CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Courtney Topic
Hearing dates:	19 – 23 March 2018; 26, 27 and 29 March 2018; 16 April 2018.
Date of findings:	30 July 2018
Place of findings:	NSW Coroner's Court, Glebe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner.
Catchwords:	CORONIAL LAW – death as result of police shooting – high risk mental health related incident – whether responding police breached policies and procedures – whether police response was appropriate – recommendations.
File number:	2015/42730

Representation:	Counsel Assisting the Coroner: Mr GP Craddock of Senior Counsel with Mr J Harris of Counsel, i/b Crown Solicitor's Office. The Topic family: Ms S Beckett, Public Defender with Mr D Evenden, i/b Legal Aid Commission of NSW. Senior Constable E Tesoriero: Mr B Haverfield of Counsel i/b Walter Madden Jenkins. The NSW Commissioner of Police, Constable A Tyson and Senior Constable D Jones: Mr R Hood of Counsel i/b NSW Police Force Office of the General Counsel. The NSW Police Association: Mr P Madden of Counsel i/b Mr D Kennedy, NSW Police Association.
Findings:	**Identity** The person who died is Courtney Topic born 27 February 1992. **Date of death** Courtney Topic died on 10 February 2015. **Place of death** Courtney Topic died at West Hoxton NSW 2171. **Cause of death** Courtney Topic died from a gunshot wound to the chest. **Manner of death** Courtney Topic died in the course of a police operation. Her death was by gunshot in circumstances in which she was very likely suffering a mental health crisis and was in a public place holding a knife.

Non-Publication Order	**Terms of Order** 1 - With reference to Sgt William Watt's statement of 29 September 2015: - paragraph 31 part of the 3rd sentence from after the word "strike" until after the word "zones"; - all of paragraph 33; and - part of paragraph 37 commencing with the words "The Danger" in the first line on page 20 down to the next paragraph starting with "Based on". 2 - All references in the evidence (including the tendered brief) to the individual KS. 3 - All material in Vol 4 of the tendered brief of evidence. 4 - Material in Vol 5: - tab 100 through to and including tab 101A. 5 - All annexures to the statement of Leesa Topic of 24 October 2015. 6 - With reference to Exhibit 7, all still images following frame 194. 7 – With reference to the first video recorded by Danijel Bogunovic numbered 4718, those parts which correspond to the images referred to in #6 above. 7A – All parts of the second video recorded by Danijel Bogunovic numbered 4719. 8 - With reference to the transcripts of VKG Police radio broadcasts at tab 58A of the brief of evidence, all entries following the time stamp 11:45:59. 9 - With reference to the VKG Police radio broadcasts, all broadcasts which correspond to the entries referred to in #8 above. 10 - With reference to the VKG Police radio broadcasts, all broadcasts which have not been transcribed at tab 58A of the brief of evidence. 11 - The contents of the statement of Det Sgt Justin Moynihan of 7 March 2018.

Recommendations:	**To the NSW Commissioner of Police** **1:** Consideration be given to the MHIT and WTPR establishing and documenting a joint review of training packages for defensive tactics training where mental health is likely to be a relevant factor. **2:** Consideration be given to the greater integration of mental health informed training into tactical options training, with an emphasis on specific de-escalation techniques practiced by role play exercises. **3:** Consideration be given to requiring all present Operational Safety instructors to complete the four day MHIT training. This should be undertaken as soon as practicable, while ensuring the availability of Operational Safety instructors to meet ongoing accreditation requirements. **4:** Consideration be given to the MHIT and WTPR jointly pursuing a program of (1) reviewing international learning with respect to first responder interactions with persons in mental health crisis and (2) designing defensive tactics training that seeks to embody the learning obtained from the review. **5:** Consideration be given to requiring that all police radio and Triple 000 operators undertake training by the MHIT in skills which will better equip them to recognise signs of mental health disturbance in reports from police and civilians. **6:** Consideration be given to developing criteria by reference to which police radio operators may identify an incident as possibly involving a person in mental health crisis. **7:** Consideration be given to developing and implementing a system to dispatch four day MHIT accredited officers as first responders in cases which meet criteria indicating possible mental health crisis. **8:** Consideration be given to developing a mandatory training package for all police officers other than commissioned officers, and specifically including Local Area Commanders, to ensure understanding of the protocol for responding four day accredited MHIT officers. **9:** Consideration be given to reviewing the four day MHIT program to include more experiential learning, in the form of role play exercises. **10:** Consideration be given to offering MHIT booster training on a one to three year basis.

Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] requires that when an inquest is held the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Courtney Topic.

Introduction

1. Courtney Topic was only twenty two years old when she was shot dead by a police officer near a busy intersection at Hoxton Park in Western Sydney.

2. Courtney was holding a knife and she was not responding to police commands to put it down. The situation quickly escalated. Less than a minute after police officers arrived Courtney was on the ground, fatally shot to the chest.

3. Courtney's death is a tragedy. Three years later her family can still scarcely believe their daughter died in this terrible way. Their grief is still raw and will not be forgotten by those present at this inquest. The police officers involved in her death have been deeply affected by it.

4. It is probable Courtney was not able to understand that police were telling her to put down her large knife. She was most likely suffering a psychotic episode due to undiagnosed schizophrenia.

5. Although her death should not have happened, it would be wrong to understate the seriousness of this situation. Although we do not know for certain what Courtney was intending to do, she was moving in the direction of the police officer who shot her and she was within two metres of him when he fired his pistol. He had reason to believe his life was in danger.

6. But that cannot be all. Courtney's death is emphatically not one where it can be said '*This couldn't have been prevented'*. Her death raises broad issues about how police officers are trained to deal with people suffering a mental health crisis.

7. We ask a great deal of our police officers. We expect them to protect us in situations that are often unpredictable and dangerous. Sometimes the person they face is in the grip of a mental health crisis, as Courtney was. Her inquest forces us to ask: are there ways of reducing the risk of using lethal force, without unduly compromising police officers' safety? The conclusion I have reached is that there are.

8. If changes are not made there will be more deaths like Courtney's. The court heard that in Australia, of the persons shot by police between 1989 and 2011 nearly 42% were suffering from a mental illness. There is no reason to believe these numbers will reduce over time. More families will be left grieving, and police officers profoundly affected.

9. Courtney's death exposed a compelling need for change. The NSW Police Force understands that responding to people in mental health crisis can be difficult and

unpredictable. Some years ago they commenced the process of building police skills in this area. But Courtney's inquest has exposed gaps in the way these processes work. Errors were made that morning which made the resort to lethal force a tragic inevitability.

10. In a recent *7.30* program on police shootings the NSW Commissioner of Police Michael Fuller stated:

    '..I want the trend to be zero, but for mine it's about root cause analysis. Is there anything else we could have done? Again through oversight, through transparency, if there is anything, we will do it'.

11. Thus there is recognition at the highest level of the need to address this issue. Perhaps the greatest encouragement comes from the support the Commissioner gives to a number of the recommendations made as a result of Courtney's death.

12. Along with so many who have been involved in this inquest, I believe swift action is required to help prevent others from suffering in this way. Above all, Courtney's family needs to believe that her death was not in vain.

The Inquest

13. An inquest is different to other types of court hearings. It is neither criminal nor civil in nature. It does not determine whether a person is guilty of an offence, and it does not make findings or orders that are binding on parties.

14. This inquest into the circumstances of Courtney Topic's death is mandatory. As her death was a violent one it was required to be reported under section 6 of the Act. Section 27 of the Act mandates an inquest where it appears that a person has died as a result of homicide, and also where he or she has died in the course of a police operation.

15. A Coroner presiding over an inquest is required to confirm that a particular death occurred and make findings as to the identity of the person who died, the date and place of the death, and its cause and manner.

Issues of the inquest

16. There is no doubt that Courtney died on the morning of 10 February 2015, at Hoxton Park in Western Sydney. The direct cause of her death was a gunshot wound fired to her left chest by Senior Constable Ethan Tesoriero. Her death as a result of a single gunshot wound was confirmed in a post mortem report of forensic pathologist Dr Kendall Bailey.

