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

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| **Inquest:** | Inquest into the death of Peter Bernard Woodcroft |
| **Hearing dates:** | 29 to 30 November 2017 and 8 March 2018 |
| **Date of findings:** | **2 May 2018** |
| **Place of findings:** | NSW State Coroner's Court, Glebe |
| **Findings of:** | **Deputy State Coroner, Magistrate Teresa O'Sullivan** |
| **Catchwords:** | CORONIAL LAW – manner and cause of death – response of NSW Police Force to a Triple Zero call – operation of the Triple Zero call system. |
| **File number:** | 2016/199540 |
| **Representation:** | (1) Counsel Assisting<br>Mr Jake Harris, instructed by Ms Joanna Mooney and Ms Clare Skinner of the NSW Crown Solicitor's Office<br>(2) NSW Commissioner of Police<br>Ms Justine Hopper, instructed by Joseph McCombe of the Office of General Counsel, NSW Police Force<br>(3) Danielle Morony, Zoe Sanders, Brendon Botha and Michael Field<br>Mr Paul Madden, instructed by Kenneth Madden of Walter Madden Jenkins<br>(4) NSW Ambulance Service<br>Steven Woods, instructed by Les Sara of Hicksons Lawyers<br>(5) Telstra Corporation Limited<br>Ms Jane Paingakulam, instructed by Jacqueline Wootton of Herbert Smith Freehills |

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| **Non publication order:** | 1. Pursuant to section 74 of the *Coroners Act 2009* there shall be no publication of:<br>a. the name, address (excluding suburb) or any other information capable of identifying any member of the public involved in a police incident referred to in the brief, other than Peter Woodcroft;<br>b. any information relating to the "road rage" incident referred to by police on VKG radio at 6.22am on 30 June 2016, including all related CAD messages;<br>c. The information contained in annexures JLE 4 and JLE 5 to the statement of Jane Louise Elkington (tab 69A);<br>d. The following NSW Police Force Policies:<br>i. PoliceLink/ROG Telephony/Dispatch SOPs Version 49; and<br>ii. Dispatch Broadcast Procedures.<br>e. The statement of Jane Elkington dated 28 February 2018 (tab 69B) and the annexures JLE6 and JLE7.<br>2. Pursuant to section 74 of the *Coroners Act 2009* there shall be no disclosure of any of the information listed in Attachment A to the letter of Jennifer Windsor dated 9 November 2017 and such information shall be redacted from the brief. |

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| **Findings:** | **Identity of deceased:**<br>The deceased person was Peter Bernard Woodcroft<br><br>**Date of death:**<br>Mr Woodcroft died on 30 June 2016<br><br>**Place of death:**<br>Mr Woodcroft died at Waterloo, NSW<br><br>**Manner of death:**<br>Mr Woodcroft suffered a medical emergency and phoned Triple Zero. He was unable to tell the operator what he needed. Mr Woodcroft died before police attended his home. His death was from natural causes in the course of police operations.<br><br>**Cause of death:**<br>Heart failure or arrhythmia, secondary to ischaemic heart disease. |
| **Recommendations:** | To: Commissioner of NSW Police Force,<br>Commissioner of NSW Ambulance Service, and<br>Telstra Corporation Limited<br><br>I recommend tabling for consideration at the next National Emergency Communications Working Group (scheduled for 23 May 2018) the following agenda item:<br><br>The development of a system that would allow the following information to be readily accessed by, or provided to, the relevant Emergency Services Operator (ESO), where this is permitted by privacy legislation:<br><br>(a) the audio recording of Triple Zero calls that is captured by Telstra;<br>(b) a caller's Triple Zero call history, as held by Telstra; and<br>(c) a location's previous Triple Zero call history, as held by each ESO. |
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*The Coroners Act 2009 in s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

*These are the findings of an inquest into the death of Peter Woodcroft.*

# Introduction

1. Peter Bernard Woodcroft was born on 6 September 1937, and he was 78 when he died on 30 June 2016. He was at his home at 4.32am that morning when he suffered a medical emergency and called Triple Zero. Although police were notified of the call, it took them almost 4 hours to attend Mr Woodcroft's property, where they found him deceased.

2. As Mr Woodcroft died in the course of police operations, an inquest is required to be held pursuant to ss. 23(c) and 27(1)(b) of the *Coroners Act 2009* (NSW) ("the Act").[1]

## *The nature of an inquest*

3. The role of a Coroner, as set out in s.81 of the Act, is to make findings as to:

    a. the identity of the deceased;

    b. the date and place of the person's death;

    c. the physical or medical cause of death; and

    d. the manner of death, in other words, the circumstances surrounding the death.

4. There is no controversy about Mr Woodcroft's identity, or about the date and place of his death. As to the cause of death, the available medical evidence suggests that the most likely causes were either sudden heart failure or an arrhythmia.[2] Accordingly, the focus of the inquest was on the manner of death, and in particular the actions taken by emergency services following Mr Woodcroft's call to Triple Zero.

[1] Note that Mr Woodcroft's death occurred prior to the amendment of s. 23 of the *Coroners Act 2009* on 1 July 2017, pursuant to Sch. 6.5 cl. 1 of the *Law Enforcement Conduct Commission Act 2016*

2 A/Prof Holloway, brief 2/80 [12]

5. A secondary purpose of an inquest is to determine whether it is necessary or desirable to make any recommendations in relation to any matter connected with the death, including in relation to matters of public health and safety.[3]

# The Facts

## *Background*

6. Mr Woodcroft was born and raised in Randwick. He was a twin, although his brother died aged 40 of a heart attack. During his working life he was employed by Trans Australia Airlines. He was also a keen sportsman. As a young man in the 1950s he played for Coogee Rugby League Football Club and he later became an official with the NSW Professional Runners Association.

7. In the early 1960s he married Maria Eirth and they had three children, Anthony, Victoria and James. The couple divorced in the 1970s although Mr Woodcroft continued to live with the family off and on over the years. In the 1990s he moved to a unit at 1707, 1 Phillip Street, Waterloo. That property is also known as Turanga, it is a high-rise block housing mostly elderly public housing tenants.

