



**STATE CORONER'S COURT
OF NEW SOUTH WALES**

Inquest: Inquest into the death of AA

Hearing dates: 7 November 2016

Date of findings: 14 November 2016

Place of findings: NSW State Coroner's Court, Glebe

Findings of: Magistrate Derek Lee, Deputy State Coroner

Catchwords: CORONIAL LAW – self-immolation, suicide, police operation

File numbers: 2015/21976

Representation: Mr C McGorey, Counsel Assisting, instructed by Ms J Murty (Crown Solicitor's Office)

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Non-publication orders:

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*Coroners Act 2009*, the statement of Senior Sergeant Peter Davis dated 12 October 2016 (including all attachments) is not be published.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Act 2009*, the last two paragraphs on page 7 of Annexure E to the statement of Lisa Odgers dated 27 September 2016 is not to be published.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of the *Coroners Act 2009*, annexures A, D, E and F to the statement of Brendan Forde dated 27 September 2016 are not be published.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

Findings:

I find that AA died on 22 January 2015 at Royal North Shore Hospital, St Leonards. The cause of death was complications of thermal injuries as a consequence of actions taken by AA with the intention of ending his life.

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Introduction

1. Mr AA was 43 years old at the time of his death. In his 43 years he had experienced extreme tragedy and hardship, both in his homeland in the Middle East and also in his adopted country of Australia. Despite these adversities, Mr AA was also shown kindness, friendship and generosity from people who were complete strangers to him. With the help of these people, who would later become his close friends, and through his own resilience, Mr AA later established a life for himself that was largely free of the adversity that he had previously experienced.
2. Sadly, Mr AA died on 22 January 2015, after intentionally taking his own life, in the most tragic of circumstances.

Why was an inquest held?

3. When a person's death is reported to a Coroner there is an obligation on the Coroner to make findings in order to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances in which that person died.
4. In AA's¹ case the answers to most of these questions could easily be answered from the material which formed the brief of evidence submitted by the investigating police to the Coroner's Court. The only question which will be considered in detail in these findings is the manner of AA's death.
5. However, because police officers were called to the scene where AA's fatal injuries were inflicted, and because they were present when this occurred, AA is considered to have died in the course of a police operation. This means that, under section 23(c) of the *Coroners Act 2009* (the Act), an inquest into AA's death must be held.
6. The inquest examined issues surrounding the lead up to the fatal incident on 19 January 2015 and the appropriateness of the actions taken by police officers and others involved in the incident. These issues will be explored in greater detail below.

AA's life

7. Before going on to provide a factual summary of the 19 January 2015 incident, and the relevant events both before and after it, it is appropriate to briefly acknowledge AA's life.
8. AA was born in Basra, in southern Iraq, in 1971. Following the death of his father in the 1980s, AA, his mother and brother moved to Iran and later Syria as a result of the Iran-Iraq conflict. AA's mother later took her own life, leaving AA and his brother on their own. They eventually went to live with their uncle in Baalbek, in northern Lebanon. Following the end of the Gulf War it is believed that AA's brother joined a local militia before he later disappeared and was presumed to have died.

¹ As Mr AA's close friends, Ms Michelle McDonald and Mr Gavin Fry, both referred to Mr AA by his first name during the inquest, I will do the same in these findings. No disrespect is, of course, intended.