17. These matters are not in dispute. It was the manner of Courtney's death which provided the focus for the inquest. Specifically:

    - what was Courtney's mental state on 10 February 2015?
    - what did police do in response to the situation?

- did police act in accordance with NSW Police Force policies and procedures?
- was the police response appropriate?

18. The inquest also raised questions about the way police officers are trained and tasked to respond to emergency mental health incidents. Two areas of training in particular are fundamental to police work. I will first briefly describe these two programs, as they are critical to an understanding of the police response to Courtney on 10 February.

Police training: Tactical Options and Mental Health.

19. All NSW officers below the rank of Senior Sergeant who carry arms and appointments must complete annual operational safety training. The purpose is to train officers in determining what tactical options and level of force is appropriate in different situations. There are scenario-based exercises to test officers' skills in using communication when people resist police directions. Sometimes but not always these exercises involve a high risk mental health incident.

20. Attending mental health incidents also requires specific training. The NSW Police Force wants its officers to learn skills which will reduce the risk of harm to themselves and to mentally disordered people. Therefore since 2013 all NSW police officers have been required to complete a mental health awareness program.

21. The mental health training is designed and delivered by the NSW Police's Mental Health Intervention Team [MHIT]. The MHIT's one-day program is mandatory for all sworn officers. Officers are instructed in identifying the signs of mental illness and appropriate ways of de-escalating situations where it is present.

22. The MHIT also offers an optional four-day program. This provides a stronger focus on communication and de-escalation techniques, and more role playing exercises. At the current time over 2,500 NSW police officers have been trained in this specialist program.

23. I will return to these matters when addressing the need for recommendations.

Courtney's life

24. Courtney was born on 27 February 1992. She was the much-loved and only daughter of Leesa and Ronny Topic, and beloved sister of older brother Kristopher born in 1989, and younger brothers Zachary born in 1995 and Brodie born in 1998.

25. Courtney grew up in an exceptionally close and loving family. Leesa and Ronny Topic are loving, intelligent and attentive parents. From Courtney's early childhood they identified aspects of her social and emotional development which concerned them. They found professional help for her and supported her with consistent and loving care. Their raising of Courtney was informed by their desire

that she develop into an independent, physically and emotionally healthy young woman.

26. The Topic family lived in a five-bedroom home at Carnes Hill in Western Sydney. They gathered each night for their evening meal and enjoyed spending time together on family outings. All four children received their high school education at Freeman Catholic College Bonnyrigg.

27. Courtney was born a healthy baby. She was a bright girl who enjoyed her first couple of years of primary school. However when she was in Year 2 Leesa saw she was falling behind academically and socially, and losing confidence at school. She arranged for her to have a psychometric assessment.

28. The resulting report found Courtney to be an intelligent and imaginative girl with weaknesses in attention skills and auditory short term memory. She was diagnosed with 'Attention Deficit Disorder – Inattentive' and was prescribed the drug Dexamphetamine. This was soon changed to Ritalin when Courtney's parents saw that the Dexamphetamine was making Courtney sad.

29. Throughout her primary school years Courtney's parents made sure she received tutoring and psychological support to build her confidence. She made friends, went to birthday parties and enjoyed doing gymnastics. Her parents described her as a calm girl who did not show extreme highs or lows in her emotions. By the time she was twelve years old her parents were confident she was ready for high school.

30. At high school Courtney made new friends, but as she got older it became evident to Leesa and Ronny that she found it a struggle socialising at parties. She completed her Higher School Certificate in 2009 but was unsure what she wanted to do next.

31. When she was eighteen Courtney told her mother she wanted to get psychological help. Leesa went with her to Headspace Campbelltown where Courtney was initially assessed by Mental Health Nurse Tony Raeburn. Mr Raeburn considered she was *'clearly exhibiting traits of dissociative personality disorder with some significant disorganisation, and emerging schizophreniform disorder'.*

32. When Courtney was assessed a few days later by Headspace psychiatrist Dr Leonard Chin he did not think she had a psychotic condition. He did however note that she *'…does not experience a sense of emotional rapport with others* [and] *has been experiencing a lot of conversational internal dialogue of a somewhat dissociative nature, and even given names to the different internal voices'*.

33. Dr Chin diagnosed Courtney with Aspergers Syndrome.

34. After the assessment Courtney told her mother she had been hearing voices for a very long time. Leesa was concerned to hear this, but Courtney told her she was not worried by it.

35. In October 2010 Courtney commenced casual work as a cashier at a Woolworths supermarket near her home. Her supervisor Ms Moyra Watson spoke highly of her as a very good worker who performed tasks well and without hesitation. Ms Watson commented however that Courtney did not generate conversation and preferred to spend her breaks by herself.

36. Courtney struggled with the short notice she often received for her work shifts. She also found it stressful to deal with people when she was working longer shifts. Her parents explained the problem to her sympathetic supervisor, who ensured Courtney received regular hours divided into four hour shifts. This worked better for Courtney and enabled her to continue her job.

37. About 18 months before her death Leesa observed that Courtney became less less motivated to do things, and more withdrawn from family life. Her father Ronny commented that around this time she began to spend more time in her bedroom with the door closed.

38. One evening in December 2014 Courtney became distressed and told her parents she wanted to seek professional help again. With Leesa's help Courtney was referred to child and adolescent psychiatrist Dr George Liangas in North Parramatta. Dr Liangas saw Courtney on three occasions before she died.

39. Dr Liangas cast doubt on the Aspergers diagnosis and was of the view she was suffering a major depressive disorder of moderate severity. He prescribed the anti depressant drug fluoxitane. Leesa and Ronny thought that with this medication Courtney's mood gradually improved and she started interacting more with her family.

Courtney's mental state on 10 February 2015

40. The question of what was happening in Courtney's mind on the morning of 10 February was of great importance to those attending the inquest, especially her family. What could explain the confounding fact that Courtney, a gentle-natured young woman who had never displayed aggressive or antisocial behaviour, had left her home that morning holding a large knife? And why hadn't she put it down when police armed with weapons demanded her to?

41. At the inquest the court heard evidence that on the day of her death Courtney probably had untreated schizophrenia and was likely suffering a severe episode of psychosis.

42. Forensic psychiatrist Dr Kerri Eagle reviewed the evidence and interviewed members of Courtney's family. She also reviewed Courtney's private writings which were discovered in her bedroom after her death. Unknown to her family, these writings documented bizarre and highly disturbed beliefs of being controlled, of her mind being read by others, of being forced to participate in an experiment, and of having lost her true identity. The discovery of these anguished writings after Courtney's death must have been a fresh source of grief for her family.

43. Dr Eagle explained that schizophrenia is a severe chronic mental illness characterized by delusions, hallucinations, and grossly disorganized behaviour. It is also associated with significant cognitive and functional deficits, including the ability to interpret emotions in other people.

44. Although Courtney had never been diagnosed with schizophrenia Dr Eagle thought she had suffered its symptoms for a sustained period. She cited Courtney's lengthy history of reporting auditory hallucinations. She also noted Courtney's report to Dr Liangas two months before her death that she was experiencing *'invasive memories – fear/panic …I do everything out of fear … Fear of safety if I don't do what I'm supposed to do'.*

45. Dr Eagle thought Courtney's private writings indicated a mind *'tormented for several years with an internal world characterized by identity disturbance, persecutory themes …and perceptual abnormalities'*. Dr Eagle speculated that these feelings may explain Courtney's possession of a knife on 10 February.

46. Dr Eagle also noted Courtney's increasing difficulties with social interactions, explaining that '…e*mpathy relies on an ability to be able to accurately perceive another person's emotions, beliefs and motivations in a given situation. This has been found to be impaired in schizophrenia.'*

47. In her opinion it was most likely that on 10 February Courtney was struggling to process what was happening around her, resulting in her being unable to respond to police commands that she put down her knife.