8. Mr Woodcroft suffered from poor health. He had been exposed to asbestos during his life and had also smoked and drank heavily from his teens through to his fifties. The family also report a downturn in his health following an assault he suffered in his early 70s.[4] His GP records that he had Chronic Obstructive Pulmonary Disease, emphysema, pulmonary fibrosis, atrial fibrillation, congestive heart failure (leading to non-ST elevation myocardial infarction and angioplasty in 2013), hypertension, peptic ulcer disease, anaemia and benign prostatic hyperplasia, osteoporosis and chronic renal failure.[5]

9. From about 2014 Mr Woodcroft's health was reviewed by Dr Jankelson, a respiratory specialist, A/Professor Holloway, a cardiologist, and Dr Yuen, an urologist. He also had home visits from Clinical Nurse Specialist Cate McClary, a respiratory specialist. Her role was to support patients to manage their conditions

3 Section 82 Coroners Act 2009
4 Geraghty, brief 1/10 [13]
5 Dr Tan, brief 1/79 [5] and 1/79A/511

at home and to try to minimise the presentations to hospital. She visited him about 4 times from November 2015.

10. As a result of his poor health, Mr Woodcroft made 11 calls to Triple Zero in the three years to March 2016.[6] During each of those 11 previous calls, Mr Woodcroft stated he was having chest pains or breathing problems. Each of those calls was diverted to NSW Ambulance Service and Mr Woodcroft was taken by ambulance to St Vincent's Hospital. On six occasions, including the penultimate time he called Triple Zero in March 2016, it was also recorded that he had "difficulty speaking between breaths".[7]

11. These previous calls were not known to any of the people who responded to Mr Woodcroft's final call to Triple Zero. The information was held by NSW Ambulance, which was not contacted until after Mr Woodcroft's body had been discovered. As will be discussed, they are a striking feature of this case, and one that was explored in the evidence. This was in particular to discover what impact this information might have had on the course of events, if it had been known to those involved in the response.

## *Contact with Mr Woodcroft prior to his death*

12. On 21 June 2016 Nurse McClary visited Mr Woodcroft for the final time.[8] He told her he was feeling well, and she confirmed this in her observations that day and by weighing him and testing his respiratory function. However, Mr Woodcroft admitted to her that he had not been taking his Frusemide or Lasix medication. This is a diuretic medication used to reduce fluid retention. A build-up of fluid was likely to exacerbate Mr Woodcroft's heart condition and cause breathlessness.[9] Mr Woodcroft did not want to take this medication, because it made him urinate more frequently and this was painful for him. Instead, he preferred to control the quantity of fluid he drank, including by reducing his

6 Incident detail reports, brief 1/8A/64 to 94
7 Incident detail reports, brief 1/8A/66, 74, 76, 78, 87 and 92
8 McClary, brief 2/77 [15]
9 Dr Jankelson, brief 2/81 [11]; McClary, brief 2/77 [12]

alcohol intake.[10] Nonetheless, Nurse McClary advised him strongly to take the medication. She planned to visit him again in 6 weeks.

13. On Saturday 25 June 2016 Mr Woodcroft went on a social outing to Ettalong Beach with Chelsea Old Mates, which is a social/welfare group associated with the Men of League Foundation. He had been a loyal member of the group for some time. During that outing he drank an unknown quantity of alcohol, probably light beer, over the course of a couple of hours.[11]

14. On Tuesday 28 June his daughter Victoria visited him at home. He told her he felt good and he appeared to her to be in good health.[12]

15. The following day, Wednesday 29 June, Mr Woodcroft's son Anthony collected him and took him to vote at Botany Road. Again, he appeared to be well. After voting, Anthony dropped Mr Woodcroft at a podiatrist called "Great Feets" (sic.) in Redfern. The podiatrist Anna Crawford reviewed him and, although she found him to have an irregular pulse, she was not concerned about his health. In particular, she did not record him to have any problems with his breathing.[13]

16. During the evening Mr Woodcroft spoke with Patricia Weekes on the telephone. They had dated in their teens and had recently reconnected with each other. Mr Woodcroft called Mrs Weekes at 6.51pm and again at 8.02pm.[14] She says they spoke about football and about the goings on at his block. He told her he was feeling good. This was the last contact anyone is known to have made with Mr Woodcroft prior to his call to Triple Zero.

17. Also during that evening, at 7.43pm, Mr Woodcroft phoned his friend Neville Woods. Mr Woods told police that Mr Woodcroft always said his health wasn't good, although he didn't make any specific comment during that conversation.

## *The process of handling Triple Zero calls*

18. When a person calls Triple Zero, the call is received by Telstra, which is the "Emergency Call Person" for all Triple Zero calls made in Australia. Its

10 McClary, brief 2/77 [13]
11 Vessey, brief 1/12 [10]
12 Geraghty, brief 1/10 [20]
13 Crawford, 2/78 [20]
14 Phone records, brief 1/11A/161; Weekes 1/11 [21]

obligations are governed by a federal regulatory scheme, in particular the *Telecommunications (Emergency Call Service) Determination 2009 (Cth)* ("Determination") made by the Australian Communications and Media Authority ("ACMA").[15]

19. Under the Determination, Telstra must transfer Triple Zero calls to an Emergency Service Organisation (i.e. Police, Fire or Ambulance) where: the caller asks to be transferred to one of those services; or the caller indicates in another way that he or she wants to be transferred; or when information is given that may reasonably be relied on as indicating that the caller should contact an emergency service.[16]

20. Telstra must then provide the emergency service with the location of the caller, the identity of the customer and the telephone number.[17] For landlines, at least, this information is obtained automatically and is referred to as "Caller Line Identification" or CLI. It is sent electronically to the emergency service. Telstra must also provide other information about the call where the emergency service requests it.[18]

21. Unfortunately, there are a large number of calls made to Triple Zero that do not require an emergency service. Telstra estimates that these make up 25% of the 23,000 Triple Zero calls it receives nationally each day.[19] Sometimes there is no response at all by the caller, often because the call was made in error, but also for other reasons including nuisance calls. Where the caller does not respond at all to the operator, and there are no suspicious circumstances associated with the call and there is no indication that assistance is required, there is a procedure called the "Caller No Response Call". The Determination requires these calls be transferred to an automatic message system, called "Interactive Voice Response" or IVR. At this point a message is played three times, prompting the caller to dial 55, and if the caller does not do so the call will be disconnected automatically.[20]

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15 Made pursuant to under subsection 147 (1) of the *Telecommunications (Consumer Protection and Service Standards) Act 1999 (Cth)*
16 *Telecommunications (Emergency Call Service) Determination 2009 (Cth)*, cl. 26
17 Ibid, cl. 51
18 Ibid, cl. 52
19 Elkington, 2/69 [17]
20 Triple Zero Policy, brief 2/69D/463.68

22. However, where a caller does respond to the operator, but cannot articulate where they are and what they want, such calls are diverted to police. This is because of all the emergency service organisations, police are considered to be best equipped to respond to such calls. Where such a call is transferred to police, Telstra will provide police with the customer, telephone number and location of the service, that is, the CLI information.

