that issue any further in these reasons other than to note that, were it to be accepted, the understanding of the syndrome may contribute to an understanding of the mechanism by which death can occur in circumstances such as occurred with Jason.

Dr Judith Perl, an expert pharmacologist, also prepared a report and gave evidence at the inquest.

Dr Perl noted that at post mortem femoral blood samples taken from Jason indicated the presence of midazolam at 0.02 mg/L, amphetamine <(less than) 0.2 mg/L and Methylamphetamine > (greater than) 10 mg/L. A subclavian sample also indicated the presence of amphetamine 0.09 mg/L and Methylamphetamine 7.4 mg/L.

Dr Perl indicated that the preferred (most accurate) measure of drug toxicity at death was a sample taken from the femoral area and that she had based her opinion on that measure.

Dr Perl said that research had shown levels of Methylamphetamine above 0.2 mg/L were potentially fatal and that levels above 10 mg/L are considered likely to be fatal.

As, in Jason's case the Methylamphetamine level was found to be above 10 mg/L (it was above the level that the laboratory was able to measure which was 10 mg/L) that level was, without any other factors being taken into account, likely to be fatal even taking into account the fact that Jason was a regular user of the drug.

Dr Perl said that a blood Methylamphetamine concentration in excess of 10 mg/L was indicative of extremely high doses of Methylamphetamine being used.

She said that in her experience such concentrations tend to occur in very heavy users of Methylamphetamine and usually after a 'run.' A 'run' is when the drug is used repeatedly (i.e. several doses) over a short period of time (sometimes for 2-3 days).

During a ‘run,’ Dr Perl explained that the user ingests numerous doses of the drug over several days during which the user remains awake, hyperactive, stimulated, in a euphoric state characterised by rapid speech, often jerky movements, dilated pupils which are relatively unreactive to light, high energy , depressed appetite, tremors, increased agitation paranoia, apprehensiveness, confusion and occasionally hallucinations.

In addition to the above Dr Perl explained that Methylamphetamine was a potent central nervous system stimulant which will result in an increase of blood pressure and heart rate, pupillary dilation, palpitations, pallor, increased sweating and hyperthermia. The toxic effects included headache, palpitations, pallor, hypertension, hyper-reflexia, restlessness, nervousness, talkativeness, aggressive or hostile behaviours, paranoia, hallucinations, mental processes sped up and attention jumps ineffectually and rapidly form one thing to another (a flood of thoughts) and a person may appear as if in a manic psychosis and there may be continued purposeless motion.

It was Dr Perl’s evidence that as a result of the increased blood pressure and cardiac effects at high doses, death can occur as a result of a stroke or cardiac arrest. Methylamphetamine use, especially chronic use, was also known to cause cardiomyopathy.

In summary it was Dr Perl’s opinion that the Midazolam found in Jason’s blood at autopsy was likely to be the result of the drugs administered by the paramedics who were attempting to resuscitate Jason and that it was highly unlikely to have directly contributed to the cardiovascular collapse that led to Jason’s death.

Dr Perl was also of the opinion that the extremely high Methylamphetamine concentration found in in Jason’s blood at autopsy was highly likely to have produced toxic effects and likely fatal effects due to cardiovascular effects. She said that even the emergency treatment with Midazolam (to reverse the toxic effects of Methylamphetamine and to sedate Jason so that proper assessment and treatment could be administered), naloxone (to reverse possible overdose effects of suspected narcotic drugs and adrenaline for cardiac life support, may be insufficient to reverse the toxicity due to an extremely high blood level of Methylamphetamine.

Dr Perl therefore concluded that in Jason's case sudden death due to such a high Methylamphetamine concentration may have occurred at any time irrespective of the restraint that he experienced or the emergency drug treatment he received.

Consideration and Conclusions:

The circumstances of Jason's death highlight the devastating consequences that can arise from the abuse of the illicit drug Methylamphetamine which is commonly known as Ice or Speed.

There is no doubt that Jason was a chronic user of the drug and had been using it for a number of days prior to these events. The evidence from those who observed him was that he was said to be *'off his face'* and *'had not slept for a number of days'*. There were also indications that he was exhibiting paranoia and possibly experiencing hallucinations.

These effects almost certainly explain his actions of driving against the flow of traffic on the M1 Freeway which ultimately resulted in the collision with the motor vehicle driven by Christine O'Donnell.

The O'Donnell family are also victims of the use of this terrible drug. At the inquest I had available an impact statement form Christine O'Donnell that outlined the devastating consequences that this event had had on herself and her family. Ms O'Donnell recorded that for her the event had been life changing and that she had lost nearly two years of her life fighting for some quality of life to be restored. At the time of the inquest she had had thirteen operations and had not been able to weight bear on her right leg for three months.

Ms O'Donnell was, however, remarkably forgiving and saw the real culprit as being the Methylamphetamine rather than Jason. She expressed the hope that the coronial process might result in recommendations that *would increase mandatory help for individuals with repeat appearances before the court in relation to Narcotics.*

It is also important to remember that as well as the O'Donnell family Jason's mother was also a victim of Methylamphetamine. The evidence is that she undoubtedly cared for her son and tried her best to encourage him away from the abuse of the substance. Unfortunately she was unsuccessful and has now lost her son to this tragedy.

I have indicated above that part of the role of the coroner in cases such as this is to examine the actions of the police to determine whether or not their actions contributed to the circumstance of the death being examined. In this case the question to be asked would be whether or not it was appropriate for Jason to be restrained by police and, if so, was he restrained appropriately?

As far as the need for restraint is concerned there is no doubt that it was necessary to restrain Jason. The toxic effect of the Methylamphetamine in his system was such that he needed to be restrained for his own protection.

This was for a number of reasons not the least being the evidence, which I accept, that he was trying to escape in the direction of the M1 freeway carriageway which, had he got onto the carriageway, may have resulted in him being hit by a passing motor vehicle at speed.

Having taken over the restraint of Jason, all the evidence from the lay observers, which I accept, was that the police officers involved did so in a remarkably restrained and patient manner using only the force that was necessary. The officers involved are to be commended for their actions.

As to whether or not the actions of the police involved contributed to Jason's death the evidence of Dr Beer was that the manner of the restraint by the police was a minimal, if any, contributor to Jason's death occurring at the time it did. I accept that evidence.

It is also the case that there is no evidence to suggest that the ambulance officers involved acted other than appropriately in caring for Jason. Unfortunately their efforts were unable to assist him. Indeed it was Dr Perl's opinion that given the level of Methylamphetamine in Jason's system it was unlikely that they would have been able to revive him in any event. They nonetheless tried to do so in a proper and professional manner. They too are to be commended for their efforts.

Description of cause of death:

As set out above there is a subtle difference in the views as to the cause of Jason's death between that of Dr Beer and Dr Perl. Put simply Dr Beer has, as a forensic pathologist, taken into account all the circumstances of the death and the various factors that would, to a greater or lesser degree have resulted in Jason's death at the time. Dr Perl does not disagree with Dr Beer but opines that the level of Methylamphetamine in Jason's system would have been fatal.

I accept Dr Perl's opinion that the level of Methylamphetamine in Jason's system would have likely been fatal to Jason and that his actions in the period preceding his death particularly his confused driving and resistance, can be explained by the effects of the Methylamphetamine however it is clear that he was at the time suffering from a cardiac condition that would, no doubt, have been a contributing factor to his death occurring at the time it did. I therefore consider that a variation of the cause of death recommended by Dr Beer would be appropriate in explaining what happened.

I therefore propose to record the cause of Jason's death as being:

The combined effect of Methylamphetamine Toxicity and prolonged restraint in a person suffering from single vessel coronary artery disease.

Formal Finding:

Jason William Rea (born 15 February 1975) died on 5 February 2014 whilst en-route by ambulance from the M1 Freeway, near the Brooklyn Bridge, to Gosford Hospital, Gosford in the State of New South Wales. The cause of his death was the combined effect of Methylamphetamine Toxicity and prolonged restraint in a person suffering from single vessel coronary artery disease. The Methylamphetamine had been self-administered without the intention of ending life.

Section 82 Recommendations:

Ms O' Donnell, as already mentioned, hoped that recommendations might come from the inquest that would mandate that persons such as Jason who were suffering the effects of the abuse of Methylamphetamine and other such illicit drugs might be mandated to undergo treatment programmes that might assist them to overcome their addiction.

Unfortunately the evidence available in this inquest is not such as would allow me to make such a recommendation as the nature of such programs and other structural information was not presented during the inquest. I have, however, noted that in recent times a body has been appointed by Government to exam this issue on a national basis. Hopefully appropriate recommendations will come from that body.

I do not consider that any other issues raised by the examination of Jason's death make it necessary or desirable for me to make any recommendations in accordance with Section 82 of the Act.

I do note, however, that the evidence before me shows that circumstances of Jason's death has led to the Ambulance Service examining, and updating, the protocols used by ambulance officers in such situations. As I have found the actions of the ambulance officers involved was completely appropriate however it is good to see that the Ambulance Service has used this situation to review such protocols. They are to be commended for their action.

25. 83267 of 2014

Inquest into the death of Sean Waygood finding handed down by State Coroner Barnes at Glebe on the 16th June 2015.

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

These are the findings of an inquest into the death of Sean Laurence Waygood.

Introduction

Mr Waygood was a prisoner serving a jail sentence when he died of natural causes in the Prince of Wales Hospital secure wing.

While none of the findings a coroner must make in all cases is in doubt - the identity of the deceased; the date and place of the person's death; and the manner and cause of the death - because Mr Waygood was in custody when he died, an inquest is mandatory. Reflecting the policy underpinning that requirement, the inquest focused on whether the medical care provide to the deceased while he was in custody was appropriate.

The evidence

Social history

Sean was the younger of two children. He apparently had a stable and loving up-bringing. Apart from asthma he suffered no unusual childhood illnesses.

After he left school Mr Waygood joined the army and succeeded in becoming a commando and being awarded a Green Beret.

He appears to have had a happy marriage and he is survived by four children.

It seems his part time work in the security industry brought him into contact with criminal involved in illicit drugs.

Although Mr Waygood had previously come before the courts for only relatively minor matters, in 2009 he was convicted of a number of serious offences. On the 28 May 2010, he was sentenced at the Sydney District Court to a term of imprisonment of 20 years, with a non-parole period of 15 years for the offences of Conspiracy and Agree to murder, Discharge a Firearm with intent to cause grievous bodily harm, and other serious firearm and drug offences. The earliest release date for parole was the 18 January 2024.

His wife, mother and children visited him regularly while he was in prison. It is clear that his death was a severe blow to each of them. I offer his family my sincere condolences.

Custodial history

On the 23 January 2009, Mr Waygood was received into Corrective Services custody at the Long Bay Correctional Centre. He was assessed by NSW Justice Health where he reported no medical issues or thoughts of self-harm or suicide.

On the 27 January 2011, he was transferred to the High Risk Management Correctional Centre (HRMCC), otherwise known as "Supermax' at Goulburn. Every new reception into this area is placed on a segregation order and accommodated in unit 7 of the HRMCC while they are assessed for suitability into the HRMCC program in accordance with the HRMCC Standard Operating Procedures.

On the 1 March 2011, Mr Waygood was declared an Extreme High Security (EHS) inmate by the Commissioner for Corrective Services. The effect of this placement is that his overall management, classification and placement within the correctional system are overseen by the High Security Inmate Management Committee (HSIMC).

On the 7 March 2011 he was moved out of unit 7 and released from the segregation order and accommodated on unit 8 for normal routine within the centre.

He remained at the HRMCC until his transfer back to Long Bay Correctional Centre in early 2014 to enable on-going medical treatment.

Prison health history

During his first year in custody, Mr Waygood experienced no ill-health of significance.

On the 21 April 2010, he reported an upset stomach with associated abdominal symptoms. This resolved with minimal treatment.

On the 17 May, he complained of increased gas, constipation and a "twisting of intestines". This was again treated as a gastric complaint and seems to have quickly resolved. Pathology tests revealed nothing of significance. He was prescribed Fasigyn tablets for a possible Giardia infection.

Throughout the rest of the year there were apparently no health issues of significance.

On the 5 March 2011, Mr Waygood complained of abdominal discomfort and constipation. He was given Metamucil. The next day the medical notes indicate, "*Nil problems raised*". On the 7 March 2011, the notes record that he "*feels much better".*

On the 15 March 2011, the nursing notes state that Mr Waygood claimed to have been unwell for approximately 10 days, during which time he had experienced some cramping in the stomach. He was unable to eat the previous day and had general pain in his abdomen. He was flushed in the face. It seems Mr Waygood told the nurse that he had *"passed bright frank blood when having bowels opened.*" This entry also details that Mr Waygood was unable to be seen because the door to the cell at that point was not able to be unlocked. A further entry for the same day made by a general practitioner who saw Mr Waygood states that he had abdominal discomfort and pain spasms for 10 days. It records him to be tender in left upper and left lower quadrant of his abdomen but it was not distended. A differential diagnosis of pancreatitis or renal calculus was made. He was prescribed tramadol and buscopan for pain relief.

On the 16 March, the medical notes record that Mr Waygood was still experiencing some cramping and that he hadn't eaten breakfast. Later on that day the notes indicate that "*the pain is much improved".*

On the 17 March the medical notes record that his pain was improving. Consistent with this he was seen working in the library.