9. AA attended university in Beirut before eventually finding work as a journalist for local newspapers. He later married and had a son, Iskander. Due to his job as a journalist AA encountered pressure from a militant political group which sought to use the newspaper as a means to further its own ends. AA was resistant to such pressure and this resistance would later prove to be catastrophic. AA's wife and young son were killed when a bomb was detonated in their home whilst AA was away.
10. Seeking to leave behind the tragedies that had plagued him AA travelled to Australia sometime in 2001 seeking to gain entry by unlawful means. He was taken into immigration detention and transferred to Woomera Detention Centre. In May 2002 AA was released from detention on a temporary protection visa and he made his way to Melbourne. He later discovered that a friend, Osama, who had been with him in detention at Woomera was now housed at Villawood Detention Centre. AA travelled to meet Osama and it was during a meeting at Villawood that Osama introduced him to Michelle McDonald. Ms McDonald had previously taken an interest, and become involved, in supporting refugees and persons seeking asylum who were housed in detention centres. Osama asked Ms McDonald if she could help AA who, at that time, was without accommodation or any financial means.
11. Ms McDonald generously agreed and brought AA to her home in Sydney's northern beaches. It was there that AA met Ms McDonald's then partner, Gavin Fry. The fortuitous meeting at Villawood would produce a friendship between AA, Ms McDonald and Mr Fry for the years to come.
12. Over time AA gradually developed a life for himself in Australia, working a number of different jobs whilst enjoying the vibrancy of living in Sydney's inner city suburbs where there was a strong cultural presence. AA kept in semi-regular contact with Ms McDonald and Mr Fry and they continued to support AA with their friendship and kindness. AA's last job was as a truck driver for an ice works company making deliveries to all parts of Sydney.
13. Following a workplace injury whilst at this job, AA was unable to work again. Due to the limitations that unemployment placed on his financial situation, AA was forced to move from his home in Campsie. Over the following years, AA lived in different areas including Katoomba, Gymea, Newcastle, Oberon and, eventually, Singleton. Sadly, his forced relocation meant that he lost contact with Ms McDonald and Mr Fry. AA's inability to work and his life in remote areas only added to this social isolation.
14. Much of AA's frustration at not being able to return to work stemmed from his work ethic. AA was known to be hard-working, with a strength and energy for the difficult tasks that his jobs demanded of him. In his lighter moments, Ms McDonald described AA as being funny and engaging, with remarkable mimicry skills and a zest for life, especially before his injury. AA also never forgot the kindness that Ms McDonald had originally shown him, repaying that kindness by helping her when bushfires threatened her home and by looking after her following an operation.

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

15. On 23 January 2007 AA was at work when he slipped and fell from the back of a truck and onto the road, fracturing his wrist in the process. He subsequently lodged a claim for compensation. The claim was handled by QBE Workers Compensation (NSW) Limited (QBE). The inability to

work frustrated AA and had an adverse effect on his mental well-being. As part of his claim AA received both medical treatment for the injury itself, and also psychiatric counselling. AA also received weekly entitlement benefits and was paid a permanent impairment settlement amount in April 2010.

16. Over time, the frustration at being unable to work, AA's isolated existence, and the demands that were made of him to attend medical assessments as a routine part of the compensation claim manifested themselves in anger and rash behaviour on AA's part. In October 2008 and January 2010 AA made threats towards QBE staff members and also a solicitor who had been working with AA in relation to his compensation claim. These incidents were reported to the police² but, following discussions with the people involved, were not taken any further.
17. AA's claim was eventually transferred to the QBE office in Newcastle. One of the case managers there, Patrick Walker, took over the day-to-day management of AA's claim in March 2012.

What happened on 12 November 2012?

18. On 12 November 2012 AA went to the QBE Newcastle office for an unscheduled meeting with Mr Walker to discuss his compensation entitlements. Peter Bell, another QBE employee, was also present at the meeting. The meeting was unremarkable until at some point AA told Mr Walker and Mr Bell, "I have petrol and I want to kill myself".³ AA reached into a backpack that he had brought with him to the meeting and withdrew a plastic drink bottle which contained some type of liquid.
19. Mr Bell asked AA if the liquid was petrol and AA confirmed that it was. Mr Bell asked AA if he could smell the liquid in order to see for himself. AA allowed him to do so and, after smelling the contents of the bottle, Mr Bell recognised the smell of petrol. Mr Bell placed the bottle on the ground away from AA. It appears that the meeting continued without further incident.
20. After the meeting ended AA asked for the bottle back but Mr Bell refused to return it and instead left the meeting room in order to secure it in another part of the office. AA did not appear to be troubled by the bottle not being returned because when Mr Bell re-joined the meeting, AA shook their hands, thanked them and left.
21. Immediately after the meeting Mr Walker and Mr Bell told Lisa Odgers, the portfolio manager of the Newcastle office, about the incident. Mr Walker also told AA's treating psychiatrist at the time, Dr Samir Benjamin, about the incident.⁴ Ms Odgers in turn notified Brendan Forde, the State Manager of QBE, via email and also notified QBE security staff in the Newcastle office. The security staff suggested to Ms Odgers that she should call the police and so Ms Odgers did so. She called Newcastle police station and passed on the details she had been given about the incident.⁵

What happened leading up to 19 January 2015?

22. Mr Walker called AA on 5 November 2014 in order to discuss an upcoming appointment that AA had with a doctor regarding his injury. AA expressed some unhappiness at being referred for

² Exhibit 2, Tab 22.