23. Once a Triple Zero call is transferred to police, the call is received by PoliceLink command. The Telstra operator remains on the line until contact is established and then the call is released, leaving only the caller and PoliceLink connected. The role of PoliceLink is to speak with the caller, triage the call and then summarise the information provided in a CAD incident message. That message is then relayed electronically to the relevant Local Area Command on the Police CAD system. PoliceLink also ascribes a priority rating for each incident, with priority 1 and 2 requiring an immediate response and priority 3 a non-urgent response. A non-urgent response means "respond when there are no priority one or priority two matters outstanding … police to attend as soon as possible".[21]

24. Where there is no response from the caller to PoliceLink, the Standard Operating Procedures ("SOPs") state that the call should be terminated and the person called back to establish whether an emergency exists. If there is still no response, a CAD incident is to be created with the category "Check bona fides", and a police unit is sent to check the circumstances. [22] There are a large number of such calls received by police each week.[23]

25. Once the CAD incident is created, it is picked up by Police Radio Operations Group. Dispatchers will broadcast the message over VKG radio to the appropriate Local Area Command. They obtain and broadcast available background information about the call, such as warnings or other information known about the person or location involved. Dispatchers can also change the priority of the CAD message, or request other resources, including an ambulance.

21 NSW Police Force Handbook, see Walters brief 1/19 [12]
22 PoliceLink/ROG Telephony/Dispatch Standard Operating Procedures, brief 2/64C/448.36
23 B Botha, brief 1/36 [16] – "We receive hundreds of these jobs a week"

26. The Radio Operations Group's Dispatch Broadcast Procedures require priority 3 incidents to be broadcast within 150 seconds of being received, and thereafter every 300 seconds or 5 minutes, or less if possible.[24] In the event that the incident is not acknowledged by the Local Area Command within 30 minutes, there is a procedure where the Radio Operations Group Dispatcher alerts their supervisor, and the supervisor contacts the Local Area Command to escalate the matter.[25]

27. From here, local police units will acknowledge the job and respond to it, according to the priority of the job and any competing priorities.

## *The action taken in response to Mr Woodcroft's call*

28. At 4.32am Mr Woodcroft called Triple Zero.[26] The call was answered by an Emergency Operator for Telstra, Gerard Cogley, who was based in Melbourne. This call was recorded and it and other recordings were played during the inquest.

29. Mr Cogley said "*Emergency, Police, Fire or Ambulance?*" and he heard Mr Woodcroft say "*I can't hear you*". Mr Cogley repeated his question and he then heard Mr Woodcroft moan but make no other response. Approximately 27 seconds after receiving the call, Mr Cogley transferred it to police in NSW.

30. At PoliceLink, the call was answered by Dominic Sirone. Mr Cogley told Mr Sirone "*I've got a caller on the line but I'm not exactly sure what they're after, I'm not sure if they can hear properly.*" Mr Cogley did not say Mr Woodcroft had said the words "*I can't hear you*", nor did he mention the fact that Mr Woodcroft had moaned. This was explored in evidence.

31. Mr Sirone asked if the caller needed the police, to which there was no response. Mr Sirone indicated to Mr Cogley that he would take the call, and accordingly Mr Cogley disconnected. After asking repeatedly for a response, Mr Sirone

24 Dispatch Broadcast Procedures, brief 2/64B/448.15
25 Ibid, 1/64B/448.16; this period of time is now 60 minutes, cf. Gates brief 1/7 [141]
26 Phone records, brief 1/11A/161 at 4.32:16

disconnected the call, although before doing so he believed he could hear a moan. Mr Sirone attempted to call Mr Woodcroft back, but the line was open.[27]

32. A further call was made to Mr Woodcroft's phone shortly afterwards, which was not answered; this was probably also made by police.[28]

33. Mr Sirone then created a CAD incident. Although he had not spoken, the CLI information (Mr Woodcroft's name, telephone number and address) was known, having been provided electronically by Telstra. Mr Sirone gave the incident a priority 3 rating, meaning a non-urgent response, and described it as a "concern for welfare".

34. The CAD message was sent to Radio Operations Group. Patricia Kudric was the Dispatcher at Radio Operations Group for the relevant area that evening. She viewed the CAD message at 4.36am and shortly afterwards also viewed information about the location, provided by Mr Sirone.[29] Ms Kudric broadcast the incident promptly at 4.37am.[30]

35. Ms Kudric went on to broadcast that message again three more times, at 5.09am, 5.46am and 6.04am. However, these broadcasts were not performed as frequently as is required by the Radio Operations Group Dispatch Broadcast Procedures, and nor were they escalated after 30 minutes, as was then required. Her reasons for this were explored in evidence.

36. There were two police units available at Redfern Local Area Command that morning. One of these, Redfern 16 (Leading Senior Constable Welch and Constable Brennan) responded to an Aggravated Break and Enter at about 4am and was occupied in relation to that incident over the course of the morning. I am informed that incidents of that nature are considered to be an operational policing priority. In those circumstances, it appears reasonable for those officers to have continued to focus on that incident, rather than respond to the job relating to Mr Woodcroft's call.

27 Phone records, brief 1/11A/161 at 4.33:57
28 Phone records, brief 1/11A/161 at 4.37:11 and 4.37:45
29 Incident log print, brief 1/14A/181 at 4.37:20
30 Kudric, brief 1/14 [20]

37. The other unit, Redfern 17 (Senior Constable Morony and Constable Katsogiannis) was available at Redfern police station when the initial broadcast was made. They heard the broadcast and they discussed attending it. They did not consider the incident to be urgent, and they did not acknowledge the job. Their actions were explored in evidence.