On the 18 March a Visiting Medical Officer (VMO) examined Mr Waygood and recites that he reported abdominal pain for the past 14 days but that it was *"getting better over last 2 days."*

On the 20 March the notes state that when examined by a nurse Mr Waygood told him/her that he was in pain, had been vomiting, and his stomach was bloated. "*When lying flat, patient was quite distressed and in obvious pain, his whole body was quivering and his jaw was jittering".*

The VMO was contacted and requested that Mr Waygood be sent to Emergency Department at the Goulburn Base Hospital for review. This resulted in some disagreement between the medical staff and the custodial staff.

The medical notes indicate that Department of Corrective Services staff requested that he be sent to Long Bay Hospital rather than Goulburn. The after-hours Nurse Manager was contacted and requested that the on-call medical officer be contacted regarding this decision. That doctor, who was working at Long Bay, was contacted and asked that Mr Waygood be sent to Goulburn Hospital for urgent review. The medical notes record that the Goulburn Correctional Centre General Manager, Michelle Paynter, became involved and refused to send Mr Waygood to Goulburn Hospital due to his extreme high risk status. The VMO was requested to consult with Ms Pointer regarding this refusal. After doing so the VMO agreed that Mr Waygood could go to the Long Bay Hospital.

As it transpired the debate was rendered nugatory by events: on route to Long Bay Hospital, Mr Waygood's condition deteriorated and the vehicle transporting him was redirected to Goulburn Base Hospital.

Upon admission a CT scan of his abdomen quickly demonstrated an acute obstruction in his sigmoid colon due to a mass suspected of being malignant. What were thought to be metastases were also detected in his liver.

On the 22 March, Mr Waygood underwent a sigmoid colectomy to enable the removal of that part of the colon affected by the lesion. Because the obstruction had been in place for a number of days, the colon could not be rejoined and so a colostomy was fashioned.

A pathology report confirmed the patient had colon cancer. Five of 10 lymph nodes were positive for metastatic disease.

On 1 April 2011, Mr Waygood was transferred to Long Bay Hospital for further oncology review at the Prince of Wales Hospital (POWH).

On the 24 May 2011, a PET scan at the POWH determined that Mr Waygood had further lesions in his liver, indicating a high grade tumor.

On the 1 July 2011, he underwent a left liver resection at the POWH for a segment 4 high grade liver metastasis.

On the 6 September 2011, chemotherapy was commenced and continued through to March 2012.

In May 2012 in the POWH the Hartman's procedure was reversed. During this procedure it was noted that a further tumor had developed on the rectal stump. It was also re-sectioned and the colon was rejoined.

In September 2012 a medical report was prepared by the treating oncologist indicating that Mr Waygood's colon cancer had metastasized to the pelvis and lung. The report cited that the condition was incurable and terminal, with an average life expectancy of someone who develops lung metastases from colon cancer at 12-18 months.

In March 2013, Mr Waygood was readmitted to the POWH with acute renal failure. Stents were inserted and dialysis undertaken.

In June 2013, a repeat CT scan noted the slowly progressive pulmonary metastases. In January 2014, he was readmitted to the POWH with urosepsis and acute renal failure.

In February, due to the side effects of the chemotherapy, Mr Waygood declined any further treatment which for some months had only been palliative in any event.

On 14 March, he was transferred to the POWH suffering multi system failure. Four days later, on 18 March, Sean Waygood passed away.

Investigation

Autopsy results

Even though the cause of Mr Waygood's death was well known even before it occurred, because he was in custody at the time of his death and for a considerable period before, an inquest was mandatory so that the standard of health care provided to him while he was in custody could be independently critiqued.

The cause of Sean's death is cited in the post mortem report under the hand of Pathologist Rebecca Irvine as acute renal failure and ureteral obstruction due to metastatic colorectal carcinoma.

Complaint to HCCC

Relevantly, on 14 November 2011, Mr Waygood raised concerns about his health care to that point in a complaint he made to the Health Care Complaints Commission (HCCC). He outlined the course of his illness commencing with bloating, abdominal pains and constipation in August and November 2010 and noted the symptoms passed.

He complained of acute abdominal symptoms some months later when he informed a nurse on the 5 March 2011. She gave him Metamucil. On 10 March, the symptoms progressed and Mr Waygood asked to see a doctor. He was told he had to see a nurse first. At this stage he was passing stools with blood. On the 15 March he was seen to by a VMO who allegedly dismissed the bloating and suggested it was referred pain from kidney stones. He was administered 2 injections for the management of his pain.

Mr Waygood complained that the VMO inferred the abdominal pain was due to him either taking drugs or committing an act of self-harm. He stated that the doctor informed him that he believed he had a bacterial infection and that the pain would pass soon. He was not prescribed any medication.

He alleged that the lack of action regarding his physical presentations of pain resulted in his intestines being so stretched that they could not be rejoined after removal of the lesion. He states that this left him to manage a colostomy.

The HCCC concluded that the response of the VMO who saw Mr Waygood on 15 March 2011 failed to have sufficient regard to the fact he had reported passing frank blood in the days before that consultation and a longer history of colicky abdominal pain.

The HCCC found the VMO who examined Mr Waygood on the 18 March also failed to acknowledge or adequately respond to Mr Waygood's recent history of malaena and an 11 month history of intermittent abdominal pain and changing bowel habits.

The HCCC was critical of the VMO for failing to make a differential diagnosis of bowel cancer and failing to urgently investigate this possibility.

The conduct of the two VMOs involved was referred to the Medical Council of NSW which in response interviewed the doctors and reviewed the then available evidence.

It concluded that the complaint highlighted the difficulties of providing timely and appropriate medical care to a group of patients with complex medical and security problems.

The Medical Council found that the presentation was atypical for the pathology eventually encountered. Mr Waygood's previous episodes of severe abdominal pain had quickly resolved; his condition improved between the 15 and 18 March, and then a further deterioration occurred over the weekend. Examination of his abdomen was unremarkable on the two separate occasions. The facilities available to the doctors were limited and access to imaging was restricted. Both the doctors recognized that there could be a problem that needed further evaluation. Follow-up was organized and enacted.

The Council found that the major problem appears to have been logistical, resulting from the complainants need for the highest level of security available, delaying his transfer somewhat. Neither of the doctors, nor the treating surgeon, believed that the delay the patient experienced contributed to his long-term prognosis.

Accordingly, the Medical Council found that they did not have any concerns with the assessment, examination and treatment initiated by the medical officers involved.

Coroner's expert

The Court retained an independent expert to review aspects of the case. Professor Richard Fox, an eminent oncologist, reviewed the medical charts and the statements of the nurses and doctors involved in Mr Waygood's care.

In summary, he came to the conclusion that once Mr Waygood was admitted to the Goulburn Base Hospital on 20 March 2011, the care he received for the rest of his life was of the highest standard. He had some concerns about the care provided at the High Risk Offenders Unit but in view of his evidence that the tumor that led to Mr Waygood's death developed over years – up to a decade – there is no basis for concluding any undue care contributed to the death. Once the primary cancer was established and numerous metastases proliferated throughout various organs, Mr Waygood's chance of survival evaporated.

Professor Fox pointed out the danger of using hindsight to critique events. However, he concluded that the abdominal pains experienced by Mr Waygood in 2010 were probably the earliest symptoms of the cancer that took his life.

He was also adamant that they were by no means definitive and as they resolved quickly, they did not warrant further investigation in such a young and apparently healthy man.

He was less forgiving of the failure of the VMOs who saw Mr Waygood in March 2011. By that time Mr Waygood had passed blood per rectum and that should have been investigated and colon cancer should have been part of the differential diagnosis. He was confident however, that even had Mr Waygood been hospitalised in early March the outcome would almost certainly have been the same, albeit he would have been spared the pain and discomfort for the intervening days and a colostomy may well have been avoided.

Conclusions

There is no doubt that Mr Waygood died from the complications of colon cancer that had developed in his body over many years. While, with the benefit of hindsight, it is likely that the abdominal discomfort and other symptoms he experienced and reported in 2010 were caused by the tumor developing in his sigmoid colon.

It was not unreasonable for the medical staff at the Long Bay Correctional Centre to assume they were caused by something less sinister. When the symptoms resolved, there was no reason to investigate further. However, by the time the two VMO's at the HRMCC saw Mr Waygood on 15 and 18 March respectively, he had a constellation of symptoms recorded in the medical chart that included the passing of frank blood that should have led to more urgent investigation, in my view. I accept that the slightly earlier detection of the tumor that could have resulted is unlikely to have changed the outcome. Nevertheless, it was in my view sub-optimal care and resulted in Mr Waygood needlessly suffering.

I do not consider the security classification of Mr Waygood as Extreme High Risk compromised his access to adequate care and treatment. There was some uncertainty and confusion about where he should be taken when it was determined that he need to be admitted to a hospital on 20 March 2011, but as matters played out he was taken to the closest hospital in any event. From that point on I am satisfied that Mr Waygood received a high standard of health care that was as good as he is likely to have received had he been in the community.

Findings required by s81(1)

The identity of the deceased

The deceased person was Sean Laurence Waygood.

Date of death

He died on 18 March 2014.

Place of death

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

Manner of death

He died from natural causes while serving a prison sentence.

Cause of death

The cause of Mr Waygood's death was acute renal failure caused by bilateral ureteral obstruction due to metastatic colorectal carcinoma.

26. 88509 of 2014

Inquest into the death of AC finding handed down by Deputy State Coroner Dillon at Gundagai on the 5th August 2015.

NOTE: NON-PUBLICATION ORDERS HAVE BEEN MADE PROHIBITING PUBLICATION OF IDENTIFYING DETAILS OF AC AND HIS RELATIVES,; THE POLICE IN CAR VIDEO OF THE INCIDENT AND SOME PHOTOGRAPHS. PLEASE CHECK WITH CORONERS COURT REGISTRY FOR FURTHER DETAILS

Introduction

This is an inquest into the death of AC. who died during the course of a police operation, a routine traffic law enforcement stop in Wagga Wagga on 23 March 2014. Because his death occurred in the course of a police operation, the Coroners Act requires that an inquest be held to enquire into the circumstances surrounding it.AC died after falling from an electricity transmission tower in the early afternoon of Sunday, 23 March 2014. He had been pulled over by a local police officer after being detected speeding at more than 45 kph over the speed limit. When told by the police officer that his licence would be suspended and his car seized, he lost his temper, walked away from the officer and climbed up a high voltage power transmission tower. While standing on the tower, he was hit by high voltage electricity that arced from a power line above him and fell to the ground.

The coroner's functions and the nature of the inquest.

A coroner is obliged to make findings, if possible, as to the identity of the person who has died, the date and place of death, the cause of death and the manner or circumstances of death. In this case, it is the manner and circumstances of this very unfortunate death that raise the difficult questions. They are:

- How did the incident occur?
- Why did the incident occur?
- Could AC's death have been prevented?

- Are there any recommendations that ought to be made?

AC's background

AC was a young man, only 30 when he died. His death was therefore not only sudden and shocking, but very premature. He was the middle child of three with an older brother BC and younger sister, JC. When AC was a very young age AC's father suffered a stroke and had to live in a nursing home. The family moved to Wagga Wagga to be close to the father and has lived there ever since. In about 2000 AC's mother remarried, to Mr AR. During school, AC was a very talented gymnast.

In 2011 onwards AC obtained employment in a car detailing workshop and remained employed there for several years. In recent years he had been in a relationship with a young woman, SO, who was with him on the day of his death. AC cording to newspaper reports, friends of AC, of whom there were apparently, many, described him as an adventurous spirit with a sense of humour and quick wit who could make them laugh and who lived his life with passion. AC's death has been a terrible and tragic blow to his grieving family, his partner and all of his friends in the local community.

Despite descriptions of a happy-go-lucky young man, over the years, AC apparently suffered from what his sister described as depression and for which he had some help dealing with it, from a professional perspective, certainly from 2011 and possibly onwards. At one point his sister feared that he had become involved in drug use. After his death, he was found to have had a significant concentration of methylamphetamine in his system at the time of the incident. Before his death, he visited his mother and sister and appeared distressed. This raises a question of whether his death may have been a deliberate act of self- harm.

On Sunday 23 March 2014 SO and her sister SA were both present with AC in his car when he was pulled over by police and both were witnesses to his tragic death. SA described AC as having a happy personality who would always make them smile. AC had been working until a few weeks before his death and owned the car that he was driving that day. It is not entirely clear why or how AC had stopped working, but it seems that he was facing some pressures in his life around that time and subsequently.

AC according to SO, however, that morning he had been in a good mood and had been to the car show at Wagga Wagga. The three of them were heading home after visiting friends.

How did the incident occur?

At about 12:35 PM, Highway Patrol officer Senior Constable Owen was carrying out duties in an unmarked Highway Patrol vehicle on Tasman Road East Wagga, doing stationary speed enforcement.

He saw a white Commodore travelling towards him quickly and it was seen to be doing 100 km per hour in a 50 kilometre per hour zone. He followed the car and turned right into Copland Street, where the driver, AC, stopped the Commodore and was spoken to by Senior Constable Owen. The two women in the car advised that they needed to use a toilet urgently, which was why it had been speeding.

Officer Owen advised AC that he would be receiving a speeding infringement ticket and that his vehicle would also be seized and his licence suspended because the vehicle had been travelling more than 45 km per hour over the speed limit. This is a power available to police to exercise under the *Road Transport Ac t 2013*.