³ Exhibit 2, Tab 29, para 9.

⁴ Exhibit 2, Tab 31B, annexure C.

⁵ Exhibit 2, Tab 31B, paras 58-60.

another assessment⁶ but eventually agreed to attend. Mr Walker called AA back on 11 November 2014 in order to advise him that the appointment, which had been scheduled for the following day, needed to be changed to a different day due to the doctor being unavailable.

23. On 14 November 2014, the day after the scheduled appointment, AA called Mr Walker back. During the call AA indicated that he was frustrated about the brevity of the appointment and about having to attend in the first place. AA also asked for a referral to a psychiatrist. Mr Walker explained that a referral from AA's treating doctor was required before a psychiatrist could be engaged.⁷
24. In December AA received two letters from QBE dated 15 December 2014 and 16 December 2014. At this time AA was receiving entitlement benefits that were paid fortnightly by direct deposit into his nominated account. The letters explained that there would be a change in the usual schedule of AA's payments due to the upcoming Christmas and New Year period.
25. Effectively the only change was that instead of receiving a fortnightly payment on 29 December 2014, AA would be paid his fortnightly entitlement 8 days earlier on 21 December 2014. This change in payment schedule was routine practice for QBE, and was applied to all persons receiving entitlement payments, due to reduced staff levels over the Christmas period. However, it is unclear why two letters in the same terms were sent to AA, when only one was required.⁸

What happened on 19 January 2015?

26. Sometime before 10:30am on 19 January 2015 AA parked his car on Throsby Street, Wickham about 900 metres from the QBE Newcastle office located on level 4 at 28 Honeysuckle Drive, Newcastle. AA secured the car's steering wheel with a lock and locked the car. He walked to the office building, entering at 10:34am.⁹ AA caught a lift from the entry lobby to level 4 where the QBE reception area is located. The reception area is typically staffed however on this day, due to a staff meeting at the time, the area was unattended. Typically, members of the public do not visit the reception area with walk-in enquiries.¹⁰
27. The reception area is located to the right of the elevators as one exits the elevators and consists of a front counter and a waiting area with armchairs. The front counter itself has two glass panels, from the counter to the ceiling, with a gap in the centre through which people can speak and papers can be passed through. There is also call button to alert staff if the counter is unattended. A large window is located to the right of the counter area, with a glass door located to the left of the counter for staff to enter and exit.
28. AA walked into the reception area carrying a backpack and some papers in his hand. He was wearing jeans, a long-sleeved collared shirt and a baseball cap. At 10:35am AA placed his backpack on one of the armchairs and removed a 1.25 litre plastic drink bottle from the backpack. For the next 9 minutes AA is seen on CCTV footage to be pacing around the reception

⁶ Exhibit 2, Tab 35.

⁷ Exhibit 2, Tab 37.

⁸ Exhibit 2, Tab 31, paras 12-13.

⁹ Most of the times that are referred to concerning the incident on 19 January 2015 are taken from the timestamps on CCTV footage from the QBE office building. The times shown on the CCTV footage are approximately 10 minutes ahead of the actual time but the correct adjusted times are used in these Findings.

¹⁰ Exhibit 2, Tab 32, para 4.

area, standing and looking out the window, and at times talking to himself. At 10:44am AA placed the papers in his hand on the front counter.