38. At 4.56am a second priority 3 job was broadcast, involving a female with possible mental health problems being abusive towards security staff, and the Redfern supervisor on duty at the time (Sergeant Botha) asked Redfern 17 to respond to that job, which they did at about 5.10am. They returned to the station 15 minutes later at 5.25am. Shortly afterwards, they encountered the oncoming shift, being Redfern 15 (Senior Constable Botha and Probationary Constable Field). They did not mention the outstanding job relating to Mr Woodcroft's call, and neither did the supervisor Sergeant Botha mention it to his replacement, Sergeant Hill, and nor was it mentioned in any documents handover.

39. Nonetheless, Senior Constable Botha noticed the outstanding CAD message on starting his shift and he acknowledged the job at 6.11am. Unfortunately, before attending Mr Woodcroft's home, another urgent priority 2 job relating to a "road rage" incident was broadcast.[31] Both available police units and the supervisor attended this incident. While Redfern 16 (Welch/Brennan) became available soon afterwards, they returned to their investigation of the Aggravated Break and Enter. Redfern 15 (Botha/Field) did not become available until 6.46am. After returning to the police station, they completed COPS entries and then attended a morning intelligence meeting for about 15 minutes at 7.30am. Accordingly, they did not respond to Mr Woodcroft's call until 8.05am, arriving on scene at 8.14am.

40. By this stage, it had taken approximately 3 ¾ hours for police at Redfern Local Area Command to respond to Mr Woodcroft's Triple Zero call.

## *Police arrive at Mr Woodcroft's unit*

41. On arrival at the Turanga block, Senior Constable Botha and Constable Field spoke with security, discovering that Mr Woodcroft had last used his key fob to

[31] The details of that incident are subject to a non-publication order

enter the building on Saturday 25 June 2016.[32] As I have noted above, this was not the last occasion he left his unit. Police made their way up to the 17th floor and knocked on Mr Woodcroft's door and announced their presence. After getting no response, Senior Constable Botha tried the handle and found the door was unlocked.

42. Police immediately saw Mr Woodcroft lying on the floor of his unit. They checked for signs of life, and finding none they commenced CPR. They contacted the supervisor Sergeant Hill and called for an ambulance, which arrived a short time later.

43. Sadly, it was not possible to resuscitate Mr Woodcroft and he was pronounced deceased.

44. Paramedics who attended observed that Mr Woodcroft appeared cold to the touch, and also that hypostasis or livor mortis was present, suggesting he had been dead for some time.[33] When police had first attended Mr Woodcroft the phone receiver was located underneath him, which suggests he became incapacitated at the time of his phone call. Police also noted that the radio was switched on, which explains the background talking that had been heard by Mr Sirone.

## *Autopsy*

45. A limited autopsy was performed, which stated the cause of death as ischaemic heart disease.

46. Further enquiries with A/Prof Holloway, Mr Woodcroft's treating cardiologist, and his respiratory specialist, Dr Jankelson, suggest that the most likely causes of death were either sudden heart failure or arrhythmia. A/Prof Holloway estimates that Mr Woodcroft was unlikely to have survived without receiving medical assistance within 30 minutes, in the case of heart failure, or as little as 10

[32] *Printout of FOB access card entries,* brief 2/76/B

[33] The precise time of death was not able to be determined

minutes in the case of arrhythmia. In that event, Mr Woodcroft's chance of survival would have been "exceptionally slim".[34]

## Issues explored at the inquest

47. A list of issues was circulated to the interested parties, outlining the broad areas of interest for the inquest as follows:

    1. *Findings, as required by s. 81 of the Coroners Act 2009, as to identity, date and place of death and the manner and cause of death.*

    2. *In particular, the following matters as to the manner of death:*

        *(a) Was adequate information regarding Mr Woodcroft's 000 call on 30 June 2016 conveyed by Telstra to PoliceLink?*

        *(b) Was the CAD message created by PoliceLink appropriate and in accordance with NSW Police Force policy, in light of the information known?*

        *(c) Was the incident broadcast and monitored by NSW Police Force Radio Operations Group adequately and in accordance with NSW Police Force policy?*

        *(d) Was there a reasonable opportunity for police to attend Mr Woodcroft's home prior to 8.14am, and if so, why was there no attendance prior to that point?*

        *(e) Was the response by Redfern Local Area Command adequate and appropriate in all the circumstances?*

    3. *Is it necessary or desirable to make recommendations in relation to any matter connected with the death?*

48. I will deal with these issues in turn.

[34] Holloway, brief 2/80 [13]

## *Was adequate information conveyed by Telstra to PoliceLink?*

49. Mr Cogley heard Mr Woodcroft say "*I can't hear you*". He said he formed an impression "*that they were having trouble hearing me*" and that "*they obviously need some service but whether its police, fire or ambulance I couldn't tell*".[35] Mr Cogley said it was not the role of Triple Zero operators to make assessments of calls. Nonetheless, he formed the impression was that it was a "*genuine call for help*".[36]

50. He said that, as Mr Woodcroft had not identified which service he required he technically could have diverted the call to the automated system as a no response call, but he decided to "*err on the side of caution*" and transfer the call to NSW Police.[37] This evidence was unconvincing. Having formed an impression that Mr Woodcroft needed help, it would not have been appropriate to treat the call as a "no response" call. It clearly did require a response.

51. Mr Cogley did not tell Mr Sirone that Mr Woodcroft had said "*I can't hear you*" but instead told him "*I'm not sure if they can hear properly*". Mr Cogley did not accept the distinction between the two. He said "*I think I communicated that appropriately when I told the police that the caller could not hear me properly, so there's obviously been some communication*"[38] and "*I don't think the meaning is different than what was conveyed*".[39] I do not accept this evidence. If Mr Cogley had told Mr Sirone that Mr Woodcroft had actually spoken to him, it would have been clear that a person was on the line who was unable to communicate; the words that Mr Cogley said did not give that impression.[40]

52. Similarly, Mr Cogley did not tell Mr Sirone that Mr Woodcroft had moaned during the early part of the call. When asked why he did not do so, he said he did not consider it to be relevant at the time.[41] He further explained "*Yeah, it's policy … Only to state the facts and not presume that the moaning means anything – it*

35 Transcript 29/11/17 p. 26:32 – 34, 48-50; p. 27:1.
36 Transcript 29/11/17 p. 27:25-36; p. 36:5-17.
37 Transcript 29/11/17 p. 33:
38 Transcript 29/11/17 p. 32:8-13
39 Transcript 29/11/17 p. 29:17-50; p. 30:1-7.
40 See Transcript 29/11/17 p. 29:17-50; p. 30:9-14.
41 Transcript 29/11/17 p. 30:40-42.