AC became very upset at the information that his car would be impounded and locked it and took a long neck of beer from the car. Senior Constable Owen announced that he was going to search the car and called AC back to unlock it. AC did so and then walked off towards Tasman Road. Officer Owen at this point radioed for assistance and then noticed that the two female passengers from the car were walking off behind AC in the direction of a transmission tower on the south-western corner of Tasman and Copland streets. He saw AC begin to climb the tower.

Senior Constable Owen radioed for an ambulance and told radio what was happening. SA witnessed AC tear his shirt on the barbed wire barricade as he climbed up the tower and take it off. Senior Constable Owen went to the base of the tower and tried to get some information about AC so that he could try and negotiate him down, as AC continued to climb. During this time the in-car video in the police car was running and recording what could be heard from outside the car.

Once up the tower, AC remained angry about the taking of his car and climbed to the first horizontal spar or arm high on the tower, where he stood and had a shouted exchange with the people down below. AC was saying things like he was “over it” and couldn't deal with life any more. Officer Owen suggested that he would go away if AC came down.

After a few minutes a second police officer arrived on the scene, HWP supervisor Senior Sgt Wayne McLachlan. That officer asked Owen to call off the tow truck as it would aggravate the situation and to stop someone on the ground filming.

McLachlan spoke to the two women present to try and calm them down and began to try and negotiate with AC. AC was still upset about his car.

The in-car video in Senior Sgt McLachlan's car was also left running and recorded some of the exchange he had with AC, via a microphone on Senior Sgt McLachlan’s shirt. While Senior Sgt McLachlan and AC were talking AC, who had his arms in the air, possibly waving them around, was hit by current arcing from the nearby wires and fell to the ground. Police restrained the two young women, who were deeply upset and in shock, from approaching AC, as they thought there was a danger of further electric shock. Senior Sgt McLachlan then checked AC for a pulse and thought that AC was deceased. More police and ambulance officers arrived and confirmed that to be the case.

During the incident, the whole of which took only 12 minutes, police radio was asked to arrange for Fire and Rescue to attend with a view to trying to help AC down from the tower and to contact the electricity company. A radio operator did try to contact an electricity company (in fact contacted two) but they were not the company who controlled this tower, Transgrid.

Why did the incident occur?

This is a more difficult question to answer. AC was certainly in an unstable frame of mind. He was certainly upset by the impounding of his car and the suspension of his licence but his reaction was extreme. It seems probable that his judgment was affected by having taken drugs. This may have contributed to him speeding in the first place.

It is a matter of common knowledge that methylamphetamines have the effect of causing users to become highly volatile in some situations.

AC's low mood, which he may have been trying to self-medicate with "ice", may also have contributed to his loss of judgment in this situation. Certainly his decision to climb the tower was impulsive and obviously dangerous. He was not deterred by warning signs on the tower nor by the anti-climbing barrier of six strands of barbed wire which tore his shirt as he forced his way through them.

He made various statements during the incident to the effect that he was sick of life and was "going to do [himself] in" that suggest possible suicidal intentions but which could equally have been expressions of anger, resentment of what he perceived to be his bad fortune or general exasperation. There is no evidence of previous suicide attempts or severe mental illness.

Before a finding of suicide will be made by a coroner, he or she must be satisfied to a high degree that it this was the probable manner of death. It is possible that AC climbed the tower with an impulsive intention of killing himself. Yet the evidence is ambiguous.
He, of course, left no suicide note or history of previous attempts to self-harm or text messages or other indicia of a firm intention to take his own life.

What exactly was in his mind at the time when he raised his arms and the electricity bolt hit him we do not and cannot know. Certainly he did not fall voluntarily from the tower and he was not tall enough to reach the power cable above his head.

For these reasons, I cannot be satisfied that AC's death was intentionally self- inflicted.

There was no act or omission on the part of the police officers or Transgrid that caused or contributed to causing AC's very unfortunate death.

People in a rational state of mind, and most whose judgments had been affected, would readily be deterred from climbing high voltage electricity towers by the knowledge of the danger, the cautionary signs that warn of danger that are found on all such towers in good repair, and by the barbed wire barricades that surround the bases of the towers.

The police officers who were first present, Senior Constable Owen and Sen Sergeant McLachlan not only attempted to reason with AC and to talk him down from the tower but had the terrible experience of seeing him killed in front of them by electricity. They both showed genuine concern for AC before he was killed and sought to obtain more assistance for him.

In no way did they fail in their duties as police officers. On the contrary, their concern and professionalism was exemplary.

Could AC's death have been prevented?

The short answer to this question is that it could not in the time available. If AC had not been struck by arcing electricity but had stayed where he was without moving, it is likely that a negotiator would have been called to attempt to talk him out of endangering himself. The electricity lines close to him would have been de-energised and rescue personnel would have been able to approach him and bring him to the ground. He would have been medically and probably psychiatrically assessed and, if necessary, treated.

Unfortunately, time ran out for AC too quickly. On the evidence of a senior Transgrid manager, Mr Mark Britton, it would have taken at least an hour and possibly longer to de-energise the lines and make them safe for electricity crews and emergency services crews to approach AC.

While circuit-breakers isolating a stretch of line can be opened quickly by computer, this does not make the line safe. It is necessary for electricity crews also to visit the relevant sub-stations to check the lines are de-energised, set an air lock and to earth the wires.

In this case, it would have been necessary to call out crews on a Sunday some of whom were not on call and send them to three different sub-stations plus the tower itself (where the de-energised line would be earthed).

Emergency services personnel, for obvious reasons, are not permitted to work close to high voltage lines until the electricity crews declare them safe.

While a trained negotiator could have been called to the scene, that process would have taken more than 12 minutes. Even if Sen Constable Owen had requested a negotiator as soon as AC started to climb the tower, it would have travel to the scene in the time available.

In any event, given the situation that arose, both Sen Constable Owen and Sen Sergeant McLachlan immediately undertook what appear to have been very appropriate negotiation tactics in an attempt to reduce AC's anxiety and anger levels and to calm him down and to reduce the risk of harm.

Lessons learned from the incident

Although they made no difference to the outcome, lessons can be learned from the incident.

First, in situations in which people are in danger from live high voltage power lines, it is critical for police or other emergency personnel on the scene to identify the unique identifying numbers of the transmission tower and the lines in question, plus the location of the tower. This information needs to be passed on to police radio operators who will then get in touch with the relevant power company who will set in train the process of de-energising and making lines safe.

Second, those identifiers are found on notices at the base of towers. The notices also nominate the power company which owns or controls the tower. This information is also important to pass on to the radio operator.

Third, in this case, a request was made to police radio to notify the power company. Unfortunately, the drop down menu with contact numbers for power companies used by operators, and the Standard Operating Procedures, did not include Transgrid in their listings. Transgrid's grid covers the whole of New South Wales and connects to all the retail distributing companies in the State and with grids in Queensland and Victoria.

The NSW Police Force emergency contact list therefore needs to upgraded and the Standard Operating Procedures amended to ensure that Transgrid is included in its listings.

Fourth, for obvious reasons, Transgrid procedures require that incoming calls requesting emergency de-energisation of power lines be verified. At present, if police make a call to Transgrid, it will request a telephone number that can be used to call the relevant police unit to verify the authenticity of the call. This may take a few minutes. Those minutes may be vital. This raises the question whether there is a fail-safe means of automatically identifying incoming calls from the Police Force or emergency services more generally.

In fairness to Transgrid, this was a question that only arose late in the day and there was no opportunity to obtain evidence concerning the possible ramifications of a recommendation to this effect. I propose making a recommendation only that the question be considered by Transgrid and to be implemented only if reasonably practicable.

Conclusion

The sudden and unexpected death of a loved one is shocking blow to those close to that person. In this case, two of the people close to AC had the dreadful experience of seeing his death occur. His mother has lost a son whom she would have hoped to see live many more years yet.

There is no "closure" and no consolation that can be offered to the bereaved family and friends in these circumstances.

All I and the team that assisted me in this inquest can do is hope that AC's family and friends have many happy memories of him that will in time outlast and outweigh the horror and shock that his death has caused, and that they will accept our sincere condolences on losing this young man whom they loved.

Formal Finding:

I find that AC died on 23 March 2014 on or near Transgrid Electricity Tower 625 near the intersection of Tasman and Copeland Streets, Wagga Wagga New South Wales due to electrocution and multiple injuries he suffered when struck by arcing of electricity from a high voltage line on the tower which he had climbed and from which he fell after being struck. This occurred in the course of a police operation, namely a traffic law enforcement stop.

Recommendations

I make the following recommendations to the Minister and Commissioner for Police:

- That the Standard Operating Procedures for Police radio operators concerning notification and contact with electricity companies be amended to insert a list the following power companies: Ausgrid, Endeavour, Essential and Transgrid;
- That the Standard Operating Procedures also be amended to instruct radio operators getting in touch with power companies concerning lines down or other electricity jobs that the power companies require: The exact location of the tower or pole; The identifying numbers of the tower and power lines (to be obtained from notices on the tower or pole); and whether the wires were previously strung between two poles or towers (pole to pole) or between a pole/tower and building.
- That the drop-down "Resources Menu" used by police radio operators be amended to include the contact details or shortcut telephone numbers of the following electricity companies: Ausgrid; Essential; Endeavour and Transgrid.

I make the following recommendation to the Chief Executive Officer of Transgrid:

That to expedite verification of incoming calls from police or emergency services concerning lines down or other emergencies requiring de-energisation of power lines, Transgrid consider, if it is reasonably practicable, implementing an automatic incoming call identification system for those services.

27. 161167 of 2014

Inquest into the death of AA finding handed down by State Coroner Barnes at Cessnock on the 16 July 2015.

This is a mandatory inquest required to be held by s 27(1)(B) of the Coroner's Act 2009. AA died whilst he was a sentenced prisoner lawfully detained at Cessnock Correctional Centre. At the time of his death, AA was 42 years of age. He never married and had no children. He had no family visitors during this time in custody and made no phone calls.

On 24 July 2013 AA was convicted of two offences, assault with act of indecency and detain a person with intent to obtain advantage. AA was sentenced to four years imprisonment with a non parole period of three years, his earliest release date was to be 7 July 2016.

On 1 May 2014 AA was transferred to Cessnock Correctional Centre having been classified C1 minimum security. Initially he was housed in E block, sharing a cell with another inmate. On 24 May AA was moved to B block into a single cell. AA was last seen at 6.55pm on 27 May 2014 when he was secured in cell 2111 by Correctional Officers Sargent and Partington.

At 6.20am on 28 May 2014 Correctional Officer Byrnes attended cell 2111 for morning checks of inmates and discovered AA with a torn bed sheet around his neck, the other end attached to the ceiling light fixture. A A was in an upright position facing the bunk beds with his hands partially gripping the side of the top bunk. AA was attended to by correctional officers and Justice Health registered nurses. No signs of life were detected and resuscitation was not attempted. New South Wales Ambulance and police were notified.

All policy and procedure regarding critical incidents were adhered to by Corrective Services and Justice Health. There are no suspicious circumstances surrounding the death of AA and no issues to be addressed at inquest.

As you are all aware, s 81 of the Coroner's Act requires that following an inquest the Coroner prepares a written report of his or her findings.

I will do that in due course but I am satisfied that there are no suspicious circumstances or other matters of concern in connection with this matter. I will therefore give an oral finding in relation to the findings required.

Having considered all the documentary evidence and the oral evidence heard at the inquest I am able to confirm that the death occurred and make the following findings in relation to it.

Formal Finding:

That AA on or between the 27th and 28th May 2014 died in Cessnock in the state of New South Wales the cause of his death external neck compression (hanging). The death was intentionally self inflicted while he was serving a sentence of imprisonment.

There was an issue concerning immediate access to a cut-down knife by those who first found the dead man. I am satisfied that that has been addressed. There is therefore no need for me to make any preventative recommendations.

28. 166723 of 2014

Inquest into the death of Brian Carman finding handed down by Deputy State Coroner Dillon at Glebe on the 14 July 2015.

Sadly there are no members of the family here today and for the reasons that Detective Inspector James has given, no doubt due to long history of unhappiness in the family. The members of the family did become estranged from Mr Carman. Mr Carman was a prisoner at the Dawn De Loas Correctional Centre at Silverwater having been convicted of a number of fraud offences.

He died in gaol at the Dawn De Loas Correctional Centre on 3 June 2014.

As Detective Inspector James has said he was a man who was addicted to both alcohol and gambling and it seems that in particular the gambling, but also no doubt the alcohol which affects people's judgment, played a part in the catastrophe really which befell him, but also his victims, who were until he defrauded them, his friends.

He was convicted of a number of fraud offences and was serving a sentence for dishonestly obtaining advantage by deception. He had been sentenced to a period of imprisonment of two years and he was also convicted of a further offence of a similar nature which was also to a period of two years. He was due for release in September next year.

Mr Carman not only suffered from alcohol dependency which clearly brings with it all sorts of other co-morbidities, but he most particularly suffered from asthma and apparently quite severe asthma, asthma so severe that he needed to a nebuliser to manage it and that was revealed to the Justice Health officers or clinicians when he was imprisoned. He was provided with a nebuliser and other medications, including Ventolin and Ventolair Pulmicort for his condition, Pulmicort being a steroid which reduces the inflammatory response which asthma is.

For reasons which are not entirely clear Mr Carman, although he was very concerned about the extent of his asthma, was also quite secretive about the severity of it.