29. At 10:57am two QBE staff members, Candice Taylor and Nikki Lopez, walked out of the door next to the counter on their way to the elevator. Ms Taylor saw AA looking out the window and saw the plastic bottle in his right hand which she noticed was half-full of a yellow-coloured liquid. Ms Taylor initially thought that the liquid was alcohol. She asked AA if he needed any assistance and when AA did not answer, Ms Taylor repeated the question. AA half-turned in Ms Taylor's direction and mumbled the word "trick" which Ms Taylor assumed to be a reference to Patrick Walker. She walked back into the office area and told Mr Walker, who was at his desk in the office area behind the counter, what had just occurred. Mr Walker looked through the counter area and immediately recognised AA from their earlier meeting in November 2012.
30. Mr Walker told Mr Bell, who was also in the office area behind the counter, that AA was in the reception area and asked him to speak with AA. Ms Taylor explained that, as Mr Bell was previously employed as a police officer, he was often asked to speak with persons at the front counter if there is a concern for staff safety.¹¹
31. Mr Bell and Mr Walker both walked to the front counter area at 11:01am but remained behind the glass partition. They saw that AA was still looking out the window. As they approached, AA raised the bottle next to his shoulder and poured the liquid inside the bottle around his shirt collar and onto his clothing. Analysis would later reveal that the liquid was mineral turpentine.¹²
32. Seeing this, Mr Bell told Mr Walker to call the police immediately. Records from the police incident despatch log indicate that this call was received at about 11:02am. Mr Bell approached AA, saying, "Come on mate. Let's talk about this". AA initially did not reply and instead raised his left hand, showing Mr Bell that he was holding a cigarette lighter.
33. For the next 8 minutes Mr Bell attempted to engage AA in some general conversation in order to distract him from using the lighter. Mr Bell repeatedly told AA that he would like to talk with him but that he (AA) needed to first put the lighter down. AA was unresponsive to Mr Bell's requests. At some point AA said, "I only have two regrets in my life. That is my mother and father meeting and having me, and me coming to Australia from Iraq in 2001".¹³ Mr Bell continued trying to engage AA in other general conversation, again in order to distract him. During this time, another QBE staff member, Matt Angelov, entered the counter area and asked AA if he could do anything to help. Mr Angelov saw that AA was crying and heard AA say, "I have no future".¹⁴
34. After Mr Bell's call was entered on the police despatch system it was acknowledged at 11:04AM by Leading Senior Constable (LSC) Benjamin Kelly and Constable Aaron Hudson. At the time, both police officers were performing general duties in the Newcastle area in a police vehicle with call sign NCC-19. LSC Kelly and Constable Hudson proceeded to the QBE office building, arriving at 11:07am.
35. Mr Bell kept trying to engage AA in conversation, however AA would either only nod or stand in silence looking out the window. By also looking out the window Mr Bell saw vehicle NCC-19

¹¹Exhibit 2, Tab 32, para 9.

¹² Exhibit 2, Tab 6.

¹³ Exhibit 2, Tab 29, para 19.

¹⁴ Exhibit 2, Tab 29, para 20.

approaching the building. He wrote the words “Cops downstairs” on a piece of paper and showed it to Mr Angelov. He also whispered to Mr Angelov, “Can you go around and stop them at the elevators”.

36. Meanwhile, LSC Kelly and Constable Hudson had already arrived at the scene. As he exited his vehicle LSC Kelly grabbed a fire blanket that was kept within the vehicle as part of equipment used in bush fire situations. LSC Kelly and Constable Hudson entered the building and made their way to the elevators in order to reach level 4.
37. Upon reaching level 4 at 11:09am, LSC Kelly stepped out the elevator and immediately smelled a strong odour of what he described as some type of accelerant.¹⁵ He saw that AA was standing to his right in front of the window about 10 metres away. LSC saw that AA had something in his right hand and that his left arm was held out in front of him. LSC Kelly called out to AA by saying, “Hey mate”. According to Mr Angelov, he heard one of the police officers say something similar to, “Are you OK?”, followed by the words, “Put the lighter down”.¹⁶
38. As the police officers walked towards the reception area, AA moved his left hand towards his right arm and struck the lighter.¹⁷ This ignited the mineral turpentine on AA’s clothing, producing flames on AA’s left arm which, almost immediately, engulfed his entire body. AA initially stood in one place waving his left arm around, then turned in the direction of the police officers and ran towards them, yelling as he did so. Constable Hudson used his radio to call for further assistance, indicating that AA had set himself alight.¹⁸
39. LSC Kelly initially stepped backwards, unfolding the fire blanket as did so, concerned that AA would run at himself and Constable Hudson and set them alight.¹⁹ However as AA ran towards him LSC Kelly moved forward, yelling at AA to drop to the ground. LSC Kelly threw the blanket over AA and pushed him to the ground, using the blanket to suppress the flames. LSC Kelly called out to Mr Bell for a fire extinguisher. As he attempted to smother the flames surrounding AA’s body, LSC Kelly yelled at AA to roll around on the ground, hoping that this would help to put out the flames.
40. Within seconds Mr Bell obtained a fire extinguisher which he directed at AA and extinguished the remaining flames. Another QBE staff member, Allan Mitchell, obtained another fire extinguisher and used it to combat flames which had spread to the carpet in the reception area.
41. The conflagration which engulfed AA burnt almost the entirety of his clothing, leaving his skin extremely blistered. Although AA was still conscious, he was unable to speak. LSC Kelly spread the fire blanket flat on the ground and instructed AA to roll on to it. Then, with the assistance of two QBE staff members, the police officers carried AA down the fire escape stairs in the makeshift stretcher made from the fire blanket. Once they reached the building’s car park ambulance personnel, who had arrived at the scene by this time, they took over AA’s care.
42. AA was taken by ambulance to John Hunter Hospital and later airlifted to Royal North Shore Hospital in Sydney for treatment of 65% total body surface area full thickness burns. AA’s

¹⁵ Exhibit 2, Tab 9, para 6.