*could – the moaning could have meant anything. I didn't want to bias the police into anything … It's only in retrospect now that we hear the phone call, hear what has happened, that the moaning does take on a different aspect, but at the time it meant nothing*".[42]

53. Mr Cogley did not have an independent recollection of the call, and so he gave his evidence in retrospect, after having listened to the recording in order to prepare his statement.[43] He said it was only in hindsight that he formed the view that the noise he heard sounded like a moan.[44] However, it seems likely that Mr Cogley would have formed a similar impression at the time of the original call. Listening to the audio recording, with the words Mr Woodcroft said followed shortly thereafter by his moaning, gives an impression that he was unable to communicate.

54. Mr Cogley also pointed out that, as Mr Woodcroft was still on the line, then the police would be able to find out what he needed.[45] This, in his view, lessened the need for him to provide such information to police. However, he accepted that he couldn't be confident that Mr Woodcroft would have been able to communicate with the police operator once the call was transferred. After all, he had been unable to get further information from Mr Woodcroft. Nonetheless, he maintained "*I handled it the way I would have handled any other call in the same situation*".[46]

55. Telstra's Triple Zero Policy[47], as Mr Cogley correctly identified, requires its operators to "clearly and simply state the facts" and not to offer judgments or opinions. However, Mr Cogley did not do what the policy required. He did not state the fact that Mr Woodcroft had spoken during the call, or the fact that Mr Woodcroft had moaned.

56. In considering the appropriateness of Mr Cogley's actions, I bear in mind three significant matters. First is that Mr Cogley was dealing with the call in real time, as the events were occurring. He had just 27 seconds to make an assessment and a short time thereafter to communicate information succinctly to Mr Sirone.

42 Transcript 29/11/17 p. 36:39-50; p. 37:1-8, 27-32.
43 Transcript 29/11/17 p. 38: 25-50; p. 39: 1-7.
44 Transcript 29/11/17 p. 41: 26-46.
45 Transcript 29/11/17 p. 31:11-24.
46 Transcript 29/11/17 p. 34:13-17.
47 There is a non-publication order over the contents of this policy

The recording of the call was played several times during the inquest, which also had the benefit of background information about Mr Woodcroft; Mr Cogley did not have that advantage.

57. Second is that Mr Sirone says he heard Mr Woodcroft moan at the end of the call, which led him to think that there was a concern.[48] This cannot be heard on the audio recording, although he was confident he heard it.[49] In that light, Mr Cogley's failure to mention this fact is of less significance.

58. Third is that Telstra has, in light of matters raised during this inquest, prepared a draft amendment to its Triple Zero Policy.[50] This draws attention to the situation where a caller is unable to speak, and prompts an operator as to what information should be provided to Police, including any words said by the caller and other noises such as moaning. This provides greater guidance to operators than was available to Mr Cogley at the time.

59. However, Mr Cogley's omissions contributed to a dilution of the information, as it passed along the chain of communication from Telstra to the responding officers. While the information he conveyed to Police was adequate, not all of the important details were communicated. This, in my view, contributed to the fact that police officers responding to the call treated it with less urgency than they otherwise would, if they had known all relevant details.

## *Was the CAD message appropriate?*

60. Although Mr Woodcroft did not speak to Mr Sirone, the CLI information (Mr Woodcroft's name, telephone number and address) was known, having been provided electronically by Telstra. After Mr Sirone attempted to call Mr Woodcroft back, he completed the CAD message, as follows[51]

*Priority 3 - Concern for Welfare (017)*

*FROM CLI - TURANGA,, LOT UN 1707/1 PHILLIP ST, COPE ST, WATERLOO, SYDNEY (LGA) 2017*

48 Transcript 29/11/17 p. 45: 6-15.
49 Transcript 29/11/17 p. 45:33-38, 46-47.
50 The non-publication order was extended to cover the contents of this draft policy
51 Incident log print, 1/14A/181

*NIL REQ FOR POL - TELSTRA COULD HEAR NOISE IN THE BACKGROUND - ON TRANSFER NIL RESPONSE BUT COULD HEAR TALKING IN THE BACKGROUND - JUST B4 TERMINATED CALL COULD HEAR A MOAN - UNABLE TO CALL BACK AS LAND LINE OPEN - NFI - CHKS OTW.*

61. Three aspects of this CAD message are significant. First, the message stated "nil req for pol" (nil request for police) although it required a priority 3 response. Mr Sirone did not accept that there was any contradiction between saying there was a concern for welfare on the one hand, but there was nil request for police on the other.[52] However, the description "nil req for pol" contributed to an impression that the incident was of low importance.

62. Second, the reference to "talking in the background" does not reflect what Mr Sirone heard, which he believed to be a television in the background and which turned out to be a radio.[53] As Mr Sirone agreed, the reference to talking suggests that another person was present, albeit unaware of the call, and it again tends to lessen the seriousness of the incident.[54]

63. Third, the reference to a "moan" was, to some extent, ambiguous. Mr Sirone said that he thought the person on the line was unable to communicate, he was concerned for their welfare and they needed assistance.[55] This impression was not conveyed. Ms Kudric thought it could be a couple engaged in an intimate moment; Senior Constable Moroney thought it could be an intoxicated or drug-affected person, which was a frequent occurrence.[56]

64. As a whole, while the details of the CAD message were accurate, the three matters referred to above were potentially misleading. The terms of the CAD message also contributed to a dilution of the information communicated to the responding police, and gave the impression that it was of less urgency, as was reflected in Ms Kudric's evidence.

52 Transcript 29/11/17 p. 49:29-32.
53 See Cst Field, Transcript 30/11/17 p. 55:37
54 Transcript 29/11/17 p. 51:26-37.
55 Transcript 29/11/17 p. 54:30-49.
56 Transcript 29/11/17 p82:13

## *Was the incident broadcast and monitored adequately?*

65. Ms Kudric initially broadcast the incident message promptly at 4.37:50am, which was about 90 seconds after she first received it. However, as she accepted in evidence, she did not continue to broadcast the message as frequently as she was required pursuant to the SOPs.