Evidence was obtained from friends that he had not wanted to be moved from the Dawn De Loas Correctional Centre, that he feared that if he revealed the severity of his asthma he would be moved to the Long Bay prison hospital for treatment and while I can understand not wanting to go to Long Bay it is not quite clear what the attraction of the Dawn De Loas Correctional Centre was.

In any event sadly and I think to his own very great disadvantage he did not reveal the extent and severity of his asthma, but no doubt if he was being treated with a nebuliser and these other quite powerful medications at least to all appearances his asthma was being controlled properly and he may well have not been transferred to the Long Bay hospital in any event.

He was in a cell two out with another inmate. There was some suggestion made and I note really that sometimes in these kinds of cases there can be both mischievous information, or disinformation given to investigators, but also there can be a high deal of suspicion and other alarmist kind of thinking that goes on in prison environments that led or might lead to claims of abuse or of misconduct of some sort.

In this case there was some information given to the investigators suggesting that the fellow inmate might have turned off Mr Carman's nebuliser and that therefore might have caused him to die. Detective Inspector James both in his brief and in his evidence this morning has told the Court that he believes that this information or these suspicions have absolutely no basis. Mr Whiteoak it seems was frank with the investigators. Yes he was irritated by the noise of the nebuliser, they are fairly noisy little machines I know and he did sometimes find it irritating and no doubt that sometimes led in such an environment to arguments perhaps, but there is no suggestion or at least there is no evidence that Mr Whiteoak was in any way responsible for Mr Carman's death.

Detective Inspector James gave evidence this morning that Mr Carman had been using the nebuliser, that seems to be clear and that he had been sitting upright when he died. There may have been a harsh issue involved, but there was no evidence found of that, but it is well known and well understood I think that asthma, severe asthma attacks can lead to heart arrhythmias and so forth. So if a heart issue was involved unfortunately hearts, once they stop pumping, leave no evidence if the disturbance is an arrhythmic one.

There was no evidence of the alarm system being operated. There is no evidence to indicate any tampering with the nebuliser or the alarm system. The alarm system was found to be in working order and Mr Carman did not use the knock up button, nor did Mr Whiteoak.

Mr Whiteoak presumably did not notice that Mr Carman had died until the morning when his death was discovered.

There is no evidence of any negligence on the part of Corrective Services staff or Justice Health staff. The relevant officers seem to have reacted appropriately and provided adequate and prompt first aid, but due to Mr Carman having passed away he was beyond recovery.

New South Wales Ambulance also attended and provided medical attention, but he was clearly beyond resuscitation.

So it is quite clear that Mr Carman was suffering from a severe medical condition that was always potentially fatal. It was being adequately treated and in most situations the nebuliser and the other medications would have been sufficient, but he was also 67 and a man in general poor health having a severe asthma attack on top of all those conditions no doubt was the last straw on the camel's back, if I can put it that way.

He died of natural causes and as has been submitted by Sergeant Bain it is clear that that particular natural cause was bronchial asthma.

Formal Finding:

I find that Brian Douglas Carman died on the 3rd June 2014 at the Dawn De Loas Correctional Centre Silverwater the cause of death Bronchial Asthma while an inmate in the correctional facility.

29. 174768 of 2014

Inquest into the death of AA finding handed down by Deputy State Coroner O'Sullivan at Glebe on the 15th December 2015.

Pursuant to s.75 of the *Coroners Act 2009*, I order that there be no publication of a report of the proceedings (or part of the proceedings) of the inquest.

Section 81(1) of the Coroners Act 2009 requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of AA.

This is an inquest into the death of AA who died on the evening of 11 June 2014 after jumping from a cliff at The Gap, in Watsons Bay. AA was aged 58

AA's death was a suspected suicide which occurred in the context of a current police operation, as AA was on the telephone to an officer from the NSW Police Force ("NSWPF") just prior to apparently jumping to his death.

As the death occurred during the course of a police operation, the holding of an inquest by a Deputy State Coroner is mandatory under ss. 23(c) and 27 of the *Coroners Act 2009* ("the Act").

Background

AA had a challenging life, which included a strained relationship with his family from whom he was estranged at the time of his death. For his family, it seems that AA's sexuality, as a gay man, was difficult to accept. AA's parents are now both deceased.

There is also some evidence which indicates that AA may have been sexually abused as a child whilst at school in Queensland.

After leaving school, AA held various jobs, including as a retail manager between 1999 and 2008. After 2008, AA worked a number of odd jobs but it seems that his self-confidence began to significantly decline around that time.

In 2012, AA invested money received from his father's estate in a futon business, 'Fantasy Futons' on King Street, Newtown. Nine months later, however, the factory which manufactured the futons was destroyed in a fire. As a result, AA lost his business and shortly after became homeless. Over the following two years, AA stayed temporarily with a number of different friends and relatives.

In 2013, AA secured a job as a forensic cleaner of crime scenes. Although not talking openly about the effect of this work on his frame of mind, A's long- standing friend LR did not think that this was a healthy occupation for AA to be undertaking. Subsequently, AA received Centrelink payments, which again appears to have adversely affected his self-esteem.

By 2014 AA's mental health began to decline.

In particular, medical records indicate that on 4 February 2014 AA attended Newtown Medical Practice where he disclosed to Dr Pit Young that "he was suffering depression due to the loss of his business and loss of all property due to being sold a business that had failed…". During that consultation, Dr Young noted that was "clinically depressed… had suicidal ideation but no plan". Dr Young prepared a Mental Health Care Plan, noting the action to be taken as seeing "psychological services for job seeker at Communicare". A A subsequently attended Newtown Medical Practice on three further occasions, with the suggestion of mental health follow up in a note made on 6 May 2014 that states: "counselling about job seeking".

Mr Roberts recalled AA to have had an inflated sense of what was proper, and that he had placed himself under a great deal of pressure. In his view, Mr Roberts thought AA "… saw his life slipping away from him and a future of just becoming a cleaner looming", which he considered demeaning. A A apparently often referred to himself in conversation, including on the day of his death, as having become a "factotum" (that is, a general servant).

Since 2013 up until his death, had been living with an old friend, HD, at her house in Newtown rent free to enable to him to get back on his feet financially. Ms D provided a statement to investigators in which she comments that AA was under a strain. She states that he felt like a failure as a middle- aged man with no assets or career, and was ashamed of what his life had amounted to.

The night prior to his death however (that is Tuesday, 10 June 2014), AA and Ms D had been to her brother's house in Glebe for dinner, at which time AA had seemed in "good spirits", and had not appeared to be a person contemplating suicide.

Events of 11 June 2014

At around 12.27pm, AA received a call from Mr R. The two spoke for approximately 20 minutes, during which time Mr R became concerned because AA made the comment that he was going to kill himself (although he only mentioned it once). Troubled by the call, Mr R then contacted their mutual friend FU, and relayed his concerns. Ms U then rang AA at 1:51pm.

The pair spoke for approximately 7 minutes, and made plans for the days following. Ms U has since stated that the fact that AA made plans with her conveyed the false belief that he was "okay".

It appears AA then drove to Watsons Bay in his car, a white Toyota starlet (Reg. UPL-792) and parked on Military road. At approximately 5:00pm, AA purchased a pie and drink at Watson's Bay Milk Bar. The shop owner, Mr Con Georgio, provided a statement to police. He recalled AA as being "very quiet…" and thought "something seemed off". At 5:47pm, AA made a call to Lifeline. AA spoke to Linda Thompson of Lifeline for 13 minutes, during which time he stated "killing myself is the right decision… I'm standing on the edge of a cliff and it's a beautiful evening". During the call, Ms Thompson signalled a colleague, Ms Poppy Krallidis, to contact "000". Ms Krallidis phoned "000" at 5.53pm, and relayed that Lifeline was dealing with a "person at the Gap", who was "apparently on the edge"; Ms Krallidis also told the "000" operator that the man was not giving details, but had given his age (58), had an Australian accent, and importantly, she also provided AA's mobile phone number.

Response of the NSW Police Force

The Gap area at Watsons Bay falls within the geographic boundary of Rose Bay LAC. Officers from that command are frequently called to attend and patrol the GAP area and consequently have particular training and expertise in dealing with such incidents. A specific set of standard operating procedures entitled 'Gap Park NSW Police Force Standard Operating Procedures, Rose Bay LAC' ("Gap Park SOPS") also informs police practice in this regard.

On 11 June 2014, Sergeant Matthew Hall, an officer of some 12 years experience who had been at Rose Bay LAC since February 2013, had just commenced his shift at Rose Bay police station as the Internal Supervisor for Rose Bay LAC. A/Sergeant Bradley Rodwell was the mobile supervisor for the shift.

Immediately following the "000" call from Ms Krallidis at Lifeline, at 5:53pm, a "concern for welfare" CAD message was sent on police radio (known as "VKG") stating that a call had been received from a male located at The Gap who was "on the edge and going to jump".

At around 5.55pm, that is within 2 minutes, Senior Constable Davies and Constable Street (in RB 400) had responded to the job and were on-scene at The Gap attempting to locate AA. Another unit conveyed by A/Sergeant. Reynolds in RB 14, comprised of Constables Alexander and Reynolds also commenced searching for AA minutes later.

At 6.05pm, a request was made by A/ Sergeant. Rodwell to the Duty Operations Inspector (DOI), Inspector Paul Smith, to triangulate further calls to AA. However, it appears that request was taken to be declined, with the DOI responding that a phone diverting to voicemail could not be triangulated. He also replied in the CAD message that since there were no phone towers in the sea, only a di-angulation could be obtained.

At 6:10pm, 6:15pm and 6:27pm, Sergeant Hall attempted to contact AA on his mobile. All three calls diverted to voicemail.

At 6.10pm, Sergeant Hall also sought to arrange for police to attend AA's residence in Newtown to advance the investigation as to his location.

At 6.25pm, following a brief conversation with Sergeant Hall, the DOI, Inspector Smith, sent a request in respect of AA's mobile phone number to his carrier, Telstra, seeking a mobile location or triangulation.

At 6:29pm, Sergeant Hall sent a text message to AA, stating " please contact Rose Bay Police 9362 6399 or 000 ASAP, Matt Hall Sgt". Sergeant Hall made two further calls which diverted directly to voicemail at 6:33pm and 6:40pm.

By around 6.38pm the officers searching The Gap for AA were directed to return to their regular duties until further information concerning his location was available.

At 6.44pm, a facsimile from Telstra provided an indication of the mobile number/handset being in the Watsons Bay area, together with some longitudinal and latitudinal coordinates.

At around 6:57pm Sergeant Hall was told by an officer at Rose Bay Police Station that AA was on the phone requesting to speak with him. The two spoke for approximately 12 minutes, during which time Sergeant Hall attempted to ascertain AA's location, assuring him that he would like to help. AA told Sergeant Hall "I can see the ocean, my heart's in a good place, just let me go, I'm sorry that I have had to involve you in this". It seems that he was otherwise unwilling to give information about his location.

At 7:09pm, AA terminated the call.

At 7:12pm, Sergeant Hall attempted to contact AA again by phone. It rang for a considerable period before AA answered. This conversation was only around two minutes long and Sergeant Hall specifically noted that AA "appeared to be greatly agitated in comparison to the previous conversation". During the call, Sergeant Hall again repeatedly asked AA to step away from the edge of the cliff, to which he responded "I am going to terminate now, I am going to jump". Sergeant Hall tried to engage AA once more, saying " just talk to me", before he heard a male scream. Believing AA to have jumped, Sergeant Hall then broadcast this via VKG.

Constables Reynolds and Alexander who were monitoring events on police radio began running in a northerly direction towards HMAS Watson and were first on the scene minutes later sometime between 7.15 and 7.20pm. They located AA's belongings on a sandstone rock at the top of the Gap Bluff, near Gunnery Range.

By 7:53pm, officers attached to the Marine Local Area Command were searching the water surrounding The Gap area in WP34 (*The Valiant*).

At 8:06pm, AA's body was located in the water and he was brought on board the water police vessel minutes later.

Notwithstanding a sustained attempt to resuscitate AA by Sergeant Trussell and Senior Constable Glen of the Water Police, he could not be revived. AA was pronounced deceased by officers from the NSW Ambulance Service at Watsons Bay ferry wharf at approximately 8.25pm.

Autopsy results

Forensic pathologist, Dr Kendall Bailey, conducted a post-mortem examination on 12 June 2014. The examination was limited to an external examination, radiography and toxicological sampling. In her report, Dr Bailey concluded that AA died from the combined effects of blunt force injury of the chest and immersion.

Identification

AA was identified at the Glebe Morgue on 12 June 2014 by his sister in law, JA. She had known AA for 36 years.

Critical incident investigation

At 8.39pm, the matter was declared a critical incident by Assistant Commissioner Murdoch, with Kings Cross LAC allocated the investigation and Sutherland LAC the review.

Since that time, Detective Sergeant Mark Carter of Kings Cross LAC, has conducted the substantive investigation into AA's death and compiled the two volume coronial brief of evidence.

The Gap Park CCTV system

Since 2013 as part of a self-harm minimisation strategy targeting The Gap as a suicide hotspot in Australia, a CCTV system to assist police and emergency services quickly locate persons at risk of suicide has been up and running.