48. Courtney's observed behaviour that morning supports Dr Eagle's opinion that she was cognitively disconnected from what was happening. As will be seen, almost all witnesses were struck by her extraordinary lack of responsiveness to a situation where uniformed police officers were shouting commands and pointing weapons at her. She was described as looking as though she was *'in a daze or in her own little world'*, of looking *'like a zombie'*, of moving *'in a jerky and uncoordinated way'*.

49. The involved police officers too had expressed bewilderment at her unresponsiveness to their actions and words. Constable Tyson commented she appeared to be '*in some type of trance, unaware of her surroundings*'. Senior Constable Jones remarked '*She was uncommunicative. That bothered me greatly'*; and Senior Constable Tesoriero repeated: '*she didn't even acknowledge we were there ..she wasn't doing what normal people do in public ..it was as though …it didn't register'.*

50. The court accepts Dr Eagle's opinion that on 10 February Courtney was suffering undiagnosed schizophrenia, and was probably experiencing a severe episode of psychosis.

51. The tragic significance of this is that Courtney's ability to understand what police officers were asking her to do that morning was most likely severely impaired.

The events of 10 February 2015

52. Nothing about Courtney's behaviour in February 2015 struck her parents as particularly unusual or gave them cause for acute concern.

53. On the afternoon of 9 February 2015 Courtney worked her shift at Woolworths and then had dinner with her family as usual. After dinner Courtney followed her routine of having a shower, then having a snack and pacing up and down the dining area while the family watched television. Her mother went to bed at about 10.30pm after kissing Courtney goodnight.

54. The next morning Leesa rose early as usual to get ready for work and was surprised to find Courtney up already. Leesa greeted her but Courtney did not respond.

55. At about 10.00 or 11.00am Courtney's brother Zac knocked on her bedroom door to tell her he was on his way out. He heard Courtney reply from inside '*Not a worry, see you later*'.

56. Courtney left her family home soon afterwards. For reasons we will never know, she took with her a large knife from the kitchen. It had a silver blade 25cm in length and a 15cm wooden handle. Courtney had never done anything like this before.

The first call to police

57. At 11.05am a camera at Carnes Hill Shopping Centre captured an image of a female believed to be Courtney on Stonequarry Way, a few minutes' walk from the Topic family home. That Courtney would go out walking by herself was considered most unusual by her family.

58. Fourteen minutes later, Mr Robert Maguire was driving his delivery truck south along Cowpasture Road in West Hoxton when he saw Courtney walking northwards. Mr Maguire noticed Courtney's hand was up against her head. She seemed to be yelling and screaming, although he could not hear what she was saying. He then saw she was holding a large knife in her other hand. She was making no attempt to conceal it, and was moving it with her hand so the blade would '*go up and down in front of her'*.

59. In his evidence to the inquest Mr Maguire said he had felt concerned for the mental health of this young woman. He was worried she would harm herself or members of the public. At 11.19am he rang Liverpool Police Station and spoke to the officer performing station duties, Constable Grace Beasant. He told her: *'I think I just saw a female walking along the side of the road with a knife. I think she was talking to herself because there was no one else there'.*

60. When Constable Beasant asked Mr Maguire if he was sure about the knife he replied: '*Yes. She was carrying it in one hand and it looked like she was hitting herself in the head with the other'*.

61. He went on to say: '*She looks upset. She might hurt herself*'.

The first CAD message and radio broadcast

62. After taking Mr Maguire's call Constable Beasant entered details onto what is known as the police Computer Aided Dispatch [CAD] system.

63. The police CAD system contains a computer generated police messaging system. When a call is made to '000' or to a local police station, the police officer or operator taking the call logs into the CAD system. He or she assigns an incident type and a priority classification, then keys in a narrative of what is happening. The message is then able to be sent out to police car units for their response.

64. The operator who takes the call also sends the CAD message on to police radio operations. A radio operator uses this to send a voice message over the police radio system.

65. Based on what Mr Maguire had told her, Constable Beasant allocated his call a 'Priority 2'. This is determined as:

> *'No police at the scene however an urgent response is required due to violent or the possibility of violent and/or exigent circumstances, or police at a scene require further assistance'.*

66. Constable Beasant entered the Incident Type as a *'Concern 4 welfare'.* Her CAD message about Courtney read as follows:

> *''Inf requesting police. He was driving along Kurrajong Road and observed a female talking to herself. She then hit herself with one hand and in the other hand she held a knife. POI distressed. POI described as female, Caucasian, long dark brown hair, blue and white striped shirt. Inf concerned that she is MH and going to hurt herself. Knife NFD.'*

67. Constable Beasant explained that with the words '*inf concerned that she is MH*', she intended to convey that the police response needed to be one that was sensitive to likely mental health issues. She had hoped the Incident Header detail of *'Concern 4 welfare'* would prompt a response from an officer who had completed the four day MHIT training.

68. As a result of Constable Beasant's CAD message, a voice broadcast was sent out to police units as follows:

> *'Green Valley car, thanks in the Kurrajong Road, Carnes Hill. Informant was driving along Kurrajong Road, observed a female talking to herself. Apparently she hit herself in the head with one hand, and in the other hand she was in possession of a knife. She was distressed. Informant's a bit worried she might be going to hurt herself. Female Caucasian, long dark brown hair, blue and white striped shirt. Green Valley car thanks.'*

69. At 11.31am, as no police car units had responded to the broadcast, a second voice broadcast went out. It repeated information that the young woman was talking to herself and hitting herself in the head with a knife.

Ms C'Eladoure's call to 000

70. While this was happening Courtney was approaching the Hungry Jacks restaurant at the intersection of Cowpasture Road and Hoxton Park Road. This is a busy intersection with multi lanes in all four directions controlled by traffic lights. A footpath and grassed area wraps around the corner of the intersection which adjoins the Hungry Jacks restaurant and car park.

71. The time needed for Courtney to walk to this location from her home would have been about twenty minutes.

72. Ms Annabelle C'Eladoure and her young son were sitting in her car which was parked about seven metres from the entrance to Hungry Jacks. Ms C'Eladoure saw Courtney rest the blade of her knife on her own head, then enter the restaurant. Once inside Courtney held the knife behind her back and bought a frozen coke drink.

73. The Hungry Jacks staff member who served Courtney did not recall anything remarkable about her, except that she was wearing her sunglasses inside the restaurant and did not respond in any way to her greeting.

74. Ms C'Eladoure observed Courtney leave the restaurant and stand outside its entrance. After a few minutes Ms C'Eladoure rang 000 and asked for police. She told the operator of a girl walking around with '*a pretty big knife'.* She described Courtney as '*probably about 16 to 17 maybe'* and that she looked like '*a very odd girl'*. Courtney was by herself, and was waving the knife at cars, brushing her hair back with it, and at one point had pointed it into her stomach *' as though she was gonna stab herself*'. Ms C'Eladoure continued: *'And so, I just don't know what she's doing … it doesn't look like a safe situation'.*

75. Regarding Courtney's movements Ms C'Eladoure told the 000 operator: '*She'll walk and then stop and then maybe walk somewhere else and then stop …it's odd'.*

76. The operator promised to get police to attend as soon as possible. She asked Ms C'Eladoure if she thought the girl needed an ambulance as well. Ms C'Eladoure replied: *'Just the police at this stage, but I'm not sure what she could do…I have no idea what her intentions are'*.

77. Ms C'Eladoure told the inquest that although the young woman's actions were not aggressive or threatening, she felt the situation was unpredictable. She was concerned Courtney might harm herself or someone else, so she wanted the police to disarm her.

78. As Ms C'Eladoure continued to watch, Courtney walked slowly through the car park and passed through some shrubbery. She moved onto the grassed area at the corner of the intersection.

79. According to footage captured on a CCTV camera outside Hungry Jacks, Courtney spent the next three minutes alone on the grassed area. During this time she can be seen pacing from left to right with the knife down by her side, before the first responding police car arrived at 11.45am. It pulled up on the eastern kerbside of Cowpasture Road, and Constable Tyson and Senior Constable Tesoriero can be seen getting out and moving towards her.