¹⁶ Exhibit 2, Tab 30, para 11.

¹⁷ I note that in his statement (Tab 9, para 7) LSC Kelly states that he saw AA was holding the lighter in his *left* hand and used it to ignite his *right* arm. However the CCTV footage clearly shows flames on AA’s left arm immediately following ignition. There is nothing to suggest that this inconsistency adversely affects the reliability of LSC Kelly’s evidence in any way.

¹⁸ Exhibit 2, Tab 10, para 6.

¹⁹ Exhibit 2, Tab 9, para 8.

condition was considered to be extremely grave. Despite advanced life support measures AA later died at hospital on 22 January 2015.

What was the cause of AA's death?

43. Dr Kendall Bailey, forensic pathologist, performed the postmortem examination on 23 January 2015 at the Department of Forensic Medicine in Glebe. She found that AA had suffered significant loss of skin and subcutaneous tissue from his upper limbs. Dr Bailey ultimately concluded that AA died from complications of thermal injuries, noting that such injuries cause dysfunction in regulation of blood pressure, heart rate, and body temperature, as well as decreased blood oxygen levels and increased risk of infection.²⁰

Was the response to the incident on 12 November 2012 appropriate?

44. There is no evidence to suggest that the QBE staff did not appropriately deal with the incident on 12 November 2012. It is clear that after Mr Bell confirmed that the bottle that AA produced did in fact contain some type of accelerant, it was removed and not returned to AA. Further, it appears that Mr Bell and Mr Walker sat with AA for 30 minutes to discuss his claim and then they called AA's general practitioner, Dr Khalil, to notify him of the incident and AA's emotional state.²¹ Pre-approval was also given by QBE for any treatment that Dr Khalil felt was required. This seems to have resulted in a referral by Dr Khalil to Dr Samir Benjamin, a consultant psychiatrist.²² Following the meeting, QBE staff attempted to call AA a number of times to check on his welfare, but the calls were not answered.²³ Ms Odgers also reported the incident to the local police.
45. However, there is no police record of this call having been made²⁴, although there is a contemporaneous note made by Ms Odgers.²⁵ It is not known why this is the case. However, it seems by the time the matter had been reported to the police any possible risk of self-harm, or harm to another person, had subsided. All accounts indicate that by the time of the report AA had returned to his usual functioning and appropriate follow-up steps had been put in place by QBE staff. As no further action was required, this may explain why no police record was made of the report.
46. In any event, there is no evidence to suggest that any further action should have been taken by either QBE staff or by the police. Given that this incident occurred a little over 2 years prior to the fatal incident, it also cannot be said that any action or inaction taken by QBE staff or the police contributed to AA's death.

What prompted AA to go to the QBE office on 19 January 2015?

47. The evidence suggests that the two letters AA received from QBE in December 2014 motivated AA to attend the QBE office. It was these same two letters that AA placed on the counter in the reception area on 19 January 2015.

²⁰ Exhibit 2, Tab 5.

²¹ Exhibit 2, Tab 31B, Annexure B.

²² Exhibit 2, Tab 31B, Annexure D.

²³ Exhibit 2, Tab 31B, Annexure B.

²⁴ Exhibit 2, Tab 8, para 23.

²⁵ Exhibit 2, Tab 31B, Annexure B.

48. Mr Fry was well aware that changes to the frequency of AA's entitlement payments troubled AA and caused him concern. Mr Fry explained that, because of AA's financial situation, even a small change in the frequency of payments made it difficult for AA to manage his budget.²⁶ Although Mr Fry had in the past tried to help AA plan for such periods by setting aside some money in advance of them, AA still found these periods challenging.
49. As already mentioned above, the change in the timing of AA's entitlement payments was routine practice for QBE and not in any way unusual. It was a practice applied to all entitlement recipients. AA did not suffer any financial disadvantage as a result of this practice. Financial statements confirm that AA received the payment that he was entitled to, the only difference being that it was paid 8 days earlier (on 21 December 2014). However this earlier payment meant that AA's next payment would not be for another 22 days (on 12 January 2015). Given AA's difficulties with budgeting that Mr Fry described, it seems clear that this extended period between payments would have caused AA concern and prompted him to act by going to the QBE office on 19 January 2014. The fact that AA had also in November 2014 expressed his dissatisfaction with his ongoing medical assessment requirements probable also played a part in AA's decision to act.