66. Her computer screen did provide a visual prompt, displaying messages in yellow where they have not been broadcast as frequently as required.[57] Despite that prompt, she did not re-broadcast the message until 5.09am, some 30 minutes after the first broadcast, by which time the SOPs (as then in force) required her to escalate the incident to the supervisor at the Local Area Command.[58]

67. By way of explanation, Ms Kudric recalled that she was busy with another job at Leichhardt, and was attempting to find an address. However, a close examination of the timeline of broadcasts provided by Police shows that a request was not made to check this address until 4.51am, almost 15 minutes after the broadcast.[59] The SOPs required Ms Kudric to broadcast the message two further times over that period. The evidence revealed no reason why Ms Kudric was unable to re-broadcast the message. It is likely that at least part of her reason for not doing so was because she formed the impression that the incident was of lower priority.

68. It is probable that Ms Kudric's failure to broadcast the incident as frequently as required also contributed to the responding officers considering it to be of less importance. Had they been reminded of the outstanding job more frequently, it seems likely they would have responded. To her credit, Ms Kudric frankly admitted that she had not done what the policy required of her.[60]

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[57] Transcript 29/11/17 p80:26

[58] The SOPs now require escalation after 60 minutes. Note that there was no visual prompt regarding this deadline for escalation - Transcript 29/11/17 p82:20

[59] Brief 1/8C/98, see Transcript 30/11/17 p

[60] Transcript 29/11/17 p. 78:33, p79:8

## *Was the response by Redfern Local Area Command appropriate?*

69. As noted above, it took approximately 3 ¾ hours for police at Redfern Local Area Command to respond to Mr Woodcroft's call. This was an inadequate response.

70. Senior Constable Morony and Senior Constable Sanders were at Redfern station when the incident relating to Mr Woodcroft was broadcast by Ms Kudric. They had previously attended an urgent job, but were updating information on the COPS computer system at the time the job came in. Senior Constable Morony asked her colleague if she wanted to attend the job, and Senior Constable Sanders said yes. However, Senior Constable Sanders continued to work on the computer and so eventually Senior Constable Morony logged back on.[61] This is supported by an audit of the COPS computer.[62]

71. Both officers had attended similar CLI jobs numerous times in the past, and on each occasion these had been a "false alarm".[63] The impression that the job was of low importance was fortified by the reference to talking and other noises in the background.[64] This influenced their approach to this incident, and led to a degree of complacency. The incident was given a priority 3. This required a non-urgent response, but it still required officers to attend as soon as possible, if no priority 1 or 2 jobs were outstanding.[65] They did not do so.

72. Unfortunately, as noted above, a second priority 3 job was broadcast at 4.56am, relating to a woman shouting at security in Walker Street, Redfern. Officers Morony and Sanders did not immediately respond to that job either, but their supervisor Sergeant Botha asked them to attend that job, which they did at 5.10am.

73. Walker Street bisects Phillip Street, where Mr Woodcroft's home was situated. It would clearly have been possible for the officers to attend both jobs, given their

[61] Transcript 30/11/17 p. 6-10; p27-29

[62] Brief 1/8D/102, 110

[63] Transcript 29/11/17 p. 11:32; p.28:17

[64] Transcript 29/11/17 p. 27:27

[65] See above at [23]

proximity. They did not do so. They returned to Redfern police station at about 5.25am. At that point they were approaching the end of their shift, and they prioritised other tasks they needed to complete. They did not draw the attention of the oncoming shift to the outstanding job. This is not something they would ordinarily do, given that outstanding CAD messages are displayed on a monitor in the station and also on computers used by police.

74. I find that there was an opportunity for Senior Constable Morony and Senior Constable Sanders to attend Mr Woodcroft's home, either before or after attending the Walker Street job. It was remiss of them not to do so. To their credit, however, they each frankly accepted that it would have been possible for them to attend the job, and they expressed regret for this.[66]

75. Senior Constable Botha and Probationary Constable Field were the oncoming shift. Senior Constable Botha acknowledged the outstanding job relating to Mr Woodcroft shortly after his arrival, at 6.11am. Senior Constable Botha felt it was not of an urgent nature due to the nature of the CAD message, but he intended to attend the job in any event.[67] As noted above, he was unable to attend the job due to an urgent priority 2 job that was broadcast at 6.20am. There was an opportunity for them to attend after returning from that job at 7am, which Senior Constable Botha accepted. Instead, they decided to attend the morning meeting at 7.25am. That meeting was one which police are expected to attend. I accept that that decision was not unreasonable in the circumstances.

76. Accordingly, I find that there was an opportunity for police from Redfern Local Area Command to attend the incident before they eventually did at about 8.14am. The fact that the call was described as a CLI call lead to an impression that it was of low importance, and this was compounded by the missing information and the terminology used in the CAD which I have described above. Another factor that contributed to this impression was the fact that the involved officers' experience of CLI calls was that they were never "genuine" calls.

77. I find that the response of Redfern Local Area Command to this incident was not adequate.

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[66] Transcript 30/11/17 p. 21:3-9, p. 30:13;

[67] Transcript 30/11/17 p. 46:42

## Is it necessary or desirable to make a recommendation?

78. Two potential areas for recommendations arose in the course of the inquest. The first was the fact that the information received by Telstra and PoliceLink was "diluted" as it passed through the hands of Mr Cogley, Mr Sirone and Ms Kudric en route to the responding police. Each of the responding police said they were misled by the information in the message, and would have viewed the incident differently if they had known details such as the fact that Mr Woodcroft had spoken or that the talking was believed to be a television rather than a person. This is supportive of recommendations relating to the policy about what information should be supplied by Telstra to emergency services, and also of the possibility of making audio recordings available to the emergency services. These are discussed below.

79. A second issue was the potential use of a Triple Zero caller's call history. Mr Woodcroft's previous 11 calls to the emergency services were not known to any of the people who responded to Mr Woodcroft's final call. When asked whether this knowledge would have had any impact on the way that they responded to the incident, almost every witness stated that they would have responded differently.