The second CAD message and radio broadcasts

80. After receiving Ms C'Eladoure's '000' call an operator prepared and disseminated a second Priority 2 CAD incident message. It read:

> *'Female seen walking around with a large kitchen knife. POI desc 16-17 old, Cauc app, wearing jeans and a blue and white striped short, brown hair, blk sunglasses. POI has been pointing it into her stomach and brushing her hair away from her face with it. Ambo declined.'*

81. At 11.43am and 11.44am two further voice messages were broadcast to police units. Both referred to a young woman armed with a large kitchen knife. The second broadcast mentioned reports she had been pointing the knife at her stomach, and that '*there's people concerned about she's going to self-harm with it'.*

What the responding officers recalled about the broadcasts

82. Four police cars responded to the messages and broadcasts, and drove to the Hungry Jacks intersection. Officers Tesoriero and Tyson arrived first, and Senior Constable Darren Jones seventeen seconds later. Senior Constable Stephen McEvoy and Sergeant Glenn Sadler were next, arriving in time to witness the fatal shot but too late to have any influence on events. They were followed almost immediately by Constable Sanya Djuric and Senior Constable Paul Falzon.

83. As can be seen, the police radio broadcasts contained elements signalling that the young woman with the knife was displaying behaviour consistent with disturbed mental health. A striking aspect of this matter however is the lack of recall which most responding officers had of those details.

84. The three involved officers remembered registering that the young woman was armed with a knife and was in the area of a shopping centre. Only SC Jones described the thought crossing his mind that she may be suffering some kind of mental illness.

85. It is not surprising that responding police would focus on details which indicated a potential threat to public safety. However their inattention to the equally strong

indications of disordered mental health meant that Courtney's likely mental state played no part in their decisions about how to interact with her once they arrived.

86. I turn now to describe what happened when the first police officers arrived at the scene. These were Constable Angela Tyson, at that time a Probationary Constable, and Senior Constable Ethan Tesoriero. They were closely followed by Senior Constable Darren Jones.

87. It is important to understand that events unfolded with great rapidity. From the arrival of officers Tyson and Tesoriero, a mere forty one seconds elapsed before Courtney was shot. The speed with which things happened, and their violent and distressing nature, has inevitably affected the accuracy of the accounts provided by police officers and civilians.

The arrival of officers Tesoriero and Tyson

88. On 10 February Constable Angela Tyson was working with her Field Training Officer, Senior Constable Ethan Tesoriero. Constable Tyson had commenced work as a police officer in August 2014, and she had undertaken the mandatory one-day mental health workshop. SC Tesoriero had been working as a police officer for five years. He too had completed the one-day mental health workshop.

89. When Courtney's location at the Hungry Jacks intersection was broadcast SC Tesoriero drove there with lights and siren on, pulling up on Cowpasture Road.

90. As they pulled up Constable Tyson could see Courtney walking slowly on the grassed area near the intersection. Constable Tyson thought she looked '*dazed*', not taking in her surroundings and not reacting to the police car's lights and sirens.

91. The two officers had a brief conversation. Constable Tyson pointed out Courtney's knife which she still held down by her side. SC Tesoriero said: '*Ange, you right, you've got your Taser?*' Constable Tyson understood from this that she was to be ready to draw and use her Taser if necessary.

92. At the inquest both officers were asked whether prior to getting out of the car they had discussed what their best approach to the situation should be. Could they have taken a little time to observe Courtney's behaviour and assess the risk she posed, in order to decide an appropriate response? Could they perhaps have enquired whether other police cars were close by, which might have made available to them some additional responses?

93. Constable Tyson replied that from her point of view they did not have time to do any of these things. The young woman had a large knife, she might walk to the nearby intersection or car park and restaurant where people were. Their job as police officers was to get the knife from her as soon as possible.

94. SC Tesoriero too replied that in his opinion the situation required an immediate response. There was not enough time to consider other measures such as clearing the car park or requesting further police assistance.

95. Both officers got out of their car. Constable Tyson walked then ran towards Courtney, calling out to her to put her knife down. SC Tesoriero followed, also telling Courtney in a loud voice to drop her knife.

96. As she got nearer Constable Tyson saw with concern that Courtney didn't seem to be comprehending what was being said to her. For his part SC Tesoriero noticed that Courtney had not turned to look at them but was standing in the same position, eyes cast downward while moving her body to left and right. It crossed his mind that mental health issues may have been present. But as he described it, the priority was: '*The weapon has to go'.*

97. Courtney was not complying with their requests to drop her knife, so as SC Tesoriero approached he drew his pistol into the cover position – that is, he pointed it towards the lower half of Courtney's body.

Constable Tyson's attempt to discharge her Taser

98. Constable Tyson ran to a position a little ahead of Courtney and repeatedly called out to her to put her knife on the ground. Her evidence is that at this point Courtney took a couple of steps towards her with the knife slightly raised and pointing towards Constable Tyson. Fearing for her safety and that of SC Tesoriero, Constable Tyson said she drew her Taser and flicked the switch to arm it, then attempted to fire it. It did not discharge. She called out: '*Taser's not working'.*

99. Constable Tyson's Taser was fitted with a camera. The court heard evidence that when a Taser is armed, its camera begins to record within one to five seconds. The camera fitted to Constable Tyson's Taser recorded a video of twenty two seconds in duration.

100. The Taser video footage shows Courtney standing on the grass with her back to Hungry Jacks. She has a drink in her right hand. Her left hand holds the knife down by her side. Officers Tyson and Tesoriero are not in view but they can be heard repeatedly commanding her to put the knife on the ground. After a few seconds Courtney tosses her drink to the ground, then turns her head to look in Constable Tyson's direction.

101. Seven seconds later SC Tesoriero can be heard saying a phrase containing the word '*Taser*'. Courtney begins to walk slowly to her left. From the left side of the screen SC Jones' outstretched arm can be seen holding a canister in Courtney's direction. She glances his way then breaks into a run in the opposite direction, heading towards Cowpasture Road. The video stops abruptly.

102. The Taser video bears out the observations of numerous witnesses, that Courtney appeared oddly unresponsive to the people and events surrounding her. Until SC Jones deployed his OC spray her actions do not seem to bear any relationship to those of the police, unless her discarding of her drink can be interpreted as a confused response to the commands to put down her knife.

Did Courtney move towards Constable Tyson?

103. As can be seen from the above description, the Taser video does not show Courtney taking any steps towards Constable Tyson; nor does it record the words '*Taser's not working'*. It is possible these events occurred before the Taser was armed and the video commenced, as Constable Tyson suggested in her evidence.

104. However this explanation seems unlikely in view of the following evidence:

- Twelve seconds into the video SC Tesoriero can be heard apparently prompting Constable Tyson to use her Taser. He is unlikely to have done this if she had already told him it wasn't working.

- According to expert evidence, the most likely explanation for the sudden failure of the Taser camera to continue recording was Constable Tyson's attempt to fire the Taser, although this witness acknowledged that other possibilities existed.

105. On balance it appears likely Constable Tyson's recollection of this sequence of events was affected by the stress of her situation and the speed with which events unfolded. The most likely conclusion is that Constable Tyson attempted to fire her Taser not before the commencement of the Taser footage, but only moments before the footage came to an end. By this time Courtney was moving away from officers Tyson and Tesoriero, in the direction of Cowpasture Road.

106. As to why Courtney decided to run towards Cowpasture Road, we cannot know this for certain. The likely reason is that she was fleeing the OC spray which by then was being discharged by the newly arrived SC Jones. This conclusion is reinforced by what can be seen on the Taser video. Just prior to its abrupt cessation it shows Courtney breaking into a run in the opposite direction to SC Jones' extended arm.

107. Given this, and the fact that Courtney was not moving towards either police officer at the likely time Constable Tyson attempted to fire her Taser, it was submitted on behalf of Courtney's family that using a Taser at that point may not have been a justified use of force. However it is also fair to acknowledge that if Courtney was fleeing the scene, this too posed a public safety problem for the responding police. This was because no perimeter had been established to prevent her from running to areas nearby where other people were present.