Was the response by QBE staff to the 19 January 2015 incident appropriate?

50. According to the CCTV footage, AA was in the reception area for approximately 23 minutes before he had any interaction with QBE staff. As explained already, the counter of the reception area is normally staffed but was not on this particular day due to a staff meeting. In any event there was a call button which AA could have used to alert a staff member of his presence. However, AA did not use this button and the CCTV footage indicates that AA was not demonstrating any signs of urgency, or any frustration that his presence in the reception area had not been acknowledged. Apart from the times when he was talking to himself, the footage suggests that AA was waiting calmly in the reception area, often looking out the window. There is no evidence to suggest that the delay in attending to AA influenced his later actions.
51. There is also no evidence to suggest that any interaction with the QBE staff prompted AA to pour the mineral turpentine on his clothing. The CCTV footage clearly shows that this occurred as Mr Bell and Mr Walker walked into the counter area. Neither Mr Bell nor Mr Walker had any opportunity to speak with AA before this occurred.
52. Having seen what AA had done, a call was immediately placed to the police. There is no suggestion of any delay in responding to the situation, or any suggestion that there should have been any other response. For approximately the next 8 minutes Mr Bell sought to direct AA's attention away from the prospect of causing himself, or anyone else, harm. The evidence establishes that AA was largely non-responsive to Mr Bell's attempts to engage him. Again it does not appear from the CCTV footage that AA was visibly disturbed by Mr Bell's attempts, nor by the presence of Mr Angelov and his offer of assistance. I can find no evidence that the actions of Mr Bell and Mr Angelov were not an appropriate response to the confronting situation which they faced. Instead, they should be commended for dealing with an extremely difficult situation in a calm and compassionate manner.

²⁶ Exhibit 2, Tab 28, para 23.

Was the response by the attending police officers to the 19 January 2015 incident appropriate?

53. It should be noted at the outset that there is no suggestion on the available evidence that the actions of the attending police officers on 19 January 2015 was anything other than appropriate. However, one of the primary reasons why an inquest must be held when there is a death in the course of, or arising from, a police operation is so that an independent investigation can be conducted into the circumstances of the death and the actions of the police involved.
54. The involvement of the police in AA's case raises two issues. Firstly, did any action by the police in the reception area contribute to AA's death? Secondly, did the absence of a fire extinguisher in the vehicle NCC-19, and therefore the inability of LSC Kelly and Constable Hudson to use one, contribute to AA's death?

(a) Did any action or inaction by the police officers contribute to AA's death?

55. The first issue arises primarily due to the evidence of Mr Bell. In his statement²⁷ Mr Bell says that he asked Mr Angelov to stop the arriving police at the elevators. Mr Bell did not specify whether he was referring to stopping the police from entering the elevator on the ground floor lobby, or whether he was referring to stopping the police once they exited the elevator on level 4. However, given the close proximity of the elevators on level 4 to the reception area, it seems that Mr Bell was referring to stopping the police from entering the elevator in the lobby. It appears that Mr Bell's made this request because he was concerned that the sudden arrival of the police might trigger an adverse, unwanted response from AA.
56. However, there is an inconsistency in Mr Angelov's evidence regarding this issue. In his statement Mr Angelov said that Mr Bell told him that the police were downstairs and to make sure that they were able to access the building. As neither Mr Bell nor Mr Angelov gave oral evidence at inquest, it is not possible to resolve this inconsistency. However, resolution is unnecessary because the evidence given by Detective Senior Constable (DSC) Darren Evans, the officer-in-charge of the investigation, during the inquest was that LSC Kelly and Constable Kelly would not have acted any differently even if Mr Bell had made his request and it had been passed onto them. DSC Evans explained that this is because LSC Kelly and Constable Kelly were confronted with an imminent threat of harm, not only to AA but also to other persons in the building.
57. This then leads to consideration of whether the subsequent actions taken by LSC Kelly and Constable Hudson were appropriate. It seems clear that the arrival of the police officers on level 4 prompted AA to act by striking the lighter and igniting his right arm. This is because by the time this occurred AA had been in the reception area for approximately 34 minutes. It had also been approximately 8 minutes since he had poured the mineral turpentine on his clothing. Given this amount of time, during which AA had demonstrated no other steps towards self-harming behaviour, the fact that he acted within seconds of the arrival of the police would not appear to be mere coincidence. Furthermore, it seems likely that AA was aware of the imminent arrival of the police officers. Mr Bell could clearly see the approaching police vehicle from his view out of the reception window. It is very likely that AA also had the same view.