In general terms, the system consists of some 38 CCTV cameras that cover the cliff line and entry points at The Gap. The cameras run a constant stream and interface with thermal and motion sensors along the fence line of The Gap, which activate alarms when people are in designated danger areas. Police from Rose Bay police station can view the CCTV cameras. I had the benefit of a view of the equipment at Rose Bay Police Station in the lead up to this Inquest. A firm, Electro-Monitor and Computerised Security is retained to undertake maintenance of the cameras.

Yates Security monitor The Gap computer 24 hours per day, 7 days per week. Operator intervention is only required when an alarm is triggered, which occurs when either or both the motion or thermal sensor is interrupted. When this alarm is triggered, an operator of the camera is given an outline of where the activation occurred and the operator can review the footage to confirm what has triggered the alarm. After the operator has monitored the activation they then manually enter the activation, the camera number and the reason for the activation into the security system log. After viewing the activation, the operator has to manually acknowledge that they have done so on The Gap computer.

The Gap camera log for 11 June 2014 was reviewed for the purposes of this investigation. It shows two activations at 5:18pm and 5:44pm. However, there was no alarm triggered for these activations. The likely explanation for the non-activation of the alarms was that the internet was down at the time of the sensors being activated. Notably the evidence indicates that from May 2014 to June 2014, Yates Security experienced difficulties with their internet provider, Telstra. This issue has since been rectified by Yates Security obtaining backup internet providers so as to immediately remedy such outages.

Determination of the statutory findings required by s.81(1) of the *Coroners Act 2009*

Having regards to the oral and documentary evidence I am able to find:

Identity
The deceased was AA, aged 58.

Place of death

The Gap, Watsons Bay, Sydney.

Date of death

11 June 2014.

Cause of death

The combined effects of blunt force injury of the chest and immersion.

Manner of death

As a result of deliberately jumping from a cliff at The Gap Park, Watsons Bay, with the intention of ending his life.

Consideration of whether the applicable NSW Police Force policies and procedures have been followed, including the GAP Park SOPS (Rose Bay LAC) and the Critical Incident Guidelines

I am satisfied that the NSWPF policies and procedures have been followed. In particular, I am satisfied that the NSWPF Gap Park SOPS have been adhered to, and that the police operation undertaken with respect to Mr Garner was appropriate and professional.

Triangulation of mobile phones to locate persons at risk

I turn briefly to the evidence on the use of triangulation of mobile phones at The Gap Park. I refer to the evidence of Inspector Paul Smith, the DOI. In his statement (Tab 13 Ex.1) in paragraph 8 he states, "It has been my experience in my years as DOI, that triangulations around the seaside suburbs, such as Watsons bay…do not have successful results, as the signal cannot be triangulated due to water mass and often towers on the other land mass will pick up the signal and confuse the actual location."

I note that the Gap Park SOPS (which were tendered into evidence in these proceedings as Exhibit 2) expressly contemplate the use of triangulation as a means of isolating the general area in which a person might be (see pp 17, 23-24, 54-55), and that there was certainly utility in using that function on this occasion.

The triangulation established that AA was in the Watsons Bay area thus providing police with a concrete location to search. It would appear on the evidence in this Inquest that triangulation was in fact possible despite the location being in a seaside area. I note the other concern held by Inspector Smith was that, to his knowledge, triangulation would not be possible if the phone went to voicemail as was the case prior to the successful triangulation occurring. (Tab 13 Ex 1 paras 9,10).

I am satisfied that the Critical Incident Guidelines were followed.

Consideration as to whether any recommendations are desirable or necessary (per s. 82 of the *Coroners Act 2009*).

I do not consider that recommendations would be desirable or necessary.

Concluding remarks

The evidence in this case clearly establishes that at approximately 7:14pm on 11 June 2014, AA jumped from the cliff edge around Gunnery Range, in the area near The Gap Bluff and collided with either the rocky terrain at the base of the cliff and/or the water shortly thereafter. I have no doubt that AA's death was self-inflicted with the intention of him taking his life.

I am satisfied that the NSWPF policies and procedures have been followed. In particular, I am satisfied that the NSWPF Gap Park SOPS have been adhered to, and that the police operation undertaken with respect to AA was appropriate and professional.

AA was a very popular man dearly loved by his numerous friends, many of whom he had known for decades. I am grateful to Mr R and Ms U for their moving statements about their dear friend. AA was described by Mr R as "one of the most loving people I've ever met and a great friend", while Ms U said he was "a charming, articulate man with the most wonderful sense of humour".

Ms U told the Court about AA's love of literature and the arts, his passion for reading and concerts, and his talent as a conversationalist – he was "the ideal, indeed essential, dinner party guest." Ms HD, another of AA's very close friends, has described him as a "a very good person" whom she loved dearly, and who had a great sense of humour. Ms D describes his death as a "tragic waste of a wonderful person". FM, a friend of some 20 years, stated that AA was a very kind and generous person, greatly missed by the friends he has left behind. I offer my condolences to AA's dear friends.

I would like to thank Detective Sergeant Carter for his work as OIC. I would also like to thank Rose Bay LAC for arranging for the views that were so helpful.

30. 192992 of 2014

Inquest into the death of Dylan Maher finding handed down by Deputy State Coroner Grahame at Glebe on the 17th February 2015.

Introduction

Dylan was a 25 year old man living in the Illawarra region of NSW. He was well loved by his close family and community. He was described as a kind and generous uncle and loving son. He was outgoing and had many friends. At the time of his death, Dylan had a substance abuse issue and was known to use ice and cannabis.

The role of the Coroner and scope of the inquest.

The role of the Coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The Coroner is also to address issues concerning the manner and cause of the person's death In addition, the Coroner may make recommendations in relation to matters that have the capacity to improve public health and safety.

In this case there is no dispute in relation to the identity, time and place of death or in relation to the medical cause of death. The inquest focussed on the tragic manner of Dylan's death and to questions about whether his death could have been avoided.

Dylan died during a police pursuit and for this reason the inquest has been conducted by a senior coroner, pursuant to the Coroners Act 2009 ("the Act"). It has been observed that "The purposes of a s 23 Inquest are to fully examine the circumstances of any death in which police…have been involved, in order that the public, the relatives and the relevant agency can become aware of those circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers…will be thoroughly reviewed. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s 82."

In recent times the complex issues surrounding police pursuits have been widely debated in public and have been the subject of significant research and investigation throughout many parts of the world. A number of the issues as they relate to NSW have previously been examined extensively in this Court. The issues clearly have a wide public interest. The question of whether or in what circumstances police should pursue a vehicle is a complex one and one that has been approached differently in various jurisdictions.

There are no obvious or easy answers and reasonable people may differ on the correct approach to take. Ultimately it involves a careful balance between interests that at times conflict – the need to ensure the road safety of all citizens and the need for consistent law enforcement. Providing police with sound guidance in the operation of their discretion to pursue becomes a difficult but necessary task, particularly because decisions to pursue are so often made quickly and in highly stressful circumstances. Over the years, many in the community have been rightly concerned at the number of deaths arising from police pursuits. As the Commissioner of Police, Mr Andrew Scipione states in his foreword to the current Police Safe Driving Policy, "the police motor vehicle, if used irresponsibly and inappropriately can result in it being the most deadly weapon in the police arsenal. Police do not have to keep going until told to terminate…Please be assured that any decision to terminate a pursuit, for your safety or others, will not result in criticism."

A list of issues relevant to Dylan's death was circulated prior to the inquest commencing. The following questions were posed.

- Was the pursuit conducted in accordance with the NSW Police Force Safe Driving
- Policy (SDP)? In particular;
- Was it reasonable to commence and continue the pursuit?
- Did the conduct of the pursuit comply with the SDP (including the adequacy of the communication with police radio VKG)?
- Have any changes in the NSW Police Force practice or policy been instituted as a result of this incident or in response to recent coronial recommendations?

- Ought any recommendations to be made pursuant to s 82 of the Coroners Act 2009?

The Inquest proceeded over two days. A large number of statements were tendered, as were photographs, maps of the area, expert reports, and audio and visual recordings. Oral evidence was also received, including from both officers involved in the pursuit

Background

On 27 June 2014, Dylan Maher was driving a red Holden commodore (BH93JV) in the Berkley area. The car did not belong to Dylan and had been reported stolen on 13 June 2014 from a service station in Wollongong. At around 3.20pm Senior Constable Mark Deans and Sergeant Shane Brown from Lake Illawarra Target Action Group were driving in a fully marked police vehicle on Winnima Way, Berkley when they saw the red Commodore. At that time the officers had no idea the vehicle was stolen and noticed it only because of the way it was being driven.

Senior Constable Mark Deans was driving, and Sergeant Shane Brown was in the passenger seat. Senior Constable Mark Deans activated the lights and sirens on the police vehicle in an attempt to signal the driver to pull over, instead, the red car drove off at speed. Policed then notified VKG that they were in pursuit. Almost immediately the Police vehicle struck traffic and the officers lost sight of the red car for a short time.

Just 72 seconds after the pursuit had been notified, Senior Constable Mark Deans told VKG that there had been an accident. The red car had hit a power pole on Northcliff Drive and the driver, later identified as Dylan Maher, had been ejected from the vehicle. He was unconscious. The ambulance and NSW Fire brigade attended. Dylan was treated at the scene, but did not recover and was later pronounced dead at Wollongong Hospital.

Identification

Dylan was identified at the scene that evening by his cousin, Alana Maher. Police also found that there were personal documents including his birth certificate on the roadway and inside the vehicle. Dylan’s identity was later formally confirmed by fingerprints.

The Autopsy

On 28 June 2014, an autopsy was conducted by Dr Rebecca Irvine at The Department of Forensic Medicine, Glebe. Dylan was found to have multiple injuries as a result of the accident. The most serious of which included avulsion of the brain stem and multiple skull fractures. It was the Doctor's view that the brain stem injury was significant enough to have caused virtually immediate brain death. Dylan also had lung collapse, other multiple bodily fractures and lacerations to his kidney and liver, among other injuries.

Toxicological examination revealed the presence of methylamphetamine in a blood concentration that would be classed as within the lethal range. However, there is significant overlap between toxic and non-toxic concentrations and it appears from other evidence that Dylan was a regular user of the drug. He also tested positive to cannabinoids.

Expert opinion was obtained from Dr William Allender, of the NSW Police Force's Clinical Forensic Medicine Unit in relation to the likely impact of the observed drug levels on Dylan's capacity to control a motor vehicle. Given the high levels found in his blood, it was Dr Allender's view that at the time of driving Dylan would have been under the influence of methylamphetamine and cannabis "to the extent that his driving ability would have been substantially impaired".

The Investigation

After the collision there was an extensive police investigation into all aspects of Dylan's death. The death was quickly identified as a "critical incident" and Detective Senior Sergeant Darren Kelly was tasked to take charge of the investigation. It appears that the relevant investigative protocols were correctly undertaken. Both officers involved were separated and drug and alcohol tested. They were directed and gave typed interviews within an appropriate time frame. Outside officers were brought in to assist and ensure independence. A substantial effort was made immediately and in the days following to locate independent witnesses to the collision and to the course of driving that preceded it. A canvass occurred in the local area and CCTV, where available, was obtained. The relevant police radio recordings were secured. The roadway and both vehicles were examined and tested. I am of the view that the investigation of this tragic incident was both thorough and properly conducted.

Dylan's manner of driving prior to the pursuit

Over forty independent witness statements were obtained in this matter. Taken together they assist the Court in understanding how the pursuit developed and how the collision occurred.

As one would expect, there was some individual variation in the statements and some conflicting details such as when or if the lights and sirens were turned on and in relation to the estimates of the exact speed each vehicle was travelling. However it is important to note that there is no suggestion in any statement that the police car was directly behind the vehicle Dylan was driving at the time of the crash or that it touched his car or forced it towards the pole. This is of course consistent with the forensic examination of the motor vehicles at the scene.

It is also important to note that the weight of the evidence is that the vehicle Dylan was driving was going well above the speed limit and way too fast for the road conditions. An expert estimated that the vehicle Dylan was driving was travelling a minimum of 119.91 kilometres per hour around the time of the collision, substantially above the posted 70km/h limit.

Two independent eye witnesses were also called to give oral evidence. Around 3.20pm on Friday 27 June 2014, Geoffrey Manksie and his partner Carly Dorahy were driving to a doctor's appointment at the Berkley Medical Centre. Carly was driving and they were both familiar with the area. As they drove towards the intersection of Parkway Avenue and Winnima Way they both noticed a red Commodore coming in the opposite direction towards them.

In his statement to police Mr Manskie stated that the driver of the red car "was driving along at a normal speed for the conditions at about 40 or 50 kilometres an hour but that quickly changed". He noticed the police car behind the red vehicle and almost immediately "the red Commodore accelerated off towards Parkway Avenue at an erratic speed." He observed the vehicle to be travelling fast and noticed that it did not slow down to give them right of way. He commented that if his partner had not slowed, there would have been a serious accident. Mr Manskie said he watched the red Commodore as it went down Parkway Avenue and he saw that the car moved onto the wrong side of the road, the driver was not wearing a seatbelt and it looked dangerous. In court he agreed the red car was driving in a reckless and foolhardy manner.

Ms Dorahy's account was similar. She stated that she had to stop to avoid a collision with the red car. The red vehicle did not indicate and took the corner at around 80km an hour. She saw the car "fish tail" up Parkway Avenue. Ms Dorahy was worried about the real danger to pedestrians and remembered commenting to her partner "that guy is going to kill someone. Or himself". She saw the police chase the red car. It was her view that the police were also travelling at speed but appeared to be "more in control".