108. Why did Constable Tyson's Taser fail to discharge? She had followed police procedure that morning by carrying out a 'spark' test. This is a limited check that the Taser is working correctly and the battery is sufficiently charged.

109. The Taser was subsequently given extensive testing by Sergeant Christian Halbmeier, Senior Armourer in the NSW Police Force. Sergeant Halbmeier found that it had battery degradation and damaged cartridges. These had most likely caused it to shut down when Constable Tyson attempted to discharge it.

He said that Taser batteries required monthly extended testing which in this case appeared not to have been performed. This issue is addressed later.

SC Jones' deployment of OC spray

110. Only seventeen seconds after officers Tyson and Tesoriero arrived at the scene they were joined by Senior Constable Jones.

111. On the morning of 10 February 2015 SC Jones was attached to Fairfield Highway Patrol and was patrolling the Fairfield/Liverpool area. When he saw one of the CAD messages about Courtney he acknowledged the job via police radio and drove to the Hungry Jacks intersection.

112. SC Jones got out of his car and immediately ran to the grassed area while pulling out his OC spray canister. He could see Constable Tyson with her Taser drawn and pointed towards Courtney. As he approached he also saw SC Tesoriero with his firearm pointed towards her. He could hear both officers telling Courtney to drop her knife. Courtney herself he described as looking pale and still. He said it '*bothered me greatly*' to see that she was not responding in any way to their commands.

113. SC Jones did not exchange any words with officers Tyson and Tesoriero, and so was not aware of the limited nature of their interactions with Courtney. He said he assumed they had been attempting de-escalation tactics. He thought Constable Tyson may have already discharged her Taser. He wanted to provide a further tactical option, being the use of OC spray. The aim was to temporarily incapacitate Courtney and enable them to disarm her without violent confrontation.

114. SC Jones positioned himself to the right of Courtney and slightly to her rear, then discharged his canister for a couple of seconds. Although he thought he had aimed with accuracy, he did not believe the spray had any effect on Courtney.

115. I accept the submissions of Counsel Assisting and Counsel for the Topic family, that SC Jones was mistaken in this belief. The autopsy report of Dr Bailey noted the presence of OC particles around Courtney's left eye and shoulder, her right cheek, her hair and her clothing. In addition the video evidence plainly depicts Courtney running to her left in a stumbling fashion almost immediately after the appearance of SC Jones' outstretched arm and canister.

116. The strong inference is that Courtney did feel the effects of the OC spray and was fleeing from it. Most unfortunately however, while she was affected she was not incapacitated by it.

117. There is no basis to conclude that SC Jones gave intentionally false evidence on this matter. In common with many witnesses, certain impressions he formed during these critical moments proved erroneous in light of other evidence and the benefit of careful review.

118. Like officers Tyson and Tesoriero, SC Jones was certain that use of appointments was the only appropriate response to Courtney's non-compliance. This was despite his awareness that repeated directions to put down her knife were not having the desired effect. In his words, no other approach was appropriate so long as she had a knife. She had to be disarmed.

119. At one point in his evidence SC Tesoriero qualified this position. Responding to questions from Counsel for the family, he agreed that Courtney had not reacted to repeated commands to put down her knife. He agreed with the further suggestion that he and officer Tyson therefore needed to re-assess the situation – however as he noted, at that point SC Jones intervened and the situation quickly escalated.

120. What might have happened had the OC spray not been used and Courtney had not run from the scene? Might SC Tesoriero have rethought their approach? We do not know. What happened was that the situation immediately escalated out of the control of the police officers, setting off a tragic chain of events.

The discharge of SC Tesoriero's pistol

121. SC Tesoriero's description of what followed is generally consistent with what can be seen on a second important piece of video evidence. This is footage taken on a mobile phone camera operated by Danijel Bogunovic. Mr Bogunovic was the driver of a car which had pulled up at the intersection. His recording commenced a second before the Taser video came to an end.

122. As the Bogunovic video commences SC Jones can be seen spraying OC in Courtney's direction. Officers Tyson and Tesoriero have their backs to the screen, pointing their weapons towards Courtney. She is running away from SC Jones, heading in the direction of Cowpasture Road. As she runs she pitches forward and appears to stumble, then straightens.

123. Courtney pauses, then turns her face and body in SC Tesoriero's direction. She moves in his direction with her left arm bent, causing the knife to move to to a level between her waist and chest. As she moves, SC Tesoriero backs away to his right and is obscured by a traffic signal box. Courtney advances in the same direction. She is herself lost to view behind the signal box just as SC Tesoriero re-emerges at its other side.

124. SC Tesoriero continues to move backwards towards the footpath adjoining the intersection. Just as Courtney emerges from behind the signal box, the knife now in her right hand, the sound of a gunshot is heard. Courtney takes a few steps, then crumples to her knees and slumps forward. She collapses onto her right side.

125. SC Tesoriero told the inquest that when he saw Courtney running towards Cowpasture Road he moved sideways in an attempt to keep pace with her, while covering her with his pistol. He said that after a few stumbling steps Courtney stopped and turned her face and body in his direction. Head facing downwards,

she commenced to move forward. He responded by moving backwards and to his right until he was close to the footpath.

126. By then he felt he had little or no further room to retreat. When Courtney was less than two metres from him he fired a single shot from his pistol.

127. The Bogunovic video supports SC Tesoriero's evidence that in the seconds before she was shot Courtney changed direction and, knife in hand, advanced towards him. She continued to do so while he backed away. Some witnesses described Courtney moving with deliberation; that certainly was SC Tesoriero's impression. When asked by Counsel Assisting what he thought was going to happen in those moments, SC Tesoriero replied simply: *'I thought she was going to stab me'*.

128. It was not asserted in submissions that SC Tesoriero did not have a basis for believing his life was in danger at the point he fired his pistol. I accept that he had a reasonable subjective basis for this belief.

Did Courtney intend to harm SC Tesoriero?

129. Nothwithstanding the above finding, in my view the answer to this question cannot be known. With the benefit of other evidence the court is able to dismiss the claims of some witnesses that Courtney was '*slashing*' at police officers with her knife. None of the attending officers made such a suggestion. Nor is this observation supported by the video evidence. It is not suggested that these witnesses deliberately fabricated their testimony.

130. In my view the evidence does not enable a finding as to what Courtney's intention was when she moved in SC Tesoriero's direction. It is possible she intended to harm him, given the likelihood she was frightened by the OC spray and may have felt herself to be under attack. It is equally possible that she remained distracted and confused, unable to appreciate the significance of what was happening, and wanted to get away from the situation.

131. For these reasons I make no finding as to what Courtney's intention was in the seconds before she was shot.

The aftermath

132. Moments after Courtney was shot more police officers arrived at the kerbside. One of these was Senior Constable Stephen McEvoy, a police officer with over 28 years' experience who had completed the four day MHIT program. Another was Senior Constable Paul Falzon. He too had completed the four day program.

133. SC McEvoy ran to Courtney and immediately commenced first aid, taking the lead role with CPR. In between compressions he held Courtney's head and talked to her, telling her to '*hang on'* and *'keep with it'*. SC Falzon attempted to perform mouth to mouth resuscitation. SC McEvoy continued his CPR efforts until handing over to another officer, just before the ambulance crew arrived.

134. The Bogunovic video shows that after firing the shot SC Tesoriero pulled on gloves, presumably to assist in the first aid efforts. By then however a small group of officers was kneeling around Courtney. SC Tesoriero can be seen dropping to one knee, apparently in shock. He was helped from the scene by Constable Djuric.

135. An ambulance arrived quickly, but paramedics immediately saw that Courtney could not survive her injury. Nevertheless they continued CPR efforts while she was taken to hospital. There she was pronounced deceased at 12.02pm. NSW Police immediately established a Critical Incident Team to investigate Courtney's death. Its Officer in Charge is Detective Chief Inspector Gary Jubelin. He proceeded to coordinate a thorough investigation into what happened that morning.

Did police breach NSW Police Force policies and procedures?