²⁷ Exhibit 2, Tab 29, para 22.

58. Despite the arrival of the police prompting AA to act, there is no evidence to suggest that they could have done anything to prevent AA from doing so. The CCTV footage shows that a mere 13 seconds elapsed from the time the police officers exited the elevator to the time that AA ignited his arm. There was no opportunity for anything other than a very brief moment of interaction between LSC Kelly and AA. I acknowledge that there is a discrepancy in the evidence regarding what LSC Kelly actually said to AA.²⁸ However, given the brevity of the interaction and the absence of any response from AA, it does not appear that what was actually said by LSC Kelly prompted AA to act.

59. So far as the response by LSC Kelly and Constable Hudson are concerned, the inquest received evidence in the form of a statement from Senior Sergeant Peter Davis. [REDACTED]

[REDACTED]

60. There is no evidence to suggest that LSC Kelly and Constable Hudson should have been acting in accordance with any standard operating procedure on 19 January 2015. The situation that they were confronted with was unusual and required initiative and swift thinking. It is clear that both police officers demonstrated these attributes in dealing with the situation. They, like the QBE staff members, are to be commended for doing so. Once AA had ignited his arm, LSC Kelly acted appropriately and bravely by moving towards AA in order to more quickly use the fire blanket to combat the flames around AA's body. LSC Kelly gave appropriate directions to AA for him to get on the ground and called for the QBE staff to assist by obtaining a fire extinguisher.

(b) Why was there no fire extinguisher in police vehicle NCC-19?

61. This leads to the second issue concerning the absence of a fire extinguisher in police vehicle NCC-19. The vehicle was a Ford Ranger dual cab utility that was regularly used by general duties officers from Newcastle police station. At the time of the vehicle's original fit out on 8 October 2013, a fire extinguisher was located in the vehicle. Although sometimes fire extinguishers in police vehicles were mounted to a bracket in the front passenger footwell, on occasions the extinguishers were stored loosely in the rear seat footwell area in order to avoid obstructing the front seat passenger.³²

62. LSC Kelly said that he only briefly looked for a fire extinguisher in the vehicle before grabbing the fire blanket. According to inspection records for NCC-19 between November 2014 and

²⁸ Mr Angelov states that LSC Kelly asked AA to put the lighter down, whilst Mr Bell states that he heard LSC ask AA if he was OK. LSC Kelly himself states that he simply greeted AA by saying, "Hey mate".

²⁹ Exhibit 2, Tab 58, para 4.

³⁰ Exhibit 2, Tab 58, para 9.

³¹ Exhibit 2, Tab 58, paras 7, 20-21, 26.

³² Exhibit 2, Tab 8, para 7.

February 2015 it appears that the fire extinguisher was last recorded as being present on 30 November 2014. An inspection record for 7 December 2014 notes that it was to be replaced, which suggests that it was no longer present by this date. On 18 January 2015 the word “nil” was recorded in the inspection entry.³³ All of this suggests that there was no fire extinguisher within NCC-19 on 19 January 2015. The reason for this is unknown.

63. Notwithstanding, there is no evidence that the absence of a fire extinguisher contributed to AA’s death in any way. LSC Kelly had equipped himself with the fire blanket and was conscious of the fact that there would be fire extinguishers available within the building.³⁴ The CCTV footage establishes that within 10 seconds of ignition LSC Kelly was using the fire blanket to suppress the flames whilst AA was on the ground, and that within 21 seconds of ignition Mr Bell had obtained a fire extinguisher and began discharging it on the remaining flames on AA’s body. There is no evidence to suggest that earlier use of the fire extinguisher would have prevented AA’s death or that the absence of a fire extinguisher in vehicle NCC-19 contributed to it in any way.

What was the manner of AA’s death?