She gave strong oral evidence, she confirmed the red car was "going too fast", it was "flying" and "erratic". As she watched it go down Winnima Way, it was "fishtailing" and swerving. Ms Dorahy gave evidence of the police lights coming on and of the pursuit commencing. She was very concerned at how dangerous the situation was and thought the police officers acted appropriately in trying to stop the car.

What was the reason given for the commencement of the pursuit?

Both the driver of the police vehicle, Senior Constable Mark Deans and his passenger, Sergeant Shane Brown gave directed interviews on the evening of 27 June 2014 and gave oral evidence before me. Their evidence to the inquest was clear and forthright. In my view they were trying to assist the court by giving their honest recollection of events at all times.

While it is possible their assessment of Dylan's driving is affected to some degree with hindsight of the tragedy that unfolded, I am certainly satisfied, given the independent eye witness accounts, that police had sufficient cause to attempt to stop the red car when they did.

Senior Constable Mark Deans was an experienced police officer with silver certification as a police driver. He had previous experience of being involved in a variety of police pursuits. He was aware of the Safe Driving Policy and the factors he needed to consider when initiating a pursuit.

On 27 June 2015 Senior Constable Deans was driving a fully marked police vehicle on Winnima Way, when he noticed a white sedan come around the corner near the Berkley Sports and Social Club. Immediately afterwards he noticed a red coloured Commodore sedan come at speed around the same corner as the white vehicle. What raised his attention was "the speed it was doing and how close it was to the other car".

At that time Sergeant Brown said to him “we’ll have a look at that one”. As they passed the red car the driver leaned down and it was Senior Constable Dean’s view that he was trying to avoid being identified. The officer immediately conducted a u-turn with the intention of pulling the red car over for a breath test. Shortly afterwards Sergeant Brown told him to hit the sirens as “I think we are going to be in pursuit”.

In his evidence to the inquest, Senior Constable Deans clarified that the red car was to be stopped for its speed, dangerous manner of driving and to conduct a breath test. He considered the offences serious, noting that the “drive in a manner dangerous” charge was “gaolable”. He was unable to get a number plate and his vehicle was not fitted with a number plate recognition facility. He did not know the car was stolen and was not able to recognise the driver. Once the car had failed to stop he believed he was well within policy to pursue it.

Sergeant Brown was also an experienced police officer with silver certification. He gave evidence in similar terms. It was the manner and speed of the red vehicle that caught his attention. It was so close to the car in front, Sergeant Brown was of the view it could not have safely stopped had it needed to. It was Sergeant Brown’s evidence that he called the pursuit halfway down Parkway Avenue. He was of the view that they had no other means of responding to what was obviously dangerous driving. Once the vehicle pulled away there was no chance to get the registration plates or any chance of identifying the driver.

The course of the pursuit

The Court received detailed evidence outlining the course of the pursuit. It was a short course of driving, and while it is somewhat hard to determine the exact moment the pursuit commenced, it can be safely estimated to have been less than 2 kilometres in total length. The pursuit commenced in or near a shopping precinct. Winnima Way is a built up area and has a speed limit of 50 km per hour. The road loops back on itself and is connected by Parkway Avenue. There is a pedestrian crossing where the cars would have travelled from Parkway Avenue south on Winnima Way towards Wilkinson Street. After several hundred metres Winnima Way merges into Wilkinson Street as the road bends to the left. There is a stop sign at the intersection of Wilkinson Street and Northcliff Drive.

The route the cars took continued east onto Northcliff Drive. The road at that point is a two lane sealed bitumen carriageway with a grass median. There is also a breakdown lane. At Venn Street there is a 40 kilometre per hour school zone sign that continues until the George Street intersection. This school zone, adjacent to the playground of Illawarra Sports High School was operational at the time of the pursuit. From the intersection at George Street a 70 kilometre per hour speed limit commences and the breakdown lane is merged. There remains a dual carriageway with a grass median and the road starts to veer to the right rising up to the crest of a hill. From Caroona Street there is a metal Armco railing that runs along the grass central strip.

Prior to reaching the crest of the hill there is a slight dip in the road. At the crest the road bends to the left somewhat and narrows at the collision site.

During the course of the pursuit, the police officers lost sight of the red vehicle due to other traffic on the road. It appears that as a result, Dylan Maher was able to gain some distance on the police. When the police vehicle crested the hill, the collision had already occurred. It appears that Dylan had lost control of the vehicle and collided heavily with a power pole. He was not wearing a seatbelt and was ejected from the vehicle onto the roadway.

Beyond the collision site, the road continues its downhill slope and travels through another school zone.

The Safe Driving Policy

The Safe Driving Policy (SDP) is a NSW Police Force internal policy document which guides police driving practice and strategies, including the conduct of high speed pursuits. The Traffic Services Branch is responsible for the policy, which is updated from time to time. The latest version (7.2) was published in November 2009, and has a stated review date of November 2010. A copy of that document was tendered. The Court was also greatly assisted by the evidence of Sergeant Kris Cooper who is the Senior Policy Advisor to the Assistant Commissioner for Traffic. He has responsibility for policy aspects in relation to the review of the SDP.

Since the last review of this policy, there have been significant changes to similar policies in other Australian jurisdictions and overseas. The Court was informed that Queensland, for example has greatly restricted the circumstances where pursuits are commenced. There have also been a number of recommendations from NSW Coroners about the current operation of the policy in NSW.

Unfortunately, while it appears certain a substantial review of the policy has already occurred, the new document has not yet been released. Sergeant Kris Cooper, of the Traffic Policy Sectiongave evidence at the inquest, indicating that there were some substantial changes to the wording of the policy likely to emerge from the review process but given that the document was still with the Minister for Police, the proposed changes could not yet be revealed. It was even suggested that further Coronial recommendations in relation to the SDP might slow the process for the release of the new policy. Given this evidence it certainly appears to be a task of no lasting benefit to embark on a detailed critique of a policy that is, in effect, already surpassed. Nevertheless it is necessary to consider the policy at least in general terms.

Part 6 of the SDP deals with 'Urgent Duty and Pursuits".

Deciding to initiate a pursuit is an inherently difficult balancing exercise

I am of the view that the policy issues raised in this regard have been well ventilated in Deputy State Coroner Dillon's detailed findings in the Inquest into the Death Of Hamish Raj, and given the evidence of Sergeant Cooper that those considerations have recently been considered, it seems unnecessary
to repeat them at this point.

Was the pursuit compliant with the Safe Driving Policy?

The Safe Driving Policy mandates, among other matters, and level of driver certification that are pre-requisites for a pursuit. In this case

Sergeant Cooper's review of the incident on 27 June 2014 found it compliant in relation to all matters clearly mandated in the policy and I note that an alternative analysis was not suggested by the legal representative who appeared for the Maher Family. I accept Sergeant Cooper's analysis in relation to these matters.

From the evidence before me, the decision to pursue was also compliant with the policy, given the broad discretion involved. In simple terms, the officers regarded the driving conduct as dangerous, they signalled for the driver to stop and when he did not, they called a pursuit, immediately contacting police radio. Having listened to the VKG tape, it is clear the siren was engaged, giving Dylan fair warning to pull over. I accept that the police were unable to see the registration plates or to identify the driver, which may have given them an alternative option of dealing with him by a court attendance notice at a later date. I am also satisfied that given the length of the pursuit – that is around 72 seconds, there is no clear evidence that the police continued the pursuit improperly. I note both officers gave evidence that once they got to the top of the hill they would have reconsidered the pursuit, taking into account whether or not they could still see the red vehicle, among other factors. It was Sergeant Brown's evidence that termination was already in his mind as an as yet uncommunicated possibility.

As the Safe Driving Policy is currently worded, police are given a wide discretion about when it is appropriate to commence and continue with a pursuit.

There is no specific guidance given to forbidding or discouraging pursuits in certain areas or at certain times of the day [redacted] there are few mandatory requirements once there is reasonable cause to believe an offence has been committed or attempted and the alleged offender has commenced to evade apprehension.

The decision to initiate a pursuit involves weighing the need to immediately apprehend the offender against the degree of risk to the community and police as a result of the pursuit. In practice, police are required to make a quick decision and to evaluate whether to continue while concentrating on assessing the various specific dangers as they arise.

Once a pursuit has been commenced, police are obliged under the policy to continually re-evaluate this decision to pursue and to decide whether to continue or not by again "weighing the need to immediately apprehend the offender against the risk to the community and police as a result of the pursuit".

Both police officers had some knowledge of the local conditions which they said they took into account when assessing the risks involved once the pursuit was underway. Senior Constable Deans, for example stated that he took into account the dangers posed by the school zone at Illawarra Sports High School, but was aware that the school was set back from the road and that students did not generally congregate around the Northcliff Drive area. Both officers said they took into account what they observed in terms of the number of people around and the amount of traffic present. Sergeant Cooper described the risk assessment process as an evolving or dynamic situation, which needs to recognise that conditions can change depending on all kinds of factors including the time of day, weather and number of people about.

Both officers were examined in relation to the potential dangers ahead, including the fact that had the pursuit continued the vehicles would have entered another school zone, this time relating to a primary school situated closer to the road. They were questioned on the difficulty of assessing this kind of risk in circumstances where the other vehicle has already pulled away and may already be confronting dangers unseen or uncontemplated by the pursuing vehicle.

The policy provides that the VKG supervisor also has the right to terminate a pursuit.

However, given the pursuit only lasted 72 seconds, there was in my view little chance that real guidance or oversight was possible from the VKG supervisor in this case. The VKG operator had only just begun to get the necessary information from the police involved by the time the collision had actually occurred. Sergeant McCann, the VKG supervisor had very little information with which to properly consider termination. He did not even know the reason for the pursuit. Sergeant Brown was only able to communicate a small amount of information once the broadcast channel had been cleared.

The challenge of providing proper oversight of pursuits is a real one. Sergeant Cooper gave evidence that during the last year, 67% of pursuits conducted by NSW Police were concluded in two minutes, 19% were over in one minute. Realistically, as we have seen in the circumstances of this case, that provides limited opportunity for meaningful oversight, particularly in urban areas or where the radio is not immediately cleared so that information can be shared quickly.

It is clear that technological advancements may continue to assist in this regard. In this case the police vehicle involved in the pursuit does not appear to have been fitted with a mobile CAD unit that could transmit its location directly to the supervisor monitoring the pursuit. However it was Sergeant Cooper's evidence that a broad roll out of that technology, providing the capacity for more accurate and objective information for supervising officers, is currently a priority for the NSW Police Force. Similarly in certain circumstances the need for some pursuits may be less pressing with the continued roll out of mobile Automatic Number Plate Recognition (ANPR) technology.

Was Dylan's death avoidable?

Dylan Maher's death is a terrible tragedy that commenced with a traffic offence. It is crucial that as a community we are able to question whether the balance struck by law enforcement on that day was the correct one and to question the basis of the policies involved.

In this case it is difficult to know what might have happened had the police decided not to pursue the red car or had decided to terminate the pursuit prior to reaching the crest of the hill. It is important to note that such a decision would also have been compliant with current policy.

With hindsight it is clear from the toxicology results that Dylan was drug affected and that his driving and judgement may have been impaired to a significant extent.

He knew he was in a stolen car and may have made a decision to flee as soon as he saw the police, that is, even prior to the police decision to commence a pursuit.

It certainly seems likely from the evidence of independent witnesses that Dylan's driving was affected prior to the police giving chase. It follows that it is also possible, given his manner of driving, that an accident injuring himself or others may have occurred even without police involvement. Equally it is possible that his risky manner of driving may have continued even if police had terminated their pursuit. At the time of the collision Dylan was already well out of sight. He would not have immediately known had the pursuit been terminated, even if police had stopped well prior to reaching the crest of the hill. It is certainly possible that he may have lost control believing police were still behind him, even if the pursuit had already been terminated. At the time of his collision Dylan was hurtling towards another school zone, just 800 metres ahead, the potential danger at that time was certainly extreme.

In some circumstances, without the benefit of hindsight, it is difficult to know with any certainty whether a police pursuit will increase or decrease the risk of a road fatality. Sergeant Cooper stated in evidence that statistics for the last year showed that 30% of offending drivers stop once a pursuit commences and for this reason it must properly be regarded as a valid law enforcement technique. Nevertheless pursuits are inherently dangerous and should perhaps be reserved for situations where the dangers clearly outweigh the risks involved.

The decision to pursue on this occasion was made in a manner that was compliant with the Police Force's current Safe Driving Policy. It may be that the policy does not provide adequate guidance for officers in the field. [redacted] This Court awaits the new policy document with great expectation.

Recommendations

It appeared from the evidence of Sergeant Cooper that Deputy State Coroner Dillon's detailed recommendations made in relation to the Safe Driving Policy at the conclusion of the Inquest into the Death of Hamish Raj, have already been considered as part of the current policy review.

This includes such issues as clarifying the language of the policy that guides police discretion in relation to the initiation and continuation of pursuits. In particular, Sergeant Cooper indicated that the guidance given to police in the exercise of their discretion had been carefully considered and change is afoot. I am of the view that the facts of this case do not raise issues which extend beyond those already raised by Deputy State Coroner Dillon in his comprehensive review of the SDP in the Raj inquest and for that reason I am satisfied that any concerns this court may have arising out of the circumstances of this inquest, will already have been recently considered by those redrafting the relevant policy.