136. In closing submissions, Counsel Assisting the inquest and Counsel representing the Topic family took issue with the police response in this matter. The submissions of Counsel Assisting focused not so much on the actions of officers Jones, Tyson and Tesoriero in discharging or attempting to discharge their weapons, but rather at the decisions which had preceded these resorts to force and made them a tragic inevitability. The submissions of Counsel Assisting were therefore largely directed at decision-making within the NSW Police Force regarding training and deployment.

137. Those representing the family went further, asserting that it was open to refer officers Tyson and Tesoriero to the Law Enforcement Conduct Commission for their conduct in drawing their respective weapons as they approached Courtney. It was asserted that in doing so the two officers did not act in accordance with their powers under the *Law Enforcement and Powers and Responsibilities Act* 2002. Nor, it was claimed, did they act in accordance with the Tactical Options Model, the framework which guides NSW police officers in their decisions about use of force.

138. The court's attention was drawn to the Standard Operating Procedures for use of a Taser. These stipulate that a drawn appointment is a '*use of force'.* Officers Tyson and Tesoriero drew their weapons in circumstances where, it was argued, immediate action in the form of a use of force was not required or justified. The two officers were thus in breach of police powers.

139. I do not accept this submission. As noted in submissions of Counsel Assisting, the threshold set in the Standard Operating Procedures for drawing an appointment is not that the officer is justified in using it. It is that he or she is *'likely to be justified in using it'*. This constitutes a lower threshold than actual use. It reflects a common sense appreciation that drawing an appointment only at the point where a use of force is in fact justified may not leave sufficient time for it to be discharged.

140. As further noted by Counsel Assisting, the Tactical Options Model is best understood as a set of principles to guide decisions about the appropriate use of

force. Given the unpredictability of high risk situations and the range of tactical responses available, it is not prescriptive. It is left open to an individual officer to judge which tactical option is, in his or her subjective view, required to control the situation confronting him or her.

141. For these reasons I do not find that officers Tyson and Tesoriero breached NSW Police Force policies or procedures when they drew their weapons on their approach to Courtney.

142. No party submitted that the three involved officers breached police powers or procedures by discharging their weapons. The family's submissions fairly acknowledged that prior to discharging his OC spray, SC Jones was unaware of the limited interaction of his fellow officers with Courtney and of the non-confrontational nature of her conduct.

143. Regarding Constable Tyson and her attempt to discharge her Taser, the family submitted that Courtney had not actively threatened police or public so as to justify this response. However it was conceded that her flight from the area created a potential risk due to the absence of a perimeter within which to contain her movements.

144. It was accepted that at the point of firing his pistol SC Tesoriero believed he was under threat of serious harm or death.

145. I accept these submissions. The evidence supports a finding that when the three officers discharged or attempted to discharge their weapons they had subjectively reasonable grounds to do so. Their actions did not breach NSW Police policies and procedures.

Was the police response appropriate?

146. This is a different question. Counsel Assisting the inquest submitted errors were made by those in the NSW Police Force who are responsible for tasking officers to respond to mental health related incidents. Errors were also made by the responding police in their approach to Courtney: specifically they failed to factor in the strong indications of her mental disturbance. This, it is asserted caused them to adopt an approach to disarming her which was entirely inappropriate and had the most tragic consequences.

147. I accept these issues go to the heart of what went fatally wrong that morning.

148. Taking issue with decisions made by first responders to a high risk situation should not be done lightly. At an inquest actions are assessed with the clarity of hindsight, with the benefit of information which those in the midst of the crisis did not have, and in entirely different conditions to those they faced. Moreover, as emphasised in the submissions of Counsel Assisting and those on behalf of SC Tesoriero, it is no part of the function of the Coroner's Court to assign blame for a person's death.

149. It is however central to the Coroner's task to identify cause, and to examine whether there are ways to prevent human lives being lost in the future. It is in this context that I now examine the appropriateness of the police response to Courtney.

150. Counsel for the Commissioner submitted that the responding officers ought not to have been expected to realise that Courtney may have been suffering a mental disturbance.

151. I do not accept this submission. The CAD messages and radio broadcasts clearly signalled the likelihood that a response sensitive to mental health issues was going to be required. Courtney's appearance and behaviour could only have reinforced those signals. From the outset officers Tyson and Tesoriero saw she was not behaving in a way which might be expected: she seemed '*dazed'* and was unresponsive to their presence, commands, and weapons.

152. The Commissioner's further submission was that the reports about Courtney, and her observed behaviour and appearance, may equally have caused the responding officers to conclude she was drug-affected. I accept it was open for them to conclude this. But why would this not similarly alert them that a different communication approach may be needed to disarm her?

153. Submissions made on behalf of the Topic family highlighted common features of communication which have been identified in studies of police shootings of mentally disturbed people. One such feature, the '*presumption of rationality'*, is evident in the approach taken in this case. It is described as the failure to recognise that the disturbed person may be unable to think and respond rationally, and that shouting commands and drawing weapons may panic or aggravate him or her.

154. As noted, the NSW Police Force accepts that dealing with mentally disordered persons is a challenging part of police work. It can put police officers at risk as well as those they are dealing with. Hence the commendable decision to build skills in communicating with mentally unwell people, in the form of the MHIT training.

155. This understanding also informs the Tactical Options Model. It stipulates that a person's mental condition must be taken into account when applying the Model.

156. The court heard expert evidence about this from Sergeant William Watt. Sergeant Watt is a senior operational instructor with NSW Police Weapons and Tactics Policy and Review [WTPR]. His unit trains the Operational Safety instructors who deliver tactical options training to police officers.

157. In his statement to the inquest Sergeant William Watt identified '*mental state'* as a special circumstance which needed to be considered in a risk situation. Thus:

> *'A subject who is affected by drugs/alcohol or suffers a mental disorder may require a different choice of tactical option or level of force response to maintain control in an effort to resolve the incident confronting the officer'*.

158. Sergeant Watt declined to be critical of the approach taken by the responding officers. In his opinion it was within the bounds of NSW Police protocols and procedures. He did however acknowledge they had missed important information about Courtney's mental disturbance which needed to be incorporated into their planning.

159. Sergeant Watt emphasised that it was always important for officers to assess a situation and plan their approach, unless the level of risk required an immediate reaction. He acknowledged that alternative approaches could have been considered in similar situations. It may have been an option for the two officers to keep Courtney under observation, while ascertaining via police radio whether any MHIT accredited officers were nearby and able to act as first responders. The two officers could then have assessed whether it was consistent with safety to await their arrival.

160. Sergeant Watt also told the court that in de-escalation role plays involving someone who has to be disarmed, he would expect to see the responder attempt to persuade the person to put the weapon down, while maintaining a safe distance. There were different methods of persuasion, and shouting commands would not always be appropriate.

161. It is a striking feature of the evidence in this case that despite all involved officers having completed the one-day mental health training course, none appeared to appreciate that the communications skills required to deal with a mentally disordered person were also applicable when the task was to disarm him or her.

162. This disconnect was exemplified in the following evidence given by one of the police officers:

Q. How do you respond to somebody with a mental health crisis in a mental health incident? What were you trained during that one day to do?

a. *You obviously assess it and if they need help you give them help and – but in this situation there's a weapon, it's a different scenario.*

Q. Are you saying …you believe if they had a weapon then you treated it in a different way than if it was just simply somebody who looked like they were in the middle of a psychosis for example?

A. Yes. You would take the weapon out of play and then you can speak to them calmly, … safety first, disarm and then you can reassess.

How could de-escalation strategies have helped?

163. Some of the communication strategies mentioned by Sergeant Watt were referred to in evidence given by Inspector Michael Brown, presently seconded to the College of Policing and the National Police Chiefs Council in the United Kingdom. Inspector Brown has extensive experience in police training. His expert comment had been sought as to whether a different approach was

available on 10 February which might have led to an outcome not involving lethal force.

164. The specific challenges of this incident were acknowledged by Inspector Brown. Nevertheless in his opinion the optimum police strategy in such situations is to stop, observe and assess – but only to the extent consistent with public safety. This, he acknowledged, could be a very fine judgement call.