64. It is clear that AA brought the bottle containing mineral turpentine and a cigarette lighter with him to the QBE office. What AA’s exact intentions were up until the point of ignition will remain unknown. AA himself may not have known what he was planning to do. There is the possibility that he may have brought the items, and poured the mineral turpentine on himself, as a way to draw attention to his perceived grievance with the change in his entitlement payment schedule or his dissatisfaction with having to frequently attend medical appointments. This is because the evidence establishes that AA parked his car in the closest non-metered parking area to the QBE office. He also locked his car and secured it with a steering wheel lock. These factors suggest that AA wanted to avoid being given a parking ticket and that he intended to return to his car at some stage.
65. Furthermore, Mr Fry visited AA’s unit in Singleton the day after AA’s funeral in order to gather some of his personal belongings. Mr Fry had visited the unit before and on this occasion found it to be tidy, organised and well kept. As someone who was familiar with the various homes where AA lived, Mr Fry expressed the opinion that there was nothing to suggest that AA was not planning to return to the unit.
66. The incident on 12 November 2012 is the only evidence of any time that AA had previously expressed any intention of harming himself. None of the medical records³⁵ indicate that AA had previously expressed any suicidal ideation. Indeed, the most recent record in about February 2013, prior to AA’s death, indicates that he had denied any thought of self-harm.³⁶
67. However, there is other evidence indicating that AA deliberately ignited his arm and that his intention in doing so was to end his own life. I consider the evidence to be sufficiently cogent and persuasive to allow such a conclusion to be made for the following reasons:

³³ Exhibit 2, Tab 8, para 11.

³⁴ Exhibit 2, Tab 8, para 9.

³⁵ Exhibit 2, Tabs 38 to 51.

³⁶ Exhibit 2, Tab 50.

- (a) Firstly, even allowing for the discrepancy (already referred to above) regarding which hand AA used, the evidence of both Mr Bell and LSC Kelly is that AA deliberately moved the lighter to his arm and ignited it.
- (b) Secondly, this was done with knowledge of AA's own deliberate act in pouring the mineral turpentine on himself.
- (c) Thirdly, the presence of both the lighter and the mineral turpentine were preparatory acts taken by AA.
- (d) Fourthly, AA had been diagnosed as suffering from adjustment disorder with depressed mood in February 2013.³⁷ Given AA's increasing social isolation and his growing dissatisfaction with aspects of his claim in November 2014 it appears that his mental well-being was in sharp decline.
- (e) Finally, AA's unsolicited comments to Mr Bell and Mr Angelov indicated feelings of regret about his own life and existence and, by inference, an intention to act on such feelings.

68. Having considered all of the above, I conclude that AA's death was deliberately self-inflicted.

Should any recommendations be made?

- 69. Section 82 of the Act allows a coroner to make recommendations in relation to any matter connected with a person's death. The words of section 82 say that such recommendations may be made if the coroner considers them to be necessary or desirable. Issues of public health and safety can be, and often are, the subject of recommendations.
- 70. Given that I have found that the actions of the QBE staff and the police officers were entirely appropriate, and that there is no evidence that any action or inaction taken by them contributed to AA's death, it is neither necessary nor desirable for any recommendations to be made.

Findings

- 71. Before turning to the findings that I am required to make, I would like to acknowledge and thank Mr Chris McGorey, Counsel Assisting, Ms Jessica Murty, instructing solicitor from the Crown Solicitor's Office, and Detective Senior Constable Darren Evans for their assistance and valuable contributions both before, and during, the inquest.
- 72. The findings I make under section 81(1) of the Act are:

Identity

The person who died was AA.

Date of death

AA died on 22 January 2015.

Place of death

AA died at Royal North Shore Hospital, St Leonards NSW 2065.

³⁷ Ibid.

Cause of death

The cause of AA's death was complications of thermal injuries.

Manner of death

AA died as a consequence of actions taken by him with the intention of ending his life when he deliberately set himself alight.

Epilogue

73. AA's early life, and the last moments of it, was filled with tragedies and hardships that most people fortunately do not experience. However, during the years between these periods AA found kindness, generosity and friendship in the most unlikely of places. AA was also shown kindness in death with his funeral rites performed by stranger whose only connection to AA was that he came from the same hometown as him. Despite AA living a mostly solitary life during his time in Australia it is clear that he made a lasting connection with the lives of others. To those people, I would like to extend my condolences on behalf of the Coroner's Court.

Magistrate Derek Lee
Deputy State Coroner
14 November 2016
NSW State Coroner's Court, Glebe