It is disappointing that a new policy has not been released 5 years after its stated review date. I am keen not to delay the release of that document any further. I support the recommendations made in the Raj inquest, but I decline to make any further formal recommendations in this matter.

Formal Finding: On the balance of probabilities,

I find that Dylan Maher died at approximately 3.21pm on 27 June 2014 on the roadside of Northcliff Drive, Berkley. The cause of death was multiple injuries sustained as a result of the collision of the car he was driving with a power pole and from being ejected from that vehicle. The manner of his death was as a result of crashing during a police pursuit.

31. 221203 of 2014

Inquest into the death of Neal Richardson finding handed down by Deputy State Coroner Truscott at Glebe on the17th February 2015.

This is a mandatory Inquest into the death of a person in custody pursuant to section 23(d) of the Coroners Act 2009.

Neal Richardson was born on 14 May 1966 in United States of America. His family relocated to Australia, his father died in 1985 and his mother in 1996. He has a brother Craig who is aware of today's proceedings.

In about 1997 Neal Richardson became addicted to heroin and in about 2002 he commenced the methadone programme. He worked for 12 years in the Qantas library and also as a labourer in the building industry. From about 2005 he lived in Wyee Place Malabar. Over a period of about 13 years, Neal Richardson was arrested and charged on 13 occasions. He spent 2 periods of less than a month respectively in custody during that time. On 4 May 2010 he was arrested and charged with the murder of his de facto wife Nicole Grant with whom he had associated on and off since about 1997. He was ultimately convicted and sentenced to 28 years imprisonment with a 21 year non-parole period. He was serving that sentence when he died.

Prior to entering prison on this last occasion, Neal Richardson had a history of a medical condition referred to as renal calculus. He also had diabetes mellitus treated with insulin delivered by injection.

On 29 April 2014 he had an appointment at Lithgow Base Hospital to undergo X-ray and attend an urologist. This appointment was made as 2 days prior a CT scan had revealed calculus in the wall of the bladder and multiple small intra-renal calculi within the medullary pyramids of both kidneys. Mr Richardson cancelled the appointment as it coincided with another arrangement he had. He said he had no further pain or haematuria.

The sequence of events which follows is set out in a letter dated 27 August 2014 to Peter Severin Commissioner of Corrective Services NSW from Dr Karin Lines, Acting Chief Executive Justice Health and Forensic Mental Health Network.

This is located at Tab 6 of the brief identified as "Justice Health (JHFMHN) Patient Health Record. Between 30 May and 23 June 2014 Neal Richardson attended the Health Centre at Lithgow prison primarily for pain, originally associated with a kidney stone which he passed on 6 May. He also had an infiltrating basal cell carcinoma removed from his nose. On 4 June and 11 June he complained of chronic pain to his hands, shoulders, back, hips and most joints for which he was prescribed Panadeine. He was unable to be reviewed on 19 June as the visiting medical officer was not available.

On 23 June 2014 Neal Richardson complained of severe back and central abdominal pain. He was transferred to and admitted to Lithgow Base Hospital and underwent CT scans. It was identified then that since his scan on 27 April 2014, metastatic disease with multiple liver lesions and lung lesions had developed. There was also a left adrenal lesion and a bony metastasis of the L4 vertebrae. That day he was transferred to Long Bay Prison Hospital.

On 24 June 2014 Neal Richardson was transferred to Prince of Wales Hospital where he remained until his death on 26 July 2014. He received appropriate palliative care and treatment. He was last attended at 0300 a.m and at 0400 a.m he was found in bed unresponsive. He was declared deceased at 0420 a.m.

His death was reported to the Coroner and upon medical review an autopsy was dispensed with and a coronial certificate was issued. There are no issues arising from this Inquest. Accordingly I now make my formal findings:

Formal Finding:

Neal Richardson died on 26 July 2014 at Prince of Wales Hospital Randwick. His cause of death was natural, namely large cell carcinoma of lung with metastases; he died in palliative care.

32. 226574 of 2014

Inquest into the death of Joseph Gumley. Inquest suspended by Deputy State Coroner Truscott at Glebe on the 14th September 2015.

Joseph Gumley 47 old was a patient of the high dependency observation ward, Elouera West mental health Unit, Shellharbour Hospital.

Mr Gumley was an involuntary patient with several diagnosed mental health issues. Mr Gumley was located deceased in his bed by staff on the morning of 31 July 2013. The cause of his death was unnatural.

The Coroner having been informed by Police that a known person has been charged with an indictable offence arising out of the death suspended the inquest on the 14th September 2015.

33. 229687 of 2014

Inquest into the death of Kelvin Gardoll finding handed down by Deputy State Coroner Forbes at Glebe on the 19th October 2015.

Introduction

This inquest concerns the death of Kelvin George Gardoll who died on 4 August 2014. He was a 61 year old man who was an inmate at Bathurst Gaol.

His death was reported because it occurred whilst he was in custody. An inquest is mandatory pursuant to the combined operation of ss. 27 and 23 of the *Coroners Act 2009.*

"The purposes of a s.23 Inquest are to fully examine the circumstances of any death in custody …… in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."[14]

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

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

This Inquest has been a close examination of the circumstances surrounding Mr Gardoll's death and pursuant to s.37 of the *Coroner's Act 2009* a summary of the details of this case will be reported to Parliament.

Mr Gardoll

Mr Gardoll was from Wellington, NSW. He had 8 children and 5 siblings. He primarily worked as a labourer and he also worked at a mine in Newcastle.

At the time he entered custody in September 2011 he had a number of chronic health issues including diabetes mellitus, moderate chronic kidney disease, chronic obstructive pulmonary disease, ischaemic heart disease and chronic emphasymia. He also suffered from painful diabetic peripheral neuropathy which was controlled with Gabapentin.

His earliest release date was 2 September 2015. In 2011 whilst he was in custody he had a mole removed from his back. In June 2013 a CT scan was performed of his chest and imaging results indicated that he had multiple lesions in his lung.

On 15 June 2013, he was transported to Long Bay Gaol. He was admitted to Prince of Wales Hospital, Randwick on several occasions to receive chemotherapy and radiotherapy in an attempt to reduce the size of the tumours.

On 17 July 2013 Dr Christopher Pene, Prince of Wales Hospital, reported to the gaol that Mr Gardoll had received his first cycle of palliative chemotherapy. He noted that Mr Gardoll had bilateral lung lesions in the right lower and left upper lobes and left hilum and a chronic left interlobar arterial occlusion. According to Detective Brad Young, Mr Gardoll was aware that his condition was terminal and an Advanced Care Directive was signed by Mr Gardoll that he was not for resuscitation. This directive was reviewed 3 monthly and continued until his death.

Mr Gardoll remained under the joint care of Long Bay Hospital and the Prince of Wales Hospital Palliative Care Team providing regular review. He was located at the Medical Sub Acute Unit for Palliative Care at the Long Bay Hospital. In June 2014 his disease progression caused increased shortness of breath and pain requiring intermittent oxygen therapy. On the 15th July he experienced a fall and his health continued to deteriorate due to increased pain, nausea, vomiting and shortness of breath. At this point, palliative chemotherapy treatment had ceased.

On the 3rd August 2014 it is recorded in the medical notes that he had poor oxygen saturation and required assistance with his daily care. On the morning of 4 August 2014 his family visited him for the last time. At about 12.15pm on 4th August 2014 he passed away in the Long Bay Hospital.

His room was secured by Corrective Services New South Wales (CSNSW) in accordance with Policy and Procedures, who awaited the arrival of Police and CSNSW Investigators.

At 2.10pm, Detective Brad Young from the Corrective Services Investigations Unit attended the gaol and commenced the investigation. Detective Young did not find any indication of anything suspicious or untoward surrounding his death

Detective Young spoke to Mr Gardoll's sister, Ms Debbie Jones who had no issues or concerns regarding the management and care of Mr Gardoll whilst in prison. She indicated that he had made no complaints about the medical treatment that had been provided to him. Ms Jones described how she and members of the family had visited him on the morning of his death and his sister recalled how happy he was to have seen his family that morning.

A Post Mortem was conducted by Dr Brouwer on Tuesday 5th August 2014 who determined that the cause of death was lung carcinoma.

Mr Gardoll's medical history consisted of 7 volumes of material with detailed progress notes recorded of his treatment whilst in custody. The medical notes also record the various medications he was administered during his custody for his cancer treatment and pain relief.

Medical Review of Care and Treatment

A review of his medical treatment was undertaken by Dr Katerina Lagios, New South Wales Justice Health & Forensic Mental Health Network[15]. This review was initiated as a result of a comment that had been made by Ms Debbie Jones to Detective Young as to whether the removal of the mole on his back may have been connected to his subsequent development of lung cancer.

Dr Lagios provided a chronology of his treatment whilst in custody surrounding the removal of his mole. She stated

On 22 June 2010 it was recorded he had a 'scaly patch between scapulae' which was recorded by the GP.

On the 6th August 2010- there was a review of the lesion and it recorded that George preferred to wait till after court in October before the lesion was excised

On the 23rd November 2010 the lesion on his back was excised with 4 x sutures placed by the GP

On the 9th December 2010, the Histopathology of the excised Lesion recorded:

-specimen 15mm x 7mm and 6mm thickness, bearing on it's outer surface a keratotic lesion measuring 4mm,

-Histopathological diagnosis: central intraepithelial squamous cell carcinoma

basement membrane intact

no evidence of invasive lesion in the dermis which shows lymphocytic infiltration

-Excision line is clear of the lesion.

According to Dr Lagios, the skin lesion was removed in accordance with the Australian Guidelines and the removal of the lesion was localised. She reported that his histopathology was reviewed by the GP and it was an *'unremarkable clinical examination for axilla and neck lymphadenopathy*'.

Dr Lagios review went on to note that in August 2011 Mr Gardoll had a chest X-ray and cardiac review as a result of recurrent dysponea and chest pain and that nil abnormalities were found.

She reported that on 8th May 2012 he had a further CT of his chest and the findings at that time indicated *'on examination the right lower lobe bronchi are patent but there is little peribronchial inflammatory change around the basal segmental bronchi in the right lower lobe, which has not completely cleared. It said the appearances are consistent with a slowly resolving inflammatory process"*

Dr Lagios noted that on 17th April 2013 the medical notes stated that Mr Gardoll had been complaining of chest pain radiating down his L arm and through his back which he had for 3 days. It recorded his past relevant medical history included *'emphysema and hypertension'*. Medical staff sought to refer him at the time to Hospital for a review although the notes say *'patient refused and signed a cancellation form'*. The following day he did have a blood test which indicated that his white cell count WCC appeared to be in normal range.

Mr Gardoll continued to develop chest symptoms and on 3rd June 2013 he had a chest X-ray at Bathurst Hospital which indicated that he had a 38mm diameter rounded lesion in the right lower lobe of his lung.

On 12 June 2013 a further CT was performed on his chest at Bathurst Hospital which highlighted that there had been considerable change since the previous examination.

It recorded that *'a mass of 30mm in diameter has developed in the right lower lobe in the area of the previous consolidation that was eventually diagnosed to be a lung squamous cell carcinoma'.*

According to Dr Lagios, he had many lung lesions but nil lesions were identified in the brain, abdomen, pelvis or bony areas. Dr Lagios noted that Mr Gardoll did have the risk factors for developing this disease because of his lengthy history of smoking. She was of the opinion that his care and treatment whilst he was in custody was appropriate.

Conclusion

I am satisfied that Mr Gardoll died of natural causes and that his medical care and treatment in custody was appropriate.

Formal Finding:

I find that Kelvin George Gardoll died on 4 August 2014 at Long Bay Gaol Hospital, Malabar, NSW. I am satisfied the cause of his death was lung carcinoma and the manner of his death was natural causes.

34. 239934 of 2014

Inquest into the death of Allan Gillard finding handed down by Deputy State Coroner Dillon at Glebe on the 17th February 2015.

Allan Raymond Gillard born on the 30th October 1946 was arrested for child sex offences in 2014 remanded in custody and ultimately incarcerated on the 11th June 2014 at the Long Bay Correctional Complex Hospital for treatment of a pre existing throat cancer.

His cancer was end stage and despite ongoing treatment his condition continued to deteriorate. On the 27th June the deceased signed a non resuscitation order. In the days leading to his death he became increasingly confused and ceased eating and drinking. During the evening of the 13th and 14th August his condition was such that he could not talk, he was extremely unsettled and close to death, he was administered morphine and oxygen for pain. At 4am he was found deceased in his bed.

Nil recommendations warranted.

Formal Finding

I find that Allan Raymond Gillard died on the 14th August 2014 at the Long Bay Correctional Medical and Surgical Unit due to metastatic squamous cell carcinoma of the tongue. The manner of death was natural causes.

35. 253769 of 2014

Inquest into the death of Robert Britten finding handed down by Deputy State Coroner Truscott at Glebe on the 13th March 2015.

This inquest concerns the death of Robert Gordon Britten who was a forensic patient under the Mental Health (Forensic Provisions) Act 1990 (MH (FP) Act). Mr Britten was detained in a unit of the Macquarie Hospital known as “Lavender House” which is a 30 bed secure Rehabilitation Unit for Older people who have a mental illness and challenging behaviour. The facility is a “Declared Inpatient Mental Health Facility” so gazetted on 9 March 2001.