165. Inspector Brown noted that Courtney had not threatened anyone with the knife. Nor was she immediately proximate to members of the public. In these circumstances the officers might have considered keeping her under observation for a short while to consider what their options were. He acknowledged this strategy would have to be reassessed if Courtney had started to move into an area where other people were present.

166. In Inspector Brown's opinion de-escalation strategies increased the potential for an incident to be resolved without use of force. As he described it:

> *'..the calmer the officers can be, the more empathetic they can be, the less rushed they can be, … the more human they can be, all these things are potentially only going to increase the likelihood that they can resolve an incident safely without the use of force or by reducing the amount of force that is in fact necessary. And the opposite is also true that the more rushed they are, the more commanding and instructing and shouting that they do, all those sort of things only increases the level of anxiety.*
> *So the big message to police was just calm down, take your time, recognise where there is no urgency and deploy your tactics and your manner and your speech accordingly.'*

167. In her evidence to the inquest Dr Eagle confirmed that a calmer and slower approach would have been more likely to secure Courtney's compliance.

168. Dr Eagle conceded that de-escalation tactics were more challenging when the situation was unfolding in an open space and there may be a sudden need to react quickly. However Courtney seemed disconnected and unresponsive - therefore a different mode of communication was needed to help her understand what the officers needed her to do. This would involve a slower-paced plan of trying to engage her in conversation aimed at showing her they understood she felt disturbed and unsafe, and wanted to help her.

169. Having reviewed the evidence in this inquest, I have concluded that the responding police took an approach to disarming Courtney which was not appropriate. The presence of mental disturbance as a special circumstance ought to have caused officers Tesoriero and Tyson to give thought to the communication skills that might be needed to disarm her. The critical question is that posed by Counsel Assisting in his submissions: '*How best to persuade a person in mental health crisis to give up the weapon? That necessitates enabling police to understand and employ communication skills best suited to securing compliance by persons in mental health crisis'.*

170. This leads me to consider whether there are practicable reforms which might reduce the risk of such a tragic outcome in the future.

Question of recommendations

171. Counsel Assisting the inquest proposed recommendations within two broad categories: police training, and deployment of officers to emergency mental health incidents. The aim of the proposals was to reduce the risk of lethal force being used in such incidents, without unduly compromising police officer safety. These were circulated to interested parties. All provided constructive submissions which have assisted me in deciding what recommendations should be made.

172. Having reviewed the proposals and responses I have determined that it is necessary and desirable that all but one of the recommendations proposed by Counsel Assisting be adopted. I also adopt two recommendations proposed by Courtney's family. The recommendations and my reasons appear below.

Training: Recommendations 1- 4.

173. The question one is left with is why an understanding of mental health did not guide the approach of the responding officers, despite their having received MHIT training.

174. I accept the submission of Counsel Assisting that the failure arose in part from a lack of integration of the skills taught in MHIT training with those in operational safety training.

175. In the recent Inquest into the death of Stephen Hodge (20 April 2018), Deputy State Coroner O'Sullivan made the following recommendation:

> *'That consideration be given to the greater integration of mental health informed training into tactical options training, with an emphasis on specific de-escalation techniques practiced by role play exercises.'*

176. The inquest into Courtney's death identified the same need. There would be real and demonstrable benefits in achieving a better integration of the skills taught in these two critical areas of training. This is the subject of four recommendations, as follows.

> **Recommendation1**: Consideration be given to the MHIT and WTPR establishing and documenting a joint review of training packages for defensive tactics training where mental health is likely to be a relevant factor.
>
> **Recommendation 2**: Consideration be given to the greater integration of mental health informed training into tactical options training, with an emphasis on specific de-escalation techniques practiced by role play exercises.
>
> **Recommendation 3:** Consideration be given to requiring all present Operational Safety instructors to complete the four day MHIT training. This

should be undertaken as soon as practicable, while ensuring the availability of Operational Safety instructors to meet ongoing accreditation requirements.

Recommendation 4: Consideration be given to the MHIT and WTPR jointly pursuing a program of (1) reviewing international learning with respect to first responder interactions with persons in mental health crisis and (2) designing defensive tactics training that seeks to embody the learning obtained from the review.

177. These recommendations are supported by the Topic family. Most encouragingly, they are also supported by the Commissioner.

178. I note also in passing that Sergeant Watt, who attended each day of the inquest, told the court he had decided to undertake the four day MHIT training and wanted his team at WTPR to do so too.

Radio and CAD Communications: Recommendations 5 and 6

179. On 10 February 2015 the radio operators and Constable Beasant competently communicated the signs that Courtney was suffering a mental health crisis. The two recommendations below are made because at present there are no protocols or training concerning communications where mental health issues seem to be present. Operators would not necessarily require the one day MHIT training to achieve this purpose.

Recommendation 5: Consideration be given to requiring that all police radio and Triple 000 operators undertake training by the MHIT in skills which will better equip them to recognise signs of mental health disturbance in reports from police and civilians.

Recommendation 6: Consideration be given to developing criteria by reference to which police radio operators may identify an incident as possibly involving a person in mental health crisis.

180. Recommendation 6 is designed to facilitate the tasking of MHIT accredited officers as first responders, a key recommendation which I address below. It calls for a set of criteria to be developed which would guide police radio operators in identifying an incident as involving a person in mental health difficulty.

181. The Commissioner supports recommendation 5. The Commissioner does not support recommendation 6, for reasons which are explained below.

Priority deployment of MHIT accredited officers: Recommendations 7 and 8

Recommendation 7: Consideration be given to developing and implementing a system to dispatch four day MHIT accredited officers as first responders in cases which meet criteria indicating possible mental health crisis.

182. Counsel Assisting the inquest and Counsel for the Topic family emphasised the need for a system to task MHIT accredited officers as first responders wherever possible in likely cases of mental health crisis.

183. This proposal was not supported by the Commissioner, for two reasons. The first is that NSW Police resources do not permit MHIT accredited officers to be available only for mental health related incidents. But this misunderstands the intention of the recommendation. It is accepted that MHIT accredited officers must be rostered for general duties work. It is likewise accepted that there will be incidents where an MHIT accredited officer is unable to attend. These realities do not diminish the need for a system to deploy accredited officers wherever possible.

184. The second objection is that it is unknown whether the dispatch of MHIT accredited officers to this scene would have brought about a better outcome. Of course it is not possible to assert this. But to accept this argument is to beg the question why the NSW Police Force resources the MHIT program at all, if it is not the case that the Commissioner acknowledges its potential to deliver real benefits to the welfare of police officers and mentally unwell people.

185. It is clear that accredited MHIT officers were intended to be deployed wherever possible as first responders to emergency mental health situations. This was the evidence of the former head of the MHIT, Chief Inspector Joel Murchie. He stated that graduates of the four-day program '*become prioritised first responders to mental health or suicide prevention incidents within their Local Area Commands'.*

186. This strategy is a rational one. It is designed to employ the skills of a corps of specially trained officers where they are needed most. But it emerged during the inquest that no system has been developed to prioritise accredited MHIT officers in this manner.

187. It so happened that in this case two police officers with MHIT accreditation arrived at the scene just as Courtney was shot. They were SC McEvoy and SC Falzon. They arrived tragically too late to assist a young woman who was greatly in need of their help.

188. This was not the fault of officers McEvoy and Falzon. No one had directed them to attend the scene as first responders. They went there only because they happened to be in the area. That they were not specially tasked to respond was a consequence of the NSW Police Force's failure to develop a system to dispatch accredited officers in the manner contemplated by the MHIT scheme.

189. SC Falzon told the inquest that at the time of Courtney's death he had never been tasked to attend an incident in his capacity as an MHIT accredited officer. Nor has he since that time. It was most disheartening to hear this evidence, given the numbers of people in Courtney's situation who have been fatally shot both before and after her death. This is not good enough. It makes no sense for the NSW Police Force to make such poor use of a highly valuable resource. Worse still it lets down a most vulnerable group of people.