80. Mr Sirone would have been concerned Mr Woodcroft was having another medical emergency, and would have linked in NSW Ambulance.[68] Ms Kudric would have changed the priority and would also have contacted NSW Ambulance. Officers Morony, Sanders and Botha all stated they would have attended the job urgently if they had known this information.[69] Only Mr Cogley believed he would have handled the call in the same way, which is perhaps reflective of his understanding of his employer's policy, to treat every call on its merits.[70]

81. In my view, the responses of the other witnesses were compelling. Their evidence is supportive of a recommendation that, in an appropriate case,

[68] Transcript 29/11/17 p. 58:23-37

[69] Transcript 30/11/17 p. 13:4, 31:36, 47:18; see also Field at 30/11/17 p. 54:4

70 Transcript 29/11/17 p. 35:30-40.

information as to a caller's previous history should be made available to responding police. This is explored further below.

82. The inquest had the benefit of evidence from three senior witnesses, who between them have a substantial experience and expertise in the handling of Triple Zero calls in NSW. Christopher Beatson is the Director of PoliceLink Command within NSW Police Force. Jamie Vernon is Assistant Commissioner of NSW Ambulance, with responsibility for the management of Triple Zero and 131 emergency calls in NSW. Jane Elkington is the Emergency Answer Point General Manager for Telstra. Their evidence was extremely helpful in crystallising the issues and identifying the competing considerations.

83. After the conclusion of the factual evidence, those witnesses were posed a series of questions regarding possible areas for recommendation. They convened a joint conference to discuss those questions, and the minutes of that conference were tendered at the inquest.[71] They also gave oral evidence to the inquest on 8 March 2018. Following that evidence, the interested parties were given an opportunity to respond to possible recommendations. The following issues were canvassed.

## *Information provided by Telstra to the police*

84. Mr Beatson confirmed that the expectation was that Telstra would provide PoliceLink with an accurate account of what was heard during the call. Ms Elkington believed that Telstra's policies already provided for this, and in her view Telstra was doing this already. However, as I have noted above, the information Mr Cogley told police was not complete.

85. Ms Elkington explained that Telstra advises their operators not to offer opinions or judgments about the call, due to the risk that an operator may mislead emergency services about whether a call is genuine. Mr Beatson identified a "grey area", where background noises or things said cannot be communicated verbatim. In those circumstances, the operator would need to give their impression of what was heard.

[71] Exhibit 2

86. Prior to giving her evidence, Ms Elkington had reviewed the relevant policy and produced a draft revised policy concerning information that Telstra operators should provide to the emergency services.[72] It provides more specific guidance on what information should be provided to the emergency service organisation, underlines the need of accuracy, and picks up on some of the details that were missed in Mr Woodcroft's call. Furthermore, a draft work instruction has been produced, which will form the basis of training that can be provided to operators very quickly if adopted.

87. In light of this, in my view it is not necessary or desirable for me to make a formal recommendation about the information that Telstra should provide to the emergency services. I do, however, endorse the draft policy, and I would expect Telstra to bring the policy into effect, with appropriate training, at the earliest opportunity.

## *Transfer of the audio recording*

88. A central issue in the inquest was the "dilution" of information. Mr Sirone and Ms Kudric did not hear what Mr Cogley heard. Had they done so, it is probable that their responses would have been different, which in turn may have affected the actions of responding police.

89. A possible solution that avoids dilution of information would be for the audio recording itself, during which only Telstra and the caller are on the line, to be made available to the emergency services. Such an option would only be exercised where appropriate, for example where the caller cannot themselves communicate, where there are indistinct background noises or the words said by the caller are unclear.

90. It was pointed out by Mr Beatson and Mr Vernon that, in the vast majority of cases, this option is not necessary. In that respect, the circumstances of Mr Woodcroft's case is an "outlier" and does not reflect the requirements of most Triple Zero calls.[73] Mr Vernon said that NSW Ambulance does sometimes

[72] The policy is subject to a non-publication order

[73] NSW Ambulance submissions [10]

contact Telstra, to clarify what was said, but this was rare; NSW Ambulance have high degree of confidence in the information provided to them by Telstra.

91. Mr Beatson also raised a concern that this option would inject delay into the process, where the priority was to get police to respond to the incident.[74] It was also unnecessary if Telstra provided sufficient information.[75] Submissions from NSW Police Force further raised a concern that this option would create a situation where police operators would have to make a "judgment call", whether or not to listen to the audio, the implication being that it would expose police to criticism or liability if the option was not exercised.

92. Ms Elkington explained that the current technology would not allow for transmission of audio recordings in real time.[76] Audio recordings of Telstra calls are all stored in the ECLIPS database. However, that recording does not complete until the call is wholly transferred to an emergency service. At present, audio could not be transferred until after that time, and at present this would require a manual request. Ms Elkington noted that there was an existing "workaround", whereby if an emergency service wanted access to the audio recording, a specific request could be made and it could be either reviewed by the supervisor or played via the phone line.[77] There are similar policies and practices already in place which allow for transfer of sound files between NSW Ambulance and NSW Police Force.[78]

93. Telstra, in closing submissions, noted that as an organisation it is open and committed to improving the Triple Zero service. NSW Ambulance made a similar submission, and I have no doubt NSW Police Force adopt a similar approach. Telstra itself maintains a "roadmap" of possible future technological advances. Ms Elkington in evidence suggested this option might be added to that roadmap.

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[74] Exhibit 2 at p3; see also NSW Ambulance submissions [10].

[75] Exhibit 2 at p4

[76] Telstra submissions [4(c)]

[77] Exhibit 2 at p4

[78] PD 2017-001 *Sharing Sound Filed With Emergency and Rescue Services* and PD 2017-002 *Joint Communications between NSW Ambulance and New South Wales Police Force*

94. However, there are barriers to introducing new technologies. One obvious barrier is funding, which on Telstra's part is determined at a Federal level.[79] I cannot make a recommendation as to funding, but nor should funding considerations preclude a recommendation where it is necessary or desirable to be made.

95. Another is the fact that, as Triple Zero is a national service, any changes or improvements must be nationally coordinated, to ensure viability and consistency between the States.[80] For those reasons, Telstra urged that any recommendation be framed as an issue to be raised at the National Emergency Communications Working Group.[81] I accept that submission.

96. In my view, despite the concerns and barriers raised, this is an improvement which is supported by the evidence and which should be explored further.

## *Sharing a caller's Triple Zero history*

97. As noted above, the response of the witnesses in this case to the information that Mr Woodcroft had frequently phoned Triple Zero was striking. Had they known this fact, it is probable that they would have behaved differently. Accordingly, the inquest explored whether such information could be made available to the emergency services.