Mr Britten had been admitted to Lavender House in July 2009. On 11 February 2004 in the District Court, Mr Britten was been found not guilty by reason of mental illness of charges of attempt aggravated sexual intercourse with child under 16 and aggravated indecent assault of child under the age of 16. He had been arrested on the day of the alleged offence being 7 March 2002. Following the finding of not guilty by reason of mental illness Mr Britten was detained in the Long Bay Prison Hospital until his transfer to Morisset Hospital on 1 March 2007 but he was transferred back to Long Bay Prison Hospital on 5 June 2007 where he remained until his transfer to the Forensic Hospital. On 19 August 2009 Mr Britten was transferred to Macquarie Hospital, specifically the Lavender House secure unit.

In 30 March 2010 the Mental Health Tribunal determined it was appropriate to review Mr Britten every 12 months and his reviews have been annual reviews since that time. His last review was on 25 March 2014 under s46 (1) of the MH (FP) Act. The Tribunal had determined to continue Mr Britten’s detention due to his physical state and mental illness (see s43 of the MH (FP) Act. The Tribunal determined to again review Mr Britten in 12 months.

From 25 March to 28 August 2014 Mr Britten’s physical health continued to deteriorate. The record shows that his treating doctor, Dr G McLean signed “End of Life-Care orders” on 3/11/13 following a previous directive dated4/10/2012. The document indicates that Mr Britten did not have capacity to consent nor was there a family member or guardian involved. From the records by at least early August 2014 he appears to have been mainly bedridden and dependent on oxygen by mask.

By mid to late August he was receiving palliative care until his death on 28 August 2014 when he was found deceased in bed that morning.

From a review of the medical records relating to the months prior to his death, it is apparent that Mr Britten received appropriate and adequate care and treatment whilst he was a detained in Lavender House under Mental Health (Forensic Provisions) Act.

On 4 September 2014 a Coronial Certificate setting out the cause of Mr Britten's death was issued by the Coroner's Office in Glebe. Mr Britten's death, though natural and not unexpected, was required to be reported to the Coroner under s6 (f) of the Coroner s Act 2009 as died in a declared mental health facility within the meaning of the Mental Health Act 2007 and while the person was a resident at the facility for the purpose of receiving care, treatment and assistance. That was not the sole purpose of Mr Britten's detention though it can be said he was receiving care, treatment and assistance.

Under s27 (b) of the Coroners Act an Inquest is required to be had if jurisdiction arises under s23 which is entitled "Jurisdiction concerning deaths in custody or as a result of a police operation. Section 23 relevantly provides jurisdiction to a Senior Coroner to hold an inquest concerning the death of a person if it appears to the coroner that the person had died (a) while in the custody of a police officer or in some other lawful custody. There is no definition of what constitutes that "other lawful custody" but under (d) a "detention centre" within the meaning of the Children's Detention Centre Act 1987, a correctional centre within the meaning of the Crimes (Administration of Sentences) Act 1999 or a lock up is specified if the death occurred in one of those places or where the deceased was temporarily absent from one of those places.

A person resident in a declared mental health facility for the purpose of receiving care treatment and assistance is not necessarily a detained person under the Mental Health Act a person can be resident as both an involuntary or voluntary patient. If an involuntary patient leaves the premises without permission an order for their apprehension and detention can be made under s49 of the Mental Health Act 2007. Under s59 Mental Health (Forensic Provisions) Act 1990 a Mental Health Tribunal can order a forensic patient to be transferred back to a correctional centre. The Mental Health (Forensic Provisions) Act 1990 distinguishes a forensic patient from a correctional patient or an involuntary patient (under the Mental Health Act): see s3 definitions and sections s41and 42:

"Correctional patient" means a person (other than a forensic patient) who has been

Transferred from a correctional centre to a mental health facility while serving a

Sentence of imprisonment, or while on remand, and who has not been classified by

The Tribunal as an involuntary patient.

Mr Britten has never been classified as an involuntary patient by the Mental Health Tribunal – he has always remained as a Forensic Patient. Under s54 a person who ceases to be a forensic patient (other than a person classified as an involuntary patient under section 53) must be discharged from the mental health facility in which the person is detained.

The word detained must refer to being lawfully detained. Indeed section 70 Mental Health (Forensic Provisions) Act 1990 refers to a person who is absent from a mental health facility without a leave of absence by the Tribunal under s75 as an "escapee" who is liable to be apprehended and detained:

A forensic patient or correctional patient who escapes from a mental health facility or other place may be apprehended at any time by any of the following persons:

the medical superintendent of the mental health facility or any other suitably qualified person employed in the mental health facility who is authorised to do so by the medical superintendent, a police officer, a person authorised by the Director-General or the medical superintendent, a person assisting a person referred to in paragraph (a), (b) or (c).

On being apprehended, the patient is to be conveyed to and detained in the mental health facility or other place from which the patient escaped. This section does not affect any power of any other person to apprehend a person under the *Crimes (Administration of Sentences) Act 1999.*

Mr Britten had been in lawful custody since his arrest on 7 March 2002, initially police custody until his transfer to corrections custody from Queanbeyan Local Court on 12 March 2002. He remained solely in corrections custody until his first transfer to a mental health facility on 5 March 2007 and his was transferred back and forth between a mental health facility and a corrections centre until his final transfer in 2009 to Lavender House.

I would think that under those circumstances he is in “lawful custody” at the time of his death and I accordingly consider that the Inquest is mandated under s27 of the Coroners Act.

Formal Finding:

That Robert Gordon Britten died on 28 August 2014 of natural causes at Macquarie Hospital North Ryde. The direct cause of death was bronchopneumonia with underlying Chronic Obstructive Pulmonary Disease. Other conditions included congestive cardiac failure, organic brain syndrome, dementia and epilepsy. At the time of his death Robert Gordon Britten was a patient under the Mental Health (Forensic Provisions) Act 1990 and there are no issues regarding his care and treatment.

36. 64664 of 2014

Inquest into the death of Paul Gatien finding handed down by Deputy State Coroner Dillon at Glebe on the 7th December 2015.

This is a Death in Custody under section 23(d) of the Coroners Act as at the time of his death, Mr GATIEN was an inmate and temporarily absent from the Goulburn Correctional Centre.

An inquest into Mr GATIEN'S death is mandatory under section 27 (1) (b) of the Coroners Act.

Mr GATIEN'S next of kin, his twin brother Peter GATIEN, has been notified of today's proceedings. They have that due to a recent death in the family they would not be able to attend today's proceedings.

No parties are in attendance. Only the OIC, Detective Senior Constable Melissa MARTENS was called to give evidence.

Paul Anthony GATIEN was 72 years old at the time of his death and had a number of medical conditions including Ischaemic Heart Disease, Type 2 Diabetes, GORD, Peripheral Neuropathy and Congestive Cardiac Failure. Paul was prescribed a number of medications to manage his conditions.

Paul was arrested and charged by police for a breach of a domestic violence order on 10th February 2015 and following this, he was refused bail and remanded at the Goulburn Correctional Centre. He was scheduled to appear before Goulburn Local Court on 8th April 2015.

On the morning of 25th February 2015, Paul was inside his two-out cell, Cell 15, within A Deck of the multipurpose unit of Goulburn Correctional Centre. His cell mate at the time was Wayne MASON.

Around 8.30am, Wayne MASON told police that he saw Paul was slurring his speech and he was touching both sides of his face. Paul told Wayne '*something's wrong with my face, it's all numb'*. Wayne offered to 'buzz up' and alert correctional officers that Paul needed assistance however he refused. Paul was massaging his left arm. Wayne asked Paul if he was ok and he replied '*nothing's wrong with me, I'm fine*'.

Wayne MASON left the cell to make a phone call as the inmates had been let go. Around 15 minutes later he returned to Cell 15 and saw Paul sitting on a chair. He had his right arm on the desk holding a cup and his left arm was hanging down by his side. Wayne entered the cell and asked Paul if he was alright, Paul responded with a moaning noise and said '*my arm*.' Wayne noticed that Paul's arm was completely limp and realized he needed medical attention.

Correctional officers were called to assist and arrived quickly to attend to Paul. Further nursing staff attended followed by ambulance officers. Paul was transported to Goulburn Base Hospital with a suspected stroke. In the days that followed, Paul received treatment in the Intensive Care Unit at Goulburn Base Hospital. He remained in ICU and on 28th February 2015 he suffered a cardiac arrest following which he remained unresponsive. Following a discussion with Paul's family, a decision was made to remove his breathing aids and he passed away at 10.46pm that evening with life formally pronounced extinct at 12.25am on 1st March 2015.

A Coronial Certificate as to cause of death was issued on 4th March 2015 listing the cause of Mr. Gatien's death as:

Complications of Ischaemic, Hypertensive and Arrhythmogenic Heart Disease in a person with recent MCA Territory Cerebral Ischemia

- No suspicious circumstances were identified.
- Mr. GATIEN's family has not raised any concerns in regards to his care and treatment in custody or at Goulburn Base Hospital.

Formal Finding:

I find that Paul Anthony Gatien died on the 1st March 2015 at the Goulburn base Hospital due to complications of Ischaemic Hypertensive and Arrhythmogenic heart disease with recent MCA territory cerebral Ischaemia.

Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed as at 31 December 2015

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	71675/12	02/03/12	Tamworth	40	Police Op
2	192526/12	19/06/12	Randwick	27	In Custody
3	273783/12	01/09/12	Silverwater	49	In Custody
4	20175/13	21/01/13	Silverwater	30	In Custody
5	114526/13	14/04/13	Cessnock	32	In Custody
6	162787/13	24/05/13	Junee	49	In Custody
7	177495/13	08/06/13	Malabar	37	In Custody
8	203515/13	03/07/13	Nerong	43	Police Op
9	267697/13	03/09/13	Silverwater	38	In Custody
10	286184/13	20/09/13	Coffs Harbour	37	Police Op
11	354840/13	24/11/13	Westmead	33	In Custody
12	59894/14	25/02/14	Parklea	42	In Custody
13	214164/14	19/07/14	Randwick	80	In Custody
14	261690/14	04/09/14	Ryde	54	Police Op
15	286081/14	29/09/14	Baulkham Hills	60	Police Op
16	307093/14	18/10/14	Silverwater	56	In Custody
17	309325/14	21/10/14	Morisset	49	In Custody
18	315543/14	25/10/14	Malabar	60	In Custody
19	341985/14	19/11/14	Macksville	63	Police Op
20	343092/14	20/11/14	Hurstville	18	Police Op
21	368701/14	16/12/14	Sydney	-	Police Op
22	368881/14	16/12/14	Sydney	-	Police Op
23	369898/14	16/12/14	Sydney	50	Police Op
24	379966/14	26/12/14	Cessnock	68	In Custody
25	6538/15	06/01/15	Malabar	32	In Custody
26	7720/15	08/01/15	Westmead	17m	Police Op
27	9161/15	11/01/15	Liverpool	51	In Custody
28	11170/15	11/01/15	Bowral	38	Police Op
29	21976/15	22/01/15	St Leonards	43	Police Op
30	23577/15	24/01/15	Malabar	30	In Custody
31	24641/15	26/01/15	Randwick	82	In Custody
32	32915/15	02/02/15	Malabar	44	In Custody
33	89150/15	06/02/15	Malabar	61	In Custody

34	42730/15	10/02/15	West Hoxton	22	Police Op
35	44176/15	11/02/15	Goulburn	50	In Custody
36	59013/15	24/02/15	Ballina	40	Police Op
37	57379/15	28/02/15	Goulburn	72	In Custody
38	64088/15	01/03/15	Gosford	45	Police Op
39	109556/15	13/04/15	Rankin Park	55	In Custody
40	112961/15	15/04/15	Ballina	45	Police Op
41	116507/15	19/04/15	Randwick	91	In Custody
42	124748/15	27/04/15	Camden	43	Police Op
43	125390/15	27/04/15	Cessnock	32	In Custody
44	139332/15	10/05/15	Berkshire Park	48	In Custody
45	141687/15	12/05/15	Randwick	90	In Custody
46	141693/15	12/05/15	Silverwater	31	In Custody
47	145121/15	14/05/15	Wallendbeen	20	Police Op
48	155740/15	25/05/15	Silverwater	31	In Custody
49	19431/15	02/07/15	Malabar	52	In Custody
50	162071/15	01/06/15	Murwillumbah	28	Police Op
51	208086/15	15/07/15	Maryvale	18	Police Op
52	254391/15	29/08/15	Young	36	Police Op
53	265616/15	09/09/15	Warners Bay	51	Police Op
54	269065/15	11/09/15	Malabar	66	In Custody
55	59317/15	11/09/15	Goulburn	23	In Custody
56	288035/15	01/10/15	Malabar	67	In Custody
57	289369/15	02/10/15	Parramatta	15	Police Op
58	321206/15	31/10/15	Randwick	70	In Custody
59	323840/15	03/11/15	Malabar	74	In Custody
60	323811/15	03/11/15	Wellington	34	In Custody
61	329568/15	09/11/15	Camperdown	25	In Custody
61	336444/15	13/11/15	Malabar	65	In Custody
62	351469/15	26/11/15	Goulburn	46	Police Op
63	363999/15	10/12/15	Tamworth	76	Police Op
64	381722/15	29/12/15	Malabar	26	In Custody
65	382641/15	30/12/15	Rutherford	80	Police Op