190. I fully accept the submissions of Counsel Assisting and the family, that there is a compelling need for NSW Police to develop a system to triage and deploy accredited officers to emergency mental health incidents.

191. I most strongly urge the Commissioner to reconsider his position on this proposal. It would be difficult to envisage a situation which more starkly highlighted the need for it.

192. To support the proposal, Counsel Assisting proposed that all senior officers receive training to ensure they understand the new protocol for deploying MHIT accredited officers. This makes sense and I adopt it as follows:

> **Recommendation 8**: the Commissioner consider developing a mandatory training package for all police officers other than commissioned officers, and specifically including Local Area Commanders, to ensure understanding of the protocol for responding four day accredited MHIT officers.

Post-incident counselling

193. Counsel Assisting the inquest made a further recommendation, that NSW Police introduce a program whereby all officers involved in an event involving the death or injury of a person in mental health crisis be counselled by an Operational Safety Instructor as to approaches which may have avoided the death or injury.

194. Counsel Assisting explained that the aim would be to allow instructors to better understand any gaps in their training, while giving involved officers the opportunity to enhance their own skills.

195. This proposal was not supported by the Commissioner or by the NSW Police Association. Both were concerned about the impact such a process may have on the welfare of officers involved in civilian deaths or injuries. It is natural for them to be deeply affected by these events. It was noted that in almost all cases, involved officers would already have undergone a critical incident interview requiring them to relive their experience.

196. I accept the submissions of the Commissioner and the Police Association. I am not persuaded the benefits of this proposal will outweigh its potential impact on officer welfare.

Recommendations proposed on behalf of the Topic family

197. The Topic family proposed several additional recommendations, addressed below.

Mental Health training: Recommendations 9 and 10

198. The Topic family sought a recommendation that all general duties officers undertake the four day MHIT training.

199. According to the submissions of Counsel for the Commissioner, the NSW Police Force plans to have all front line officers trained in this program. This is a most welcome initiative. However I did not hear evidence about its feasibility, in particular how this very significant commitment of resources would be implemented. I do not make it the subject of a formal recommendation.

200. A further recommendation is sought that the four day MHIT program include more role play-based exercises, and that refresher MHIT training be offered. This recommendation was earlier proposed by a team of independent experts who evaluated the NSW Police's MHIT program in 2015.

202. The report's findings reflected the common sense principle that learning is more effective when it is delivered in a 'hands on' form; and that maintaining skills and competence usually requires booster training. I make recommendations as follows:

Recommendation 9: That the Commissioner consider reviewing the four day MHIT program to include more experiential learning, in the form of role play exercises.

Recommendation 10: That the Commissioner consider offering MHIT booster training on a one to three year basis.

Additional priority response category

203. Courtney's family asks that the Commissioner consider creating an additional 'Priority 2' CAD category. The current definition is set out at par 65 above. On the basis that at the time the call was made Courtney did not pose any immediate threat to life, Counsel for the family urged a further category calling for immediate police attention, in circumstances where there was no immediate or serious threat to life.

204. I do not consider this recommendation is necessary. I note that the current definition is not confined to situations of violent or exigent circumstances, but extends to the possibility of these. It could not be denied that the situation to which police were called on 10 February fell within the latter category.

Operational changes

205. Courtney's family urges the Commissioner to consider adopting the Victorian Police model based on the Ten Operational Safety Principles, and further that the NSW Police's Tactical Operations Model be reviewed with a view to removing 'Control Theory'.

206. I am not in a position to support these two recommendations. Evidence about how the Victorian model operates was not heard at the inquest. Furthermore it is evident that the NSW Tactical Operations Model expects officers to build into their response to an incident the elements of planning, risk assessment, and effective communication. The inquest exposed failures in the way these elements were put into practice on 10 February.

Extended Spark Tests

207. The Taser issued to Constable Tyson had a degraded battery. This caused it to malfunction at a critical point that morning. This failure was not the responsibility of Constable Tyson, who had performed the required 'spark' test when the Taser was issued to her that morning. This type of Taser required a monthly extended test to check its battery life, and there was no evidence this had been performed.

208. Counsel for the family rightly submitted the failure to properly maintain the Taser was a serious lapse. The family asks the Commissioner to institute a system of regular audits and records confirming that monthly extended spark tests have been carried out.

209. I am satisfied this proposal is unnecessary. The inquest heard evidence that changes have been made to NSW Police's Command Management Framework, bringing in mandatory checks to ensure the monthly tests take place. The changes include a system of audit.

Review of police shooting deaths

210. The Topic family wants the NSW Police Force to undertake a systematic review of fatal police shootings in NSW, to identify recurring themes and opportunities for improvement.

211. While there may be value in such a review, a recommendation that it be undertaken goes beyond the scope of this inquest.

Final comments

212. Courtney's death and the way she died are profoundly sad. Her family loved her and miss her deeply. Leesa and Ronny, Kris, and Courtney's grandparents Bede and Judy attended each day of the inquest, and on the last day Leesa bravely bore witness to her daughter in a deeply moving statement. They will always grieve for Courtney, but I hope that in time they will find some measure of peace.

213. Acknowledgement is due to the NSW Police's comprehensive and transparent investigation into this tragedy. The inquest was attended throughout by the Officer in Charge Detective Chief Inspector Gary Jubelin and by Homicide Squad's Detective Sergeant Justin Moynihan. I am aware Courtney's family appreciated the sensitivity displayed by DCI Jubelin in his communications with them throughout the long process of the investigation.

214. I am deeply appreciative of the outstanding assistance given by Senior Counsel and Counsel Assisting the inquest, and the Crown Solicitor's Office. I acknowledge also the assistance received from the legal representatives for all the interested parties, and the support given to Courtney's family throughout the inquest by counsellors of the Department of Forensic Medicine.

Findings required by s81(1) Coroners Act 2009

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to make the following findings.

The identity of the person
The person who died is Courtney Topic born 27 February 1992.

Date of death
Courtney Topic died on 10 February 2015.

Place of death
Courtney Topic died at West Hoxton NSW 2171.

Cause of death
Courtney Topic died from a gunshot wound to the chest.

Manner of death
Courtney Topic died in the course of a police operation. Her death was by gunshot in circumstances in which she was very likely suffering a mental health crisis and was in a public place holding a knife.

Recommendations pursuant to s82 Coroners Act 2009

To the NSW Commissioner of Police:

Recommendation1: Consideration be given to the MHIT and WTPR establishing and documenting a joint review of training packages for defensive tactics training where mental health is likely to be a relevant factor.

Recommendation 2: Consideration be given to the greater integration of mental health informed training into tactical options training, with an emphasis on specific de-escalation techniques practiced by role play exercises.

Recommendation 3: Consideration be given to requiring all present Operational Safety instructors to complete the four day MHIT training. This should be undertaken as soon as practicable, while ensuring the availability of Operational Safety instructors to meet ongoing accreditation requirements.

Recommendation 4: Consideration be given to the MHIT and WTPR jointly pursuing a program of (1) reviewing international learning with respect to first responder interactions with persons in mental health crisis and (2) designing defensive tactics training that seeks to embody the learning obtained from the review.

Recommendation 5: Consideration be given to requiring that all police radio and Triple 000 operators undertake training by the MHIT in skills which will

better equip them to recognise signs of mental health disturbance in reports from police and civilians.

Recommendation 6: Consideration be given to developing criteria by reference to which police radio operators may identify an incident as possibly involving a person in mental health crisis.

Recommendation 7: Consideration be given to developing and implementing a system to dispatch four day MHIT accredited officers as first responders in cases which meet criteria indicating possible mental health crisis.

Recommendation 8: Consideration be given to developing a mandatory training package for all police officers other than commissioned officers, and specifically including Local Area Commanders, to ensure understanding of the protocol for responding four day accredited MHIT officers.

Recommendation 9: Consideration be given to reviewing the four day MHIT program to include more experiential learning, in the form of role play components.

Recommendation 10: Consideration be given to offering MHIT booster training on a one to three year basis.

I close this inquest.

Magistrate E Ryan

Deputy State Coroner
Glebe
30 July 2018