98. I should note that NSW Ambulance already has a project that deals with people who frequently call Triple Zero, called the Frequent User Management program. That provides casework assistance to individuals to frequently call Triple Zero, with the intention of putting in place services that will reduce the reliance on ambulances. Mr Woodcroft did not meet the definition of a "frequent user", being a person who calls 10 times in 6 months.

99. There were five considerations raised by the interested parties that weigh against sharing information about a caller's Triple Zero history. The first is the fact that it would not be of any use for an emergency service to know a caller's history in the vast majority of cases. Mr Beatson doubted that it would change the way police

[79] Telstra submissions [8(a)]; NSW Police Force submissions [9], NSW Ambulance submissions [9]

[80] Telstra submissions [8(c)]; see also NSW Ambulance submissions [12], which refers to the Federal Department of Communications and the Arts

[81] Elkington 2/69A/463.6 [32]

respond to an incident in any event. This was in contrast to the balance of the witness evidence. He was also concerned that requiring emergency services to review such information could delay the response.[82] Of course, it is not suggested that such information must be reviewed in every case, but only where the caller does not communicate and there is uncertainty about the need for attendance.

100. The second is the current incompatibility between the information held by the different organisations. Telstra holds information about all calls received via Triple Zero on its ECLIPS database.[83] It records information according to the CLI information, being the phone number and the owner of the service, and also records the emergency service to which the call was diverted. NSW Police Force records names and locations of interest, and also warnings or firearms information. NSW Ambulance is concerned with locations only, as the identity of the caller is of less significance. In addition, NSW Ambulance records are held in an accessible form for only 2 months.[84]

101. NSW Ambulance pointed out that information it has about a location may not be of any use if supplied to police. For example, some locations - such as nursing homes or sporting venues - make a large number of Triple Zero calls, most of which would be irrelevant to police. However, in the present case, the records relating to Mr Woodcroft's address, which was known to NSW Ambulance, would have been very significant to police.

102. The third is that providing a caller's history has the potential to mislead. For example a caller calls Triple Zero 10 times for an ambulance, and then on the 11th occasion calls Triple Zero because there has been a burglary; or a caller who calls 10 times accidently and then makes a genuine emergency call on the 11th occasion. This is a clear risk, but it is not suggested that a caller's previous history alone should determine the response by emergency services. Instead, it should inform the responding emergency service of a known history where the

[82] Exhibit 2 p6

[83] Telstra submissions [4(c)]

[84] Exhibit 2 p8

caller is unable to articulate why they need help. A careful development of policy would be required to ensure the information is used only where necessary.

103. The fourth is privacy, which would also potentially affect the sharing of audio recordings.[85] In helpful submissions, NSW Ambulance and Telstra have described the impact of privacy considerations on this proposal.[86] Sharing a caller's medical history between different services would inevitably risk exposing their private health information. There could be highly undesirable consequences, for example: disclosing health information about a location that is not about that caller, but about another person;[87] or disclosing health information about a person to police that could affect the manner in which the police deal with that person in the future.

104. The *Health Records and Information Privacy Act 2002 (NSW)*, and equivalent Commonwealth legislation, operate to restrict the use of private health records. However, NSW Ambulance submits that the Privacy Commissioner may in an appropriate case issue a guideline (with the approval of the Minister) to determine the use of private health information. It may be therefore be possible to overcome the privacy concerns, and devise policy on sharing a Triple Zero call history in circumstances where it is required.

105. The fifth is the fact that current technology does not exist to allow ready sharing of information. Any change would encounter the problems I have described above.

106. In all, I accept that there are significant barriers to progressing this option. The considerations raised above demonstrate that any change in policy must be carefully calibrated to avoid undesirable consequences, and should only progress if it can be justified. While the circumstances of Mr Woodcroft's death are not ordinary, I am not satisfied that they are so unique that they will not be replicated. It is clear to me that it is worth exploring this option further. I therefore intend to make a recommendation that the interested parties raise the option of sharing a Triple Zero caller's history in the appropriate forum.

[85] Telstra submissions [8(b)(iv)]

[86] Telstra submissions [8(b)]; NSW Ambulance submissions [14]

[87] NSW Ambulance submissions at [20]

## Conclusion

107. Mr Woodcroft's death occurred in circumstances where the response by the emergency services was not adequate. In light of the seriousness of his medical condition, it is not known whether an earlier response would have prevented his death. However, areas for improvement can be identified, and should be explored, to ensure that people who contact emergency services in similar circumstances in the future are provided an optimal response.

108. I thank the office in charge of the investigation, Detective Sergeant David Gates. I thank my counsel assisting Mr Jake Harris for the enormous amount of work he put into assisting me aided by his instructing solicitors, Ms Joanna Mooney and Ms Clare Skinner.

109. I offer my heartfelt condolences to Mr Woodcroft's family. They obviously cared for him and loved him very much. Despite how painful it must have been, I hope that this inquest has answered some of their questions.

110. I make the following findings and recommendations.

## Findings

Pursuant to s. 81 of the *Coroners Act 2009*, I make the following findings.

### *The identity of the deceased*

The person who died was Peter Bernard Woodcroft

### *Date of death*

Mr Woodcroft died on 30 June 2016

### *Place of death*

Mr Woodcroft died at Waterloo, NSW

### *Cause of death*

Heart failure or arrhythmia, secondary to ischaemic heart disease.

## *Manner of death*

Mr Woodcroft suffered a medical emergency and phoned Triple Zero. He was unable to tell the operator what he needed. Mr Woodcroft died before police attended his home. His death was from natural causes in the course of police operations.

# Recommendations

Pursuant to s 82 of the *Coroners Act 2009*, I make the following recommendations.

*To the Commissioner of NSW Police Force, the Commissioner of NSW Ambulance and Telstra Corporation Limited:*

> *I recommend tabling for consideration at the next National Emergency Communications Working Group (scheduled for 23 May 2018) the following agenda item:*
>
> *The development of a system that would allow the following information to be readily accessed by, or provided to, the relevant Emergency Services Operator (ESO), where this is permitted by privacy legislation:*
>
> *(a) the audio recording of Triple Zero calls that is captured by Telstra;*
> *(b) a caller's Triple Zero call history, as held by Telstra; and*
> *(c) a location's previous Triple Zero call history, as held by each ESO.*

111. I close this inquest.

**Teresa O'Sullivan**
Deputy State Coroner
Glebe

**Date:** 2 May 2018